A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE SOUTH

FINAL

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1. Analysis of Findings

The Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the Health Services Executive (HSE), South under Section 69 (2) of the Child Care Act 1991.

The centre was designated a short to medium term residential centre, providing a maximum placement of six months to boys and girls aged from 12 to 18 years. It was located in a large modern two-storey house with two large gardens and an all weather basketball/tennis court and playground on the outskirts of a town. At the time of inspection there were three adolescents (two boys and one girl) living in the centre. It had previously been a short term residential centre which had been housed in a number of temporary locations over the five and half years prior to inspection. Residential services in the community care area had been reconfigured in the year prior to inspection. This resulted in a decision to have two residential services, a medium term residential centre and a short term residential centre. However, in September 2006 due to staff shortages in both centres, a decision was made to amalgamate them with the purpose and function of the one centre becoming short to medium term residential care.

The staff team was made up of personnel from previous temporary centres. The centre had been monitored by the local HSE monitoring officer. The monitoring officer completed a report in February 2007. Reference to its findings and recommendations are made in this report.

The key concern for inspectors was the serious lack of interdisciplinary co-operation, communication and consistency amongst the professionals working with the young people in the centre. This was further compounded by the fact that none of the young people had current up-to-date care plans which was reflected in the chaos and differences of opinion as to what were the long term plans and goals for each young person. Inspectors found that this had a negative impact on the three young people and on their general safety, health and welfare. Inspectors were of the view that the internal and external management of the service did not have sufficient impact on practice. The absence of affective safeguards within the service seriously compromised the safety, health and well being of the young people.

Practices that met the required standard

There was a good standard of key working and individual work in place. The young people all described having a good relationship with their key worker. Some key workers showed commitment by attending meetings, reviews or court hearings at times when they were scheduled to be off the roster.

The HSESA had established a full time position for a dedicated psychologist for the residential service and this post was filled two weeks prior to inspection. The office for the psychologist was located in the centre, and the new psychologist had met all of the young people on an informal basis at the time of inspection. She was available to provide assessments and do direct work with all the young people in the centre. She had attended a staff meeting and part of her role was to offer support and consultancy to staff. This is a welcome development.

In general, specialist services were readily available for those young people who required them and staff expressed their satisfaction with them. However, some of the

young people did not wish to actively engage or participate with the services. All of the young people had regular contact with outreach workers from the respite/residential service as part of the service provided by the area. They were satisfied with the level of contact and activity they had with this service.

Administrative files were generally of a good standard.

Overall, staff presented as professional and inspectors found them aware of their strengths and weaknesses. They were prepared to acknowledge that changes in the structure of residential services, amalgamation of different staff teams, change in purpose and function of the centre, and lack of leadership and direction over time resulted in practices that did not meet the required standards.

Practices that met the required standard in some respect only

Inspectors found evidence of confusion about the purpose and function of the centre. This matter was identified by the monitoring officer during his monitoring visit in December, 2006. It was compounded by the fact that the centre was used for other functions as follows: offices for the regional co-ordinator of residential services and the psychologist, and a building at the rear of the centre used as a class room for one of the young people from the centre and by the outreach service for other young people not resident in the centre. Inspectors are of the view that the purpose and function should be reviewed and clarified as a matter of priority. The centre should be either a dedicated centre for the residential care of young people or moved to a setting that is a dedicated child-centred unit. The agreed purpose and function should also be made available to young people, their parents, carers, supervising social workers, the monitoring officer, and other professionals involved.

The centre had a staff complement of 19 and half posts: the centre manager, three child care leaders, one acting child care leader, 14 and a half child care posts. The centre also had a part time house keeper. They were assisted by an established shared relief panel of three staff that covered for sick leave and annual leave in the centre. Inspectors were told that a new roster had been introduced a few weeks prior to inspection to ensure there was provision for three staff to be rostered at all times. However, at the time of inspection, because of both sick leave and maternity leave, it had not been possible to operate the revised roster. This impacted on practice in the centre in terms of supervision being cancelled, fewer key working opportunities, and agreed tasks not being carried out. Young people told inspectors that when there were only two staff on duty sometimes it was not possible to engage in activities external to the centre. Inspectors agree with the young people's view that there was insufficient provision for activities and interests. There were weekly staff meetings, but not all staff attended team meetings, even though the roster allowed for all staff to attend. Inspectors were concerned that this impacted on effective team working, accountability and communication within the centre. The deployment of staff needs to be reviewed to ensure that safe care can be provided. In conducting this review managers should consider whether the many experienced and qualified staff are being used in the most effective way to improve outcomes for the young people.

There was a management structure in place. There had been an acting centre manager in post for nearly a year prior to inspection. The centre manager took up his position four weeks prior to inspection. He attended meetings with the co-ordinator of the

residential respite/outreach service. There was an on-call service shared between three managers. Supervision of the centre manager by the co-ordinator of children's residential services was formalised. However, within the staff team inspectors found the practice of formal recorded supervision to be irregular and infrequent and in some cases staff had not had formal supervision in the six months prior to inspection. In the absence of regular formal supervision in the centre, staff experienced poor leadership and direction internally and externally. Inspectors found that staff had little opportunity to reflect on their practice and on individual work with the young people.

Staff received training in Therapeutic Crisis Intervention (T.C.I.), and Children First, and all staff were up to date with T.C.I. refresher training. Staffs availed of and were satisfied with the support they received to attend training. The record of attendance and participation in training was maintained separately to their personnel files and not easily accessible to the centre manager.

Practice in relation to seeking three references and garda clearance for existing and newly recruited staff was poor. This was also identified by the monitoring officer in his report of February 2007. The majority of staff in the centre did not have the required three references on file. There was no record of garda clearance on five of the personnel files examined. These included the centre manager, who was appointed four weeks prior to inspection, and a permanent child care leader who had commenced employment the week of inspection. The HSESA must ensure that garda clearance and references are sought immediately in respect of all staff, that with regard to future appointments staff are appropriately vetted and do not commence employment prior to completion of vetting.

The centre kept a register. Inspectors found that information about the discharge of two of the young people was not recorded, nor were the parent's/carer's names for one young person, nor the previous placements for another. The HSESA should ensure that the register is maintained in accordance with regulations.

Staff encouraged and facilitated family contact where possible. Parents and foster carers attended review meetings and received minutes. They expressed their satisfaction with the provision of some aspects of primary care in the centre. However, parents and foster carers of the three young people told inspectors that they were very concerned for their child's mental health and welfare and they noted a significant deterioration in the young people's behaviour and general demeanour over the weeks prior to inspection. Parents and foster carers told inspectors that they received regular communication from centre staff, but they were not satisfied with the quality of contact. They did not know if and when they could visit their child in the centre. Their perception was that they could not call to the centre unannounced and were not familiar with the "rules" of the centre. They told inspectors that whilst they were notified of most serious events they were not informed of all matters concerning the children and would like to be involved in decision-making about any plans being made in respect of their child. They also told inspectors that they experienced inconsistencies with regard to communication between staff with and about the young people, and one of the families expressed dissatisfaction about the management of a complaint made by their child.

Staff were generally willing to share information with the young people. However, there was a lack of clarity over access to young peoples care files. Inspectors recommend that all staff receive guidance in this matter.

Staff told inspectors some work had been carried out with one of the young people in preparing her for aftercare. However, inspectors were concerned that in the absence of a comprehensive care plan and agreed views as to her future care, the young person was not in a position to engage in the aftercare programme in the area. The HSESA needs to provide a comprehensive and systematic aftercare programme to all young people in accordance with the standards.

Practices that did not meet the required standard

The standards on fire safety, monitoring, complaints, care planning, education and health, inter-professional partnership, child protection and safeguarding were not met. Inspectors found that the failure to meet these standards was a cause for grave concern for the mental health, safety, protection and welfare of the three young people in the centre.

Premises Safety

Fire safety
The monitoring officer stated in his monitoring report of February 2007 that the centre was in serious breach of Standard 10 on fire and safety. At the time of inspection inspectors found that five recommendations which he made in regard to this Standard had not been implemented. The centre did not have written confirmation relating to fire safety and building control as required by standard 10.19. There was no record that any fire drills had been undertaken. There was inadequate recording of fire equipment servicing. At the time of inspection the fire extinguisher for the kitchen was stored in the staff office, but there was no record of a review of this decision and what to do in the event of a fire in the kitchen. Managers need to ensure that staff awareness of fire safety is significantly improved. The HSESA should review the practice of fire safety within the residential service as a matter of urgency and satisfy itself that regulations are complied with and standards are fully met.

The co-ordinator of children's residential services had completed a health and safety audit of the centre a few weeks prior to inspection, but this had not been signed off, nor were the staff aware of its findings and recommendations at the time of inspection. Few staff in the centre had been trained in First Aid.

Inspectors were told of long delays in response to maintenance requests. The young people had asked for shelving in their bedroom some months prior to inspection but this work had not been completed at the time of inspection. There was an inadequate number of dining and kitchen chairs for the young people and visitors. A large freezer was located in the dining room. Inspectors found a poor standard of general physical care. The lack of homeliness and poor standard of cleanliness about the house and garden gave an impression of the centre not being sufficiently cared about. Inspectors are of the view that it is important to maintain a high standard in terms of the physical environment of a residential centre to give the young people who live there a clear message about how they themselves are valued. Internal and external managers have a key role and responsibility to ensure a high standard of accommodation, and in accordance with standard 10.11 regularly review and assess the physical state and quality of the centre. There was no record of external line management routinely monitoring the premises to ensure the maintenance of safety standards.

Safe guarding and child protection
Inspectors had serious concerns about safeguarding and child welfare and protection in the centre. Parents, foster carers, centre staff, supervising social workers and other professionals working with the three young people all told inspectors of their concerns about the young people's emotional health, welfare and protection. Staff told inspectors of the young people being very lonely, "in the dark", and expressed concern about the young people's lack of motivation. The young people also expressed their level of unhappiness and distress to inspectors which was visible to all involved in their care. They described self-harming and watching other young people self-harm. They felt that some staff did not listen to their views or have any awareness of the impact of the lack of care plans, or the reasons for their lack of motivation to engage with school, training or specialist services. They were not attending school or training, and had little opportunity to engage in external activities.

A finding of particular concern to inspectors was that supervising social workers could not satisfy themselves that the young people were well cared for and safe. All of the young people had allocated supervising social workers. They visited the centre, but the frequency of visits varied for some of the young people. Social workers told inspectors that they did not read centre records as the standard requires. The HSESA should ensure that supervising social workers comply with the regulations and standards.

Inspectors were concerned at the quality of leadership, direction and support from external management in the operation of the centre. Senior managers told inspectors that they were aware of some of the concerns as outlined in the monitoring officer's report and brought to their attention by some staff. However, they did not effectively address these issues and this had a significant impact on the standard of care provided to the young people. Inspectors found little evidence of an assessment of the quality and effectiveness of services provided by the centre in terms of positive outcomes for the young people.

Monitoring
The monitoring officer visited the centre regularly. Staff told inspectors that they found him supportive. In his report of February 2007 he made 24 recommendations concerning the care of the young people. Whilst a few of the recommendations had been implemented, inspectors were concerned that the majority of them were not, particularly those regarding the review of the placement one of the young people, and fire safety. The monitoring officer has an important safeguarding function. However, since his report had not received an appropriate and timely response, the safeguarding function was ineffective. The recommendations made by the monitoring officer should be given due consideration by all managers of the service. For this standard to be met, his recommendations must be implemented in a timely fashion and to his satisfaction.

Children's rights/Complaints
Practice in relation to children's rights did not meet the standard. Whilst the young people told inspectors they had choices in relation to food and activities they also said that their views and requests were not listened to. Weekly meetings of young people were held and key workers sought their views but the young people believed that they had no influence in how the centre was run. More effort needed to be made to listen to the views of the young people.

There was a complaints policy in place and the young people were given information about the complaints procedure. However, inspectors found evidence of serious deficits

in the practice and operation of the complaints policy. The three young people expressed a lack of confidence in the procedures. Whilst young people had made two complaints, both of which raised safeguarding concerns, these were not processed through the formal complaints procedure nor followed up in accordance with *Children First: National Guidelines for the Protection and Welfare of Children.* A supervising social worker for one of the young people told inspectors she was made aware of the complaint by the young person but not by centre staff.

In addition, one of the above complaints which the young person had addressed in writing to the local general manager had not been forwarded by staff to the general manager but was notified to the residential services co-ordinator and monitoring officer. Inspectors had serious concerns that these complaints had not been reported as child protection concerns nor had they received a comprehensive, co-ordinated or satisfactory response at the time of inspection. Inspectors recommended, as a matter of urgency, an immediate response to these complaints as child protection concerns. The HSESA should carry out a complete revision of how the complaints and child protection reporting procedure is put into practice, ensuring that there is clarity about the distinction between a complaint about dissatisfaction with a service and a child protection concern. This review should be carried out in consultation with the young people, their parents and carers and the supervising social workers.

Care planning

Inspectors had concerns that the three young people had no current care plan. This had a significant impact on the quality of planning and care. It was reflected in the challenging behaviours and confusion presented by the three young people in the centre, and in the weeks prior to inspection they began to abscond from the centre placing themselves at significant risk when out during the night. Inspectors found little evidence of current comprehensive placement plans for the young people. Staff made efforts to convene and hold placement planning meetings, but in the absence of care plans it was difficult to prepare and implement effective placement plans.

The poor inter-professional partnership, inconsistencies and ineffective management had a serious impact on the mental health, safety and welfare of one of the young people. Inspectors recommended an immediate review of this young person's placement and that a care plan be prepared before the court hearing due to take place two weeks following the inspection. Inspectors also noted that this young person had been allocated to six supervising social workers in the year prior to inspection. Inspectors were of the view that the high turnover of social workers impacted on the opportunity for the young person to engage with and trust any professional in a meaningful way.

Education

At the time of inspection only one young person was attending school. One of the young people had stopped attending school five months prior to inspection, and another young person had not attended school since his placement in the centre six weeks prior to inspection. The principal of the school for High Support Services in the region, as part of a one year pilot project for the residential services, had agreed with managers that she would provide teaching hours for the young people in the centre and tried creative ways to engage the young people in education. The impact of not attending school or training was such that the young people had a lack of purpose and direction to their day. They had difficulties settling at bedtime, and in the weeks prior to inspection became involved in risk activities and offending behaviours at night. Inspectors were of the view that as a

matter of priority the HSESA should review the practice in the centre of engaging with young people, and ensure that they receive education and training.

Health and Emotional Wellbeing
Inspectors were concerned that practice in relation to the mental, emotional well-being of the young people did not meet the standard. Each of the young people told inspectors that they had self-harmed and this was confirmed by their parents, foster carers, centre staff and other professionals working with them. Inspectors found little evidence of a consistent, co-ordinated response to situations where young people self-harmed or threatened self-harm. This was further compounded by young people's refusal to engage in some of the interventions because of conflicting diagnostic assessments. This is a serious safeguarding concern. Inspectors found little evidence of comprehensive assessment and management of risks for the young people. The HSESA should ensure that supervising social workers arrange medicals on admission and gather medical histories from parents and carers if possible, as well as information about engagement in risk behaviours. Inspectors considered that there was a need for advice and guidance in areas of teenage health issues, in particular appropriate sexual health and relationship development.

Inter-professional Partnership
Inspectors had serious concerns about the inter-professional relationships between the residential services and social workers and other professionals working with the young people. Inspectors found conflicting differences, a distinct lack of trust, and at times hostile and tense relationships between the residential services and social workers which presented a serious, chronic and significant safeguarding concern. Young people, their parents and some professionals told inspectors that the young people were given confusing and misleading information about their future care.

Specifically, the inspectors' concerns were about the following:

- The assessment and management of risk of self-harm for each of the three young people required urgent attention.
- The recent monitoring officer's report and recommendations were not implemented.
- Staff's management of unauthorised absences and young people's involvement in offending behaviour needed to be refocused on the level of risk young people were putting themselves at.
- The complaints procedure was not working and the young people had no confidence in the system.
- Child protection reporting procedures were not activated or followed in relation to two serious allegations made by two of the young people.
- Social workers were not promptly notified of some serious complaints in some cases. They were they not made aware of the on-going young people's distress. They did not read the centre's daily logs.
- The three young people had no care plans despite a series of professional meetings held in respect of each of them.
- Staff needs to be directed, supported and encouraged to provide a more nurturing level of interpersonal contact with the young people.
- Supervision of staff was poor and infrequent and did not focus on the needs and rights of the young people.
- The standard on partnership between the residential service and the local social work department was not met and serious inter-professional differences and lack

of effective communication had a negative impact on the care, protection and welfare of the young people.

- External management did not provide direction or leadership sufficient to ensure the safety and well-being of the young people in the centre.

Inspectors brought the concerns as outlined in the report to the attention of local HSESA senior managers and have received written confirmation from the general manger that actions to respond have been initiated. An external HSE child care manager completed a review of the complaints and met with the young people and all relevant parties, and a report has been made available to the inspectors**.** A comprehensive review of the placement of one of the young people took place the week after the inspection, and a comprehensive "exit strategy" was prepared. Inspectors were advised that the acting principal social worker and the co-ordinator of residential services are currently examining how inter-professional relationships can be improved. The local HSE fire safety officer carried out a fire safety inspection of the centre the week after the inspection. Social workers are visiting the centre frequently, and the monitoring officer is satisfied with the significant progress made with regard to some of his recommendations in the weeks following inspection. Inspectors have visited the centre since the inspection and will visit the centre again in the near future in order to assess further progress being made to meet this report's recommendations.

2. Introduction

The Social Services Inspectorate carried out an announced inspection of a children's residential centre in the HSE Southern Area. Mary Tallon (lead inspector) and Kieran O'Connor (support inspector) conducted the inspection over a three day period from the 15th to the 17th May 2007.

2.1 Methodology

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

- The centre's statement of purpose and function
- Policy and procedures
- The young people's care files
- Questionnaires completed by social workers (three)
- Questionnaire completed by a parent and foster parents
- Questionnaire completed by a school principal
- Letters from 2 parents
- Census forms on management and staff
- Children's census forms
- The monitoring officer's report
- Administrative records
- Health and safety records
- Confirmation of insurance
- Details of unauthorised absences (3)
  For the previous 12 months
- A sample of the staff duty roster

In the course of the inspection, inspectors interviewed:

1. The centre manager
2. One child care leader
3. Four child care workers
4. Three young people
5. The monitoring officer, HSESA
6. Three social workers
7. One team leader
8. The centre psychologist
9. Two parents and foster parents
10. The Guardian ad Litem for one of the young people
11. The co-ordinator for children's residential services in local area.
12. The school principal for High Support school in the South Eastern Region
13. The child care manager for local area.
14. The general manager for local area.
15. The local health manager for local area.

As well as those above the lead inspector had telephone contact with a parent and a school principal.

2.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the young people, their families, the manager and staff of the centre, the social workers, team leader, and psychologist, co-ordinator of children's residential services and external managers and others who participated in the inspection.

2.3 Management structure

The centre manager reported to the co-ordinator of children's residential services who was also line manager for a residential respite and outreach service in local area. The co-ordinator of children's residential services reported to the local general manager administratively and to the local child care manager for clinical supervision.

2.4 Data on young people

Young Person	Age	Legal Status	Length of Placement	No. of previous placements
# 1 (female)	16	Care order	9 months	One residential placement
# 2 (male)	16	Care order	3 months	Two foster placements and one residential placement
# 3 (male)	15	Fit Persons Order	6 weeks	One respite residential placement and one foster placement

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 ensure that the agreed purpose and function should be for a dedicated children's centre and that it is reflected in all documentation and distributed to the young people, their parents, supervising social workers and to the authorised monitor.

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		√	
Supervision and support		√	
Training and development	√		
Administrative files	√		

Recommendations:

2. 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.

3. The HSE South should ensure that the register is maintained in accordance with the regulations.

4. The HSE South should ensure the provision of formal supervision on a regular basis to all staff.

5. The HSE South should ensure that staff receive direction and support in working with young people directly.

6. The HSE South should ensure that external line managers monitor practice and evaluate its effectiveness on a continuous basis.

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 monitoring officer's recommendations of February 2007 are implemented to his satisfaction as a matter of urgency.

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 consultation with the young people is effective and that they have confidence in it.

9. The HSE South should carry out an urgent review and evaluation of the operation of the complaints procedure, in consultation with the young people, their parents, carers and supervising social workers.

10. The HSE South should ensure that young people's right to access their records is made clear to young people and staff.

11. The HSE South should ensure that staff receive training in children's rights.

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		√	
Aftercare		√	

Recommendations:

12. The HSE South should ensure the three young peoples placements are reviewed with regard to current suitability.

13. The HSE South should ensure as a matter of urgency that all young people in the centre have an up-to-date care plan.

14. The HSE South should ensure that all social workers visit and meet with young people frequently and read centre records from time to time.

15. The HSE South should ensure that that parents and foster carers are informed and involved in all aspects of the care of the young people.

16. The HSE South should ensure that there is a comprehensive aftercare programme in place for all young people in care.

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		√	

Recommendations:

17. The HSE South should ensure that the use of order books for the purchase of clothes for young people ceases.

18. The HSE South should review the management of behaviour in the centre in the context of the young people self-harming, and placing themselves at risk.

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:

19. The HSE South should urgently review and assess the inter-professional partnership between the local social work department, centre staff and all professionals working with the young people.

20. The HSE South should review the centre's policy and procedures on the reporting of child protection concerns, and ensure that all involved have a comprehensive understanding of them.

21. The HSE South should ensure that external HSE managers monitor and evaluate the safeguarding practices in the centre.

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			√

Recommendation:

22. The HSE South should ensure that there is an effective strategy in place to enable the young people to consistently attend school or training.

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			√

Recommendations:

23. The HSE South should ensure medicals are carried out in accordance with the regulations.

24. The HSE South should ensure that children's needs for specialist services are met.

25. The HSE South should ensure there is advice and guidance available for the young people on teenage sexual health and relationship issues.

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			√

Recommendations:

26. The HSE South should ensure that all maintenance requests are responded to in a timely way.
27. The HSE South should ensure as a matter of priority that all repairs, maintenance, decoration and tidying necessary to bring the physical state of the centre up to standard are carried out.
28. The HSE South should ensure that external managers regularly review and check the physical condition of the centre in accordance with standard 10.11
29. The HSE South should carry out an urgent review of fire safety practices in the centre. They should ensure that all fire safety standards are fully met.

4. Summary of recommendations

1. The HSE South should ensure that the agreed purpose and function should be for a dedicated children's centre and that it is reflected in all documentation and distributed to the young people, their parents, supervising social workers and to the authorised monitor.

2. 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.

3. The HSE South should ensure that the register is maintained in accordance with the regulations.

4. The HSE South should ensure the provision of formal supervision on a regular basis to all staff.

5. The HSE South should ensure that staff receive direction and support in working with young people directly.

6. The HSE South should ensure that external line managers monitor practice and evaluate its effectiveness on a continuous basis.

7. The HSE South should ensure that the monitoring officer's recommendations of February 2007 are implemented to his satisfaction as a matter of urgency.

8. The HSE South should ensure that consultation with the young people is effective and that they have confidence in it.

9. The HSE South should carry out an urgent review and evaluation of the operation of the complaints procedure, in consultation with the young people, their parents, carers and supervising social workers.

10. The HSE South should ensure that young people's right to access their records is made clear to young people and staff.

11. The HSE South should ensure that staff receive training in children's rights.

12. The HSE South should ensure the three young peoples placements are reviewed with regard to current suitability.

13. The HSE South should ensure as a matter of urgency that all young people in the centre have an up to date care plan.

14. The HSE South should ensure that all social workers visit and meet with young people frequently and read centre records from time to time.

15. The HSE South should ensure that that parents and foster carers are informed and involved in all aspects of the care of the young people.

16. The HSE South should ensure that there is a comprehensive aftercare programme in place for all young people.

17. The HSE South should ensure that the use of order books for the purchase of clothes for young people ceases.

18. The HSE South should review the management of behaviour in the centre in the context of the young people self- harming, and placing themselves at risk.

19. The HSE South should urgently review and address the interprofessional partnership between the local social work department, centre staff and all professionals working with the young people.

20. The HSE South should review the centre's policy and procedures on the reporting of child protection concerns, and ensure that all involved have a comprehensive understanding of them.

21. The HSE South should ensure that external HSE managers monitor and evaluate the safeguarding practices in the centre.

22. The HSE South should ensure that there is an effective strategy in place to enable the young people to consistently attend school or training.

23. The HSE South should ensure medicals are carried out in accordance with the regulations.

24. The HSE South should ensure that children's needs for mental health services are met.

25. The HSE South should ensure there is advice and guidance available for the young people on teenage sexual health and relationship issues.

26. The HSE South should ensure that all maintenance requests are responded to in a timely way.

27. The HSE South should ensure as a matter of priority that all repairs, maintenance, decoration and tidying necessary to bring the physical state of the centre up to standard are carried out.

28. The HSE South should ensure that external managers regularly review and check the physical condition of the centre in accordance with standard 10.11.

29. The HSE South should carry out an urgent review of fire safety practices in the centre. They should ensure that all fire safety standards are fully met.