SOCIAL SERVICES INSPECTORATE

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE SOUTH

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ADDRESS: Social Services Inspectorate, 3rd Floor, Morrison Chambers,
32 Nassau Street, Dublin 2
PHONE: 01-604 1780 FAX: 01-604 1799
WEB: www.issi.ie

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1. Analysis of Findings

The Social Services Inspectorate (SSI) carried out an inspection of a children's residential centre in the HSE South, under Section 69(2) of the Child Care Act 1991, in November 2006. At the time of inspection, there were two fifteen year old boys placed in the centre.

Practices that met the required standard

The day to day care of the young people was of a high standard. Care staff related to the young people in a respectful and good humoured manner and with a great deal of warmth and expressed concern for their welfare.

The young people lived in a comfortable environment. The centre was based in a domestic dwelling in a residential area and the care staff provided a homely atmosphere. There was a plentiful supply and variety of food available to the young people who were involved in planning weekly menus. The young people were involved in household chores and both of them enjoyed cooking. They had an adequate supply of clothing, which they chose themselves and which was paid for in cash.

The care staff encouraged the young people's involvement in local activities. They sought to support the spiritual development of the young people in accordance with their interests and wishes and they facilitated one young person's exploration of issues of identity and cultural affiliation.

There was a well developed structure within the staff team. They worked in small teams of three, each of which contained a child care leader and a male staff member. The manager provided individual supervision for the child care leaders and the child care leaders supervised the child care workers. A psychologist was employed to work in the residential centres in the county. She was available to the staff team for consultation and a staff facilitator had, at various points, worked with the staff on issues of team functioning.

The team itself contained two distinguishable groups: an older group of very experienced workers, many of them nurses by training, and a younger group mainly trained in social care. This provided a good balance of age, experience and gender within the team and enhanced the service provided to the young people.

The care staff team were good at consulting with the young people. This was done formally through young people's meetings and preparation for reviews and also informally in the course of everyday conversations. The young people had been invited to participate in a recent redecoration of the premises and one of them was particularly proud of one room that had been completed in accordance with his preferences. Indeed, it looked very well.

The young people declined to be interviewed by inspectors. However, their parents were very positive about the care they received. One, whose son had had a number of placements, stated that he was very happy in the centre and that it was the most

positive of his numerous placements. The other parent was equally positive and stated that her son had made considerable progress since being placed in the centre. Both parents commented positively on their own contact with centre staff. Considerable work had gone into promoting the involvement of the young people's parents and also in building positive relationships between the parents and their children.

The social workers visited the young people on a regular basis and had read their care files (one once, the other three times). There was good access to specialist services. The psychologist provided a service to the young people and there was also a range of other services that could be accessed as required. The young people's willingness and/or capacity to engage with these services was, however, limited.

One of the young people had been out of school for approximately one year. Care staff worked in close cooperation with his social worker and succeeded in finding a place for him on a suitable education/ training programme. This had commenced some weeks before the inspection. It was a significant milestone in his care as well as his education, as it provided him with structure and routine. The other young person was enrolled in a local school where he had the services of a special needs assistant available to him. His continued enrolment in the school was due to the commitment of the school principal and the cooperation between school, social worker and care staff.

There was good attention to safety issues relating to the premises on the part of the manager and care staff. Many of the staff were trained in first aid and there were regular fire drills. The manager reported that the maintenance department of the local HSE carried out necessary repairs in good time.

Practices that met the required standard in some respect only

The young people presented with behaviour that was sometimes difficult to manage. While this behaviour would have caused problems for any team, inspectors found deficiencies in the management and staffing of the centre that impaired the capacity of the team to deal effectively with such behaviour. Inspectors learned of difficulties in internal communication within the team, of team decisions not being implemented and of incidents not being notified to social workers in a timely manner. When consideration is given to the generally low attendance at team meetings and the fact that the child care leaders did not regularly meet with the centre manager as a management team, these findings are not surprising. These are matters that can and should be addressed without delay.

A number of those interviewed by inspectors raised concerns about the functioning of the team and its capacity to embrace new ideas and different ways of working. There was evidence of this in the approach to behaviour management, where despite the recommendations of the monitoring officer in relation to the use of sanctions, they continued to be used extensively despite their ineffectiveness.

The monitoring officer visited frequently. She provided written reports and made recommendations for improvements in practice. On each visit to the centre the officer

assessed the degree to which recommendations arising from previous visits had been implemented. There was clear evidence that changes had been made in the centre and that practice had improved in many respects. This is highly commendable. On the other hand, recommendations in relation to behaviour management had been implemented in part only.

There was an openness to sharing information with the young people. For example, the young people could access their daily logs. There was a clear intention also to share documents stored on the care file with the young people to whom they referred. There were forms attached to each document to be signed by the relevant social worker to indicate consent to share them with the young person. Unfortunately, these forms were only completed on one care file and not the other. In addition, each file had a confidential section for storing those documents that it was believed were not appropriate to be shared with the young person. The criteria for inclusion in this section were not clear. Care staff stated that some documents contained sensitive information that might be upsetting for the young person. However, some of this information was information supplied by the young person in question. It is difficult to understand the logic of including it in a confidential section when it is already known to the young person. The general policy of sharing information was a good one but the practice implications had not been clearly thought out.

Staff members were open to hearing and addressing the young people's complaints. There were complaint forms and the young people were offered assistance to complete them. Even if, as often happened, the young people were reluctant to complete the forms, the manager and staff endeavoured to resolve their complaints. The handling of two complaints, however, highlighted deficiencies in the procedure. The first concerned a complaint by one young person about a member of staff allegedly assaulting another young person. This matter was investigated and a conclusion reached that the alleged assault had not occurred. This followed interviews with the young people and staff who were involved or witnessed the incident. In the circumstances the conclusion reached was reasonable and inspectors do not take issue with it. However, the process lacked credibility because it was an internal one. The social workers for both young people were informed but not immediately and, indeed, the social worker for the complainant was not informed until many months later. At the very least the social workers should have been informed immediately and asked to interview their clients in relation to the alleged incident. The staff member who initially dealt with it considered it as a child protection issue but it was dealt with through the complaints procedure only. It ought to have been treated as a child protection concern also.

The second complaint referred to alleged ill treatment of a young person by a Garda. In this instance the manager attempted to facilitate the young person to pursue the matter in an appropriate way and there were discussions with An Garda Siochana in relation to it. However, none of this was recorded on the young person's care file. The record stated only that the young person made the allegation but declined to complete the complaint form thus creating the impression that no further action was taken. This highlighted a more general problem in relation to recording in the centre in that some records were incomplete.

A credible complaints procedure is a key safeguard for young people in care and other aspects of the service provided to the young people in the centre gave rise to concerns in relation to safeguarding and child protection. The failure to notify the social workers of the complaint of the alleged assault and the fact that it was seen only in terms of a complaint and not also as a child protection issue is a matter of concern both in relation to the centre and the social work service. One of the young people, in particular, had a very high number of unauthorised absences and there were concerns about his safety. No child protection conference had been held to address this issue. Another safeguarding matter concerned vetting of staff. Inspectors examined four files of recently recruited staff and were very concerned to learn that, in the case of two of them, vetting checks had only been completed after commencement of employment.

Certain aspects of safeguarding practice were good. There was, for example, a good understanding of the need for clear professional boundaries. Some older staff had had to adjust their practice in relation to such matters as contact with the young people outside the centre. They understood and accepted the need for this. In addition, while the high number of unauthorised absences was a matter of serious concern in relation to one of the young people, staff members endeavoured to keep in phone contact with the young person. As well as contacting the Garda, they went out to look for him and often succeeded in persuading him to return to the centre. There was no hint of complacency or resignation on the part of the care staff team in relation to this matter.

Some of the behaviour of the young people was, as stated, difficult to manage. Some of it was behaviour within the centre which posed a risk to the safety of the young people and staff and some was behaviour outside the centre which posed a risk to the safety and welfare of the young people and others. The care staff team addressed these issues and they did so with some success. For example, the behaviour of one of the young people within the centre had shown a marked improvement, even though his unauthorised absences were still a cause for concern. While there was not such a clearly discernible improvement in the behaviour of the other young person, the staff had demonstrated considerable resilience in continuing to care for him.

There was some evidence, nonetheless, that measures taken to deal with inappropriate behaviour were at best ineffective and may have exacerbated it. There was a reliance on the use of sanctions to control behaviour. Despite the monitoring officer's finding that this was ineffective, and repeated recommendations to review practice in this area, sanctions continued to be frequently applied. The doors to many rooms in the house were kept locked. Inspectors were given no clear rationale for this. It contributed to a sense of care staff competing for control with the young people whereas a greater emphasis on negotiation (boundaries and limits being discussed and agreed with the young people) may well have been more effective.

All of the staff had been trained in therapeutic crisis intervention (TCI) and they valued and used the de-escalation techniques and the life space interviews. They were trained in physical restraint also and restraint was used, though sparingly, at certain times in the centre.

The care staff team attended to the health needs of the young people. However, a need for education in the areas of sexuality, relationships and associated health issues

had been identified but not met. Given the difficulties and sensitivities for all involved in addressing these issues, training for staff would be helpful.

There was some good practice in relation to care planning but the overall standard was uneven. There was a recently updated care plan for one of the young people that replaced earlier plans prepared in 2004 and 2005. It stated that the plan was for residential placement with family contact and this was reflected in practice. The plan contained biographical information, the young person's care history, an assessment of his needs and how it was proposed to address these, access arrangements, details of the consultations undertaken and a date for review of the plan. It was a comprehensive plan. An individual placement plan, prepared by the young person's keyworker detailed how the young person's placement would be used to support the care plan goals. Both were examples of good practice. Unfortunately, no minutes of care plan reviews were available on the care file, though there were some reports that had been compiled for such reviews. The care plan for the other young person was less satisfactory. It described the aim of the plan in terms of identifying the young person's needs and how best to meet these, in other words, to complete an assessment. However, the point of care planning is to map out an agreed future for a young person in care and the completion of the assessment is part of the process, not its goal. The young person's care file contained minutes of one care plan review. The minutes consisted of a list of decisions and recommendations but there was no list of attendees. The minutes referred to a need for sex education but there was no evidence that any action had been taken in relation to this.

The standard of recording was also uneven. On the one hand the care files were laid out in sections and many of the documents were typed. This made the information easy to find and read. On the other, as detailed earlier in this report, some of the records were incomplete.

Practices that did not meet the required standard

For one young person the centre was not the first choice placement. There were concerns about distance from home and from the local social work service. There were signs that he was making progress in some areas but, despite this, there were, as stated earlier in this report, continuing concerns about his safety and welfare. The other young person was also continuing to behave in a manner that sometimes put himself and others at risk. It was not clear that the centre was meeting the needs of the young people.

The stated purpose and function of the centre was as a children's residential centre for five young people. There were just two young people two in residence for a considerable period of time and no immediate plans to increase this number. In addition, there were enhanced staffing levels in the centre with three staff on duty during the day. Internally, doors were locked. These are elements more usually associated with a high support unit. The young people had both previously been referred to specialist residential services. In some ways the centre was operating like a high support unit but it was not doing so effectively. The HSE South needs to decide what type of service is to be provided in the centre and must then ensure the centre is fit for this purpose.

Inspectors were very concerned to learn that the monitoring officer and her predecessor had, over a period of years, been seeking confirmation that the premises were in compliance with fire safety requirements but without success.

Summary and conclusion

The centre had many of the elements of a good service. Particularly noteworthy and commendable were the standard of primary care, the approach to working with families and the commitment to the young people's education and training. However, the centre was operating below capacity and the behaviour of the young people was not always managed safely and well. These two issues were linked. Inspectors were of the view that the centre lacked the capacity to operate at full or even increased capacity. The core difficulty related to the fact that the centre had operated for many years as a mainstream children's residential centre but had, in more recent times, been asked to look after young people who require a more enhanced or specialised service. Thus, it had, as stated earlier, some of the characteristics of a high support unit but was not designated as one.

The centre should revert to its former role, in which case the appropriateness of the placement of the current residents should be reassessed, or else it should embrace its new role and the HSE South should ensure that the resources being put into the service are appropriate to the demands being made of it. In order to meet the particular challenges of caring for young people with emotional and behavioural difficulties, the manager must be able to ensure that staff attend meetings, implement plans, act on recommendations made by monitoring officers and inspectors, adjust practice to meet new demands and challenges, and operate as a coherent and well integrated unit.

2. Introduction

This is the report of an announced Social Services Inspectorate (SSI) inspection of a children's residential centre in the HSE, South under Section 69(2) of the Child Care Act 1991. The inspection was due to be carried out by Ann Ryan (support inspector) and Andrew Fagan (lead inspector) on 6th, 7th and 8th of November 2006. The support inspector was taken ill on the first day of the inspection and the lead inspector completed it alone. The centre had previously been inspected in 2001 ('A Children's Residential Centre in the Southern Health Board, Kerry Community Care Area' [Inspection number 42], available on www.issi.ie).

2.1 Methodology

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

- The statement of purpose and function,
- The policies and procedures document for the centre,
- The monitoring officer's reports,
- Census forms for the young people,
- A census form for the staff team,
- Questionnaires returned by the social workers for the young people,
- The young people's care files.

In the course of the inspection, inspectors spent time observing practice and participating in centre meals. The young people declined to be interviewed. Inspectors interviewed:

1. The acting manager,
2. Four other members of the care staff team in the centre and one by phone,
3. Two social workers
4. Two parents (one by phone),
5. A psychologist attached to the residential service in the county,
6. The monitoring officer.

2.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the young people, parents, managers and staff, social workers, external managers and all those who contributed to the work of this inspection. In particular, thanks is offered to those who changed their arrangements to facilitate the changed circumstances of the inspection.

2.3 Management structure

The day to day running of the centre was overseen by an acting manager, based in the centre. The acting manager reported to a child care manager with responsibility for all children's residential centres in Cork and Kerry.

2.4 Data on young people

Young Person	Age	Legal Status	Length of Placement	No. of previous placements
Boy	15	Voluntary Care	11 months	Short term placement in residential assessment unit
Boy	15	Care Order	15 months	Five respite and one short term foster placement, one high support unit placement and four children's residential centre placements

3. Findings

3.1 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 South should reassess the appropriateness of the current statement of purpose and function for the centre.

2. The HSE South should ensure that the centre has the resources to carry out its stated function.

3.2 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:

3. The HSE South should ensure that:
   - staff members attend team meetings
   - decisions made at team meetings are implemented by all staff members
   - difficulties in communication within the staff team are addressed and resolved
   - the child care leaders meet regularly with the centre manager.

4. The HSE South should ensure that all significant events in the centre, including young people's complaints, are notified promptly to their social workers.

5. The HSE South should ensure that all new staff are vetted in accordance with Department of Health and Children guidelines before commencing duties at the centre.

6. The HSE South should ensure that all recording systems in the centre contain a complete record of the events to which they refer.

3.3 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:

7. The HSE South should ensure that the recommendations of the monitoring officer's reports are implemented.

3.4 Children's rights

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

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

Recommendations:

8. The HSE South should ensure that there is a credible procedure for dealing with complaints in the centre.

9. The HSE South should ensure that the policy of sharing information with the young people in the centre is fully implemented.

3.5 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	**N/A**		
Aftercare	**N/A**		

Recommendations:

10. The HSE South should ensure that any new admissions to the centre are compatible with its statement of purpose and function.

11. The HSE South should ensure that there are care plans for the young people in the centre that are prepared and reviewed in accordance with statutory requirements.

3.6 Care of young people

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

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

Recommendation:

12. The HSE South should ensure that a thorough re-evaluation of the approach to behaviour management in the centre is completed. It should include a reconsideration of the use of sanctions.

3.7 Safeguarding and Child Protection

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

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

Recommendations:

13. The HSE South should ensure that all complaints that involve an allegation of assault are recognised as child protection issues and are so treated by the relevant social work department/s.

14. The HSE South should ensure that outstanding concerns about the safety of the young person who regularly absents himself from the centre receive the appropriate protective response from the social work department.

3.8 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	√		

3.9 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 South should ensure that information, advice and appropriate guidance is provided for the young people in relation to sexuality, sexual behaviour and relationships.

3.10 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 South should ensure that written confirmation is obtained from a suitably qualified person that the premises are in compliance with statutory fire safety requirements.

4. Summary of recommendations

1 The HSE South should reassess the appropriateness of the current statement of purpose and function for the centre.

2. The HSE South should ensure that the centre has the resources to carry out its stated function.

3. The HSE South should ensure that:

- staff members attend team meetings
- decisions made at team meetings are implemented by all staff members
- difficulties in communication within the staff team are addressed and resolved
- the child care leaders meet regularly with the centre manager.

4. The HSE South should ensure that all significant events in the centre, including young people's complaints, are notified promptly to their social workers.

5. The HSE South should ensure that all new staff are vetted in accordance with Department of Health and Children guidelines before commencing duties at the centre.

6. The HSE South should ensure that all recording systems in the centre contain a complete record of the events to which they refer.

7. The HSE South should ensure that the recommendations of the monitoring officer's reports are implemented.

8. The HSE South should ensure that there is a credible procedure for dealing with complaints in the centre.

9. The HSE South should ensure that the policy of sharing information with the young people in the centre is fully implemented.

10. The HSE South should ensure that any new admissions to the centre are compatible with its statement of purpose and function.

11. The HSE South should ensure that there are care plans for the young people in the centre that are prepared and reviewed in accordance with statutory requirements.

12. The HSE South should ensure that a thorough re-evaluation of the approach to behaviour management in the centre is completed. It should include a reconsideration of the use of sanctions.

13. The HSE South should ensure that all complaints that involve an allegation of assault are recognised as child protection issues and are so treated by the relevant social work department/s.

14. The HSE South should ensure that outstanding concerns about the safety of the young person who regularly absents himself from the centre receive the appropriate protective response from the social work department.

15. The HSE South should ensure that information, advice and appropriate guidance is provided for the young people in relation to sexuality, sexual behaviour and relationships.

16. The HSE South should ensure that written confirmation is obtained from a suitably qualified person that the premises are in compliance with statutory fire safety requirements.