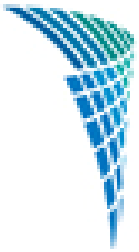

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Social Services Inspectorate

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE NORTH EASTERN AREA

INSPECTION REPORT ID NUMBER: 332

Fieldwork Date: 2nd and 3rd July 2009
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SSI Inspection Period: 11
Centre ID Number: 387

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1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre in the Health Services Executive (HSE), North East Area (NEA) under Section 69 (2) of the Young person Care Act 1991. Nuala Ward (lead inspector) and Kieran O'Connor (co inspector) carried out the inspection over a two day period from the 2nd to the 3rd of July 2009.

The centre provided medium to long term care to young children aged 12 and 18 years of age. Previously admissions were only from the local health areas of Meath, Louth, and Cavan/Monaghan. However, since March 2009 the centre now accepted referrals for children from the entire HSE North East region which included Dublin North.

The centre was situated in a detached house in a rural area on the outskirts of a village. At the time of inspection there was one boy aged 14 and one girl aged 17 in the centre. Another boy aged 13 was in the process of moving into the centre on the second day of the inspection. Two children had left the centre in the previous 12 months.

This centre had been previously inspected in 2007 and 2008 and the reports can be accessed on the ww.hiqa.ie as inspection reports 173 & 206. There were a number of concerns about the safety and welfare of the children in the inspection in 2007. In the follow up inspection in 2008 significant improvements had been made and continued improvements had been found during this inspection.

1.1 Methodology

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

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

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

- Statement of purpose and function,
- Policies and procedures (including booklet for young people),
- Young people's case files,
- Census forms on management and staff,
- Administrative records,
- Previous inspection report and follow-up report,
- Health and safety documents.

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

- The centre manager,
- The acting regional and deputy manager for residential services,
- Three social workers,
- One social care leader and 3 social care workers,

- One HSE monitoring officer,
- Two young people in residence,
- Principal social worker for two young people who had previously lived in the centre
- General manager for Dublin North in their capacity as acting local health manager with line manager responsibility for the centre

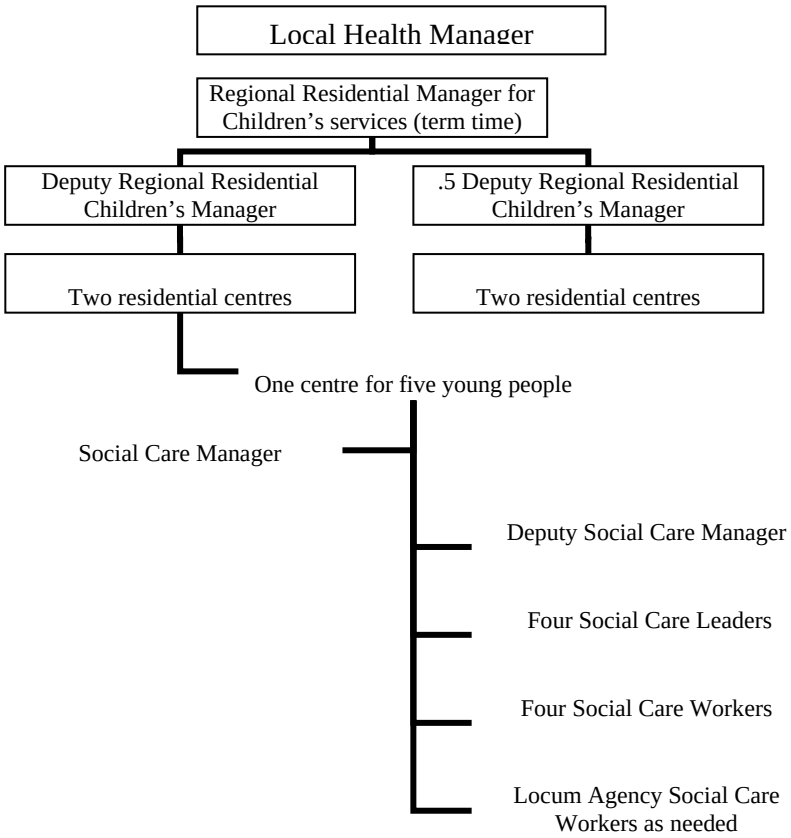
1.2 Acknowledgements

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

1.3 Management structure

The centre was managed by a centre manager who was assisted by a deputy social care manager. The centre manager reported to one of two deputy regional residential care managers (1 .5 whole time equivalent) who had direct operational responsibility for this service.

The deputy regional manager for children's residential services reported to the regional manager for residential services in the local health areas of Meath, Louth and Cavan/Monaghan. At the time of inspection, the regional manager was on term time and a deputy regional manager was acting up into the role. The local health office manager with specific responsibilities for child care services for the HSE North East had overall line management responsibility for the residential children's services.



1.4 Data on young people

During the fieldwork the following young people were residing in the centre:

Listed in order of length of placement

Young person	***Age***	***Legal Status***	***Length of Placement***	***Number of previous placements***
# 1 (girl)	17 years	Voluntary Care	10 months	1 relative foster placement 1 residential placement
# 2 (Boy)	14 years	Voluntary Care	2 weeks	2 foster placement One respite residential placement
#3 (boy)	13 years	Voluntary Care	In process of moving into centre	I residential placement 3 foster care placements

2. Summary of Findings

Inspectors found the care provided to the young people in the centre was of a good standard. The staff team were dedicated, enthusiastic and committed to the well-being and care of the young people. In the 12 months prior to the inspection, the staff team had provided care to one young person with particular challenging behaviour. There were numerous incidences of absences and aggression in the centre and the young person's onward placement was accelerated due to concerns about their safety. At the time of inspection, there had been no incidences in the previous two months and the young people told inspectors they felt safe in the centre.

All of the standards had been met or met in part. Recommendations from this inspection related to behaviour management, child protection, discharges, emotional support, the supervision of staff, records, children's rights, and planning.

Practices that met the required standard

Primary Care
The young people in the centre received a good quality of care. The staff team presented as committed and enthusiastic about their role with the young people. The young people told inspectors they liked the staff team and living in the centre. Both of the young people were in educational placements. They were encouraged in their relationships with their friends and families through visits and phone contacts. The staff team were thoughtful and considerate about the life experiences of the young people and how it impacted on them. The centre actively promoted a positive culture of care in the centre through activities internal and external to the centre. The young people had a general practitioner and a choice of male or female doctor. The staff members were well aware of their health needs and encouraged older young people to assume responsibility for their own GP visits. Food in the centre was varied and nutritious.

There were information booklets for young people and parents and young people told inspectors that they were able to buy clothes and other items as needed. They had their own bedrooms. Inspectors observed staff members interacting with young people in a sensitive and patient manner. The standard on primary care was met.

Management and staffing
The manager had a relevant qualification and significant management experience. She was assisted by a deputy manager who was qualified and had numerous years of residential experience. Inspectors found that the centre was generally well managed with good support from the external line management. The line manager visited the centre on a regular basis. The purpose and function was well understood and care practices were supported by comprehensive local policies. The centre manager has a key role in introducing new policies from Dublin North in the coming months as part of the integration of residential services in the HSE North East. The centre manager told inspectors that since the last inspection there was a greater emphasis on child protection through notifications and the involvement of external professionals in the management of risk.

There was 8 social care staff posts filled by 3.5 child care leaders (1 part-time), and 4.5 child care workers (3 part-time) All staff recruited since 2007 had been appropriately vetted with garda clearances and three references. Three staff had social care qualifications, and four had other relevant qualifications. Three were unqualified. The staff team was well deployed to meet the needs of the young people. Generally, there was two staff on duty for 24 hours approximately to provide consistency from evening to morning. Despite the challenges in the previous year the staff team presented as well motivated and cohesive. There were regular staff meetings, handover meetings and the team keywork approach ensured all staff members had a good understanding of the needs of the young people. There was a senior psychologist for children's residential services who provided training to staff teams, attended staff meetings regularly and provided guidance on the care of the young people.

Monitoring
The HSE monitoring officer visited the centre four times in the previous year. The most recent monitoring report was dated April 2009 and the majority of the recommendations had been implemented. The monitoring officer had also reviewed the placement of one young person who presented with unsafe behaviour in the centre. The monitoring role was valued by the staff team and management and had contributed to the good standard of care. This standard was well met.

Register and administrative files
These records were well maintained and the register included all information required by the regulations.

Family contact
The centre had a policy of encouraging family contact. One of the young people was in a shared care arrangement with their family. Parents were contacted weekly to talk about the young people and parents visited the centre prior to placement. One visiting arrangement to the centre had been stopped due to unsafe behaviour by the parent but this was currently being reviewed with the intention of re-introducing them. Regular phone contact and visits outside of the centre continued during this time. The standard on family contact was met.

Aftercare planning
Preparation for leaving care and after care was good. One young person spoke to inspectors about her plans for the future. The social worker and aftercare worker for the area were working together with the staff team in preparing the young person for leaving care. The young person wishes to live independently in the locality and accommodation options were being explored.

Practices that met the required standard in some respect only

Child safety and protection
The staff team displayed a good degree of awareness of child safety and protection within and external to the centre. They had a good understanding of safeguarding practice and professional boundaries and understood the systems in place to manage risks. Child protection was a standing item at meetings between staff and their manager. This was to reduce the likelihood that the desensitisation of risk noted from the previous inspection did not occur again. The staff team had been trained in the national child protection policy of Children First. The young people told inspectors they felt safe in the centre.

In the previous 12 months, the centre manager issued notifications of child protections concerns about risks associated with one young person who had now left the centre. These risks were from the young person regularly absconding from the centre and engaging in criminal and harmful behaviour. Regular case conferences had been convened in response to these along with core group meetings and care plan review meetings. These did not significantly increase the safety of the young person and a referral to a special care unit was made in March 2009. This was unsuccessful. The child continued in their unsafe behaviour of absconding and aggressive behaviour until they left the centre in May 2009.

Although there had been significant improvement in child protection including notifications, regular meetings, and external monitoring, one young person was moved to a respite placement by their social worker in February due to concerns about their safety from another young person's behaviour and did not return to the centre (see section on Discharges).

Inspectors found there was no formal mechanism for considering the safety of the other young people when potentially at risk from another young person's behaviour. The centre manager had attempted to convene a meeting in February with the social workers for all of the young people but it did not occur.

The regional residential manager should agree with all relevant child care managers how to co-ordinate cases in a manner that considers the safety and well-being of all of the young people regardless of which local health area the young person is from. This will ensure that there is adequate sharing of local information as well. This is of particular relevance to this centre as it accepts young people from all of the HSE North East.

Emotional Support
The emotional well-being of the young people was a significant focus of the work in the centre. A senior psychologist provided support to the staff team in working with the young people on specific areas such as improving self-esteem, encouraging young people to express anger in safer ways, and focusing on their mental health.

The individual needs of each young person were assessed through a placement development plan which subsequently informed interventions between the staff team and the young person. For example, staff members found reflective statements worked better with one young person than another in addressing a specific issue. This was shared with all team members, recorded and informed interactions with the young person. The process was led by keywork co-ordinators, the centre manager and the senior psychologist.

However, the centre was not a therapeutic unit and inspectors identified a need for a balance between this cognitive work and creating a home for young people. This balance on focusing on the nurturing of the young people so they feel cared for had also been identified by the monitoring officer and the centre manager. An external review of the keywork approach in residential services in the area was due to commence in the coming weeks. Inspectors welcome this review and recommend that the centre manager, monitoring officer and other disciplines such as social work are involved in the process.

Behaviour management

In the last 12 months of the year there had been 226 significant events in the centre involving two young people. These incidents were mainly one young person running away from the centre (eighty) with another young person (forty). One of the young people had been placed in special care on one occasion and referred unsuccessfully for a second placement in March of this year. As stated earlier the risks associated with the behaviour were reported by the manager through the child protection system. One of these young people left the centre in May and the other young person was still there at the time of inspection. There had been no incidents in the unit since early May 2009.

Inspectors found that the staff team focused on encouraging young people to express their feelings, used sanctions appropriately and moderately and concerns about safety of young people were discussed with all professionals involved with the young person. There were a number of systems in the centre to which guided the work with the young people including the placement development plans, keyworking approach and the Professional Management of Aggression and Violence Model (PMAV) which included physical interventions. The DICES model of risk assessment and management with the overarching child protection system were also used to manage behaviour with significant levels of risk. While staff members had a good understanding of these systems as separate systems, there was a lack of clarity about how they complemented each other, their effectiveness and how young people were consulted in the process. Inspectors caution that these various mechanisms should assist and not dominate the interventions with young people. Despite the interventions there were numerous incidences in the last 12 months whereby two children who had previously lived in centre were deemed at risk.

As new policies were being introduced in the coming weeks as the centre becomes integrated with residential services in Dublin North, inspectors were concerned that there may be further confusion. Inspectors recommend that the regional management, in consultation with the monitoring officer and the senior residential psychologist, examine the purpose of the various systems to ensure they are effective and to avoid duplication. There was also an incident review group in the area but there was no PMAV trainer on that group to examine practice in the area of physical interventions.

Discharges

The placement of two young people ended due to ongoing concerns about the safety of their situation. Neither decision was made in a care plan review forum but there had been regular communication between the social work department and residential services. Both were subsequently placed in foster care and supported lodging arrangements. Both of these young people have a history of multiple placements. One young person had an opportunity to end their time in the centre in a positive manner with a meal with staff and a memory box containing photos and mementoes of their time in the centre. This has not happened yet for the other young person and inspectors recommend that every attempt is made for this to occur if the young person wishes it.

Inspectors were told that the multi-disciplinary wraparound service for both young people had stopped since they left the centre. These should be reconvened with appropriate membership from their new placements to maintain continuity in their care. In light of the early end to the placements and their history of multiple placements inspectors recommended that a review of their placement history and discharge occurs. The purpose of the review is to establish if the learning which may assist in preventing further placement breakdown for these two young people and other children in the service.

Social work and care planning

Inspectors met three social workers, two of whom had only recently placed young people in the centre and one of whom who had a young person living in the centre for 10 months. The social workers told inspectors that communication was very good and they were confident that they would be notified of all significant events. They understood the necessity of reading records in the centre and one social worker had done so.

Care plan reviews had occurred on a regular basis for the young people but there was only one care plan on file for one young person. There had been no care plan review for either young person moving into the centre. The care plan review meeting allows all significant people including the young person and their family to be involved in any planning decisions. As a basic safeguard decisions about placements should occur within this forum or in emergencies, reviewed very soon after.

Children's Case files

One of the case files did not have any of the required information on the young person as required by regulations. This was not satisfactory or safe. In interview a social worker told inspectors of significant risks associated with one young person's family. This was not known to the centre. The centre should ensure that all information in relation to a young person is provided prior to admission.

There was also a large amount of information recorded by staff. Inspectors were told that there were 16 case files for one young person who had left the centre. The monitoring officer had asked for a review of their recording system to reduce the amount and inspectors would endorse this recommendation. All of the records were archived in a central office.

Staff supervision
The centre had a policy on formal supervision but it did not occur on a regular basis. Inspectors found that some staff members had not received supervision for a number of months. The standard of supervision when it occurred was very good with a clear focus on improving practice and child protection. The centre manager was unsure where staff supervision records were stored by some social care leaders with some records outside of the centre. The centre management needed to ensure supervision occurs on a regular basis and develop a more coherent filing system, securely maintained.

Children's Rights
This standard was met in part. The young people told inspectors that they were consulted about their daily living. They were invited to attend their care plan review meetings although one young person had not attended their last three reviews. This reluctance to attend should be explored with the young person. The young people and the staff team were aware that they could read their daily log books but did not know they could read their files. They said they would talk to a staff member or family member if they had a concern. The young people told inspectors that they did not have a copy of the young people's version of the National Standards for Children's Residential Centres.

Accommodation
The centre had moved from their old premises since the last inspection. The house was spacious and well maintained with homely touches throughout. The external door was unlocked the majority of the time and while this is generally acceptable it should be risk assessed considering the previous difficulties with one visitor upstairs unknown to the staff team.

The centre was previously a commercial centre and a large boulder advertising its products remained outside of the centre. This should be removed immediately.

Fire Safety
There had been significant improvement in fire safety since the last inspection. The fire equipment was well maintained, there were regular fire drills. The centre had recent visits by a fire safety officer and a member of staff was a designated fire safety officer. The centre had written evidence of compliance with fire safety but needed to provide evidence that the compliance was issued by a suitable qualified person and that it meets all of the requirements of standard 10.19.

Practices that did not meet the required standard
All of the standards in this centre were either met or met in part.

Findings

1. Purpose and function

Standard
The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Purpose and function	√		

2. Management and staffing

Standard
The centre is effectively managed, and staff are organised to deliver the best possible care and protection for children. 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	√		

Recommendation:

1. **The HSE should ensure that supervision occurs on a more regular basis in accordance with local policy and records appropriately stored.**

3. Monitoring

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

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

4. Children's rights

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

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

Recommendation:

2. **The HSE should ensure that young people have information about their rights and practices support the exercise of these rights.**

5. Planning for young people and young people

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Suitable placements and admissions	√		
Statutory care planning and review		√	
Contact with families	√		
Supervision and visiting of young people	√		
Social work role	√		
Emotional and specialist support	√		
Preparation for leaving care	√		
Discharges		√	
Young people's case and care records		√	

Recommendations:

3. **The HSE North East should ensure that all information required under the regulations is in each young person's file prior to admission.**

4. **The HSE North East should conduct a review of two young people's discharge and placement history for learning for the future.**

5. **The HSE NEA should ensure that as much as possible, any decision to change a young person's placement is made within the care review process.**

6. **The HSE NEA should examine the purpose of information recorded in the young people's case files in order to streamline the record keeping system.**

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. Children 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:

7. **The HSE North East should examine the various intervention systems in the centre to care for the young people to ensure they are effective and to avoid duplication.**

8. **The HSE North East should ensure that the external review of the key working system occurs promptly and involves consultation with the centre manager, the young people, monitoring officer and social workers.**

7. Safeguarding and Child Protection

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

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

Recommendation:

9. **The HSE North East should agree a system with the relevant child care managers on the management of child protection concerns in the centre as a whole.**

8. Education

Standard
All children have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate educational facilities.

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

9. Health

Standard
The health needs of the child 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	√		

10. Premises and Safety

Standard
The premises are suitable for the residential care of the children 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:

10. The HSE should remove the boulder from outside the centre immediately.

11. The HSE should ensure that the centre has written confirmation of fire safety and building control in compliance with standard 10.19.

4. Summary of recommendations

1. The HSE should ensure that supervision occurs on a more regular basis in accordance with local policy and records appropriately stored.

2. The HSE should ensure that young people have information about their rights and practices support the exercise of these rights.

3. The HSE North East should ensure that all information required under the regulations is in each young person's file prior to admission.

4. The HSE North East should conduct a review of two young people's discharge and placement history for learning for the future.

5. The HSE NEA should ensure that as much as possible, any decision to change a young person's placement is made within the care review process.

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9. The HSE North East should agree a system with the relevant child care managers on the management of child protection concerns in the centre as a whole.

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