



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

**Social Services  
Inspectorate**

**A**

**CHILDREN'S RESIDENTIAL CENTRE**

**IN THE**

**HSE WESTERN AREA**

***INSPECTION REPORT ID NUMBER: 286***

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**Centre ID Number: 339**

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# 1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection of a crisis intervention service in the Health Services Executive (HSE), Western Area (SA) under Section 69 (2) of the Child Care Act 1991. Patrick Bergin (lead inspector) and Kieran O'Connor (co inspector) carried out the inspection over a two day period from the 20<sup>th</sup> to the 21<sup>st</sup> of January 2009.

The centre was opened in July 2005 to provide emergency accommodation as a short residential placement for children and young people who required accommodation on an urgent basis. The emergency accommodation was provided under Section 5 (Accommodation for Homeless Children), and Section 12 (Powers of the Gardai to take the child to safety) of the Child Care Act 1991.

The centre was located in a housing estate close to the city centre and it had the capacity to accommodate up to six young people. During the inspection one young person was in residence. Admissions were suspended to facilitate the placement of this young person in the centre six days prior to the inspection fieldwork. On the first day of the fieldwork, a detention order was granted by the High Court and the young person was placed in a special care unit.

## 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*. Inspectors' judgements are based on analysis of findings verified from several sources of evidence gathered through interviews, observations, review of records and inspection of accommodation.

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

- centre statement of purpose and function
- policies and procedures
- young persons care file
- staff census form,
- details of unauthorised absences
- details of physical restraints
- centre register
- administrative records,
- health and safety records
- confirmation of insurance.

In the course of inspection fieldwork, inspectors interviewed the following people,

- acting centre manager
- acting child care manager
- monitoring officer
- acting operational manager
- four care workers
- one young person
- foster carer (telephone interview)

## **1.2 Acknowledgements**

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

## **1.3 Management structure**

The centre manager was on extended leave and the deputy manager was acting as centre manager. On the day of the inspection, centre staff were informed that the centre manager was vacating the post. The deputy centre manager had agreed to continue as acting manager until the post was filled permanently.

At the time of the inspection the acting centre manager reported to the acting child care manager in the local health office, who in turn reported to the acting general manager for that area. An acting operational manager provided support to the managers of the residential services in the HSE WA.

## **1.4 Data on young people**

On the first day of fieldwork one young person was residing in the centre:

### ***Details of the young person in the centre at the time of the inspection***

<b>Young Person</b>	<b>Age</b>	<b>Legal Status</b>	<b>Length of Placement</b>	<b>No. of previous placements</b>
# 1	16	Full care order / High Court Detention order	6 days	Foster placement 4 residential placements

Inspectors were informed that 89 admissions to the centre had taken place in 2008. An analysis of these admissions was undertaken by inspectors from information provided in the centre register. The 89 admissions included repeated admissions over the twelve month period. Thirty five percent of admissions were for children twelve years of age or younger. Fifty three percent of admissions were girls. On ten occasions, family siblings groups were admitted to the centre.

Inspectors were told by acting centre and external management that the placement of a 28 year old woman thorough a section 12 order occurred as it was believed she was under eighteen years of age. On receipt of confirmation of the woman's age, appropriate services were sourced for her.

## **2. Analysis of Findings**

The centre had previously been inspected by SSI in February 2007 and seventeen recommendations were made by the Inspectorate at that time. Nine of these recommendations were met with seven other recommendations met in part. One recommendation remained unmet. This related to the revision of the purpose and function of the centre.

During this inspection, inspectors found a committed management and care staff team who displayed a resilience to persist with the provision of care in difficult circumstances. The nature of the service as a crisis intervention implied the possibility of unplanned admissions, which was demand driven.

The accommodation was of a high standard which consisted of two, three bedroom semi-detached houses with combined living areas and connecting gardens. The centre was located in a city suburb a short distance from the city centre.

Inspectors found that many of the admissions to the centre were for short periods of time. Inspectors were concerned that thirty one admissions occurred of children under twelve years of age. Inspectors found that a number of teenagers continued to be placed in the centre for up to three months periods and this was not conducive with the purpose of the centre.

The centre was not accepting admissions at the time of the field inspection as it was deemed unsafe to have young people sharing accommodation with a young person already placed in the centre. This young person was placed in the centre as an interim measure while the HSE WA processed an application for a special care placement. Inspectors noted the decision and capacity of the HSE WA to establish alternative arrangements for emergency admissions to be placed in foster care during this time.

Inspectors found the primary care being provided by the staff to be of a good standard. Although the staff team had experienced challenging times in managing difficult behaviours there was a child centred focus evident within the care practices.

Inspectors were concerned as to the changing personnel within the centre management. Inspectors were informed that a reconfiguration of the residential services in the HSE WA was underway and would be completed by February 2009. Inspectors were told this reconfiguration would have an impact on staff redeployment, management positions and the number of residential places available in the area.

Key issues for the inspectors was the failure of the HSE WA to implement the recommendation of the 2007 inspection report regarding the purpose and function of the centre, in particular the practice of placing children twelve years and younger in the centre.

## ***Practices that met the required standard***

### *Register*

The centre has a register of all young people who lived in the centre. Information contained in the register was of a good standard and relevant to the nature of the service. In some instances exact dates of births were not available to centre staff and ages were entered instead. The challenge for the centre was that alternative placements were sourced before details were sourced. Inspectors advised to follow up with the relevant social work departments to source information required for the register.

### *Notifications of significant events*

Inspectors were told by the acting centre manager that 43 significant events were reported in 2008. A further four significant events were recorded in January 2009, prior to the inspection. The monitoring officer, acting child care manager and relevant social workers were notified of these events and records verified these actions. Significant events which were notified included young people displaying abusive and threatening behaviour, serious assault on staff and child protection concerns. The latter were also notified to the relevant social worker under Children First Guidelines (1999). Inspectors found this standard was met.

### *Staffing*

The centre had an approved complement of twelve staff. These consisted of one manager, one deputy manager, one child care leader and nine child care workers. The staff census presented to the inspectors indicated that eight of the twelve posts were filled permanently. A further eight staff worked temporary contracts and provided a range of cover from full-time to relief cover for annual leave and sick leave. The acting centre manager informed inspectors that she had the authority to increase staff cover to address needs of the centre and this response was evident from the centre records. The staff census form completed by the acting manager highlighted that all staff were qualified, had appropriate references and Garda vetting on file.

### *Monitoring*

The centre was monitored on a regular basis by the HSE monitoring officer. Two monitoring reports were completed in the 12 months prior to the inspection. These reports included a review of the young people's placement in the centre, discharges, progress with recommendations from last Social Services Inspection dated February 2007 and progress with recommendations from last monitoring reports.

The reports included a review of case records, significant events, and further recommendations. Action Plans were drawn up and included the action required on each recommendation. Inspectors found this to be a good practice as it allowed for ongoing review and audit of the centre in its care practices, policies and procedures. Inspectors found that this standard was met.

### *Supervision and support*

The centre had a supervision policy and staff reported to the inspectors that they received supervision on a regular basis. Supervision sessions addressed work practices, training and personal development. Inspectors found this standard was met.

### *Training and development*

The acting centre manager told the inspectors that core training was provided to the staff. Such training included therapeutic crisis intervention and first aid. The centre manager had identified drug misuse training requirements and arrangements were finalised for the staff team to be trained in this area.

### *Statutory care plans*

Inspectors found evidence that the standard practice was to schedule a statutory care plan meeting for young people whose placement was longer than two days. These meetings did not always occur as alternative placements were sourced. The centre developed placement plans as a mechanism of coordinating the care needs of young people who were not discharged immediately. Inspectors support the recommendations of the monitoring officer that statutory care plan forms are completed in full by social workers and that relevant information is presented in report format at care plan review meetings.

### *Supervision and visiting of young people*

The acting centre manager, care staff and external managers told inspectors they found social workers appropriate in their response to young people placed in the centre by the Gardai, or through emergency placements sought by a social worker. Inspectors noted from the register that while over 80% of young people were discharged within two weeks, 60% of the admissions were discharged within three days following direct contact from the relevant social work department.

### *Emotional and specialist support and preparation for leaving care*

Inspectors found evidence that a program is used to address social networking, health and well-being education and accommodation. This program is specific to older teenagers. Modules within the program are adapted to address identified areas of need. Inspectors were told that there were limitations to the degree and the depth of work undertaken with young people due to the length of placement.

### *Aftercare*

The HSE WA had a community aftercare worker available to young people placed in the centre. This worker had regular contact with the service and engaged directly with young people who were seen as needing an aftercare service. The acting centre manager identified this service as beneficial to young people over 17 years of age who were placed in the service in assisting them attain support structures outside of the centre.

### *Absence without leave*

The centre reported four incidents where young people were absent without permission. Inspectors found this level of absences to be very low considering the nature and extent of placements. Care staff told inspectors the approach adopted by them during the admission process assisted in reducing the anxiety of young people. The prompt action of the relevant social work department to follow up on admissions was seen as a positive factor in reducing the level of absences.

### *Education*

The centre assisted in maintaining regularity in the educational routines of young people placed in the centre. Where applicable the centre staff transported children to school in an attempt to maintain consistency. The decision to facilitate young people

continue with their schooling was made in consultation with the social work department, parents and the school. Each situation was assessed and potential levels of risk were considered.

#### *Accommodation*

The centre was of a good standard of accommodation which consisted of two, three bedroom semi-detached houses with combined living areas and connecting gardens. It had five allocated bedrooms with one bedroom with two cots and two beds. This room was used when young sibling groups were placed in the centre. The centre had a play room with games and books. The living room of one house was used as a staff office with the adjoining house contained the kitchen and living room areas for children, young people and staff.

An outdoor play area was located at the rear of the centre. The ground covering was of a soft cushioned material however inspectors were concerned as it had become uneven. Inspectors advised that an opinion on the hazardous nature of this area should to be sought and any remedial works to be undertaken so the play area is suitable for young people.

#### *Safeguarding and child protection*

The centre had a policy on safeguarding and child protection. The policy included acceptable routines and practices including those on privacy, sanctions and keyworking. The practices to be adopted by care staff in managing and responding to bullying in the centre were also described. The policy on child protection was clear and inspectors found evidence that this was understood by care staff.

Inspectors found evidence that staff were confident in challenging their colleagues care practices in a professional way at staff meetings. There was evidence that young people were informed of the complaints process and complaints were responded to quickly. Care staff had attended training in child protection and there was evidence they were aware how to respond to such concerns.

#### *Maintenance and repairs*

Prior to the inspection fieldwork a young person damaged a fire door and the fire alarm system. The acting centre manager had made arrangements for the repairs to be undertaken. She had made the decision not to admit any young people to the centre until all outstanding works were addressed. Inspector found evidence of systems in place to report repairs to be undertaken and monitoring of same by the acting centre manager.

#### *Fire safety*

Inspectors undertook an examination of the building. The fire alarm system was checked by staff on a regular basis and fire extinguishers had been serviced in June 2008. Inspectors were informed that fire extinguishers were moved from common living areas to stop young people interfering with them. While inspectors acknowledge this action they advise that signage erected in the centre would reflect the new location of this equipment.

The centre manager had a letter on file from a qualified engineer dated 6-8-08 confirming his satisfaction with the fire standards in the premises and the centre was in compliance with the requirement of Fire Services Act 1981/2003. This

correspondence specified a minimum of two fire drills occur per annum. Records indicate the centre is adhering to the recommendation.

#### *Individual care in group living*

Care staff told inspectors that every effort is made to create a positive atmosphere in the centre. Meals were at set times in the evening and staff and young people eat together. Shopping was undertaken by care staff and young people would accompany them when possible.

The centre had access to cash to purchase food as required and the centre was taking account of young people's wishes, within reason. A supply of clothes was evident in the centre especially for younger children placed in emergency situations. Due to the nature of unexpected admissions supplies of infant's clothes and food was maintained in the centre.

The acting centre manager told inspectors that on occasions the centre had provided emergency accommodation to non-national children. The centre manager informed inspectors of the awareness that care staff had in regard meeting these children's needs.

### ***Practices that met the required standard in some respect only***

#### *Management and staffing*

During the inspection field work, inspectors were informed that the manager was vacating her post. The deputy manager who was acting as centre manager since November 2008 has agreed to continue in the position. Inspectors were informed that a reconfiguration of residential services in the HSE WA was underway and the management structure was also to be reconsidered.

Inspectors were told there were no specific mechanisms for assessing the quality and effectiveness of the service provided by the centre. Acting centre manager and external centre managers acknowledged that some placements had continued beyond the stated purpose and function of the centre. They told inspectors that young people were placed in the centre on a crisis basis however due to a range of circumstances, placements continued as follow on placements had not been sourced.

Inspectors were concerned that centre managers and external managers had not satisfied themselves as to the quality and effectiveness of the service. They recommend an analysis of the profile of children placed in the centre and the outcomes for them. This information could inform centre and external managers and form part of the strategy in the reconfiguration of the residential services.

#### *Administrative files*

Inspectors viewed the recording system in the centre. They were concerned that it did not facilitate effective management of information. There were large quantities of information however the need to separate this information into categories was evident. A system to allow ease of access to information was necessary to allow managers review service provided. Inspectors recommend information management and filing systems are explored and a system established for the centre to meet standard 2.19.

### *Children's rights*

Inspectors found that care staff and centre managers were aware of the need to consult with children and young people. This was undertaken formally and informally with young people through engagement of care workers and the keyworker system. Inspectors found the practices within the centre were good in responding to complaints and consultation however it was evident that the policies in the centre needed to be reviewed to reflect practices.

Inspectors found evidence of confusion amongst care staff regarding the rights of young people to have access to information about them. Reference was made to a range of mechanisms for young people to access information. Inspectors recommend that a review of the policies relating to children's right to information is undertaken and practices within the centre reflect the policy.

### *Contact with families*

Inspectors were told that contact with families at initial point of placement was determined by the Gardai or the referring social worker. Centre staff told inspectors that family contact for children admitted through a social work department was agreed. Similar clarity was not evident when children were placed in the centre by Garda Siochana. This lack of clarity related to the circumstances surrounding the child been removed to a place of safety and the possible impact on the child young person should contact be initiated. Inspectors were told that following initial placement, clarification was sought regarding family contact and if possible encourage family members to visit the centre.

Inspectors recommend that clear protocols and guidelines are developed in consultation with the social work department and Gardai Siochana considering the type, level and frequency of contact. Consideration should be given to determining circumstances when contact should not occur and a system to review this policy should be agreed.

### *Discharges*

Inspectors found that 82% of discharges occurred within two weeks of admission. These were planned discharges, with 75% (66 young people) discharged within five days as required by the draft purpose and function. Inspectors were concerned that the remaining young people continued to remain in placement. Inspectors were told of two unplanned discharges which took place as it was deemed unsafe for placements to continue.

These situations related to two situations where young people were in placement for a number of months and due to aggressive behaviour, their placements ended. Inspectors recommend that the discharge policy is reviewed in the context of the purpose and function of the centre.

### *Children's case and care records*

Inspectors examined the care file system in the centre. The current system is unwieldy and problematical and does not lend itself to easy access to required information. It was acknowledged by inspectors that the number of admissions to the centre is substantial however an appropriate system needs to be established to assist in the administration of information. This system also needs to be mindful of young people's right to access to information on their files. The need to develop a

restricted section and review the operation of this process had been raised by the monitoring officer and inspectors would concur with this recommendation.

#### *Managing behaviour*

The centre has a guidance policy on managing challenging behaviour which related to the children's residential centres in the area. The purpose of the guidance document was to provide clear information and a framework for managing behaviour which is considered challenging, unsafe or out of control. The policy stated that all centres have a clear purpose and function and every referral is risk assessed. This approach was seen as a safeguarding measure in the appropriate use of residential services and an effective gate keeping measure to safeguard young people.

Care staff, centre manager and external management told inspectors that children or young people placed in the centre rarely display challenging behaviour. Inspectors were told that difficult situations related to teenagers whose placements continued beyond a short stay. Centre staff, acting centre manager and external managers told inspectors of incidents where care staff experienced assaults and physical injury from young people. Their placements ended as a result of these incidents. Two young people were physically restrained on seven occasions. Five of these occurred within a two day period shortly prior to the inspection.

Inspectors were told that a formal on call system was in place in the HSE WA residential services. Due to this system extending beyond the parameters of residential services, the managers on call withdrew the service. Inspectors were told that external managers did not support the withdrawal of the system. Inspectors understand the on call system will be explored in the context of the reconfiguration of the residential services. Inspectors were concerned this system ended and no clear strategy devised to address the difficulties experienced.

This is a matter the inspectors believe requires immediate remedy as it will provide direct support to the centre in managing challenging situations. Inspectors recommend the HSE WA explore the strategies available to the centre in managing challenging behaviour however outcome needs to consider the agreed purpose and function of the centre.

#### *Health*

Inspectors were informed by centre manager and external managers that medical examinations were sought before young people were placed in the centre. Inspectors were informed that the centre manager and external managers were not satisfied with the extent of the medical examination and reports provided by the medical practitioner. Discussions were ongoing with a local general practitioner and the child care manager in connection with the matter and a proposed report format had been completed.

Inspectors recommend that this matter is finalised as a priority as it is important that children and young people removed from a situation of risk and abuse have an appropriate medical examinations undertaken and recorded prior to admission to the centre.

#### *Safety*

The centre had a signed safety statement dated November 2005. It identified hazards and hazard controls. The safety statement recommended that a yearly

statement is undertaken and inspectors would concur with this view and recommend a safety statement is undertaken immediately.

### ***Practices that did not meet the required standard***

#### *Purpose and function*

The centre had a revised purpose and function document dated 30/08/2007 which continued to be in draft form. It stated the purpose of the centre was to accommodate homeless children under Section 5 of the Child Care Act 1991 and also to provide accommodation for children removed by Gardai under section 12 of the Child Care Act 1991 that they deem require a place of safe. As a regional service it provided emergency placements to three local health areas in the HSE WA.

The revised draft document stated the centre is "*the designated centre when residential spaces are required on an emergency basis for children over 12 years of age.*" The document also stated "*children under the age of 12 years will be accommodated with foster carers with the first point of contact by referral agency being through the centre.*"

Inspectors found, the centre provided accommodation to 31 children twelve years of age or less in 2008. The acting centre manager and external management told inspectors there was a consensus amongst HSE WA that children under 12 years of age should not be placed in the centre. They highlighted that alternative foster care placements had not been developed sufficiently to allow the practice of admitting children under 12 years of age to the centre to end.

Inspectors were informed that children between 0 and 18 could be placed in the centre. Inspectors observed sleeping facilities and clothing for young babies. Inspectors were also informed that the centre would not refuse any request for an emergency placement. An instance was cited where an adolescent had to sleep on the sofa as the centre was full. This practice was seen as exceptional but also acceptable.

Inspectors were told by centre managers that embargo's had been placed on admissions to the centre previously due to specific care needs of young people residing there. Alternative arrangements were made to find foster placements during these embargos. During the inspection, a restriction on placing any children in the centre was agreed and local health areas made arrangements to identify foster carers to be available should emergency placements be required. This arrangement ended during the inspection when the young person was placed in special care unit and the centre was reopened for emergency placements. Inspectors were impressed with the decision to stop admissions during these times of crisis. The sourcing of foster care placements to meet the demand for emergency placements should be prioritised.

Inspectors were concerned as to the mix of young children in the centre with adolescents. Inspectors recommend the HSE WA immediately cease the practice of admitting children 12 years or younger children into the centre. This practice would be in line with the revised draft purpose and function of the centre. An agreed purpose and function of the centre should be approved by the HSE WA. Inspectors also recommend that the HSE WA ensure that there are adequate and appropriate

alternative placements available for children 12 years of age and under in the event they require crisis / emergency placements.

*Suitable placement and admission*

Acting centre manager, external management and monitoring officer told inspectors their concerns as to the suitability of the centre for all children. From these discussions, inspectors identified two particular challenges for the centre in meeting the needs of young people and children placed there.

- Children 12 years of age and younger
- Children who's placement extended beyond two weeks.

Inspectors found that 31 (35%) children under 12 years of age were placed in the centre with 57 teenagers in 2008. Forty percent of children under 12 years of age were placed in the centre by the Gardai Siochana under section 12 of the 1991 Child Care Act. A further analysis by inspectors of the register highlighted 18 children under five years of age were admitted to the centre in 2008.

There were three referral pathways to the centre,

- Gardai Siochana contacting the centre informing the centre staff that they had evoked section 12 of the Child Care Act and were placing the children in a place of safety as designated by the HSE WA.
- Referring social work departments seek an emergency placement for a young person or child who presented as homeless to their services. This category accounted for 25% of admissions in 2008.
- If emergency placement was required for child or young person taken into the care of the HSE WA, the centre would facilitate admissions. These admissions accounted for 10% in 2008.

Admissions were taken in at short notice in all circumstances and a system was in place to meet the children's primary needs on admission. Inspectors were informed that as much information as possible was sourced at initial point of contact when it was indicated an admission was imminent. Further information was provided by the Gardai or social worker on arrival at the centre.

The table below provides an account of the referral path way for young people to the centre. 64% of admissions were through the Garda Siochana intervention evolving Section 12 of the child care act 1991 and 6% of admissions did not state on the register the legal status of the placement.

Section 12	Section 5	Section 4	Unknown
56 (64%)	22 (25%)	4 (5%)	5 (6%)

Inspectors were concerned that children under twelve years of age were being placed in residential care during times of crisis. All of the children less than twelve years of age placed in the centre were moved from the centre within the agreed time frame of five days as stated in the revised draft purpose and function. However

inspectors continued to be concerned as to the possible impact on young children in this environment.

Inspectors found the placement of young people over 12 years of age accounted for 57 (64%) admissions with the majority of young people falling in to 15-17 years of age category. These admissions were deemed to be appropriate placements however inspectors found 15 (26%) young people in this cohort remained longer two weeks in the centre, with 9 (15%) of these remaining in placement for longer than a month. 6 young people stayed up to three months with one person staying for five months.

Inspectors found that this standard was not met because children under twelve years of age should not be placed in residential care unless in exceptional circumstances. As indicated earlier in the report inspectors recommend alternative foster care placements should be sourced for this age group of children. The extended placement of young children in a crisis centre was not deemed to be suitable placements and should end.

# 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.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Purpose and function			√

### Recommendation:

1. The HSE WA should ensure the purpose and function of the centre is agreed, approved and reviewed on a regular basis.

## 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.

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

### Recommendations:

2. The HSE WA should ensure an analysis of the centre is undertaken to inform centre and external managers of the quality and effectiveness of the centre particularly outcomes for young people.
3. The HSE WA should ensure information management and filing systems are identified and a system established for the centre to meet standard 2.19.

### 3. Monitoring

#### Standard

The health board, for the purposes 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.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Monitoring	√		

### 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.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Consultation	√		
Complaints	√		
Access to information		√	

#### Recommendation:

- The HSE WA should put in place policies on children's right to access information about themselves and ensure it is reflected in practice.

## 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.**

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

### Recommendations:

5. **The HSE WA should ensure the practice of placing children twelve years of age or younger in the centre ceases and alternative foster care placements are sourced to be available to children under twelve requiring emergency placement.**
  
6. **The HSE WA should ensure that clear protocols and guidelines are developed in the centre in consultation with the social work department and Gardai Siochana considering the type, level and frequency of contact between children and families.**

## 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.**

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

### Recommendation:

- The HSE WA should ensure agreed strategies are in place to manage behaviours and that external managers monitor these on a regular basis.**

## 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.**

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Safeguarding and child protection	√		

## 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.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Education	√		

## 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.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Health		√	

### Recommendation:

- The HSE WA should ensure that appropriate services are available to facilitate young people receiving a medical examination prior to admission to the centre.

## 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.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Accommodation	√		
Maintenance and repairs	√		
Safety		√	
Fire safety	√		

### Recommendation:

- The HSE WA should ensure a safety statement for the centre is compiled immediately and reviewed annually.

## **Summary of recommendations**

- 1.** The HSE WA should ensure the purpose and function of the centre is agreed, approved and reviewed on a regular basis.
- 2.** The HSE WA should ensure an analysis of the centre is undertaken to inform centre and external managers of the quality and effectiveness of the centre particularly outcomes for young people.
- 3.** The HSE WA should ensure information management and filing systems are identified and a system established for the centre to meet standard 2.19.
- 4.** The HSE WA should put in place policies on children's right to access information about themselves and ensure it is reflected in practice.
- 5.** The HSE WA should ensure the practice of placing children twelve years of age or younger in the centre ceases and alternative foster care placements are sourced to be available to children under twelve requiring emergency placement.
- 6.** The HSE WA should ensure that clear protocols and guidelines are developed in the centre in consultation with the social work department and Gardai Siochana considering the type, level and frequency of contact between children and families.
- 7.** The HSE WA should ensure agreed strategies are in place to manage behaviours and that external managers monitor these on a regular basis.
- 8.** The HSE WA should ensure that appropriate services are available to facilitate young people receiving a medical examination prior to admission to the centre.
- 9.** The HSE WA should ensure a safety statement for the centre is compiled immediately and reviewed annually.