A
CHILDREN'S RESIDENTIAL CENTRE
IN THE
DUBLIN SOUTH CITY COMMUNITY CARE AREA
OF THE
HSE SOUTH WESTERN AREA

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1 Executive summary

The Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the Dublin South City Community Care Area of the Health Services Executive South Western Area (HSESWA) in October 2005. This inspection followed an earlier unannounced inspection in February 2004. At the time of the earlier inspection there were significant areas of concern. The staff team had become preoccupied with internal tensions and disagreements to the detriment of the service provided to the young people. This had reached crisis point towards the end of 2003. The centre had closed temporarily and this caused considerable distress and disruption in the lives of the young people. Inspectors were concerned that managers of the [then] South Western Area Health Board were either not sufficiently aware or had failed to appreciate the scale of the difficulties being experienced within the staff team and had not taken appropriate action to prevent the crisis that led to the temporary closure of the unit. Despite evidence of good practice in many aspects of the care provided to the young people, the centre was failing and urgent remedial action was required. The purpose of this inspection was to gauge the degree to which the service provided to the young people had improved since the last inspection and the progress made in addressing some of the difficulties that led to the temporary closure of the unit in 2003.

Inspectors found that there had been major improvements to the service provided to the young people in the centre. There were important changes in the internal management of the unit and in care practice. The centre manager had won the confidence and respect of the team members and the team had united behind her. The manager was providing regular formal supervision to all team members and was, in turn, receiving regular formal supervision from the external line manager.

The improvement in the service provided to the young people was particularly apparent in behaviour management. The general approach was better and inspectors were particularly impressed with the manner in which some members of the care staff team dealt with some incidents of very high risk behaviour. Practice in relation to health issues was also good but inspectors were concerned to learn that one young person was not receiving sufficient support with her education. The approach to sharing information with the young people, consulting with them and resolution of their complaints within the unit was of a good standard.

The monitoring officer for HSESWA had visited the centre regularly. She had done some work with the staff team after the temporary closure of the unit to help them to become refocused on their primary task of caring for the young people. Her intervention was seen by the manager and staff team as significant in bringing about necessary changes in the centre.

Changes in practice within the centre had improved the service provided to the young people. Despite this, organisational weaknesses within the South Western Area were apparent and these undermined the improvements achieved in practice within the centre. The first of these weaknesses concerned the failure of the Area to translate policy into practice. HSESWA's policy was that children under twelve years in its care should be placed with families. One of the young people had been in residential care for twelve years, from the age of three. The other young person had spent five

years in the centre and was under twelve at the time of inspection. Inspectors were given no satisfactory explanation why these particular children were not placed in foster care during a time when other children of similar age and with a similar profile were being placed in foster care by the Eastern Health Board and its successor organisations, the South Western Area Health Board and HSESWA.

Organisational weakness was also apparent in the HSESWA's failure to satisfactorily implement a change management process. HSESWA had decided to reconfigure its residential care service for children with the commendable aim of providing a service more reflective of the diverse needs of children in its care. As part of this 'residential change process' a decision was taken to close the unit on July 1st 2005. The young people were told about this in April. They were both extremely distressed and their confidence in the capacity of HSESWA to provide a home for them was seriously undermined. By the time of the inspection in November, the centre remained open but no one was in a position to tell the young people how long it would remain so or what was to happen after it closed. There were no firm plans for the future care of the young people.

HSESWA lacked the capacity to respond adequately to the young people's complaints. One young person made a complaint about the temporary closure of the unit and this was never resolved. The other young person made a complaint about the planned closure of the unit in July. There was a delay of over six weeks before a response was given to this complaint. The response acknowledged the young person's feelings about the decision and promised to keep the young person informed of developments. This, however, did not resolve the matter and the young person was clearly still unhappy with the situation.

There were safety issues in relation to the premises at the time of the last inspection that had not been addressed by the time of this one, 19 months later. The standard of accommodation was unacceptable.

Some of the recommendations of the last inspection report had been implemented but these had mainly to do with issues internal to the centre. The centre manager and the care staff team are commended for the considerable progress they have achieved. However, over one third of the recommendations that required a response from the wider HSESWA organisation had not been addressed. The failure of the HSESWA to translate policy into practice, to manage change satisfactorily, to respond to the complaints of young people in its care, to provide them with a satisfactory standard of accommodation and to implement inspection recommendations all point to an overall failure to deliver a child centred service.

2. Introduction

The Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in Dublin South City Community Care Area of the Health Services Executive South Western Area (HSESWA) on the 16th and 17th November 2005 under Section 69 of the Child Care Act 1991. The inspection was conducted by Michael McNamara (support inspector) and Andrew Fagan (lead inspector).

2.1 Methodology

During the inspection, inspectors interviewed one young person, the centre manager, two full-time and one part-time members of the care staff team, an agency worker, two social workers and the monitoring officer for the HSESWA. A meeting was held with the general manager, child care manager and principal social worker for Dublin South City. Telephone interviews were conducted with a teacher and school principal. Inspectors spent some time observing practice in the centre.

Inspectors examined documentation relating to the staff, the young people and the centre. Completed questionnaires were returned by two social workers and one teacher in advance of the inspection fieldwork.

2.2 Acknowledgements

Inspectors wish to acknowledge the co-operation and assistance of the young people, parents, Dublin South City Community Care Area managers and staff and others who contributed to the work of the inspection.

3. Setting the scene:

3.1 Background

The centre was established by the [then] Eastern Health Board ten years prior to this inspection. It was set up initially to look after young people from a larger institution that was closing down. The centre had previously been inspected in February 2004 (Report 102).

At the time of inspection a plan for the reconfiguration of residential services in HSE SWA was in the final stages of preparation. The aim of this 'residential change project' was to make the service more responsive to the range of needs of the young people entering it by maximising the use of existing resources.

3.2 Data on young people

YOUNG PERSON	*AGE*	*LEGAL STATUS*	*LENGTH OF TIME IN THE CENTRE*	*PREVIOUS PLACEMENT*
#1 (male)	15 years	Fit Person Order	10 years	One residential placement
#2 (female)	11 years	Care Order	5 years	Four foster care placements

4. Standards: the findings

4.1 Statement of purpose and function

The centre has a clear written statement of purpose and function which accurately describes what the centre sets out to do with children and the manner in which that is provided. The statement is available, accessible and understood.

The 2004 inspection report recommended that the centre have a statement of purpose and function. There was one at the time of this inspection. It was short and lacked detail. It did not, for instance, specify an age range or the number of young people the centre could accommodate. The purpose of the centre was under review at the time of this inspection. There was a lack of clear information available to both staff and young people. The uncertainty thus created was unsettling for the young people. It made it impossible for staff to plan ahead. It was unhelpful to both staff and young people.

Recommendation

1. **The local health office manager with regional responsibility for child care should ensure that an early decision is reached in relation to the future purpose and function of the centre and that this is communicated to the young people and staff.**

4.2 Management and care staffing

The centre is effectively managed, and care staff are organised to deliver the best possible care for young people. There are appropriate external management and monitoring arrangements in place.

4.2.1 Management

The 2004 inspection report recommended changes in the internal and external management of the centre and such changes had occurred with positive consequences.

There had been a change in personnel in the internal management of the unit. The manager and team addressed issues that had caused friction between them. These two changes had brought about a situation where the team had come together under the leadership of the centre manager. Differences between team members did occur from time to time but these were handled in a manner that did not threaten team cohesion. This situation was in marked contrast to that which obtained at the time of the last inspection. The team and, in particular, the centre manager are commended for the progress they have achieved. It required perseverance in the face of adversity.

There were also changes in the external management of the unit. A newly appointed external line manager, the principal social worker for Dublin South City, was providing the centre manager with regular, formal supervision. His input was experienced by the centre manager as informed and helpful.

4.2.2 Care staffing

At the time of the last inspection the [then] South Western Area Health Board did not provide full information on checks carried out on staff at the centre. The report recommended that Garda clearance and three references be obtained on all staff prior to commencement of employment. It was highly unsatisfactory that HSESWA was unable to provide inspectors with this information during this inspection. The centre manager stated that she was unable to access this information. She was not, therefore, in a position to satisfy herself that the required checks had been carried out, as required by the National Standards for Children's Residential Centres.

Extensive use was made of agency staff in the centre. The centre manager acted on the assumption that the agency had taken up references and obtained Garda clearances. Inspectors do not have information to the contrary. However, managers should be in a position to satisfy themselves that the staff employed to work in the centres they run have been through the required checks.

Practice in relation to staff checks was not acceptable.

The extensive use of agency staff led to other difficulties. The centre manager estimated that they covered approximately five day-long shifts per week. Some agency workers were undoubtedly of high calibre. The centre manager tried hard to ensure that the same ones were used as often as possible to provide continuity of care to the young people. However, this was not always possible and sometimes the young people were looked after by people they did not know. They objected to this and one of them made a complaint about it. Even where the same core group of agency workers were used, the situation was still not satisfactory. The agency workers were not fully integrated in the same team. They did not attend team meetings and they did not have formal supervision. On one of the days of the inspection there was no full time member of staff on shift. A relief worker was working with an agency worker. It was not a satisfactory situation and, given that staff members sometimes had to deal with high risk behaviours, it could not be considered safe practice.

Recommendations

2. **The general manager should ensure that the required checks are carried out on all staff employed in the centre and that information relating to these checks is available to the centre manager.**

3. **The general manager should ensure that there are sufficient staff employed at the centre so as to reduce and, in time, eliminate the use of agency workers.**

4.2.3 Supervision and support

The 2004 inspection report recommended that the manager ensure that all staff receive regular formal supervision. The centre manager assumed personal responsibility for this, whereas it had been shared with a deputy. This initiative had helped to bring the team together. The recommendation was implemented and the manager is commended for this.

4.2.4 Training and development

After the temporary closure of the centre in November 2003, the monitoring officer had undertaken a specific piece of work with the staff team to help them to refocus on their primary task of caring for the young person. A number of those interviewed by inspectors identified this input as significant in the changes that had come about in the centre. Specifically, they identified that the work of the monitoring officer helped them to realise that their pre-occupation with team issues led to a deterioration in the service provided to the young people. The monitoring officer is commended for this work.

4.2.5 Administrative files

There were good systems of administrative recording in place and the records were maintained to a good standard.

4.2.6 Notification of significant events

The social workers interviewed by inspectors stated that they were kept informed of significant events involving the young people. The monitoring officer was not sure that all events were notified to her. She discussed this with the centre manager. The difficulty appeared to revolve around the definition of a significant event. The monitoring officer favoured a broad definition and the matter was resolved to her satisfaction.

4.2.7 Register

A register was maintained of young people in the centre.

4.3 Monitoring

The Health Services Executive, for the purpose of satisfying itself that the Child Care Regulations 5 – 16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the Health Board, to monitor statutory and non-statutory children's residential centres.

The 2004 inspection report contained two recommendations in relation to this standard. The first of these was that action should be taken in response to issues raised by the monitoring officer. This was still a matter of concern at the time of this inspection. For example, the concerns raised by the monitoring officer in relation to fire safety at the centre before the last inspection had still not been addressed by the time of this one.

The second was that the monitoring officer should not be asked to assume responsibilities incompatible with her monitoring role. This concerned the work undertaken by the monitoring officer with the staff team that is discussed in section 4.2.4 of this report. This work was clearly of a high standard and helpful to the team in bringing about improvements in the service provided to the young people. The concern expressed in the last report, however, was that by becoming directly involved

in the running of the centre, the monitoring officer was precluded, for a time, from giving a dispassionate assessment of the centre's compliance with statutory requirements.

The two matters are related. The evidence of this and other inspections is that the role of the monitoring officer is not properly defined and understood in HSESWA. On the one hand, the monitoring officer was asked to undertake a piece of work that appeared to be incompatible with her role. On the other, when the monitoring officer pointed to a failure to meet a statutory requirement, this was not acted on.

Monitoring of standards in children's residential centre is required under the 1995 Child Care Regulations. It is also an important safeguard for young people in care. The monitoring officer visited the centre regularly and was well informed about care practices and related matters. However, her interventions could not be considered an effective safeguard if the recommendations she made could be ignored as they were in relation to the fire safety issue in the centre.

Recommendation

4. **The local health officer manager with regional responsibility for child care should ensure that monitoring of standards in the centre provides an effective safeguard for the young people placed there by ensuring that the role of the monitoring officer is defined and understood within HSESWA.**

4.4 Children's rights

The rights of young people are reflected in all centre policies and care practices. Young people and their parents are informed of their rights by supervising social workers and centre staff.

4.4.1 Access to information

The young people were allowed to access their care files. The staff team were also proactive in accessing information about advocacy and services helpful to the young people in exercising their rights. For example, contact had been initiated with the Irish Association for Young People in Care (IAYPIC) and the Ombudsman for Children on behalf of the young people.

Practice in relation to access to information was good.

4.4.2 Consultation

Care staff consulted with the young people in relation to day to day issues but the 2004 inspection report found that there was a lack of consultation in relation to other matters and made a recommendation that adequate arrangements be put in place for consulting with the young people. The shortcomings, however, were again apparent during this inspection. The young people were not asked for their views about possible closure of the centre. It was announced to them after the decision was made.

Recommendation

5. **The local health officer manager with regional responsibility for child care should ensure that young people are consulted on issues to do with their lives and care and not merely informed of decisions made.**

4.4.3 Complaints Procedures

The 2004 inspection report made two recommendations in relation to complaints and neither was implemented. The first recommendation was that outstanding complaints should be resolved. One such complaint referred to the temporary closure of the unit in November 2003. It had never been resolved. The second recommendation was that there should be a complaints procedure for young people in care.

Practice in relation to complaints that could not be resolved within the centre was very poor. One young person wrote to complain about the decision to close the centre. She initially received no response to her complaint. Contact was made with both IAYPIC and the office of the Ombudsman for Children. After the intervention of these organisations the young person received a response to her complaint, approximately seven weeks after her original letter of complaint. The response was to the effect that her feelings in relation to the matter were understood and that she would be kept informed of future developments. This did not constitute a resolution of the complaint and the young person was clearly still unhappy about the matter at the time of inspection. Her initial anger had given way to resignation. She had no confidence that her wishes for her future would be heard and acted on. This is a very poor reflection of the capacity of HSESWA to hear and respond to the wishes of the most vulnerable children in its care.

HSESWA's poor practice in relation to consultation and complaints requires immediate attention, no matter how pressing other priorities appear to be.

Recommendations

6. **The local health officer manager with regional responsibility for child care should take immediate steps to ensure that all outstanding complaints are resolved.**

7. **The local health officer manager with regional responsibility for child care should take immediate steps to ensure that a comprehensive and robust procedure is put in place to ensure timely resolution of young people's complaints.**

4.5 Planning for children and young people

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

4.5.1 Suitable placement and admissions

The 2004 inspection report recommended that there be no further admissions to the centre until outstanding difficulties in the management of the unit had been resolved. This recommendation was implemented. The management of the unit had improved and there had been no new admissions.

The 2004 inspection report referred to the placement of the children under 12 in the centre. The two young people in the centre at the time of this inspection had been placed there at five and six years. The policy of the [then] Eastern Health Board (EHB) was that children in its care under 12 years should be placed with a family. This policy was adopted by the South Western Area Health Board (SWAHB) and then by HSESWA. However the two children remained in the unit. During all of the time that they spent in the centre, other children of a similar age and profile were placed with families by the various agencies. Both were placed with foster carers when the centre closed temporarily in November 2003. It is difficult to escape the conclusion that foster carers were not found in response to the children's needs but were found in response to the agency's needs. Whatever the explanation, the EHB, SWAHB and HSESWA all failed to implement their policy of not placing children under 12 in residential care.

Inspectors do not underestimate the difficulty of finding foster placements for all children in need of foster care. However, it is clear that the two young people in the centre had waited much longer than other children for a foster placement and may, indeed, have waited in vain. This is not simply a question of unmet need, it is also unjust that some children have been denied the possibility of family life. HSESWA must address this issue. If children must wait for suitable placements in certain circumstances, the HSESWA must ensure equity of access so that some children do not miss out entirely.

Recommendation

8. The local health officer manager with regional responsibility for child care should ensure that the policy of placing children under 12 with families is realised in practice for all children in the care of HSESWA.

4.5.2 Statutory care plans and care plan reviews

There were two recommendations in relation to care planning and review. The first was specific to the young people in the centre and stated there should be reviews of their care plans to determine the optimal placement for each of them and that these should be pursued as a matter of priority. There were care plan reviews for each of

the young people and the option of foster care was being explored for them. This was prompted by plans to close the unit. However, it was not at all clear that foster placements would be found for either of the young people.

The second recommendation was that there should be a review of all children in residential care to determine which of them could be placed in foster care and develop a plan in relation to this. This inspection only gathered information on the two young people in the unit at the time of inspection.

4.5.3 Contact with families

Inspectors did not have the opportunity to speak with members of the young people's families during this inspection. However, there was evidence that care and social work staff worked together to ensure regular contact between the young people and members of their families. This finding is consistent with that of the previous inspection.

4.5.4 Social work role

Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the centre to whom they can confide any difficulties or concerns they have in relation to any aspect of their care.

Both of the young people in the centre had allocated social workers. The social workers visited them regularly and were working to identify suitable placements for them. Their day to day communication with care staff was good and they both confirmed that they were informed promptly of significant events involving their clients.

The two young people came from two different community care areas, the one that managed the centre and a neighbouring one, both part of HSESWA. There were tensions evident in the relationship between the latter and the centre at the time of the last inspection. A recommendation from that inspection report addressed this issue and called for clear processes of communication and clarity of roles between centre and social work staff. This recommendation had not been implemented and the tensions evident at the time of the last inspection were also apparent during this one. One such tension concerned the appropriate way to manage a young person's high risk behaviour. This is given further consideration in the next section of this report.

Another difference concerned the decision to inform the young people in April that the centre would close in July. This difference might not have arisen if the recommendation of the last inspection had been implemented. The social worker for the young person concerned, supported by her managers, was reluctant to inform him of the decision to close the unit, at least until a suitable alternative placement had been identified. However, care staff, acting on instructions from senior managers, decided that the young people had to be informed of the decision immediately. Subsequent events, that is the failure to follow through on the plan to close the centre in July or to identify suitable alternative placements for the young people, demonstrate clearly that the social worker's reservations about telling her client about plans to close the unit

were well founded. However, the real significance of the issue lies with the fact that managers within the same organisation were taking up contradictory positions on an issue of major significance to the young people in the centre. The organisation demonstrated a lack of capacity to manage change in a manner that protected the interests of the young people. This is highly regrettable. The young people were distressed initially by the decision to close the unit and on a continuing basis by the uncertainty in relation to plans for their future.

The recommendation of the last report is repeated in somewhat modified form.

Recommendation

9. The local health office manager with regional responsibility for child care should ensure that there is clarity of roles and responsibilities and clear channels of communication between all of those involved in the care of the young people in the centre.

4.5.5 Emotional and specialist support

Within the unit there was an awareness of the emotional needs of the children and these were addressed through the medium of the relationships between centre staff and the young people. Particularly significant in this regard was the role of the key workers. The key workers acted as advocates for the young people and undertook particular pieces of work with them. For example, they worked with the young people in compiling life story books. These were a means of helping the young people to understand events in their lives such as their admission to care. The key worker role was well developed in the centre and the work undertaken was of a high standard. The young people had confidence in their key workers as evidenced by what the young person interviewed by inspectors said about them and by what the centre records revealed about the capacity of key workers to help the young people through difficult situations.

The situation with respect to access to specialist services was far less satisfactory. As discussed elsewhere in this report, staff at the centre had to deal with some very high risk behaviour. One of the young people was generally reluctant to engage with specialist services but, under pressure of events, came to accept a need for more help than the centre or his social worker could provide for him. He was referred to a specialist service. On a first appointment, he was required to meet with four members of the team at the specialist service. He found this difficult and declined to engage with the service. This is consistent with other inspection findings that suggest that some specialist services are offered to young people in a manner that fails to facilitate their engagement. This needs to be addressed.

There were differences between centre staff and the neighbouring community care area in relation to the most appropriate way to manage high risk behaviour. The difference turned on whether a young person was appropriately placed or needed to be in a more restrictive environment. The option of providing assistance to the care staff in managing the situation had not been explored. Yet this was a recommendation of the 2004 inspection report. At the time of the last inspection, it was clear that

behaviour management posed particular challenges to the staff and the report called for access to specialist advice and consultation for them. This had not happened.

The practice of employing, or buying in on a consultancy basis, specialist staff to provide support, advice and consultation for staff of children's residential centres is well developed in many parts of the country. It enhances the capacity of the centres to care for young people with emotional and behavioural difficulties and reduces the demand for placement in high support and special care units. Given the reluctance of some young people to engage with external specialist services, as seen in this inspection, the practice of bringing in specialist expertise to build capacity within the care staff teams provides a more cost effective and appropriate response to the needs of the young people than placement in specialist units. The recommendation of the 2004 inspection report is repeated.

Another recommendation of the 2004 inspection report concerned the importance to the young people's emotional well being of continuity of care. This arose from the temporary closure of the unit in November 2003. While there had been no further temporary closures, the impact of extensive use of agency staff and the continuing uncertainty over the future of the centre has been referred to elsewhere in this report. Recommendation 3 applies.

Recommendations

10. The local health office manager with regional responsibility for child care should negotiate with providers of specialist services to ensure that these services are delivered in a manner appropriate to the needs of the young people in the centre.

11. The local health office manager with regional responsibility for child care should ensure that staff in the centre have regular access to specialist advice and consultation to assist them in their care of the young people.

4.5.6 Preparation for leaving care and aftercare support

There was a recommendation in the last inspection report that there should be policies and procedures in relation to preparation for leaving care and after care support. This had not happened. The implications of the planned closure of the centre for the young people have been considered elsewhere in this report and the relevant recommendations apply.

4.5.7 Discharges

The policies and procedures document for the centre had a section on planned discharges, as recommended in the 2004 inspection report. However, this policy could not be realised in practice as there was no definite plan in place for the care of the young people after the closure of the unit.

4.5.8 Children's care records

As was the case at the time of the last inspection, the care files of the young people were maintained to a high standard. The manager and staff of the centre are commended for this.

Care planning and review: conclusions

After the temporary closure of the unit in November 2003, the young people were given an undertaking that a home would be provided for them in the centre up until their 18th birthdays, provided this was consistent with their best interests. Within little over a year they were then informed that the centre would close without any apparent reference to their interests or their care plans. There was no consultation with the young people in advance of the decision to close the unit and the complaint made by one of the young people in relation to it was not addressed. The young people had, undoubtedly, been adversely affected by this. Those working with them recognised this but HSESWA as an agency had no response to the damage it had inflicted, however unwittingly, on the young people. The processes of care planning and change management within the residential sector ran on parallel lines rather than the former informing the latter.

An external professional who had seen one of the young people emphasised the importance of maintaining his friendships. The other young person expressed concerns to inspectors about the loss of friends, about having to move school and about loss of carers. The young people need care plans that address these issues. These care plans should then influence the future shape of residential services in HSE SWA. The uncertainty over the future care of the young people should be ended immediately. They ought to be informed that the undertaking given to them in the aftermath of the temporary closure of the centre in 2003 still applies unless and until alternative arrangements, satisfactory to them, are in place.

Recommendations

12. The social workers for the young people in the centre should review the care plans for the young people in consultation with them. The care plans should address the young people's needs for continuity of care, of education and in their friendships.

13. The local health office manager with regional responsibility for child care should ensure that the reconfiguration of the residential services in HSE SWA is compatible with the young people's care plans.

4.6 Care of young people

Care staff relate to young people in an open, positive and respectful manner. Care practices take account of young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities and leisure experiences to their peers and have opportunities to develop talents and pursue interests. Care staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

4.6.1 Individual care in group living

At the time of the last inspection, inspectors found many examples of good care practice but the quality of care had been undermined by the impact on the young people of the temporary closure of the unit. The good care practice was more apparent during this inspection, in large part because the staff team had refocused its attention on the care of the young people, as discussed elsewhere in this report. Particularly noteworthy was the close attention to the young people's needs and the encouragement of their friendships and activities outside of the centre.

This standard was well met and the staff team is commended for this.

4.6.2 Provision of food and cooking facilities

A recommendation concerning the young people having meals together, contained in the 2004 inspection report, had not been implemented. Inspectors accept that there were valid reasons for this but urge that the issue be kept under regular review.

4.6.3 Race, culture, religion, gender and disability

The young people were encouraged in the practice of their religion in accordance with their wishes and one of them attended church regularly.

There were, as at the time of the last inspection, no male staff. The young people lacked adult male role models. As with the last inspection report the HSESWA is urged to make efforts to recruit and retain male care staff.

4.6.4 Managing behaviour

Behaviour management was an area of major concern at the time of the last inspection. Significant progress had been achieved by the time of this one. The 2004 report recommended that there be written policies and procedures in relation to behaviour management, that staff receive training and that they have access to consultation in relation to it. This recommendation was implemented. There was a section of the policies and procedures document for the centre devoted to behaviour management. Staff had been trained in therapeutic crisis intervention (TCI). They particularly valued those parts of the training that related to de-escalating difficult situations, the use of life space interviews and so on. The TCI trainers were available to the staff team to consult with on particular issues.

Sanctions were used in the centre but only occasionally and moderately. Their use was monitored by the centre manager as recommended in the last inspection report.

The most significant change in the approach to behaviour management concerned the understanding of behaviour problems. These were understood at the time of this inspection as indicative of a young person's need for assistance. As discussed elsewhere in this report, inspectors found evidence of members of care staff helping the young people through periods of acute distress, often accompanied by high risk behaviour.

The manager and staff are commended for their approach to behaviour management.

4.6.5 Restraint

There had been just two restraints in the 12 months leading up to this inspection. These were notified to the social worker and monitoring officer.

4.6.6 Absence without authority

Absence without authority was an area of significant concern at the time of this inspection. One young person had 46 unauthorised absences, some for periods of up to three days. There was a high level of co-operation with An Garda Siochana in relation to these absences and regular inter agency meetings, attended by a Juvenile Liaison Officer, discussed them. They were decreasing in frequency by the time of inspection. Their occurrence has to be considered in terms of the overall care of the young person about which there were differences within the professional network as discussed in section *4.5.5* of this report. Recommendations10 and 11 apply.

The 2004 inspection report contained a recommendation that the appropriateness of the policy and procedure on unauthorised absences be reconsidered as it applied to community based children's residential centres. This had not happened and the recommendation is repeated.

Recommendation

14. The local health office manager with regional responsibility for child care should review the appropriateness of the policy and procedure on unauthorised absences for community based children's residential centres.

4.7 Safeguarding and child protection

4.7.1 Safeguarding

Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

Concern was expressed in the last report about the implications for safeguarding of some aspects of practice in the centre that had a safeguarding dimension. All of these

matters have been considered elsewhere in this report. One matter, that of staff checks, remained outstanding at the time of this inspection and recommendation 2 applies to it. The recommendation of the last report in relation to safeguarding was, despite this, substantially implemented.

Care staff interviewed during this inspection showed a good understanding of safe care practice. For example, there was an appreciation of the necessity for professional boundaries and of the responsibility of care staff to monitor each other's practice in a reasonable and unobtrusive manner.

This standard was met.

4.7.2 Child protection

There are systems in place in the centre to protect young people from abuse. Care staff are aware of and implement practices which are designed to protect young people in care.

There were three recommendations under this standard in the 2004 inspection report. These called for child protection training for centre staff, the development of child protection policies for the centre and for the centre to be given feedback on the outcome of child protection notifications sent to the child care manager.

One member of staff had done some child protection training. There was a section on child protection in the centre's policy and procedure document though it was not comprehensive. These two recommendations could only be considered to have been implemented in part. There had been no child protection notifications since the last inspection so that it was not possible to test the implementation of the third of these recommendations.

Recommendation

15. The local health office manager with regional responsibility for child care should ensure that there is a comprehensive child protection policy and procedure for the centre and that staff receive training in relation to it.

4.8 Education

All young people have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate education facilities.

The education of the young people was disrupted by the temporary closure of the centre in November 2003 and the inspection report of 2004 recommended that, when young people have to move, their education needs are given attention. This situation had not arisen in the period since the last inspection.

The centre staff had forged good links with the schools attended by the young people and they encouraged the young people to attend. One of the young people had not

been attending regularly but this related to other difficulties and did not indicate poor practice in relation to education on the part of care staff. However, inspectors were concerned to learn that measures, agreed between care staff and the teacher of one of the young people and designed to address educational deficits, had not been followed through by centre staff. This is highly unsatisfactory.

Recommendation

16. The centre manager should ensure that support for the education of the young people is given priority and that adequate arrangements are in place to ensure implementation of agreed plans.

4.9 Health

The health needs of the young people are assessed and met. They are given information and support to make age appropriate choices in relation to their health.

Practice in relation to health was good, as it was at the time of the last inspection. Centre staff were attentive to the health care needs of the young people and had good links with their general practitioner.

4.10 Premises and safety

The premises are suitable for the residential care of young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.

The standard on premises and safety was not met. The premises were unacceptable as a home for young people and from a safety perspective. This involves more than just a failure to implement recommendations of inspection reports or difficulties in maintenance. The premises conveyed a message to the young people about the priority accorded to them by HSESWA. The premises would be unacceptable as offices yet they were home to the young people.

4.10.1 Accommodation

The last inspection report recommended that the centre be redecorated. It was not. A young person pointed to the sitting room during the inspection and described it as 'filthy'. It was difficult to disagree with this. There was a badly stained carpet on the floor and an equally badly stained settee and chairs.

Recommendation

17. The general manager should ensure that the centre is redecorated and refurnished and that the young people are consulted in the choice of furniture and fittings.

4.10.2 Maintenance and repairs

The last inspection report recommended that repairs and maintenance in the centre should be carried out promptly. This was not implemented. Delays apparent at the time of the last inspection were very much in evidence during this one. This finding is consistent with findings of inspections of other children's residential centres in HSESWA and calls for a fundamental reconsideration of the approach to repairs and maintenance of these centres, as has occurred in other parts of the country. The current system does not work.

Recommendation

18. The local health office manager with regional responsibility for child care should review the approach to maintenance and repair of children's residential centres in HSESWA to ensure that the young people live in safe and well maintained homes.

4.10.3 Safety (including fire safety)

There were three recommendations under this standard in the last inspection report. Training in fire safety and first aid was recommended for centre staff but only the first part of this recommendation was implemented. The [then] SWAHB was required to undertake a safety audit and implement its recommendations. A safety audit had been carried out in 2002 and none since then so this recommendation was not implemented. Finally, SWAHB was asked for confirmation that the premises complied with fire safety regulations. This is a matter of grave concern. The monitoring officer had raised concerns about standards of fire safety with the [then] ACEO of SWAHB in March 2003. This inspection took place over two and a half years later. The matter had still not received attention. This is entirely unacceptable.

Recommendations

19. The general manager should ensure that centre staff receive training in first aid.

20. The general manager should arrange a safety audit at the centre as a matter of priority.

21. The general manager should take immediate steps to ascertain whether the premises comply with fire safety regulations and, if not, to carry out whatever remedial works are required.

5. *Summary of recommendations*

The 2004 inspection report contained 31 recommendations. Of these 12 were implemented in full or in part. One was not implemented for a valid reason. Three recommendations did not apply to the situation that obtained at the time of this inspection. Information was not available to determine whether two of the recommendations had been implemented. However, that left a further 13, over one third of all the recommendations, that had not been implemented at all. Those that had been implemented had mainly to do with care practice within the centre and those that were not implemented were those that called for changes within the wider organisation. This underlines the main finding of this inspection: that commendable changes had occurred in care practices within the centre but that organisational weaknesses within HSE SWA were still very much in evidence.

1. **The local health office manager with regional responsibility for child care should ensure that an early decision is reached in relation to the future purpose and function of the centre and that this is communicated to the young people and staff.**

2. **The general manager should ensure that the required checks are carried out on all staff employed in the centre and that information relating to these checks is available to the centre manager.**

3. **The general manager should ensure that there are sufficient staff employed at the centre so as to reduce and, in time, eliminate the use of agency workers.**

4. **The local health officer manager with regional responsibility for child care should ensure that monitoring of standards in the centre provides an effective safeguard for the young people placed there by ensuring that the role of the monitoring officer is defined and understood within HSESWA.**

5. **The local health officer manager with regional responsibility for child care should ensure that young people are consulted on issues to do with their lives and care and not merely informed of decisions made.**

6. **The local health officer manager with regional responsibility for child care should take immediate steps to ensure that all outstanding complaints are resolved.**

7. **The local health officer manager with regional responsibility for child care should take immediate steps to ensure that a comprehensive and robust procedure is put in place to ensure timely resolution of young people's complaints.**

8. **The local health officer manager with regional responsibility for child care should ensure that the policy of placing children under 12 with families is realised in practice for all children in the care of HSESWA.**

9. **The local health office manager with regional responsibility for child care should ensure that there is clarity of roles and responsibilities and clear channels of communication between all of those involved in the care of the young people in the centre.**

10. **The local health office manager with regional responsibility for child care should negotiate with providers of specialist services to ensure that these services are delivered in a manner appropriate to the needs of the young people in the centre.**

11. **The local health office manager with regional responsibility for child care should ensure that staff in the centre have regular access to specialist advice and consultation to assist them in their care of the young people.**

12. **The social workers for the young people in the centre should review the care plans for the young people in consultation with them. The care plans should address the young people's needs for continuity of care, of education and in their friendships.**

13. **The local health office manager with regional responsibility for child care should ensure that the reconfiguration of the residential services in HSESWA is compatible with the young people's care plans.**

14. **The local health office manager with regional responsibility for child care should review the appropriateness of the policy and procedure on unauthorised absences for community based children's residential centres.**

15. **The local health office manager with regional responsibility for child care should ensure that there is a comprehensive child protection policy and procedure for the centre and that staff receive training in relation to it.**

16. **The centre manager should ensure that support for the education of the young people is given priority and that adequate arrangements are in place to ensure implementation of agreed plans.**

17. **The general manager should ensure that the centre is redecorated and refurnished and that the young people are consulted in the choice of furniture and fittings.**

18. **The local health office manager with regional responsibility for child care should review the approach to maintenance and repair of children's residential centres in HSESWA to ensure that the young people live in safe and well maintained homes.**

19. **The general manager should ensure that centre staff receive training in first aid.**

20. **The general manager should arrange a safety audit at the centre as a matter of priority.**

21. **The general manager should take immediate steps to ascertain whether the premises comply with fire safety regulations and, if not, to carry out whatever remedial works are required.**