SOCIAL SERVICES INSPECTORATE

A CHILDREN'S RESIDENTIAL CENTRE IN THE NORTHERN AREA HEALTH BOARD COMMUNITY CARE AREA 7

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1. Executive summary

The Social Services Inspectorate (SSI) carried out an inspection of Cuan Solas children's residential centre in October 2002. The centre is located in and operated by community care area 7 of the Northern Area Health Board (NAHB). At the time of inspection the centre was operating at full capacity, with six residents aged between 12 and 17.

The centre offered a very good standard of care to the young people. However, the health board had not met with all of the requirements of the Child Care Regulations, 1995 in the service it provided for the young people in Cuan Solas.

There was a clear written statement of purpose and function that was understood by staff and young people and was reflected in practice. The statement was accompanied by a policies and procedures document that had been recently updated to reflect changes in practice.

Staff at the centre had experienced a period of professional isolation of over a year as the centre manager was effectively without a direct line manager and the young people were without social workers. This was due to shortages of social work staff in the NAHB. Shortly before inspection the situation was rectified with the appointment of an alternative care manager and the allocation of newly recruited social workers. Inspectors found evidence of some divisions within the staff team over how best to manage the young people's behaviour. Some work was required to resolve outstanding differences. Despite this, the team functioned effectively and was well managed.

Arrangements for the external monitoring of standards at Cuan Solas were under discussion in NAHB at the time of inspection. Inspectors urge that these be brought to an early conclusion and that the board meet its statutory obligations in this matter.

Practice in relation to children's rights was excellent. In particular, there was a high degree of consultation with young people in relation to the running of the centre and the young people felt involved in the decision making process.

The statutory requirements in relation to care planning and reviews had not been met. There had been no care planning or review in the two years prior to inspection, due to the lack of social workers. This process was beginning again during the inspection. The service offered to the young people and their families had suffered due to lack of social work input. The young people had no external advocates, their contact with siblings outside of the centre had diminished and their parents were not always informed of significant
Events in their lives. However, family members were welcomed to the centre and staff facilitated visits to parental homes.

None of the young people were attending specialist services. The staff team needed access to such services for consultation to better help the young people to address their difficulties.

Care practices were good.

Practice in relation to education was excellent. Three of the young people were doing extremely well at school with the help and support of the staff team. The staff were exploring education, training and employment options for the other young people.

Practice in relation to health care was generally good. Some more work was needed in the area of health education and in discouraging the young people from smoking.

The premises were too small. There was insufficient living space for the young people and insufficient work space for the staff. Though a safety statement had been prepared no safety audit had been carried out. However, the health board had acquired a larger house to which the centre was due to move within weeks of the inspection.

2 Introduction

Cuan Solas is a children's residential centre run by the Northern Area Health Board (NAHB). It was inspected by the Social Services Inspectorate (SSI) under Section 69(2) of the Child Care Act 1991 in October 2002. Anne Ryan and Andrew Fagan (lead inspector) carried out the inspection.

2.1 Methodology

Prior to inspection inspectors read documentation relating to the centre. A pre-inspection visit took place in September to explain the process of inspection to the young people and staff. The inspection took place over a three-day period during which inspectors observed care practices and participated in some of the routines of the centre. Formal interviews were conducted with four young people, two parents, the manager and four members of the staff team, two social workers, the external line manager and the general manager for the community care area. In addition, centre records were examined.

2.2 Acknowledgements

The inspection was conducted in a spirit of openness and co-operation and inspectors wish to express their gratitude to all who participated in the inspection for their assistance.

3 Setting the scene: background, the unit and its population

The centre was set up at short notice in 1996 to care for four members of the same family who were admitted to care. Later, two siblings of another family were also admitted. The centre, then based in different premises, experienced considerable instability due to a high turnover of staff. However, with the move to the current premises and the emergence of a stable staff team, the centre settled and provided the young people with stability and continuity of care. At the time of inspection the centre was based in a semi-detached house in an estate of similar, privately owned houses in a suburb of Dublin. Larger premises had been identified and there were plans to move to these shortly after the inspection.

Data on young people

Young person	Age	Length of time in centre	Legal Status	Previous placements
#1 sibling of #2	17	5 years	Care Order	2 short term foster placements
#2	14	5 years	Care Order	2 short term foster placements
#3 sibling of #4,5 and 6	17	6 years	Care Order	None
#4	16	6 years	Care Order	None
#5	14	6 years	Care Order	None
#6	12	6 years	Care Order	None

4. Standards: the findings

4.1 Statement of purpose and function

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

The centre had a statement of purpose and function that had been developed about two years prior to inspection. It described Cuan Solas as a community based home whose purpose is to provide a home on a long-term basis to six young people who require a safe, caring and supportive environment in which their individual needs can be met. The statement set out aims, values and an approach to care practice that emphasised working in partnership with families and other professionals.

The statement was accompanied by a set of policies and procedures. Many of these policies had been revised and updated in 2002 to reflect changes in policy and practice. Some of these will be considered under the relevant headings later in this report.

The statement of purpose and function was reflected in the practice of the centre. It was understood by staff and young people.

The requirements of this standard were met.

4.2 Management and care staffing

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

4.2.1 Management

Up until March of 2002, the external line manager had been the principal social worker. There had been a number of changes in personnel that led to a situation where the centre manager was effectively without a direct line manager for a period of about a year. This combined with the fact that there were no social workers assigned to the young people in the centre for the best part of two years, led to a degree of professional isolation for the centre manager. Some difficulties and tensions within the staff team, considered later in this report, had been exacerbated by the lack of external support during this period. Despite these adverse circumstances, the centre had been well managed.

Management of the centre had been strengthened by the appointment in March of 2002 of an alternative care manager. The centre manager reported to this person who, in turn, reported to the general manager. The appointment of the alternative care manager gave the centre manager access to regular formal supervision as well as informal support, often on a daily basis. In addition to supervising the centre manager, the alternative care manager visited the centre, read the records and met with the young people. He was also instrumental in resolving divisions within the staff team over approaches to behaviour management and related issues considered in more detail later in this report.

A member of the care staff deputised for the manager in her absence. Health board managers informed inspectors that this position had no official standing and did not attract any allowance. They saw a need for a position of deputy manager in Cuan Solas and in the other children's residential centres in the community care area and were seeking to put this in place. However, the person who acted for the manager in her absence had a different understanding of her role and this difference, combined with differences over care practices, led to difficulties in communication and practice that had been addressed but had not been fully resolved at the time of inspection. Inspectors consider that the two matters need to be distinguished and dealt with separately. The issue of the position of the care staff in question needs to be resolved by health board managers.

The centre manager envisaged a more developed management structure with the appointment of a deputy manager and of two child care leaders who would act as shift leaders. In practice, one person from each shift assumed responsibility for co-ordinating the shift but this was an informal arrangement. Inspectors found that management practice was good but it would have been enhanced by a more developed structure such as that outlined by the centre manager. Managers who operate without the assistance of deputies have difficulty in performing all of their management functions and this was the case in Cuan Solas where

formal supervision of care staff was just being introduced at the time of inspection. The centre manager saw this as a responsibility she could share with a deputy.

Recommendations

1. Health board managers should take steps to resolve outstanding issues in relation to the position of the staff member who deputises for the manager in her absence.
2. Health board managers should proceed with their plan to appoint a deputy manager to Cuan Solas.

4.2.2 Register

There was no register in Cuan Solas at the time of inspection. Inspectors were informed that steps were being taken to rectify this situation.

Recommendation

3. The centre manager should introduce a register for Cuan Solas as required under the Child Care Regulations, 1995.

4.2.3 Notification of significant events

With the absence, for a prolonged period, of both an external line manager and of allocated social workers the system for notification of significant events had broken down. However, at the time of inspection, significant events were being notified to the external line manager and the young people's social workers.

4.2.4 Care staffing

Young people are looked after by staff who are trained in the skills necessary to meet their needs and, who receive appropriate professional support from management for the tasks that they are required to carry out.

No member of the staff team had a professional child care qualification. Some staff members had related qualifications or degrees such as in social work and psychology. The board, through time off and payment of fees, was supporting one member of staff to obtain professional qualification. Another member of staff was doing a diploma in learning difficulties studies and the board was paying her fees and allowing time off for examinations. The board is commended for supporting staff development in this way but more needs to be done to increase the number of qualified staff.

The team was well balanced in terms of gender and the age range of staff members. While half of the team had been in post less than two years, four staff members had been looking after the young people for more than five years, thus providing them with stability and continuity of care.

STAFF EXPERIENCE, STATUS AND QUALIFICATIONS [1]

CARE STAFF	LENGTH OF SERVICE IN CUAN SOLAS	EMPLOYMENT STATUS	QUALIFICATIONS
Centre Manager	5 years 7 months	Permanent, full-time	B.A. Social Work
Child Care Worker #1	1 year 9 months	Permanent, full-time	Currently studying for a degree
Child Care Worker #2	2 years 9 months	Permanent, full-time	Diploma in Nursery Nursing
Child Care Worker #3	6 years	Permanent, full time	NCVA, Leisure Management and Outdoor Pursuits
Child Care Worker #4	5 years 5 months	Permanent, full-time	Diploma in Human Resources
Child Care Worker #5	6 years	Permanent, part-time	No Qualification
Child Care Worker #6	1 year, 5 months	Permanent, full-time	B.A. Psychology
Child Care Worker #7	1 year, 4 months	Permanent, part-time	No Qualification
Child Care Worker #8	5 years	Permanent, full-time	Diploma in Nursery Nursing
Child Care Worker #9	2 months	Temporary, full-time	B.A. H. Dip in Education
Child Care Worker #10	1 month	Temporary, fulltime	Diploma in Social Studies

Personnel records at the centre were incomplete. According to information provided to inspectors Garda clearance had been obtained in relation to ten of the eleven staff members. The exact dates on which clearance had been obtained were not known in relation to two staff and in relation to one staff member it was not known whether or not Garda clearance had been obtained at all. Of the eight staff for whom there was exact information on Garda clearances at least six had commenced employment after Garda clearance had been obtained one had started before clearance was obtained. The remaining staff member had started the same year as clearance was obtained but since the date she commenced employment was not provided it was impossible to know whether this preceded or followed clearance. Information on references was available on one staff member only. It showed that two references, rather than the required three, had been obtained only after the person had started working at the centre. This is not satisfactory. Personnel files should clearly record the checks that were carried out on staff. Garda clearance and three references are required and should be obtained before the person commences employment. The manager and alternative care manager should check existing personnel files to identify and make good

[1] Emboldened denotes qualifications listed by the Department of Health and Children as required for child care leader status.

any gaps either in the records or in the checks themselves. Proper procedures ought to be followed in the future.

Staff worked 25-hour shifts that included a sleep over. The manager worked office hours but opted to do at least one shift per week. This released a staff member to work a day shift so that some days there were three staff on duty, at least during the day. The manager considered that there was sufficient staff. Each shift began with a handover from those going off duty to those coming on duty and the latter appointed a shift co-ordinator and made a plan for the day.

The staff team met as a group every fortnight and there was an expectation that all staff members attended. Minutes were taken and typed up and those who could not attend were expected to read them. Inspectors were informed that differences within the staff team were discussed openly. In general, consensus was achieved but where this was not possible it was accepted by the team that the manager's word was final.

Staff members, in general, told inspectors that communication within the staff team was good and that team members worked well together. Inspectors found evidence to support this. However, there was also evidence that some differences of approach to behaviour management had led to divisions within the staff team. A staff facilitator had done work with the team to help the staff to change practice in response to the changing age profile of the young people in the centre. The divisions within the staff team were not critical at the time of inspection but neither had they been resolved fully and some further work was required to bring this about. Specifically, communication and conflict resolution within the team needed to improve. Some consideration needs to be given to how best this might be achieved, for instance, through further staff facilitation or through specific training or consultation for the manager.

Recommendations

4. The alternative care manager should devise a strategy to increase the number of qualified staff
5. The centre manager and alternative care manager should check the personnel files to ensure that proper checks were carried out on staff and that these are recorded on the files.
6. The alternative care manager should ensure that proper vetting procedures are followed in any future recruitment of staff to Cuan Solas.
7. The centre manager in consultation with her line manager should devise and implement a strategy to improve communication and conflict resolution within the staff team.

4.2.5 Supervision and support

The centre manager was introducing formal supervision for staff members at the time of inspection. However, the format for supervision had not been agreed and the manager expressed a lack of confidence in relation to this matter. Members of the staff team interviewed by inspectors stated that formal supervision did not occur frequently but said that the manager was available for informal supervision and that they found her to be supportive.

Recommendation

8. The alternative care manager and centre manager should explore training and/ or consultation options for the centre manager in relation to supervision of staff to ensure the full implementation of a programme of formal supervision for all members of the staff team.

4.2.6 Training and development

There was no formal induction training programme for new members of staff. However, the manager and a member of the staff team had put together various materials as an induction pack for new staff and this was being further developed at the time of inspection. Also new members of staff 'shadowed' more experienced members of the team for a number of shifts before being expected to assume the full responsibilities of a member of the staff team. The manager acknowledged that this had not always happened in the past and that sometimes people were 'dropped in the deep end' and expected to assume full responsibilities as soon as they started work. However, since the centre had become more firmly established this was unlikely to recur in the future.

Members of the staff team had participated in various in-service training programmes. All of the team had been trained in therapeutic crisis intervention (TCI). Physical restraint was not used in the centre and so TCI was seen as way of helping staff to learn techniques for de-escalating and dealing with the aftermath of tense situations. All but one staff member had attended Children First briefings and three had attended a two-day training on Children First. One member of staff had done a First Aid course and another an 'In Touch with Children' course.

As discussed earlier (4.2.4) a staff facilitator had done a number of sessions with the team in helping them to develop an age appropriate approach to the management of the young people's behaviour. The manager had also met with the facilitator and consulted with him in relation to a number of issues. He was available to the manager or the team if required. At the time of inspection, there was no definite plan for the facilitator to do more work with the staff team.

4.2.7 Administrative files

There were various recording instruments in use in the centre such as a communications book, a shift planning book and a staff signing-in book. Inspectors particularly commend the fact that the minutes of the team meeting were typed up and readily available to members of the staff team. Administrative recording was good.

4.3 Monitoring

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

There was no system for the external monitoring of care standards as required under the Child Care Regulations (1995). However, the board was aware of the need for this. Discussions were taking place within the board about the most suitable arrangements for

monitoring. Inspectors urge that these be brought to a satisfactory conclusion at the earliest opportunity.

Recommendation

9. The board should arrange for the external monitoring of standards at Cuan Solas at the earliest opportunity.

4.4 Children's rights

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

Practice in relation to children's rights at Cuan Solas was exemplary. The policies and procedures document contained a section on children's rights that had been updated in 2002. It included statements on the rights to information, to be consulted and to make a complaint. It also referred to the right to be cared for safely, the right to privacy, the right to be supported in education and so on.

4.4.1 Consultation

The young people interviewed by inspectors confirmed that staff consulted with them on a regular basis. This was done both formally and informally. Children's meetings were held at the centre but not on a regular basis. The manager stated that this was because, as the young people grew older, they were less inclined to want to sit through such meetings. She had, therefore, devised other means of consulting with them. As she worked some shifts she met with them informally to hear their views on various issues. The team acted on these wherever possible. For instance, the keyworker system was changed during 2002 because of misgivings expressed by the young people about the way it operated.

A particularly impressive aspect of consultation was that the young people had been invited to participate in some staff team meetings. This had happened during the school holidays over the summer and the manager envisaged it happening again, perhaps during the Christmas break. Some of the young people referred to this and said that they found it helpful.

At the time of inspection, an information booklet for young people was being prepared and the young people were involved in putting it together. Two of the young people had written a number of sections. Their contributions were of a high standard.

4.4.2 Complaints

There was a well-developed written complaints procedure. It clearly distinguished between complaints procedures, staff disciplinary procedures and child protection procedures. It described what young people should do in the event that they are unhappy with any aspect of the service. The procedure referred to a young person's right to appeal against the outcome of the investigation of a complaint if dissatisfied but did not state to whom the appeal should be made. Apart from this the procedure was a good one.

In keeping with best practice, complaints were dealt with in-house in the first instance. While there was a designated complaints officer and complaint forms, the young people made known their unhappiness about aspects of their care to the centre manager or to any member of the staff team. Some of the young people interviewed by inspectors provided examples of issues that they had raised that had been dealt with to their satisfaction. In one case, a young person who had continuing concerns discussed them with the alternative care manager and this appeared to resolve the issues.

Recommendation

10. The manager should amend the complaints procedure to state to whom appeals can be made in the event that a young person is unhappy with the outcome of the investigation of a complaint.

4.4.3 Access to information

The young people had access to all parts of their care file. If they wanted to see it, a member of staff facilitated this by sitting down and going through it with them. Inspectors commend this practice. However, it was not clear that the authors of reports not prepared by centre staff were made aware of this practice and inspectors consider that they ought to be informed of centre policy.

Two of the young people were approaching 18 years of age. Inspectors met with one of these young people and she was clear about the support available to her from the board for the next years of her life.

Recommendation

11. The manager should inform those who prepare reports on the young people in Cuan Solas of the centre's policy on access to information.

4.5 Planning for children and young people

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

4.5.1 Suitable placement and admissions

The young people in Cuan Solas were appropriately placed in terms of the stated purpose and function of the centre. There was a policy in relation to admissions that was in accordance with best practice but since there had been no admission for 5 years previous to inspection, practice could not be inspected.

4.5.2 Statutory care plans

There were no up to date care plans on any of the young people in Cuan Solas contrary to the requirements of the Child Care Regulations, 1995. For a period of approximately two years none of the young people had an allocated social worker due to a shortage of social workers in the health board. Just prior to inspection, two social workers, both recently recruited, were allocated, one to each sibling group. The social workers had only just been introduced to the young people and parents and it would not have been reasonable to expect that care plans could have been drawn up before the inspection. The social workers both stated their intention to draw up care plans as a matter of priority.

The care files contained copies of placement plans prepared by the young people's keyworkers. Some of these were very detailed and comprehensive and, though not a substitute for care plans, demonstrated that the care of the young people in the centre was structured and planned.

4.5.3 Statutory care plan reviews

There had been no care plan reviews, again contrary to the requirements of the Child Care Regulations, 1995. However, during the inspection review meetings were held on two young people from the same family. The young people and their parent were invited to attend. The parent was unable to do so. One of the young people participated in part of the review meeting. Further meetings were planned in relation to the other four young people.

4.5.4 Contact with families

The two parents interviewed by inspectors stated that they found members of the staff team to be helpful, friendly and welcoming. One family visit was observed and the parent was clearly at ease, had access to all parts of the house and had a meal at the centre. However, she lived some distance from the centre and needed to get two buses from her own home to the centre. Previously, her social worker had arranged a bus pass for her but, when he left, she was unable to get another, despite approaching both the centre and the social work department for assistance in the matter. Inspectors consider this unacceptable and urge that the situation be rectified immediately. The other parent preferred to meet with her children at her own home. Indeed, both sets of siblings spent time with their parents at the parental home and staff at the centre facilitated this.

One parent was unhappy about the level of communication with centre staff. She felt that she was not sufficiently informed of significant events in her children's lives, such as illnesses and injuries. This needs to be addressed and an agreement made between centre staff and social workers as to who is responsible for ensuring that parents are kept informed of events in their children's lives.

Inspectors heard from both young people and parents of unhappiness with the level of contact between the young people in Cuan Solas and some of their siblings.

Neither of the parents interviewed had been informed that there was a procedure for dealing with complaints.

Staff attitudes to family contact were positive but some practices need to change. There is a need for better communication with parents and parents should be helped with transport costs when they visit the centre.

Recommendations

12. The centre manager should agree with the young people's social workers who should keep parents informed of events in the lives of their children.
13. The social workers of the young people should ensure that parents receive assistance with transport to visit their children in Cuan Solas.
14. The social workers for the young people should ensure that the parents of the young people are aware of the board's complaints procedures.
15. The social workers for the young people should review the levels of contact between the young people in Cuan Solas and their siblings

4.5.5 Supervision and visiting of young people

Supervision and visiting of young people at Cuan Solas had not taken place for the two years prior to inspection for the reasons stated at 4.5.2. The recently allocated social workers stated the intention of visiting at least monthly. They had asked for and had been assured of free access to centre records.

4.5.6 Social work role

As stated at 4.5.2 social workers were allocated to the young people just prior to inspection.

The absence of social workers had had a detrimental impact on the service offered to the young people and their families. The young people lacked an external advocate. There had been no care planning and reviews. There was a lack of information sharing with parents and the level of contact between the young people and their siblings not living at the centre had diminished. The staff were professionally isolated and had no one to help them make sense of what was happening in the lives of the young people.

4.5.7 Emotional and specialist support

There was a keyworking system in Cuan Solas. Keyworkers took responsibility for particular aspects of the young people's care such as ensuring that they had enough clothes, that their health needs were being attended to and so on. The young people had expressed some misgivings about the keyworker system as a result of which it had changed shortly before the inspection. The young people objected to the idea that they could be assumed to wish for a close supportive relationship with a member of the staff team chosen on their behalf. They wished to have the freedom to choose in whom to confide and discuss personal issues. Inspectors commend the fact that the manager and staff took account of the expressed views of the young people and changed their practice accordingly. The young people interviewed by inspectors were able to identify members of the staff team with whom they had a trusting relationship.

None of the young people were involved with specialist services such as child guidance. All of them had experienced considerable difficulties and while some of their responses to these difficulties were positive and constructive, other responses were not. The staff at the centre offered a good standard of care. They were willing to continue working with the young

people despite some very challenging behaviour. However, this willingness to persevere was not always accompanied by a clear insight or informed response to the difficulties the young people presented. For instance, while the change in approach to behaviour management, discussed elsewhere in this report, was sensible in the circumstances it was justified by reference to the impossibility of doing otherwise rather than a sense of the possibilities it opened up for new ways of engaging with the young people. Some of the differences amongst staff in relation to this change discussed earlier (4.2.4) were expressed in terms of a conflict between 'consistency' and 'flexibility'. While there were merits in both arguments, the failure to resolve the difference in a manner that was satisfactory to all members of the staff team indicates a need to consider the issues in a wider context, one that linked specific behaviour management strategies to the identified needs of particular young people in the centre. The staff team needed help with these issues. It was clear to inspectors that many of the young people were reluctant to engage with specialist services. However, such services could be engaged to help the young people with their difficulties by offering a consultation service to the staff team.

Recommendation

16. The centre manager and alternative care manager should identify a service that could offer a consultation service to the staff team.

4.5.8 Preparation for leaving care

There were no structured programmes of preparation for leaving care in Cuan Solas. Two of the young people were approaching 18. However, there were no plans for either to move from the centre in the foreseeable future. Inspectors commend the fact that the centre and the board were committed to supporting these young people into early adulthood. Plans for their future were to be addressed through the care planning process.

4.5.9 Discharges

No young person had been discharged from Cuan Solas up to the time of inspection.

4.5.10 Aftercare

The board did not have a written after care policy that specified the supports available to young people when they leave Cuan Solas. However, since there had been no discharges after care was not an issue in Cuan Solas at the time of inspection. One of the older residents interviewed by inspectors clearly understood that support would be available from the centre after she leaves.

Recommendation

17. The alternative care manager should formulate an after care policy outlining the supports available to care leavers

4.5.11 Children's case and care records

The young people's care files were maintained to a very high standard. The files were divided into sections and information was easily accessible. A basic information sheet at the front of each file set out essential information on the relevant young person.

The manager and staff team are commended for their record keeping.

4.6 Care of young people

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

4.6.1 Individual care in group living

The care regime was constructed around the individual needs of the young people. Indeed it was noteworthy that the centre catered for young people with very disparate needs. For instance, half of the young people were attending school and, indeed, excelling academically while the others were out of school. The needs of each group were attended to and the fact that some were not at school did not appear to undermine the commitment to education of the others. The centre is commended for this, as indeed are the young people who live there.

The young people were involved in various activities in the local community and staff were proactive in encouraging their interests.

Family members who visited the centre were facilitated to meet with the young people in private. The young people had friends in the local community and could visit their friends and have their friends visit them in the centre. However, the young people were unhappy about the fact that parents of friends had to be Garda checked before they could have overnights in their houses. Inspectors urge that this policy be reviewed.

Birthdays and special events in the young people's lives such as Confirmation were marked by gift giving and celebrations that included family members.

One young person interviewed by inspectors stated that staff entered the bedroom without permission. Staff members stated that this only happened when there was a safety concern and that, in other circumstances, staff members only enter the young people's bedrooms with their permission. Other young people interviewed by inspectors confirmed that this was their experience. Inspectors suggest that the circumstances in which staff members enter young people's bedrooms without their consent be discussed and clarified with them.

The young people were given a clothing allowance and shopped for clothes with cash. The older ones went shopping on their own. The young people were also given a weekly spending allowance that they considered reasonable. There were also opportunities to earn extra money if they needed it for a particular purpose.

The young people spoke positively of holidays taken with staff including one continental holiday that had been taken at the request of the young people.

Practice in these areas was good.

Recommendations

18. The social work department should review the policy of carrying out Garda checks on the parents of friends of young people in care with whom they wish to have overnight visits.
19. The centre manager should discuss with the young people the circumstances in which staff may enter their bedrooms without their permission.

4.6.2 Provision of food and cooking facilities

There was a varied diet and inspectors found that fresh fruit and snack foods were available for the young people to make snacks for themselves. In addition, the special dietary requirements of one of the young people were met. However, while the young people were, on the whole, satisfied with their care, some complained of lack of variety in relation to the food available in the centre. This was brought to the attention of the centre manager during the inspection and she addressed the issue with the young person who expressed most dissatisfaction.

Inspectors consider that the provision of food ought to be given high priority. It can act as a point of contact and an opportunity to nurture young people who find it difficult to accept other expressions of care and concern.

Recommendation

20. The staff team should review its approach to the provision of food.

4.6.3 Race, culture, religion, gender and disability

The young people had been encouraged in the practice of their religion up to the point where they clearly expressed their wish to no longer participate in religious services. In the past, staff had helped to prepare the young people for significant religious occasions such as First Communion and Confirmation.

4.6.4 Managing behaviour

The issue of the management of the young people's behaviour had caused some differences and divisions with the staff team as discussed earlier (4.2.4). At a certain point in the recent past, the manager came to the conclusion that the use of sanctions was, in certain situations, unhelpful and that the imposition of a sanction often inflamed an already tense situation leading to destructive behaviour. With the help of a staff facilitator this was discussed within the staff team and a different approach was adopted. This did not dispense with the idea of sanctions altogether but attempted to link the behaviour to the sanction so that it could be sense as the logical consequence of the behaviour. Thus, for instance, when one young person damaged the washing machine washing of clothes was done by hand for a time, as the machine was unavailable. Such 'consequences' were recorded separately and the record checked and signed by the centre manager in accordance with best practice.

A recommendation has already been made in this report (4.5.7) that staff have access to a consultant to help them with issues such as this one.

4.6.5 Restraint

Physical restraint was not used in Cuan Solas.

4.6.6 Absence without authority

There were procedures for dealing with instances of unauthorised absence and these were followed in practice.

One young person spent more time away from the centre than in it. It had been decided that this young person ought not to be discharged, as having some contact with professional carers was deemed preferable to having no such contact. The young person spent some of the time when not at the centre with a parent. Consideration could be given to formalising this, perhaps as a shared care arrangement. It was not clear to inspectors what point there was in reporting the young person missing when it was known that the young person was staying with a parent.

Two of the other young people in Cuan Solas had unauthorised absences in the 12 months leading up to inspection. One had gone missing on one occasion, the other on two.

4.7 Safeguarding and child protection

4.7.1 Safeguarding

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

Inspectors commend the fact that there was a safeguarding policy in Cuan Solas. It dealt with a number of issues such as selection and vetting of staff, children's rights and the duty of staff members to report concerns about the safety of the young people in the centre. A section entitled 'Code of Conduct for Staff' gave sensible guidelines to staff in relation to safe care that inspectors found were followed in practice. However, the code of conduct did not deal with the issue of contact between staff and young people outside of the centre. There was awareness within the staff team that the health board did not approve of the practice of staff members taking young people to their homes. However, this awareness was accompanied by a sense that special circumstances obtained in Cuan Solas and that, therefore, the rule was not applicable. Inspectors consider that if there are to be deviations from accepted practice these need to be discussed and agreed with the board and adequate safeguards put in place.

The policy on safeguarding needs to be revised to deal with contact between staff and young people outside of the centre. This should be done in consultation with the alternative care manager to ensure consistency with health board policy.

Recommendation

21. The manager, in consultation with the staff team and the alternative care manager, should revise the safeguarding policy.

4.7.2 Child protection

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

The policy and procedures document contained a policy on safeguarding and child protection but this did not cover child protection procedures. There was a section on dealing with disclosures of abuse but the rest of the policy related to safeguarding. Staff members had been briefed on Children First, the new national guidelines on the protection and welfare of children, and three had had some follow up training. Those interviewed by inspectors on the subject had a good understanding of the guidelines. However, Children First is not a substitute for local policy and procedures. Staff and young people need to know how the board would deal with a concern about the safety of a young person in Cuan Solas and/ or an allegation of abuse against a member of staff. This could perhaps most sensibly be approached on a board wide basis.

Inspectors commend the fact that there was a policy on bullying in the centre. Prevention of bullying is a key child protection measure. Inspectors found no evidence of bullying in Cuan Solas.

Recommendation

24. The alternative care managers of the Northern Area Health Board, in consultation with centre managers and child care managers should develop child protection policies and procedures for the board's children's residential centres.

4.8 Education

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

Three of the young people were attending school and excelling academically with the help and support of the staff team. One young person had successfully completed her Junior Certificate and had opted to seek employment. Staff members were helping the other young people to find suitable educational and training opportunities.

Practice in relation to education was excellent.

4.9 Health

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

The staff team attended to the health needs of the young people in Cuan Solas. Each of the young people had his or her own medical card and could choose whether to attend a male or female doctor. On each young person's care file there was a medical section. This contained a record of all their medical appointments and of both prescribed and non-prescribed medication they had taken.

At the time of inspection, there was concern about the lifestyle of one of the young people. The staff considered that it was not a healthy one. They were working with the young person to improve this by setting small, achievable goals to address health and lifestyle issues. This, however, was meeting with limited success and inspectors consider that this is one area where staff could benefit from access to a specialist service for advice and consultation.

Health education issues were addressed with the young people. A staff member, interviewed by inspectors, described a health education programme that she had worked on with one of the young women that addressed issues to do with sexual health and relationships. While inspectors learned that such issues were also addressed with the young men in the centre this seemed to depend on staff responding to the young people in an informal way rather than following the kind of programme described by the staff member in her work with the young woman in the centre. Inspectors consider such programmes ought to be available for the young men in the centre also.

There was a policy on smoking that stated that it was forbidden in the house and that if a young person wished to give up smoking they should be supported to do so by staff. Inspectors consider that this policy is inadequate and were dismayed to observe staff members smoking with the young people. The policy of the centre should be to actively discourage smoking. Staff should not be permitted to smoke in sight of the young people.

Recommendations

24. The manager should ensure that information and advice is offered to the young men in Cuan Solas in relation to sexual health and relationships in the same way that it is made available to the young women.
24. The manager of Cuan Solas, in consultation with the staff team and the alternative care manager, should change the policy on smoking and ensure that young people are discouraged from smoking.

4.10 Premises and safety

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

Cuan Solas was about to move to new, larger premises at the time of inspection. The board had long recognised that the current premises were inadequate and had made considerable efforts to find a suitable alternative. The staff and young people were very much looking forward to the move.

4.10.1 Accommodation

The accommodation in the current premises was inadequate. There were four bedrooms upstairs, one of which was used as a staff office and bedroom. There were also two single and one double bedrooms used by the young people. Downstairs there was a kitchen cum dining room, a living room and another reception room that had been converted into a double bedroom. The two young men in Cuan Solas had their own bedrooms and the young women shared. There was not enough living space for the young people or workspace for the staff.

Eastern Health Shared Services confirmed that public and employer's liability insurance policies operated in relation to the centre.

4.10.2 Maintenance and repairs

The manager reported that essential repairs were carried out promptly.

Some parts of the house looked well, other part were a bit dishevelled but given the move to new premises it was understandable that the board had not invested in new carpets and redecoration.

4.10.3 Safety

There was a safety statement for Cuan Solas. It was comprehensive and apart from the usual hazards such as fire, it addressed issues such as assaults, bullying and stress and referred to strategies designed to deal with these hazards, including the drawing up of risk assessments. A member of staff was designated the health and safety officer. However, no safety audit had been carried out.

Two members of staff had been trained in First Aid.

Cleaning materials and medicines were stored safely.

The centre had its own minibus and inspectors were informed that the insurance on the minibus covered the carrying of family members and friends of the young people. Not all staff members were insured to drive the minibus and some used their own vehicles. The board did not encourage this practice. It was expected that, where it did occur, that the staff involved could provide evidence that their insurance covered them to carry people as part of their work. However, inspectors found no evidence that this was being checked. This should be rectified.

4.10.4 Fire safety

There was a fire blanket in the kitchen and two fire extinguishers, one on each floor. These had both been checked in June of 2002. In July, the automatic fire alarm system had been serviced. Fire drills were carried out every three months.

There was no fire certificate for the current premises. Inspectors were informed that a fire certificate would be sought for the new premises.

Recommendation

25. The general manager should ensure that regular safety audits are carried out in the new premises and that any recommendations are carried out promptly.
26. The centre manager should ensure that staff members who carry young people in their vehicles are ensured to do so and should maintain a record of the checks carried out.

5. Summary of Recommendations

1. Health board managers should take steps to resolve outstanding issues in relation to the position of the staff member who deputises for the manager in her absence.
2. Health board managers should proceed with their plan to appoint a deputy manager to Cuan Solas.
3. The centre manager should introduce a register for Cuan Solas as required under the Child Care Regulations, 1995.
4. The alternative care manager should devise a strategy to increase the number of qualified staff
5. The centre manager and alternative care manager should check the personnel files to ensure that proper checks were carried out on staff and that these are recorded on the files.
6. The alternative care manager should ensure that proper vetting procedures are followed in any future recruitment of staff to Cuan Solas.
7. The centre manager in consultation with her line manager should devise and implement a strategy to improve communication and conflict resolution within the staff team.
8. The alternative care manager and centre manager should explore training and/ or consultation options for the centre manager in relation to supervision of staff to ensure the full implementation of a programme of formal supervision for all members of the staff team.
9. The board should arrange for the external monitoring of standards at Cuan Solas at the earliest opportunity.

10. The manager should amend the complaints procedure to state to whom appeals can be made in the event that a young person is unhappy with the outcome of the investigation of a complaint.
11. The manager should inform those who prepare reports on the young people in Cuan Solas of the centre's policy on access to information.
12. The centre manager should agree with the young people's social workers who should keep parents informed of events in the lives of their children.
13. The social workers of the young people should ensure that parents receive assistance with transport to visit their children in Cuan Solas.
14. The social workers for the young people should ensure that the parents of the young people are aware of the board's complaints procedures.
15. The social workers for the young people should review the levels of contact between the young people in Cuan Solas and their siblings
16. The centre manager and alternative care manager should identify a service that could offer a consultation service to the staff team.
17. The alternative care manager should formulate an after care policy outlining the supports available to care leavers
18. The social work department should review the policy of carrying out Garda checks on the parents of friends of young people in care with whom they wish to have overnight visits.
19. The centre manager should discuss with the young people the circumstances in which staff may enter their bedrooms without their permission.
20. The staff team should review its approach to the provision of food.
21. The manager, in consultation with the staff team and the alternative care manager, should revise the safeguarding policy.
22. The alternative care managers of the Northern Area Health Board, in consultation with centre managers and child care managers should develop child protection policies and procedures for the board's children's residential centres.
23. The manager should ensure that information and advice is offered to the young men in Cuan Solas in relation to sexual health and relationships in the same way that it is made available to the young women.
24. The manager of Cuan Solas, in consultation with the staff team and the alternative care manager, should change the policy on smoking and ensure that young people are discouraged from smoking.
25. The general manager should ensure that regular safety audits are carried out in the new premises and that any recommendations are carried out promptly.
26. The centre manager should ensure that staff members who carry young people in their vehicles are ensured to do so and should maintain a record of the checks carried out.