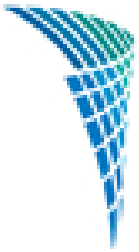

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Social Services Inspectorate

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE WESTERN AREA

INSPECTION REPORT ID NUMBER: 289

Fieldwork Date: 17 and 18 February 2009
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SSI Inspection Period: 11
Centre ID Number: 72

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1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the Health Services Executive (HSE) Western Area (MWA) under Section 69 (2) of the Child Care Act 1991. Patrick Bergin (lead inspector) and Orla Murphy (co-inspector) carried out the inspection over a two day period, the 17th and 18th of February 2009.

1.1 Methodology

The judgements of inspectors are based on an analysis of findings verified from more than one source of evidence gathered through observation of practice, interviews with relevant HSE staff members and managers, interviews with young people, examination of records and documentation and an inspection of accommodation.

The following are some of the centre documents available to inspectors during this inspection:

- statement of purpose and function
- policies and procedures
- young people's care plans and care files
- census forms on management and staff
- young people census forms
- questionnaires for social workers
- administrative records,
- previous inspection report and follow-up report
- young person questionnaires
- supervision records
- staff rotas
- safety statement.

During the course of this inspection, inspectors interviewed the following people:

- acting centre manager
- regional residential child care manager
- four social workers
- two social care leader
- two social care workers
- HSE monitoring officer
- two young people in residence

1.2 Acknowledgements

Inspectors wish to acknowledge the assistance and cooperation of the young people, staff members and other professionals who participated in this inspection.

1.3 Management structure

The centre was managed by an acting centre manager and the external management structure consisted of a regional residential child care manager who reported to the acting child care manager. They reported to the general manager who in turn reported to the local health manager for the area.

1.4 Data on young people

On the first day of fieldwork the following young people were residing in the centre:

Listed in order of length of placement

Young Person	Age	Legal Status	Length of Placement	No. of previous placements
# 1	16	Full care order	21 weeks	4 residential placements
# 2	17	(*)No care order	5 weeks	none
# 3	16	Interim care order	4 weeks	4 residential placements
# 4	18	(*)No care order	4 weeks	none

(*) Placements were under Section 5 of the Child Care Act 1991.

2. Summary of Findings

The centre had previously been inspected by SSI in 2006 and all of the recommendations arising from that inspection were met in October 2006.

The centre was an emergency and medium term children's residential centre providing accommodation for homeless boys between the ages of 15 and 17. It was located in a three storey building on a main street close to the city centre. It had a capacity to accommodate four young people. Three of the placements were deemed medium term residential beds and the fourth an emergency bed.

The medium term placements were determined by the admissions panel for residential care. The emergency placement was able to remain in the centre for a period of 28 days and such placements were dealt with by the centre manager as the need presented. The regional manager was informed of any emergencies. The centre provided a regional service to the HSE areas in counties Limerick, Clare and Tipperary.

At the time of the inspection there were four young people in residence. One was in placement 6 months while the others had been admitted to the centre in January

2009. The centre had 16 admissions in the 12 months prior to the inspection. Admissions to the centre ceased from September 2007 until August 2008 following the placement of a 16 year old boy whom was deemed to have high support needs. He remained in the centre until August 2008. Inspectors were informed the admission of this young person was not in line with the purpose and function of the centre. The placement proceeded as the young person had high level care needs and the centre was available at that particular time. Another young person who had taken up a placement at the same time also continued to reside in the centre up until January 2009.

Towards the end of 2008, there were concerns about young people abusing solvents in the centre. The staff team found it difficult to manage and the level of risk to the young people was deemed high by centre staff and management. The majority of young people involved in this behaviour had moved from the centre in a planned manner by the end of 2008 and the level of solvent abuse decreased.

Throughout the inspection, there was reference to feuding between families in the city and the associated violence with this. The concern shown by the centre staff and managers about risks to young people was evident. There was evidence that one young person was involved in the feuding conflict and associated criminal behaviours. Centre manager, care staff, monitoring officer and social worker expressed concerns as to the level of risk this young person was exposed to on a regular basis.

Notwithstanding these challenges, inspectors found the centre managed well to respond to the needs of the young people. The provision of primary care was good and the centre displayed a determination to assist young people overcome challenges. Some areas required attention and these included purpose and function of the centre, suitable placement and admissions, statutory care plans, managing behaviour, child protection and some administrative functions.

Practices that met the required standard

Management
The centre was managed by a qualified person who was in the acting post for over twelve months. She reported to the regional residential child care manager, who was line managed by the local health manager. The centre had a number of changes of managers in recent years. The regional residential child care manager acknowledged the need to have consistency in the centre manager's post for the long term stability of the service.

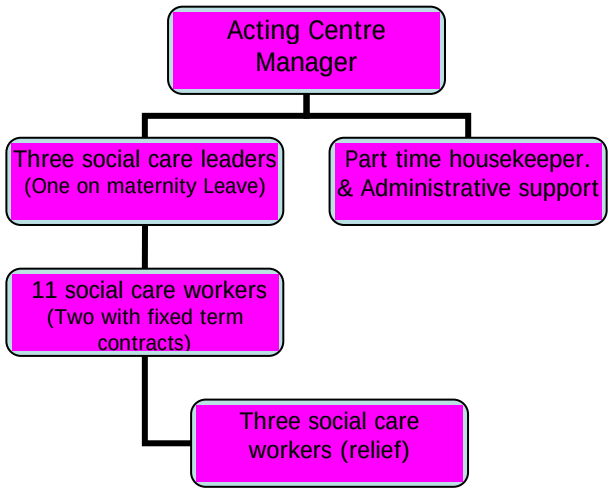
Register
The centre had a register in place. It contained the name of the young person, date of birth, legal status, social workers names and contact details. It also contained details of parents of young people and the reason for the admission and dates of discharge. The register contained the details of the follow-on placement for young people. Inspectors found the information contained in the register met the standard.

Notification of significant events
The centre had a policy on reporting significant events to include classified significant event including:

1. absconding,
2. assault,
3. threats,
4. physical intervention,
5. sexualised behaviour,
6. self harm,
7. disruptive behaviour,
8. damage to property,
9. child protection concerns
10. drug, alcohol and solvent misuse.

The document had a general heading "other" to be used when necessary. These reports were individually numbered for tracking purposes and included details on the young person, staff involved, precipitation factors, details of event, action taken by staff and action taken by social worker. These forms were sent to the social worker, monitoring officer, regional residential child care manager and the therapeutic crisis intervention monitoring and review committee. Inspectors found evidence the practice in the centre reflected policy and held that this standard was met.

Staffing
Inspectors were provided with details on the staff working in the centre. There were 18 care staff assigned to the centre covering 16 whole-time equivalent positions. A part time housekeeper was also employed in the centre. The manager had administrative support for two days a week.



Inspectors noted that centre care staff worked ten or twelve hour shifts and staff were rostered to cover day and night shifts. In the norm, staff worked three day shifts and then three night shifts. Inspectors found there was a good balance between new and long term care staff. Inspectors were satisfied that all staff had garda vetting and all references were in order. One staff member was not qualified however she was currently in training and supported by the HSE MWA. The regional residential child care manager told inspectors that a reconfiguration of residential

services was due to take place and she stated there may be an option to increase the WTE complement of centre staff considering the nature of the service.

Training and development
Centre staff had participated in training in therapeutic crisis intervention, supervision and the impact of domestic violence on children. In 2008, the centre experienced a high number of young people abusing aerosols. As a consequence, staff linked with the local HSE substance misuse team who provided training and information on the problem. Inspectors were informed that a number of staff were due to attend training in health and safety and also manual handling.

Monitoring
Following two visits to the centre, two monitoring reports were issued by the HSE monitoring officer. The visits incorporated meetings with the young people, the care staff and the acting centre manager. Documentation in the centre was also reviewed and each report examined the status of recommendations of the previous report and made recommendation on current issues.

The inspectors were told by the centre manager and the HSE monitoring officer that they differed in points made in one of the monitoring reports. Inspectors were told that following clarification on these issues, matters were concluded. Inspectors held the view this standard was met.

Access to information
Inspectors found evidence that young people had access to their records in the centre. On occasions, following an assessment that the young person may destroy the files, records were copied and given to the young people. Inspectors found section in the files where confidential material was kept and social worker provided an opinion on whether young people could access this information. Inspectors were satisfied that young people could view their files and concluded this standard was met.

Suitable placement and admissions
The placement of young people in the centre on an emergency basis was governed by the Child Care Act 1991, Section 5. Where it appeared to the HSE that a child in its area was homeless and following an enquiry into the child's circumstances and verification that there was no other accommodation available to the child, the HSE could "*take such steps as are reasonable to make available suitable accommodation for him".* The centre categorised these admissions as "*Section 5 admissions".*

Inspectors met with four social workers and there was full agreement that all four young people were appropriately placed at that time. Due to the process of accepting emergency placements, it is not always viable for comprehensive information to be available to the centre about the young person. Inspectors found good quality information available on file for two young people in the centre. The third young person had come from another jurisdiction and although the young person had provided details on previous care settings, little information was on file. The fourth young person was not previously known to the HSE and there was little supporting information on file in respect to this young person.

Inspectors found that all young people were appropriately placed however advised that clarification on core information necessary for emergency admissions should be

agreed. They also advised that agreement on who is to source this information is necessary.

Contact with families

Young people who presented to the centre as homeless had, on many occasions, experienced conflict within their families resulting in relationships breaking down. The centre had a pivotal role in facilitating young people and their families opening communication channels, re-establishing contact and rebuilding relationships where possible. Inspectors were informed by centre staff, managers and a young person that family were encouraged to visit the centre. The view was expressed by centre staff that everyone had to be mindful that the centre was the home of a number of young people and that family visits to the centre had to be arranged and managed.

Inspectors noted that the placement of young people in the centre for a number of months allowed for the development of relationships between centre staff and family members. This was a positive aspect of their placements in the centre. Inspectors found this standard was met however advised that further consideration should be given to initiating and maintaining contact between young people and families when emergency placements are required.

Supervision and visiting of young people

As indicated previously in the report, all four young people in the centre had a named social worker. One young person who met with the inspectors was very complementary of the social worker and the efforts she made to assist him when he presented as homeless. He believed the social worker was working in his best interest and she had regular contact with him. Other social workers highlighted challenges in maintaining contact with young people. Some of the young people found it difficult to engage with the social work department and would not meet with the social workers. The social workers continued to visit the centre and remained in contact with centre staff. Records of visits were maintained in the centre of social worker visits.

Social Work Role

The HSE MWA had a named social worker for all young people in the centre. Information pertaining to two young people was not sufficient however as one young person had reached his eighteenth birthday and an exit plan agreed, inspectors were informed there was no plan to seek further information. The provision of residential care plans for all young people assisted the centre staff in identifying the areas to be addressed by them. Two of the young people were not in the care of the HSE and did not have statutory care plans or statutory care plan reviews. Inspectors held the view this limited the possibility of long term planning for young people. Social workers told inspectors they were kept informed by the centre staff of all significant events including absences.

Emotional and specialist support

The centre and external managers emphasised with inspectors the positive relationship the centre staff had with a range of services in the area. These included adolescent psychiatric service, substance misuse service, probation and welfare service and youth service. Inspectors were told that the local hospital, accident and emergency department were available to provide advice to centre staff at any time. This had been of particular assistance to staff when a number of young people were involved in solvent abuse.

Centre staff reaffirmed the views expressed by managers and they believed the cooperation from local services was an important part of the success of the residential service. Care staff were in a strong position to support the emotional needs of young people in the centre. Inspectors commend the working relationship between the centre staff and local services in meeting the needs of the young people.

Preparation for leaving care
In the twelve months prior to the inspection, there were 16 young people admitted to the centre. Four young people were in the centre at the time of the inspection. The centre register indicated that seven of these young people returned home or went to live with family relations. Three moved to other residential care settings as long term placements, one went to a residential care for an assessment, another moved to independent accommodation and one received a custodial sentence. The centre manager told inspector the joint approach between the social work department and the centre staff had assisted the majority of young people return home. Inspectors advised that an analysis on information gathered in the register should be undertaken to provide qualitative information on the moving on of young people from the centre. This information would assist in the development of strategies in preparing young people for leaving care.

Discharges
On reviewing the centre register, it was found there was no unplanned discharges. The centre manager acknowledged that in some instances she was not satisfied with the quality of discharges. This related to some instances where there were challenges in managing young people's behaviour in the centre. Exit plans were moved along due to specific concerns. Inspectors found this standard was met.

Aftercare
Inspectors were told the HSE MWA operated an aftercare service area. The criteria for eligibility for aftercare services were when a young person had been in care for six months after sixteen years of age. Inspectors were informed that if a young person was not eligible for aftercare, the arrangements was that they were referred to a project worker in the homeless persons centre.

On analysis of the register, inspectors found that six young people were admitted to the centre under section 5 in the past 12 months. Three of these young people left within a month of admission and returned home. Two remained longer than a month but also returned home with the sixth young person still living in the centre.

Inspectors noted that as some young people were placed in the centre under 'section 5' and were not in the care of the HSE, they would not be entitled to access the after care service. Inspectors advise that in some circumstances, individual cases referred to the aftercare service should be considered by this service.

Children's case and care records
Inspectors found the standards of young people's care records to be good. They included information on the young people and their families. It provided clear evidence on the direct work undertaken by the centre staff with young people. Some changes were necessary to young people's case files which maintained reports from other professionals, birth certificates and care orders. Some of this information was

maintained on the care records file. Inspectors advised that a review of the current system should be undertaken to clarify where information is to be maintained. This will assist in supporting young people view their records.

Individual care in group living
The centre was initially developed as an accommodation for homeless youth where they accessed the service in the evening. The centre was closed in the day as accommodation was seen as the core service provided. The centre had evolved to providing full time residential care and the individual care of young people has also evolved. Routines have developed where young people attend education, training or places of employment where applicable. The key concept was to provide young people with a focus in improving their current situation.

The centre staff provided financial assistance to young people admitted on emergency basis in purchasing clothes or other necessities. Particular attention was given to meeting their primary needs.

Provision of food and cooking facilities
The centre staff met with young people on Sunday evenings and everyone contributed ideas for the weekly shopping list. Young people assisted in cooking on occasions and regular times were set for evening meals. Due to the nature of the centre, inspectors were advised that young people did not always return for meals. Inspectors were satisfied that this standard was met.

Race culture, religion and disability
Inspectors found evidence highlighting the centres capacity to respond to the individuality of each young person. Staff had undertaken training in the area of cultural identity. This occurred as non-national young people had been placed in the centre. The centre manager told inspectors the staff became very aware of issues such as male / female dynamics, ethnicity and African traditions.

Restraint
The centre manager reported that there were had no physical restraints in the centre over the past twelve months. Inspectors sought clarification on the use of physical interventions in the centre. Inspectors were told by centre and external managers and found no evidence on young people's files that there was physical intervention.

Absence without authority
On the first day of the field work, inspectors were informed that three young people had failed to return to the centre the previous evening. The following night, two young people had returned to the centre although centre staff had direct contact with the remaining two young people. The centre manager submitted information on the number of absences in the 12 months prior to the inspection. There were 122 unauthorised absences involving eight of the sixteen people in residence. One young person was responsible for 46% of the reports. He subsequently received a custodial sentence for criminal behaviour.

Education
Inspectors found a culture in the centre that promoted education and training. Young people were encouraged to engage with local services and schools. There was access to the local youth services and a probation youth project. One young person had secured employment. Inspectors were concerned that there was no education

information for one young person. Inspectors advise this information be sought so as to determine the education level of the young person. The social worker accepted the need to progress this matter to assist the care staff source appropriate educational services.

Accommodation
The centre was located in a mid terrace three storey building situated close to the city centre. The building was originally two houses which were converted to facilitate the service. It was a four bedroom facility with two bedrooms on each of the top two floors. Inspectors found the general condition of the centre to be good. The centre had a living room off the kitchen area with a games room set up with pool table and boxing bag. There were sufficient toilet and shower facilities in the centre. Some works remained outstanding to a shower area and inspectors advise this it rectified as soon as possible.

Inspectors noted that young people were not able to lock their doors at night and due to the layout of the premises it was not possible for night staff to monitor these areas. Inspectors advise the facility for young people to secure the doors of their bedrooms at night is progressed for privacy and safety considering the requirements of care staff to access the rooms on specific occasions.

Inspectors recommend that the HSE MWA continue to maintain the centre at an appropriate standard and consideration should be given to upgrading the kitchen units as doors were damaged.

Practices that met the required standard in some respect only

Purpose and function
The centre had a written purpose and function document which described the geographical areas serviced by the centre. It stated the centre catered for boys between fifteen and seventeen years of age on referral. Inspectors were concerned about the all encompassing statement in the document which allowed for boys and girls to be placed in the centre and allowed for younger children to be placed there in exceptional circumstances.

There was some confusion amongst care staff as to the age profile of admissions to the centre and whether all emergency placements were to be admitted. It was acknowledged by the acting centre and external managers that a review of the purpose and function of the centre was necessary. Inspectors recommend the formulation of a purpose and function statement as required under standard 1.1 National Standards for Children's Residential Centre's.

Supervision and support
The monitoring reports in 2008 had identified shortcomings in the area of supervision. The acting centre manager and regional residential child care manager confirmed the centre policy and practice was at variance with regional policy. The HSE monitoring officer acknowledged this with the inspectors. Records indicated that supervision in the centre was taking place every six weeks and regional policy recommended every four weeks. The regional residential child care manager stated the regional policy will be changed to reflect the practice in the centre. Following the field work inspection, inspectors were informed by a HSE MWA senior manager that

the policy was changed to reflect policy in the centre and this was resolved prior to the inspection.

Inspectors undertook a random check of supervision records. There was formal recording of the discussion and the outcomes. One supervision file contained a record of an assessment of core competencies for social care staff. This assessment was used to inform supervision sessions for a new staff member.

Inspectors viewed minutes of a sample of staff meetings held in the centre. Inspectors found that attendance at staff meetings was poor. Of a possible 18 staff, records highlighted three to seven staff may attend. The acting centre manager acknowledged that care staff were not rostered to attend meetings and this was a matter she intended to address. Social care leaders and the centre manager were rostered to meet on a weekly basis and this was identified as a good practice.

During the field work inspection, there was no evidence indicating that care staff off duty had read the minutes of the meetings. A sign in system was established in January 2009 for staff to record they had read minutes.

Inspectors were told by care staff that there was an employment assistance program available to them. A number of staff had utilised this services due to stress and injury suffered in the course of their work.

Inspectors recommend the centre manager and regional residential child care manager re-examine the attendance of care staff at meetings in an attempt to enhance communication and consistency in the centre.

Administrative files

Inspectors found the records to be of a good standard however there were large quantities of information retained and consideration should be given to streamlining recording mechanisms. Inspectors concurred with the view that the current administrative system needs to be reviewed.

The acting centre manager advised the inspectors she had plans to review the administrative files in the centre. There were plans to consider the current structure during staff team days however she also advised there was a need to archive some material retained in the centre.

Consultation

The inspectors found all young people were consulted following their admission to the centre. Two of the young people in residence at the time of the inspection field work had sought services due to accommodation needs through homeless team. The process in the centre allowed for an initial care plan to be drawn up between young people, social worker and centre staff. This provided a frame work for all involved to consider how best to address the needs of the young person.

One young person was in the centre five months and a number of meetings were held to seek his views and the views of his family in respect to his care. Inspectors were told the centre held a young persons meeting every Sunday evening as part of the consultation process. The agenda for this meeting was set by young people and it informed care staff of issues to be discussed at the care staff meeting. Inspectors found that difficulties arose with having young people's meetings at the designated

day and time. Often young people did not return to the centre on Sunday evening. Inspectors advised the centre manager and the regional residential child care manager to consider alternative strategies in consulting with young people to attain the outcome they aspired to achieve.

Complaints
Inspectors were informed of one complaint made by a young person which was investigated and concluded with the young person indicating he was happy with the outcome. Inspectors were told by the acting centre manager, care staff and young people of minor complaints that are made but not formalised. Inspectors were told these are processed through direct engagement with young people.

Inspectors were informed that another complaint was made by a young person when care staff refused to drive him to a particular location. This matter had been discussed with the young person and clear evidence was found as to the reason for this decision. Inspectors were told this matter continued to be raised on a weekly basis by the young person. Inspectors advised centre manager and regional residential child care manager to review the practice of dealing with complaints. It was accepted by the acting centre manager that a record of complaints processed informally needed to be maintained in the centre.

Statutory care plans
Inspectors were informed by the centre manager that two of the young people had Care Orders (One full Care Order under section 18 and One interim Care Order under Section 17 of the Child Care Act 1991). The remaining young people were placed in the centre under Section 5 of the Child Care Act 1991. One young person had reached his eighteenth birthday prior to the field work inspection.

Inspectors were informed by a social worker that the young person placed in the centre under section 5 did not require a statutory care plan. He had an initial care plan when seeking the emergency placement. Inspectors were informed by the HSE monitoring officer that the centre was not always provided with care plans. She held the view that the most recent care plan was provided because of the inspection by the inspectorate.

Inspectors found that the young people on care orders had comprehensive statutory care plan. Inspectors noted that the other young person had an initial care plan which was then developed into placement plans.

Inspectors found evidence where the centre and external managers were seeking to have statutory care plans in place for all young people in the centre. The purpose and function of the centre stated that no planned admission could take place without a care plan for the young person. Inspectors were provided with evidence highlighting that the HSE sought legal opinion on the interpretation of section 5 of the 1991 Child Care Act. Inspectors understood that a final conclusion has not been reached on this matter.

Inspectors formed the view that the admission of a young person to the centre under Section 5 of the 1991 Child Care Act was initially to address the issue of homelessness. As outlined in the Youth Homeless Strategy 2001, Department of Health and Children, Objective 6 "*A comprehensive assessment of children who*

become homeless will be carried out as the basis for individual action/care plans for case management/key working with the young person where necessary."

Inspectors hold the view that the outcome of an assessment should determine whether a young person presents with care needs. It would not be sufficient for the HSE to accommodate a young person in a care facility under Section 5 if care needs are identified.

Inspectors found this standard was met in part and recommend the HSE WA undertake an assessment of young people, in respect to his care and protection who are placed in the centre under section 5 of the 1991 Child Care Act at the time of the inspection fieldwork.

Statutory care plan reviews
Inspectors found that two of the young people had statutory care plan reviews. There was evidence of consultation with families and the young people. Inspectors found that young people placed in the centre under section 5 of the 1991 Child Care Act did not have statutory care plans. The centre operated a residential placement plan system and these were reviewed on a regular basis by the centre staff. This standard was met in part as some young people did not have reviews.

Managing behaviour
The centre had a written policy for responding to inappropriate behaviour. Therapeutic crisis intervention was identified by centre staff as the intervention used by care staff to deescalate situations. Inspectors were told by centre and external managers and care staff that the physical interventions did not occur due to the physical size of the young people and that this type of intervention could not be undertaken safely.

In 2008, the centre experienced serious challenges in managing young people who were involved in solvent abuse in the centre. Situations were described to the inspectors by centre staff where the majority of young people in the centre were sniffing aerosols in their bedrooms. Centre staff felt disempowered to address the problem. They attempted to engage with young people and accessed local services to advise them on the risks and approaches to take. The concern for staff ended when some of these young people moved from the service however centre staff were anxious that the trend could re-emerge again.

Inspectors found evidence that the centre staff had engaged with a young person who had a history of placement breakdowns. Inspectors were advised by the social worker that the approach undertaken by the care staff to engage the young person was excellent. As a consequence, the young person continued to remain in the centre and engage better with services. It was acknowledged that there were still challenges in caring for this young person, but improvements were noted. Another young person in the centre also presented with difficult behaviours including drug misuse, criminal behaviour and aggressive outbursts. External management suggested to inspectors they believed the staff team had the skills to respond to the challenges displayed by this young person.

Inspectors found that although sanctions were used in the centre they had little positive impact on the behaviour of the young people in the centre. The relationships formed between centre staff and young people appear to be the scaffolding which

assists young people to manage their behaviour. This approach should include other agencies and disciplines and evolve subject to the trends and challenges. Inspectors recommend that the HSE WA monitor the ability of the centre to manage behaviours and develop strategies to respond to evolving needs of young people in the centre.

Safeguarding

The centre did not have a safeguarding policy however centre staff were guided by the regional policy titled "Guide to Best Practice". This outlined the acceptable behaviour of care staff and focused on the functioning of professional relationship in care settings. Inspectors found that care staff had an appropriate knowledge of safe care practices. There was guidance for care staff in regard to the one-to-one relationships and contact with young people. There were facilities in the centre for young people to make phone calls in private. Inspectors recommend that centre and external managers bring together good practices in the centre to form a policy which will inform new and current staff.

Child protection

Children First, National Guidelines for the Protection and Welfare of Children 1999 was the policy of the centre in responding to child protection. Staff were trained in Children First and it was seen as one of the core areas for ongoing training for staff.

Inspectors were told of concerns the centre staff, manager, monitoring officer and social worker had for the safety of one young person who was in the centre for four weeks. It was acknowledged that he was drawn to the criminal underworld in the city. There were reports that he was in the possession of illegal substances on one occasion. External agencies were aware of his association with particular individuals and were concerned about his safety.

The social worker highlighted to inspectors her specific concerns about his safety. She outlined that two applications for special care placements had been processed for him in 2008. Both were refused, the initial application was refused due to insufficient information. The social worker was unclear as to why the second application was refused. She reaffirmed that everyone was concerned about this young person's welfare.

There was ambiguity expressed to inspectors by centre manager and HSE monitoring officer whether child protection concerns relating to young people in the centre could be submitted to the social work department through the child protection system. Some staff held the view, with respect to this particular young person, that no child protection report could be submitted to the social work department as the young person was in the care of the HSE.

External managers met with inspectors to clarify the position on this matter. They confirmed to inspectors that child protection reports for children in care can be made to the social work departments. Inspectors were told that these reports would not automatically be processed through the child protection notification system. They were told that in the specific case relating to a young person in residence, the reports would not proceed as the risk was not from parents or carers.

Two issues were identified by inspectors in regard to this matter. Firstly, the care and safety needs of this young person was of concern to centre staff, monitoring officer and social worker. Inspectors recommend a review of this young persons

statutory care plan to be undertaken as a matter of urgency, and the inspectorate informed when the review had occurred and the outcome of it.

The second issue related to the centre staff understanding of the child protection system. Inspectors were informed by external managers that the local social work department had a guidance document in respect of the child protection notification system. This was presented to the inspectors as a local practice procedure. A further document was presented to the inspectors titled Children First Child Protection Notification System 2002. Inspectors were subsequently informed this guidance document was issued to staff and managers by the former Mid-Western Health Board Assistant Chief Executive Officer for implementation in 2003.

Inspectors recommend the HSE MWA clarify the reporting system to be used by the residential centre and the grounds for such reports and that the system is congruent with Children First, National Guidelines for the Protection and Welfare of Children 1999.

Health

All young people underwent a medical examination upon admission. The centre had access to a local doctor. Young people could continue to retain their own doctor if they so wished. Inspectors were concerned about the dispensing of medication to young people by care staff especially when there were concerns that young people may have taken illegal substances. While inspectors were told by care staff that they would advise young people not to take medication if they had taken illegal substances, inspectors were concerned as to the ability of young people to make rational decision relating to their health when using illegal substances.

Inspectors noted that one young person had received three different prescribed antibiotics over a short time, sourced from different medical practitioners but had failed to complete each course of medication. Inspectors advised that this matter should be explored further with a medical practitioner. Inspectors advised that clarification be acquired on the time frames for taking a particular medication prescribed to one young person. There was uncertainty if the young person had to take this medication the same time every day.

Inspectors recommend that the HSE MWA review their policy and practices on the management of medication and that medical advice is sought on a number of matters raised in the report.

Safety

The centre had a corporate safety statement which provided a broad overview of safety requirements including a smoking policy and a fire prevention management policy. This document was dated June 2007 and signed by the acting regional residential child care manager. There was also a safety statement specific to the centre which was signed by the centre manager but not dated. The centre had a safety audit which identified hazards and the control measures to address these. This document was also not dated. The centre manager had reviewed the document prior to the inspection and acknowledged the need to formally review and update. Inspectors concur with this view.

Practices that did not meet the required standard

Fire safety

Inspectors undertook an inspection of the premises as part of the fieldwork. Documentation was provided to the inspectors which clarified that the fire alarm system was maintained and tested in January 2009 by an external fire protection company. Training in the use of fire extinguishers was also provided to centre staff in January 2009. Fire and safety checks were carried out also in January 2009 and specifically looked at fire doors, emergency lighting, fire detectors and fire escapes.

Inspectors were presented with documentation titled Building Control Act 1990. It did not provide confirmation that all statutory requirements relating to fire safety and building control had been complied with as required under standard 10.19. Inspectors recommend this confirmation is provided as a matter of urgency.

3. 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		√	

Recommendation:

1. **The HSE MWA should formulate a purpose and function statement for the centre as required under the National Standards for Children's Residential Centre's.**

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	√		
Administrative files		√	

Recommendations:

2. **The HSE MWA should ensure that staff attend centre meetings.**

3. **The HSE MWA should develop an effective administrative recording system in the centre.**

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.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
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.

	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	√		

Recommendation:

4. **The HSE MWA should review the consultation and complaints policies in the centre and develop practices in line these policies.**

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		√	
Contact with families	√		
Supervision and visiting of young people	√		
Social work role	√		
Emotional and specialist support	√		
Preparation for leaving care	√		
Discharges	√		
Aftercare	√		

Recommendation:

5. **The HSE MWA should ensure that young people in the centre have statutory care plans and reviews inline with standard 5.7 and 5.13**

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	√		
Managing behaviour		√	
Restraint			
Absence without authority	√		

Recommendation:

6. **The HSE MWA should ensure that ongoing discussion, training and reviews of the practices and policies of managing behaviour are undertaken and a multi-agency and disciplinary approach is adopted.**

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		√	

Recommendations:

7. **The HSE MWA should ensure the centre has a safeguarding policy and practices are in line with the policy.**

8. **The HSE MWA should clarify to the residential centre the reporting system to be and the grounds for such reports and that the local system is congruent with Children First, National Guidelines for the Protection and Welfare of Children 1999.**

9. **The HSE MWA should undertake a review of one young persons statutory care plan (as identified in the report) as a matter of urgency, and the inspectorate informed of the outcome of the review.**

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	√		

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		√	

Recommendation:

10. **The HSE MWA should review the policy and practices on the management of medication in the centre and that medical advice is sought on a number of matters raised in the report.**

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	√		
Maintenance and repairs	√		
Safety		√	
Fire safety			√

Recommendation:

11. **The HSE MWA should ensure re-examine the health and safety document and update it accordingly.**

12. **The HSE MWA should ensure that written confirmation from a certified engineer or qualified architect is acquired indicating that all statutory requirements relating to fire safety and building control have been complied with and the relevant document forwarded to the inspectorate.**

4. Summary of recommendations

1. The HSE MWA should formulate a purpose and function statement for the centre as required under the National Standards for Children's Residential Centre's.

2. The HSE MWA should ensure that staff attend centre meetings.

3. The HSE MWA should develop an effective administrative recording system in the centre.

4. The HSE MWA should review the consultation and complaints policies in the centre and develop practices in line these policies.

5. The HSE MWA should ensure that young people in the centre have statutory care plans and reviews inline with standard 5.7 and 5.13.

6. The HSE MWA should ensure that ongoing discussion, training and reviews of the practices and policies of managing behaviour are undertaken and a multi-agency and disciplinary approach is adopted.

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12. The HSE MWA should ensure that written confirmation from a certified engineer or qualified architect is acquired indicating that all statutory requirements relating to fire safety and building control have been complied with and the relevant document forwarded to the inspectorate.