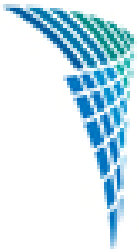

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Social Services Inspectorate

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE DUBLIN MID-LEINSTER AREA

FINAL REPORT

INSPECTION REPORT ID NUMBER: 295

Fieldwork Date: 11th -13th March 2009
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Centre ID Number: 279

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Contents

1. Introduction

1.1 Methodology

1.2 Acknowledgements

1.3 Management structure

1.4 Data on young people

2. Analysis of findings

3. Findings

4. Summary of recommendations

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), Mid-Leinster Area (MLA) under Section 69 (2) of the Child Care Act 1991. Patrick Bergin (lead inspector) and Linda Moore (co inspector) carried out the inspection over a three day period from the 11th to the 13th of March 2009.

1.1 Methodology

The judgements of inspectors in relation to this inspection are based on an analysis of findings verified from a number of sources of evidence gathered through:

- examination of records and documentation
- observation of practice
- interviews with relevant HSE staff members and managers
- interviews with young people
- an inspection of accommodation.

The following unit documents were available to inspectors during this inspection:

- statement of purpose and function
- policies and procedures (including booklet for young people)
- young peoples care plans and care files
- census forms on management and staff
- administrative records
- previous inspection report and follow-up report
- health and safety documents.

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

- centre manager, (unit manager)
- residential services manager
- four social workers
- HSE monitoring officer (telephone interview)
- four young people in residence
- four centre care staff.

1.2 Acknowledgements

Inspectors wish to acknowledge the cooperation of the young people, staff members, HSE managers and other professionals who assisted during this inspection.

1.3 Management structure

The centre was one of a four centres which formed the children's residential services in the area and serviced the areas of Laois / Offaly and Longford / Westmeath. The centre was managed by a unit manager who reported to the residential services manager who reported to the general manager for the area. The residential services manager sat on the admissions and discharge committee for the residential services.
The centre has an approved complement of 16 staff with seven positions designated as child care leaders. One of the child care leaders deputised for the unit manager when necessary.

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	Gender	No. of previous placements
# 1	17	Voluntary care	Thirty six months	Male	Three placements (excluding respite placements)
# 2	17	Full care order	Nineteen months	Female	Three
# 3	17	Voluntary care	Six months	Male	one
# 4	15	Voluntary care	One month	Female	none

2. Analysis of Findings

There were four young people living in the centre at the time of the inspection and this was the full capacity at any one time. The young people ranged in ages for 15 to 17 and there were two boys and two girls in residence. The longest placement was for three years with one young person in the centre for a month.

The centre was located in a domestic premise in a rural setting adjacent to a large town. Referrals were accepted from the areas of Laois / Offaly and Longford / Westmeath. During the field inspection, inspectors found the service in crisis. Young people were refusing to adhere to the routines and expectations of their placements. It was evident to inspectors that the centre had been damaged as a consequence to young people's behaviours. Wall pictures had been removed and food was locked away in areas accessible to care staff only. Young people had flooded part of the centre.

Inspectors found deficiencies in the admission process, in the management strategy to deal with crisis, in safeguarding practices and in the preparatory work for young people leaving care. The inspectorate sought an immediate response from HSE MLA managers to these concerns. The monitoring officer undertook a visit to the centre and submitted her views to HSE MLA managers. Short term actions were undertaken by the HSE MLA to reduce the immediate level of risk in the centre. The inspectorate was informed by HSE MLA senior managers that an interim plan was agreed to manage the identified issues. Inspectors were satisfied that the actions reduced the immediate concern. A written response to the inspection recommendations was also received by the inspectorate indicating the actions to be taken by the HSE MLA in the long term.

The centre had previously been inspected by SSI in August 2006 and the majority of recommendations arising from that inspection were met. A recommendation that was met in part related to young people leaving care needing to have access to adequate, regular and predictable aftercare services. The HSE MLA indicated that a local policy on aftercare was to be developed while awaiting a national aftercare policy.

Prior to the inspection, the centre staff had experiencing difficulties in managing young people's behaviour. The behaviours included in damage to property, absences and refusal to adhere to rules and routines and boundaries. Inspectors were concerned that there was no evident strategy to deal with the current difficulties. The inspectors held the view the care setting was in crisis.

Managers and staff were commended by inspectors for their determination and resilience in attempting to maintain routines and meet the primary care of the young people. Inspectors held the view that the staff team required support, guidance and leadership to deal with the presenting difficulties.

Recent problems highlighted weaknesses in key areas such as the admission process, behaviour management and safety of young people in the centre. The young people were sometimes at risk as care staff were unable to ensure that behaviours such as aggression and unauthorised absences were contained within safe boundaries.

Practices that met the required standard

Register
The centre had a register dated 2002. It provided details on young people as required in the standards including their names, dates of birth, parent's addresses, and discharge dates. It also included information on the follow-on placements, names of social workers and their contact details. Details pertaining to young people in residence between 1996 and 2001 were entered into the register retrospectively. A number of fields were not completed. Inspectors advised the centre managers that this information should be included in the register.

Notification of significant events
The centre had a significant events notification system. Documentation was forwarded to the HSE monitoring officer, residential services manager, social workers and where applicable to the principal social workers. The centre had separate document formats for notifying absences without leave, child protection concerns and restraints. Inspectors were told by social workers that they received information in an appropriate and prompt manner from the centre. They highlighted that while written information was processed by centre staff, direct contact was also made by care staff when matters of concern arose and required immediate attention.

Inspectors found a good system of notifying significant events and held the view this standard was met.

Supervision and support
Inspectors found that the centre supervision policy stated that all care staff should receive formal supervision every four to six weeks. The centre manager supervised the child care leaders and three child care leaders supervised the child care workers.

A random selection of seven staff files were viewed by inspectors. They found that supervision occurred every eight to ten weeks. There was an agreed format for supervision which incorporated issues relating to centre management, education and training, support and mediation, reflection on care practices and key-worker role. Inspectors found a deficiency in the recording of the supervision sessions. The connection between goals and outcomes needed to be identifiable and recorded to allow for accountability and learning.

Inspector's reviewed the records of staff meetings. Meetings were not held on a structured timetable. They were held twice a month or more often if the centre manager deemed it necessary. The centre manager and care staff informed inspectors that staff were rostered to attend when possible. Inspectors found that attendance varied from 6 to 10 people inclusive of the centre manager.

There were detailed accounts of matters pertaining to the young people recorded at each meeting. An agenda was also evident where care staff submitted issues for discussion. Inspectors noted discussions took place regarding the behaviours displayed by young people. Inspectors will discuss later in the report the option of specialised help being available to the centre.

Inspectors held this standard was met however advised the centre and external managers to restructure the recording of the supervision notes to assist in accountability and learning.

Consultation

All young people told inspectors they were included in the meetings held in the centre about their placements and care. Inspectors were concerned that while three young people expressed the view they got on well with staff, there was a general consensus from all young people that they were not happy with their placements. They sought placements in other residential care settings and cited the condition of the centre, the difficulties with care staff and a general unhappiness as their reasons for the change. Two of the young people stated they could talk to their keyworkers, but all young people indicated they depended on the other young people in the centre.

Meetings were held on a regular basis between young people and centre staff to explore issues. It was evident to the inspectors these meetings related to the daily routine in the centre and did not delve beneath the operational aspect of the centre. Inspectors found evidence where care staff had engaged with young people to address the disruptive behaviour in the centre. Individual storage areas were allocated to young people in the kitchen where they could secure their delph and cutlery for hygiene reasons. Inspectors found the presses were damaged by young people and the measure put in place had not been successful.

Inspectors were informed by centre and external manager that following consultation with young people items had been purchased for the centre. Music, computer games and equipment were provided by the centre. Subsequently these items were either destroyed or sold by young people.

Inspectors found evidence where young people's families were consulted. One young person had been informed that his long term foster carers were withdrawing their involvement and contact with him. This created a high level of anxiety and uncertainty for him as he came closer to adulthood. Another young person who had moved in to the centre prior to the inspection told inspectors that her mother had visited the centre and her family knew the centre manager. This relationship assisted in encouraging the family to make their views known to the centre staff.

The centre manager and external manager acknowledged that more could be undertaken in the centre to consult with young people about their care. Inspectors noted that the current disruptions within the centre and the challenging behaviour evident in the centre made this process very difficult. Inspectors advised that consideration should be given to enhancing consultation with young people as an over-all strategy in addressing the care of the young people in the centre.

Complaints

The centre had a comprehensive complaints policy. Inspectors found evidence of a large number of complaints on young people's files. These complaints ranged from matters relating to other young people in the centre to the impact the "HSE cut backs" were having on young people. A number of these complaints related to young people not been able to access transport from the centre to family visits or school. The matters were notified to the monitoring officer and social workers by the centre manager. Inspectors found evidence that the monitoring officer investigated the complaints and found there was provision in place to bring young people to meet their families and school. It was evident the underlining issues related to the expectation by young people that transportation would always be available at their request. Inspectors found the complaint was processed appropriately.

Inspectors were satisfied that practice in the centre was good. It was clear how to make a complaint, who was to be notified, how the matter was investigated and the communication channels between the various parties in the process. There was a comprehensive documentation system in place to allowed for accountability and monitoring. Inspectors found this standard was met.

Statutory care plans
All young people in the centre had a written statutory care plan on file. The plans included an assessment of the young person's needs, education and health plans, family details and presenting challenges. The centre had developed placement plans for the young people in the centre. The placement plans originated from the objectives set out in the statutory care plans.

Statutory care plan reviews
Inspectors found evidence on files of formal reviews of the statutory care plans on a regular basis. The reviews identified areas where progress had been made and identified areas for ongoing work. The statutory review plans identified the priority needs of the young person, what actions were agreed, who was responsible to follow up, implement the actions and the time frame for completion.

In one case the statutory care plan review was chaired by a reviewing officer. The documentation clearly stated who was in attendance, the level of consultation with interested parties in the care of the young person and the circulation of the outcome of the review.

Contact with families
The centre policy on family involvement stated the centre endeavoured to involve young people's families in all aspects of their child's life. Specifically this included contact through the admission process, care planning and reviews process, visits to the centre, facilitated access and contact outside of the centre and through written reports and letters.

The centre care staff told inspectors they had regular contact with family members or significant individuals associated with each of the young people. Inspectors found that three of the young people had regular contact with members of their families. This involved time at home, weekend breaks, phone contact and visits to the centre.

The fourth young person who was in foster care with the same family from an early age had been informed that the placement had broken down and he was not returning to their care. This young person had no contact with his biological family and was uncertain about his future care placement. The social worker had explained to the young person the reasons for the foster carer's decision. Inspectors found there was a good emphasis on family contact in the centre.

Supervision and visiting of young people
Young people in the centre told inspectors they had visits from their social workers. A review of the files by inspectors found that all social workers were visiting young people within the statutory requirement. On some occasions young people refused to meet the social workers however records indicated that on these occasions social workers were updated by care staff.

Inspectors were informed that one of the social workers was leaving the service. Arrangements had been made for the social worker file to be reallocated, a hand over had been undertaken and arrangements were made for the young person to meet with the new social worker.

Social work role
Inspectors found from file reviews and interviews with centre staff and social workers that social workers were familiar with all aspects of the young persons living in the centre. All young people had care plans in place and there was ongoing sharing of information between the centre staff and the social work departments. Two of the social workers read young persons files from time to time.

Inspectors were told by all social workers that they were aware of the challenges experiences by the care staff in managing young people's behaviour. They were aware of the potential risks however they believed the centre staff were doing all that was possible to manage the situations. They told inspectors they had raised matters of concern with young people individually and on some occasions improvements were evident for periods of time. Inspectors were told by all social workers they believed the combination of the particular young people in residence was a contributing factor to the challenges experienced by the centre staff.

Discharges
Inspectors found that all discharges from the centre in the 12 months prior to the inspection were in a planned manner.

Practices that met the required standard in some respect only

Purpose and function
The centre had a stated purpose and function which described the centre as a medium to long term placement which accepted referrals from the Laois / Offaly and Longford / Westmeath areas. Centre and external managers accepted the centre had admitted short term / emergency placements. They expressed the view that the admissions and charge committee who considered placements for all the centres in the region was aware of the purpose of the centre. In light of the current requirement to achieve value for money, the committee placed young people in the centre whose placement did not meet the stated purpose and function of the centre.

Centre and external managers acknowledged the current mix of young people was creating difficulties which the care staff could not manage. On reflection care staff and centre manager believed that new admissions should have be deferred to allow the current dynamics within the centre stabilise. Two young people in the centre expressed the view that the gender mix in the centre was contributing to the current problems and that they had shared their views with the centre manager. The young people expressed the view that although the initial placements may be short term, there was an acceptance and understanding amongst them that their placements would become long term placements.

Inspectors found the care staff were experiencing difficulties in caring for these young people safely. The mix of young people was a contributing factor to the difficulties. Inspectors advised the centre and external managers that a review of the purpose and function of the centre was necessary and the review should include the

capacity of the centre to manage the gender mix, length of placements and the gate keeping role in the admission process. Inspectors held this standard was met in part.

Management
The centre manager had a qualification in child care and managed the centre for six years. He was line managed by the residential services manager. The centre manager had the responsibility for the day to day operations of the centre while the residential services manager had responsibility for the strategic accountability of the centre.

The centre manager met with the residential services manager on a regular basis and there were formal and informal structures in place to review developments in the centre. Care practices and operational policies in the centre were ignored by young people in the centre. Some routines in the centre were not adhered to by them. Inspectors found evidence that night time was a particular vulnerable time in the centre with particular behaviours evident.

Inspectors found evidence that young people slept in each others rooms with care staff attempting to regain control. While staff on duty at night monitored and supervised young people during these episodes, there was a sense, acknowledged by care staff and centre manager, that young people were in control on the centre from time to time.

Inspectors held that this standard was met in part as some care practices and operational policies were not achieving the required objectives of the centre. They were concerned that external managers did not provide sufficient oversight, planning and management to deal with the crisis. Inspectors recommend that the HSE MLA review the effective management of the centre.

Staffing
The inspectors were informed the centre had an approved complement of 16 whole time equivalent staff excluding the centre manager. A child care leader deputised for the manager when necessary. The centre manager highlighted that there were 8 care staff on various leaves including maternity leave. As a consequence there were temporary staff filling these posts. There were 7 child care leaders on the staff team with some of these having allocated responsibilities including supervision of care staff.

Three of the care staff did not have the required qualifications however two of these were in training. Inspectors were told by the centre manager that the HSE were supportive of the third person attaining relevant qualifications.

The staff records were not maintained in the centre however the census provided by the HSE MLA to the Inspectorate indicated that all staff were garda vetted and seven of the staff did not have 3 references on file. Inspectors noted that the staff identified was employed prior to 2001. One of these had 1 reference on file. Inspectors advised that all staff employed since 2005 should have 3 references on file.

Training and development
Care staff had access to training in therapeutic crisis intervention, children first guidelines and fire extinguishers use. Further training in child protection was planned

however the centre manager informed inspectors that first aid training was still to be organised.

Throughout the filed work inspection, common themes were identified. These included young people's sexual health, life skills, independent living skills, drug and substance misuse. Inspectors advised the centre and external managers to undertake an audit of the skills within the team. If there were deficiencies within the team, a training schedule should be drawn up to equip staff to address identified difficulties.

Centre and external managers concurred with the view to consider the current skills within the staff team and to devise a strategy to utilising these skills to meet the needs of young people in the centre.

Administrative files

Centre and external managers acknowledged the need to review the administrative files. Inspectors found evidence where a number of files existed to record information pertaining to young people. Comprehensive recording systems needed to be established to allow for easy retrieval of information.

Inspectors noted there were files in the centre which were being achieved. Inspectors were told this needed to be progressed. They were also concerned that some documentation was stored in an area where young people had previously gained access to without staff permission.

Inspectors recommend the HSE MLA immediately address the need achieve records and make secure any documentation maintained in the centre.

Access to information

Centre staff were clear that young people had access to their daily records. There was evidence that some young people took the opportunity to view information recorded about them. Young people told inspectors they were clear they could view their files. Inspectors found there was a system in the centre for restricting young people from viewing confidential material. While this was necessary, there was no system in place in the centre to review the documents maintained in this file or the transfer from the confidential section to the young person's main file.

Inspectors recommend the HSE MLA review the practices in supporting young people to have access to information held in the centre about them. This should include all information held on file in the centre.

Emotional and specialist support

The centre had a key-worker system in place in the centre. Inspectors found that key workers were aware of the individual needs of the young people and there was discussion at staff meetings on each of the young people. Identified areas of need for young people in the centre included drug misuse, sexual health, aggressive behaviour, learning disabilities, attachment and independent living. The centre staff had developed links with some local services and there was evidence of direct work undertaken by care staff to progress identified areas of concern. Support was provided to care staff from the monitoring officer, the residential services manager and the centre manager.

Inspectors were told by centre and external managers that the care staff team had access to facilitation as a mechanism to review the approach taken by the care staff in meeting the needs of young people. This facilitation ended in 2006 due to cost implications. Centre and external managers acknowledged the need to seek advice and support in addressing the presenting behaviours of the young people in the centre.

The centre staff had access to the local child and adolescent psychiatric team in respect to one young person. The centre and external managers acknowledged the support provided by the service but highlighted the ongoing challenges in managing the young person's behaviour within a residential care setting. Inspectors advised the centre manager and external manager of the need for specialised support to be available on a regular basis to care staff to understand reasons for the behaviours evident in the centre. This would be one approach in determining the strategy to be adopted by the centre staff in managing the behaviours in residential care setting. Inspectors recommended the HSE MLA make available to the staff team, specialist professionals assist in understanding the contributing factors to the young people's behaviour and inform centre staff of possible options to address these behaviours.

Preparation for leaving care

The centre had a policy on preparation for leaving care and leaving care. The former policy highlighted that the centre strives to ensure that "young people have adequately prepared for when they leave care, equipped with the skills, knowledge and resources that they will require". A specific living skills program was identified in the policy as a preferred tool in attaining the objective.

Inspectors found written evidence of an initial assessment to identify areas for activity to assist young people prepare for leaving care. Three of the young people were 17 years of age and leaving care was a significant issue for each of them. Each of the young people expressed to the inspectors uncertainty as to the moving on plans for them. Inspectors were mindful that two of the young people were in the care of the HSE most of their lives and the concept of them reaching their 18th birthday was creating a high degree of anxiety for them. Inspectors recommend the centre and external managers explore the impact this uncertainty has on young people and what approaches can be developed to address the findings.

Inspectors were told that one of the young people had a learning disability and the option for sheltered accommodation was cited as a possible option for him in the long term. It was noted the matter was raised at his care plan review however no evidence was found to indicate the matter was progressing.

Inspectors recommend that the HSE MLA ensure that young people are prepared for leaving care and they have a clear understanding what the plans are and they are consulted as part of the process.

Children's case and care records

This standard was met in part. The centre had a system for recording information on daily records files. Individual work undertaken by key workers was recorded in a separate file. The young people also had a separate file with other information recorded including health and education. Inspectors found that the filing system needed to be reviewed to allow for consistent recording and accountability.

Original documentation was evident on file however there was some inconsistency on where the documents were to be maintained. The inspectors were concerned that records continued to be maintained in the staff office of young people discharged from the centre in the previous six years. A process had been instigated to archive these documents but the process had not been completed. Inspectors were also concerned that information pertaining to young people was stored in an area where young people had previously gained access and could again in the future.

Inspectors recommend a review of the current case and care records system is undertaken and old records are archived appropriately.

Individual care in group living

The relationship between care staff and young people was volatile. Inspectors found that initially young people sought to complain about care staff and the level of care they were receiving. Through the interviews with young people and the subsequent written questionnaires from three of the young people, inspectors found that they were aware their behaviour did not lend itself to appropriate group living.

Inspectors were informed there were ongoing hygiene issues associated with one young person that had possible health implications for everyone in the centre. Measures were taken by care staff to address the concern however it was acknowledged the situation continued to be unacceptable. Inspectors advised the centre and external managers to seek a report from the Environmental Health Officer on the current issues.

Young people were involved in some local group activities. One young person played in the local football club and this was encouraged by care staff. Another worked for a local business on a part-time basis.

Inspectors advise that centre managers review the practices in the centre to encourage open, honest and respectful relationships and a greater emphasis placed on creating a culture of awareness of the impact of group living for individuals and groups.

Provision of food and cooking facilities

Inspectors found that young people were receiving adequate nutritious and appetising food. In general, individual preferences were taken in to account. Young people did not have easy access to food as centre staff had locked food away due to hygiene concerns and young people destroying food. Care staff prepared meals in the evening and young people were encouraged to assist in preparation of meals.

Inspectors recommend the centre and external manager review practices associated with this standard and agree a strategy which facilitates group living.

Race culture, religion and disability

The centre had provided a placement for a young person with learning disability. Inspectors found from review of care files that many challenges were associated with his placement over the years. Care staff were resilient in their approach to support the young person in group living. Services were accessed for him and he was encouraged to function to his full potential.

Inspectors were concerned that the dynamics within the group of young people did not facilitate or encourage mutual respect or positive images of gender. This was evident in the volatile relationships each young person had with the other, the inconsistencies in their expectations and understanding of each other.

Inspectors recommend the centre and external manager review the standard and devise a strategy in the centre incorporating young people and care staff to address the current shortcomings.

Education

Inspectors found the centre placed a great deal of emphasis on education, training and employment. Each of the young people in the centre either attended school, FAS course or had employment. Inspectors found that their attendance was poor. This was particular evident prior to the inspection. One young person stated to inspectors she had never missed a day on her hairdressing course prior to her admission to the centre. Since she took up her placement, her attendance was increasingly deteriorating. This position was confirmed by care staff and reasons cited included peer pressure and unable to get up in the mornings due to disruptive behaviour during the night.

Another young person had recently completed her mock leaving certificate exams. Results were very poor and inspectors were informed by care staff and centre managers that although the young person had the ability to attain a good result in the June exams, her lack of attendance was the contributing factor to the poor results.

The view was held by social workers that there was a determination amongst the care staff to encourage young people to continue with their education and training. They reaffirmed that the underlying cause for poor outcomes was the failure of the young people to attend as required.

Inspectors noted that the strategy adopted by the HSE MLA to encourage young people to attend education and training was not attaining the desired outcomes. Inspectors recommend a change in the current approach and practices within the centre are established to maximise the opportunity available to the young people.

Health

Inspectors were informed that all young people in the centre had medical examinations on admission to the centre. No records were available on the young persons care file verifying this position. Centre and external managers told inspectors that the medical examinations were the responsibility of the placing social worker to organise. Inspectors advised that a copy of the medical should be available to the centre staff so as to inform care staff on any medical issues. Inspectors were mindful that one young man was deemed to be allergic to penicillin. This was noted on his care file however there were no medical records indicating how this view was formed.

Inspectors were concerned that the records of prescribed and un-prescribed medications were not operated correctly. Information on when young people took their medication was not always recorded and on some occasions it was unclear why the prescribed medications were not completed. The record system did not lend itself

to appropriate monitoring, accountability or reviews. The centre manager and care staff accepted the shortcomings in the system and agreed to review immediately.

Inspectors found written consent for one young person for medical treatment. Three of the young people were over 17 years of age and inspectors were informed by care staff that these young people could provide consent if so necessary. There was no medical consent on file for the young person under 17 years of age. Inspectors recommend that this matter requires immediate attention by the HSE MLA.

Young people in the centre smoked cigarettes and inspectors were informed there were on going challenges as young people smoked in their bedrooms. Inspectors found evidence of people smoking at the rear of the centre and there was an odour of smoke in the centre during the fieldwork. This matter will be further addressed under the fire safety standard.

Accommodation
The building was a four bedroom house located on the outskirts of the local town. It was situated on a cul de sac with a number of houses in the immediate vicinity. Each of the young people had their own bedrooms and there was a large sitting room towards the front of the building. The kitchen / dining room was a large room where care staff and young people congregated for dinner.

During the time of the field work, some remedial painting was underway. Inspectors found the centre bare with many of the interior decorations removed following damage by the young people. The young people's bedrooms were a good size however one young person was sleeping on a mattress on the floor following an incident where she destroyed the frame of the bed. Plans were underway to replace the bed frame.

There was one bathroom for the four young people in the centre. Staff had a separate toilet next to the young people's bedroom area. There was a toilet adjacent to the care staff office however this was not in use due to proximity and privacy issues. Inspectors were mindful of the challenges experienced in managing two adolescent boys' and girls. The inspectors advised the centre and external manager consider the current bathroom facilities lay out and whether improvements could be made to facilitate separate toilets for the males and females in the centre.

Maintenance and repairs
The centre manager told inspectors that damage to the centre had occurred recently. Repairs were carried out as soon as possible and the manager stated he there were no delays in carrying urgent repairs. The interior painting underway during the filed work was planned maintenance. Consideration was also been given to the removal of the hallway carpets following flooding by young people. More robust flooring was been considered by the centre manager.

Safety
The centre had a health and safety statement dated October 2008 signed by the centre manager and the residential services manager. It included hazard identifications, required control and risk rating. Fire extinguishers were checked in February 2009. Due to difficulties in managing young people's behaviours, fire extinguishers were maintained in locked areas. Inspectors advise the signage in the centre should reflect the current location of this equipment.

The centre had two cars. One of the cars did not have a first aid box or a reflective triangle. A first aid box was immediately placed in the car and inspectors were informed the reflective triangle would be sourced. Medicines were stored in a secure wall unit in the staff office. A secure cabinet to store knifes was also in the staff office.

Aftercare

Inspectors were informed the HSE MLA did not have an aftercare worker. A position had been advertised in recent months and plans existed to fill this position. Inspectors were concerned that the three of young people in residence would be leaving the centre in the next 12 months. Two of the young people were in the care of the HSE for most of their lives.

There were conflicting reports that aftercare services from a private provider could be accessed by young people who had been in care. Centre and external managers indicated they continue to have contact with former residents of the centre however this is not a long term formal arrangement.

Inspectors were concerned that there was no clear practice or policy in regard to aftercare services for young people leaving care. They recommend the HSE MLA outline all aspects of supports and entitlements for a young person leaving the care system.

Restraint

Inspectors were informed that there has been no use of physical restraint in the centre over the past 12 months. Reason cited for this included the physical stature of the young people and the inability of this intervention been undertaken safely. Inspectors were concerned that this view was not reflected in the individual crisis intervention plans for each young person.

Inspectors were informed that there was no physical intervention of any nature over the past 12 months. Inspectors noted a complaint made by a young person that they were removed from a bedroom by member of staff. The complaint was investigated and found the matter was managed appropriately. Inspectors noted this level of intervention was not noted as a physical intervention.

Inspectors recommend the practices in the centre on physical intervention should be reviewed and these should reflect the HSE policy.

Safeguarding and child protection

The centre had a policy on child welfare and protection. The purpose of the policy was to keep young people safe through conscious steps designed to ensure a regime and ethos that promoted a culture of openness and accountability. The centre provided a written overview of its safeguarding policy. It stated that children's rights, policies on absconding, bullying, safeguarding, child protection and complaints formed the safeguarding policy.

Inspectors found that care staff had knowledge of safeguarding policies. Inspectors were concerned that behaviours displayed by young people were unsafe. There were deficiencies in the strategies adopted within the centre to manage these situations. This was evident of the negative influence young people had on reach other, the risk

taking behaviour both within and external to the centre and the inability of the HSE MLA to remedy the situation.

The centre had a policy on child protection. Inspectors found evidence where child protection concerns were notified to the allocated social worker. The concerns identified included sexual abuse, emotional abuse and neglect. Social workers informed inspectors that they were satisfied that concerns were appropriately referred. These concerns were investigated by the social work departments and all matters were addressed. Inspectors were concerned that the centre was not familiar with the outcome of a number of referrals and recommend the HSE MLA notify the centre manager of the outcome of child protection matters referred by the centre.

Absence without authority
Ninety-one absences without leave were recorded in the centre between March 2008 and December 2008. The circumstances leading to the absences varied and involved the majority of young people in the centre during this period. In some instances young people did not return from school or other activities. On other occasions young people left the centre following arguments with staff or acting out /aggressive behaviour.

The centre had an "Absconscion Policy" dated 2008. It included a recorded risk assessment which allowed for a description of the risk, identification of the factors contributing to the risk, the decision and the outcome.

Inspectors found evidence that the level of absences of young people from the centre was a concern to centre staff and management. Strategies to manage these incidents involved staff looking for young people themselves, informing the Gardai and contacting family members to assist locate them. Inspectors found that the level of absences was connected to the challenges experienced by care staff in managing young people's behaviours.

Practices that did not meet the required standard

Monitoring
Inspectors interviewed the HSE monitoring officer by phone. The inspectors were told by the HSE monitoring officer that she had not visited the centre for five months due to sick leave and annual leave. She acknowledged that she had just reviewed a number of significant incident reports submitted to her.

The HSE Monitoring officer expressed the view she was satisfied with the level of care in the centre up to September 2009. She stated there were difficulties but the centre staff were managing these challenges satisfactorily. She expressed concern about the safety of young people and staff and had planned to visit the centre immediately.

Following her inspection another discussion took place between the HSE monitoring officer and inspectors. The HSE monitoring officer expressed concerns as to the ability of the centre to manage the challenges exhibited by the young people in the centre. She noted concern in regard to the recent admission to the centre, the volatility of the young people in the centre and the difficulties experienced by care staff. Inspectors were told that senior management in the HSE MLA were informed

by the monitoring officer of her concerns and immediate remedies had been cited by the centre manager to address these concerns.

Inspectors were concerned that there was no monitoring of the centre for five months. There were no written reports indicating compliance with regulations and standards. The inspectors recommend the HSE MLA ensure the monitoring of the centre is in line with the Child Care) Placement of Children in Residential Care) Regulations 1995, Part III, Article 17.

Inspectors recommend the HSE MLA should review the practices associated with the absences without leave policy and devise a strategy in conjunction with the managing behaviour recommendation.

Suitable placement and admissions

The purpose and function of the centre stated the centre was a medium to long term residential placement. Inspectors found that two young people were placed in the centre initially on short term placements. One of these young people was in residence 5 months and it was intended to continue with the current arrangements. The other had just taken up placement which was requested for 3 months to allow time for the young person to be reunified with her parents. Inspectors were told there was no foster care placement available for this young person.

Centre manager and external management acknowledged that placements had extended beyond initial requested time periods. Inspectors were told that the admissions committee for the centre made the final decision and that all parties were mindful of the need to utilise the places available within the HSE residential services. One social worker said to inspectors, while residential care was not the first preference, she was satisfied the residential centre met the needs of the young person.

Inspectors were concerned at the reports on file and information shared with them that young people in the centre had access to illegal substances. There was antidotal evidence that one young person was responsible for bringing substances into the centre. Inspectors were also concerned about the reported events at night when young people slept in each others rooms. Care staff supervised young people when this occurred to reduce the possibility of inappropriate behaviours escalating in the centre. Inspectors found reports of child protection concerns involving three of the young people during times away from the centre on different occasions and involving adults.

Inspectors were concerned the current placements of young people in the centre were not meeting the welfare, health, emotional and psychological needs of the young people. Inspectors recommend a review of the current placements is undertaken and a comprehensive strategy is agreed to meet the identified needs of young people in residence. The inspectors also recommend that no further placements are undertaken until the purpose and function of the centre is reviewed and robust practices are in place to manage behaviours.

Managing behaviour

The centre had a written policy on managing behaviour. This policy clarified the rights and responsibilities of young people and care staff and encouraged the consideration of underlying causes of the behaviour. The centre had a log titled

Behaviour Management Techniques. It described the behaviour of concern, the decision made to address the behaviour and the outcome. Following discussions with the inspectors, centre manager acknowledged the log was an account of sanctions used to respond to difficult behaviour.

The policy on managing behaviour was not explicit in regard to the use of therapeutic crisis intervention. The policy document referred to absconding and restraints being recorded on "TCI forms". The policy document contains details of therapeutic crisis intervention policy for the HSE MLA. During interview with centre manager, external manager and care staff, therapeutic crisis intervention de-escalation interventions were stated as the approach used in the centre for dealing with difficult situations. There was evidence on young peoples care files which described interventions used by care staff to manage situations. Social workers indicated they were kept informed of the approached adopted by the centre in responding to crisis.

Inspectors found that young people had individual crisis management plans which were reviewed periodically. There were developed in the centre by key workers and circulated to social workers for their information.

Gardai were called to the centre to respond to disturbances in the centre. Inspectors were informed that the Gardai were called to the centre when a young person destroyed her bed. Gardai charged her with the damage to property. Inspectors were informed of other similar situations.

Young people informed inspectors they were aware their behaviour was not acceptable from time to time. They cited problems in their relationships with the other young people in the centre and the lack of authority displayed by care staff as reasons they behaved inappropriately. Some young people expressed dissatisfaction that the Gardai were called to manage their behaviour.

The centre had an anti bullying policy. It explored the definitions of bullying and the impact on individuals. The policy stated the strategies for dealing with bullying in the centre. Inspectors found evidence of bullying occurring in the centre between young people. This was of particular concern as some young people felt persuaded to act in a certain manner towards care staff.

Inspectors found that care staff were aware of their need to manage behaviours. There was a high level of reliance on therapeutic crisis intervention as the approach to adopt in responding to situations. The use of sanctions was not consistent and often did no deter young people from acting out. The need to seek assistance from the Gardai while necessary on some occasions highlights the inability of the care staff team to control activities within the centre.

Inspectors recommend the HSE MLA immediately examine the policy and practices of managing behaviour. Inspectors were concerned about the level of risk to young people and care staff.

Fire safety

Inspectors were told by centre and external manager the HSE MLA did not have written confirmation from a certified engineer or qualified architect that all statutory requirements relating to fire safety and building control have been complied with.

Inspectors were told that the architect had inspected the centre and written confirmation was pending. Inspectors requested this be forwarded to the inspectorate as soon as possible however in the interim the standard was not met.

Inspectors were told by centre staff that young people smoke in their bedrooms. This was confirmed by young people. This is a dangerous practice and the HSE MLA should ensure the practice immediately ends.

Conclusion

The inspectors found there were deficiencies in key practices in the running of the centre. These specifically related to approaches in meeting their individual needs including leaving care. Inspectors were concerned that the purpose of the centre was not adhered to by the admissions committee, centre manager and external managers. The centre and external manager's strategies to deal with the difficulties in the centre were inadequate. Deficiencies in the monitoring role in recent months were also concerning.

The HSE MLA initiated practical actions to the concerns identified during the inspection. These actions were noted by the inspectorate however a comprehensive action plan to address all the recommendations will be sought by the inspectorate and a follow up inspection will be undertaken to consider if the recommendations have been met.

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 MLA should review the purpose and function of the including gender mix, length of placements and admission selection process.**

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 MLA should develop systems to ensure the effective management of the centre.**
3. **The HSE MLA should ensure that references are sourced for all staff in the centre.**

4. **The HSE MLA should ensure an audit is undertaken of the skills within the team and a schedule of training developed.**
5. **The HSE MLA should ensure a review of the administrative files are undertaken and appropriate systems are put in place.**

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			√

Recommendation:

6. **The HSE MLA should ensure the monitoring of the centre is in line with the Child Care (Placement of Children in Residential Care) Regulations 1995, Part III, Article 17.**

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:

7. **The HSE MLA should review the practices in the centre to support young people access to their information.**

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		√	
Aftercare		√	
Discharges	√		

Recommendations:

8. **The HSE MLA should ensure the appropriate placement of young people in the centre.**
9. **The HSE MLA should ensure that supports and leadership is available to the care staff to determine the underlining causes of the behaviour and formulate strategies to respond to the needs of young people.**
10. **The HSE MLA should ensure that a preparing for leaving care and aftercare programs are available to meet the needs of young people leaving the centre.**

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		√	

Recommendations:

11. **The HSE MLA should ensure the elements necessary to care for young people in residential care are reviewed and practices developed in line with the policies of the centre.**
12. **The HSE MLA should examine the policy and practices to manage behaviour and a comprehensive strategy agreed to respond to the shortcomings of the service.**

7. Safeguarding and Child Protection

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

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

Recommendation:

13. **The HSE MLA should examine the safeguarding practices and the policy is amended to incorporate all elements of best practice.**

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		√	

Recommendation:

14. **The HSE MLA should ensure the current approach to education and training practices maximise the opportunity available to the young people in the centre.**

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:

15. **The HSE MLA should ensure an immediate examination of the policies and practices of the centre and in particular consider the management of medication systems, medical examination records and consent for medical attention.**

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:

16. **The HSE MLA 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 MLA should review the purpose and function of the including gender mix, length of placements and admission selection process.
2. The HSE MLA should develop systems to ensure the effective management of the centre.
3. The HSE MLA should ensure that references are sourced for all staff in the centre.
4. The HSE MLA should ensure an audit is undertaken of the skills within the team and a schedule of training developed.
5. The HSE MLA should ensure a review of the administrative files are undertaken and appropriate systems are put in place.
6. The HSE MLA should ensure the monitoring of the centre is in line with the Child Care (Placement of Children in Residential Care) Regulations 1995, Part III, Article 17.
7. The HSE MLA should review the practices in the centre to support young people access to their information.
8. The HSE MLA should ensure the appropriate placement of young people in the centre.
9. The HSE MLA should ensure that supports and leadership is available to the care staff to determine the underlining causes of the behaviour and formulate strategies to respond to the needs of young people.
10. The HSE MLA should ensure that a preparing for leaving care and aftercare programs are available to meet the needs of young people leaving the centre.
11. The HSE MLA should ensure the elements necessary to care for young people in residential care are reviewed and practices developed in line with the policies of the centre.
12. The HSE MLA should examine the policy and practices to manage behaviour and a comprehensive strategy agreed to respond to the shortcomings of the service.
13. The HSE MLA should examine the safeguarding practices and the policy is amended to incorporate all elements of best practice.
14. The HSE MLA should ensure the current approach to education and training practices maximise the opportunity available to the young people in the centre.
15. The HSE MLA should ensure an immediate examination of the policies and practices of the centre and in particular consider the management of medication systems, medical examination records and consent for medical attention.
16. The HSE MLA 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.