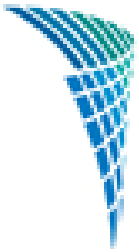

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Social Services Inspectorate

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE SOUTHERN AREA

INSPECTION REPORT ID NUMBER: 284

Fieldwork Date: 13th and 14th January 2009
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SSI Inspection Period: 11
Centre ID Number: 100

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1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's high support unit in the Health Services Executive (HSE), Southern Area (SA) under Section 69 (2) of the Child Care Act 1991. Patrick Bergin (lead inspector) and Sharron Austin (co inspector) carried out the inspection over a two day period from the 13th to the 14th of January, 2008.

The unit was large modern building and purpose built, with a spacious garden and situated in a city suburb. It provided a service to the HSE Southern Area and had a capacity for five young people. The capacity was subsequently reduced to three young people in 2008. One young person resided in the unit during the inspection field work.

1.1 Methodology

The inspection was carried out against the *Child Care (Placement of Children in Residential Care)* regulations *1995 and the National Standards for Children's Residential Centres, 2001.* This inspection was carried out to check if the recommendations of the previous inspection were implemented. Those standards that were fully met in July 2008 were not inspected on this occasion.

Inspectors' judgements were based on analysis of findings verified from several sources of evidence gathered through interviews, with HSE staff members, management, young person, observation and a review of records.

The inspectors had access to the following documents during the inspection:

- unit statement of purpose and function,
- policies and procedures
- young persons' care file
- staff census form
- details of unauthorised absences
- physical restraints
- two monitoring reports
- centre staff rotas (October, November and December 2008)
- proposed therapeutic model for children's residential care services, HSE SA Dec 2008
- action plan (October 2008)

In the course of fieldwork the inspectors interviewed the acting unit manager, deputy unit manager, the line manager for the unit and the monitoring officer. Two social care workers were also interviewed and inspectors held phone interviews with the therapeutic crisis intervention coordinator, three social workers and unit psychologist. The young person living in the unit was also interviewed by inspectors.

1.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the young person, the centre staff and HSE management during the inspection.

1.3 Management structure

The unit was managed by the acting unit manager, supported by a deputy manager and an acting senior child care leader. The acting unit manager reported to the child care manager of the North Lee Local Health Area in the HSE SA, who in turn reported to the general manager for that area.

1.4 Data on young people

On the first day of fieldwork there was one young person residing in the unit.

Young Person	Age	Legal Status	Length of Placement
# 1	17	Full care order	2.5 months

Data on young people discharged from unit since July 2008

Young Person	Age	Legal Status	Length of Placement
#1	16	Voluntary care	3 months
#2	15	Voluntary care	4 months

2. Analysis of Findings

The unit had previously been inspected by SSI in July 2008. The following standards were met, staff vetting, register, administrative files, training and development, monitoring, care files, primary care, emotional and specialist support and premises and safety.

Standards that were met in part in July 2008 included purpose and function, management and staffing, supervision and support, planning for young people and children's rights.

Standards that were not met included dealing with complaints, managing challenging behaviour, safeguarding and child protection. Ten recommendations were made following the July 2008 inspection. An action plan was submitted by the HSE SA to the inspectorate and the implementation of this plan was reviewed during the inspection. Inspectors focused on standards that were not met or met in part in the July 2008 inspection.

From July 2008 to January 2009, there were three admissions and two discharges. One discharge occurred due to concerns for the safety of a young person and in the second case; the young person was removed to bed and breakfast facilities due to the level of aggression she displayed. The decision not to return her to the unit was made by the social work department.

Two reports were completed by the Health Service Executive monitoring officer, following visits to the centre on 30/10/08 and 27/11/08. Recommendations in these reports addressed difficulties experienced by the unit in managing crisis, unplanned discharges and new admissions. The monitoring officer recommended no further admissions to the unit until the outcome of a planned review of the unit was concluded and actions agreed to manage challenging behaviour.

Inspectors found that the majority of recommendations from the July 2008 inspection had not been met. These included the purpose and function of the unit, management and staffing, children's rights, planning for children and young people and safeguarding and protection. Inspectors endorse the monitoring officers recommendations that no further admissions occur until HSE SA agree the purpose and function of the unit, address the level of staff available to the unit to meet its purpose and function and agree a model of care for the unit.

Practices that met the required standard

The following standards were not inspected as they were deemed to have been met in the July 2008 inspection; staff vetting, register, administrative files, training and development, monitoring, care files, primary care, emotional and specialist support and premises and safety.

Practices that met the required standard in some respect only

Management and staffing
The unit was managed by an acting unit manager and deputy manager. The unit manager reported to the child care manager in the HSE SA with responsibility for children's residential services. Inspectors were told by unit managers that the unit had experienced difficulties in October and November 2008 with the result that two young people were discharged during this period. Care staff shortages and challenging behaviour by young people were cited by the unit managers as factors which contributed to the difficulties experienced.

Unit managers carried out care worker duties due to staff shortages in October and November 2008. They also highlighted the difficult behaviour displayed by young people as a significant reason for them not been able to undertake their managerial duties. Inspectors found deficits in unit managers dealing with complaints, staff meetings, suitable placement and admissions. A recommendation from the July 2008 inspection stated *"The HSE SA should ensure that the unit is led and managed effectively"*. Inspectors were advised by external managers that a process was agreed to progress the recommendation. Inspectors recommend that the outcome of the review process is provided to the inspectorate by April 2009.

Staffing
Inspectors were informed by unit and external managers that staffing levels were inadequate to fulfil the unit's purpose and function. Inspectors were informed that the HSE approved complement of care staff for the unit was, one manager, one deputy manager, one senior child care leader, nine care staff for day cover and four care staff for night cover. This was a thirteen care staff excluding managers.

External managers told inspectors that the complement of staff available to all residential services in the area had fallen over the past eighteen months and that there were restrictions on replacing them by the HSE Corporate national policy on cost containment. As a consequence, staff were moved between units in the area in an attempt to provide basic cover to all residential services.

Staff rotas provided to the inspectors for October, November and December 08 indicated that there was a core group of twelve care staff available to the centre. Other staff were utilised from residential services in the area to provide annual leave and sick leave cover. Inspectors found that eleven care staff from other residential services worked in the unit during October and November 2008. They provided cover for staff on annual leave, sick leave and helped to shore up minimum cover required on weekly basis. The inspectors were told by the unit psychologist that a key component in the success of a residential staff team was the requirement of a cohesive staff team. It can only be achieved through the establishment of a consistent group. He indicated the ongoing changes in the staffing team as a contributing factor in not managing the challenges displayed by young people.

High support units evolved to provide residential placements to young people with challenging behaviour. Inspectors found that the unit has twelve named care staff assigned to the unit for the period October and November 2008. Inspectors also noted that this time was particularly difficult in the unit with increased reports of restraints and absences.

The management of challenging behaviour and the management of associated risk is the responsibility to the unit managers and external managers to regulate. Inspectors recommend the HSE SA provide the unit with an adequate level of staff to fulfil its purpose and function and ensure a balance between experienced and inexperienced staff (Standard 2.10).

Supervision

Inspectors found the supervision system for care staff was good with staff receiving supervision on a regular basis. The inspection report July 2008, recommended that all functions of supervision be carried out and recorded in accordance with standard 2.13. Inspectors found that this recommendation was met.

In July 2008, inspectors were concerned about the level of attendance at staff meetings. Records indicated that the numbers of staff attending meetings was inconsistent and there was evidence that some staff not in attendance had read minutes of meetings. This matter was raised at the July 2008 inspection however the recommendation was not met. Inspectors recommend that the level of attendance of staff at staff meetings needs to be addressed as a matter of priority in accordance with Standard 2.15.

Notifications of significant events

Inspectors were satisfied that a prompt notification system of significant events was in place. Inspectors were told a serious incident review group examined major incidents. Inspectors reviewed reports compiled by the serious incident group and were supportive of this type of review as a safeguarding and learning methodology. Inspectors found this standard met.

Children's Rights

The unit had a complaints policy. The recommendation made by the inspectorate in July 2008 stated that "*the HSE SA should ensure that complaints are dealt with in a timely and responsive manner, and young people are informed of the outcomes"*. Inspectors identified a number of complaints which were investigated and concluded in line with the unit policy.

At the time of the field work, inspectors found two complaints where investigations had been initiated but not concluded. These complaints related to young people's dissatisfaction with the availability of care staff. These complaints were outstanding and one young person had been discharged from the unit without the matter been concluded. Inspectors were subsequently informed the complaints had been processed and conclusions reached. Inspectors recommend that the HSE SA external managers monitor the unit's compliance with unit policy on complaints.

During the fieldwork, the young person stated to inspectors that she was not aware of her right to have access to her files in the centre. She confirmed to inspectors she viewed her daily reports. The young person also confirmed that she had not received a copy of her care plan and she told inspectors she was not aware that she could have a copy of it. Inspectors recommend the HSE SA provide young people with a copy of their care plan as stated in standard 5.12 and communicate to young people their right to see information about themselves.

Planning for Children and Young people

Inspectors interviewed social workers of the young people in the unit since July 2008. The social workers stated they were satisfied with the level of individual care young people received while in the unit. They described care staff as supportive and committed; however social workers noted the difficulties the young people had in managing their behaviour in a group living environment. Social workers told inspectors they were informed by centre managers of the shortages of care staff and the impact this had on routines within the unit. One social worker highlighted the difference and inconsistencies in the model of care between a special care unit and the high support unit as a contributing factor to difficulties a young person experienced in the unit in managing their behaviour.

The unit psychologist informed inspectors his role within the centre involved an assessment of need following a young person's admission. This information assisted in the formation of the placement plan. There was also provision for direct work to be undertaken with young people by the psychologist. Inspectors were told by the psychologist that he was involved in the ongoing development of a model of care for the unit with other key personnel.

Inspectors found deficiencies in the capacity of the unit to protect young people from their peers. There was evidence that a young person was subjected to bullying on a persistent and ongoing basis for a two week period**.** There was clear evidence that unit managers and care staff attempted to keep the young person safe, however the young person was subsequently discharged from the unit due to a serious incident and fears for her safety. The unit psychologist highlighted that the young persons care needs were managed by the staff team however the admission of another young person with complex and disruptive behaviour subsequently affected the young person's placement.

Inspectors recommended that the care practices take account of the need to protect young people from bullying by peers and particular attention is given to the mix of young people in the unit.

Inspectors noted the two unplanned discharges from the centre due to crisis situations. They were informed that a review of the circumstances surrounding the admissions and discharges was planned for January 2009. Inspectors request that the inspectorate is informed as to the outcome of this review by March 2009.

Care of young people

Inspectors found the unit had a written policy for responding to challenging behaviour. On the 12th of November 2008, the serious incident review group investigated the events leading to the young person been discharged from the unit.

The findings of the group highlighted deficiencies in communication amongst care staff, new care staff or agency staff not briefed sufficiently prior to commencing work and a need for more awareness amongst care staff to potential dangers and need for rapid responses. The investigation acknowledged that care staff did avert the possibility of a more serious assault on the young person and the serious incident review group made recommendations to address the deficiencies.

During the six month period prior to the inspection 12 restraints were recorded. One young person was restrained on five occasions, another on four occasions and the third on three occasions. Inspectors were informed there were six unauthorised absences by young people during the same period. Inspectors noted that these incidents occurred between the 26/9/08 and 16/11/08 and when the number of young people in the centre rose above one.

Inspectors were told by unit managers that factors contributing to the problems experienced within the unit included, staff shortage and the combination of young people in the unit. Inspectors were told that the unit psychologist attended staff meetings to support and assist staff to consider care needs of young people in the unit.

Safeguarding and Child Protection

Inspectors were told that there were no concerns of a child protection nature outstanding. The unit managers agreed that the centre team experienced a high degree of difficulties in keeping young people safe within the unit. Unit managers identified staff ratio to young people as a deficiency in the safeguarding regime. Inspectors were concerned that the decision to discharge one young person from the unit was based upon child protection concerns.

The recommendation of July 2008 inspections relating to this standard remains outstanding. Inspectors advised of improvement in safeguarding practices to ensure that complaints made by a young person are responded to promptly. External managers should give necessary direction and guidance in responding to such complaints and child protection concerns.

Practices that did not meet the required standard

Purpose and Function
The unit had a written statement of purpose and function which was reviewed in July 2008 by the HSE SA. The statement described the unit as a three bed high support residential unit for young people aged 12-18 year, who present with emotional and behavioural difficulties which cannot be met in mainstream residential care. It further stated that the unit assisted with the gate keeping for the special care unit so as to ensure that only the young people who were most at risk were placed in the special care unit.

At the time of the inspection, there was one young person living in the unit. Inspectors found that the day to day operations of the unit did not reflect the statement of purpose and function. It was not providing three high support places as determined by the purpose and function of the unit. Unit and external managers had reservations as to the capability of the centre to accept another referral for a young person in special care. Inspectors were informed the unit would better cater for referrals from the community.

Inspectors were informed by unit managers and external managers that the connection between the model of care in the special care unit and the model of care in the high support unit as a step down facility needed review. Inspectors found that there was no consistency between the care models of special care and high support unit. Inspectors formed the view that some young people were confused about expectations, routines and care when placed in the high support unit following placement in special care unit.

The unit had capacity for three young people at any particular time. Although constructed as a five bed service the capacity was reduced to three due to the ratio of staff available to the service. Inspectors were informed that the centre could not safely admit another young person who may display challenging behaviour due to current staffing shortages.

Conclusion
Inspectors recommend the HSE SA immediately review the purpose and function of the service and its capacity to operate as a high support unit. The review should consider whether the high support unit can contribute an appropriate level of service to meet the care needs of young people in the area.

Subject to the outcome of the review, inspectors recommend that agreement is reached on the models of care associated with special care unit and the high support unit and that parity is attained in assisting young people in the move from one unit to another.

Inspectors were concerned that the unit was not operating to the purpose and function. The factors contributing to this view included;

- Deficit in level of staffing in the centre,
- Capacity of management and staff to care for more than one young person at a time,
- The number of placements in the unit and unplanned discharges,
- Admissions procedure from special care unit to high support unit,
- Care model in the unit as a step down from special care unit.

Inspectors recommend these factors are considered as part of the review, however also include the efficiency and effectiveness of the current management structure for the unit. Inspectors also advise that recommendations in the 2008 July report are addressed and will be included in the action plan for monitoring compliance by the inspectorate.

Findings

1. Purpose and function

Standard
The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Purpose and function			√

Recommendations:

1. **The HSE SA should undertake an immediate review of the unit purpose and function of the service and the capacity to provide safe care.**

2. **The HSE SA should ensure an agreed model of care is established for the unit.**

2. Management and staffing

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Management		√	
Register	√		
Notification of significant events	√		
Staffing (including vetting)		√	
Supervision and support	√		
Training and development	July 2008		
Administrative files	July 2008		

Recommendations:

3. **The HSE SA should provide a report to the inspectorate outlining outcome of the review on the management of the unit by April 2009.**

4. **The HSE SA should provide the unit with an adequate level of staff to fulfil its purpose and function and attain a balance between experienced and inexperienced staff on the team (Standard 2.10).**

5. **The HSE SA should ensure that staff attend staff meetings as a matter of priority in accordance with Standard 2.15.**

4. Children's rights

Standard
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.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Consultation		√	
Complaints		√	
Access to information		√	

Recommendations:

6. **The HSE SA should ensure that the HSE SA external managers monitor the unit's compliance with complaints policy.**

7. **The HSE SA should provide young people with a copy of their care plan as stated in standard 5.12. and communicate to young people their right to see information about themselves.**

5. Planning for children and young people

Standard
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.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Suitable placements and admissions		√	
Statutory care planning and review	July 2008		
Contact with families	July 2008		
Supervision and visiting of young people	√		
Social work role	√		
Emotional and specialist support		√	
Preparation for leaving care	July 2008		
Aftercare	July 2008		

Recommendations:

8. **The HSE SA should ensure that the care practices take account of the need to protect young people from bullying by peers and particular attention is given to the grouping of young people in the unit.**

9. **The HSE SA should ensure the review of the circumstances surrounding the admissions and discharges of young people to the centre, planned for January 2009 is undertaken and the report forwarded to the Inspectorate by March 2009.**

6. Care of young people

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Individual care in group living		√	
Provision of food and cooking facilities	√		
Race, culture, religion, gender and disability	July 2008		
Managing behaviour		√	
Restraint	√		
Absence without authority	√		

Recommendations:

10. **The HSE SA should not place not place young people in the unit until the appropriate levels of staff were in place and the model of care has been reviewed.**

11. **The HSE SA should ensure a multidisciplinary approach and training is undertaken in the underlying causes of inappropriate behaviour.**

7. Safeguarding and Child Protection

Standard
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.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Safeguarding and child protection		√	

Recommendation:

12. **The HSE SA should ensure that unit staff are aware of safeguarding practices and these practices are monitored regularly by external managers.**

8. Education

Standard
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 educational facilities.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Education	July 2008		

9. Health

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Health	July 2008		

10. Premises and Safety

Standard
The premises are suitable for the residential care of the 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 & 13 of the Child Care Regulations, 1995.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Accommodation	July 2008		
Maintenance and repairs	July 2008		
Safety	July 2008		
Fire safety	July 2008		

4. Summary of recommendations

1. **The HSE SA should undertake an immediate review of the unit purpose and function of the service and the capacity to provide safe care.**

2. **The HSE SA should ensure an agreed model of care is established for the unit.**

3. **The HSE SA should provide a report to the inspectorate outlining outcome of the review on the management of the unit by April 2009.**

4. **The HSE SA should provide the unit with an adequate level of staff to fulfil its purpose and function and attain a balance between experienced and inexperienced staff on the team (Standard 2.10).**

5. **The HSE SA should ensure that staff attend staff meetings as a matter of priority in accordance with Standard 2.15.**

6. **The HSE SA should ensure that the HSE SA external managers monitor the unit's compliance with complaints policy.**

7. **The HSE SA should provide young people with a copy of their care plan as stated in standard 5.12. and communicate to young people their right to see information about themselves.**

8. **The HSE SA should ensure that the care practices take account of the need to protect young people from bullying by peers and particular attention is given to the grouping of young people in the unit.**

9. **The HSE SA should ensure the review of the circumstances surrounding the admissions and discharges of young people to the centre, planned for January 2009 is undertaken and the report forwarded to the Inspectorate by March 2009.**

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11. **The HSE SA should ensure a multidisciplinary approach and training is undertaken in the underlying causes of inappropriate behaviour.**

12. **The HSE SA should ensure that unit staff are aware of safeguarding practices and these practices are monitored regularly by external managers.**