

Health Information and Quality Authority Regulation Directorate

Monitoring Inspection Report on children's
statutory residential centres under the Child Care
Act, 1991



Type of centre:	Children's Residential Centre
Service Area:	CFA DML CRC
Centre ID:	OSV-0004159
Type of inspection:	Unannounced Full Inspection
Inspection ID	MON-0017601
Lead inspector:	Caroline Browne
Support inspector (s):	Ann Delany

Children's Residential Centre

The Health Information and Quality Authority (the Authority) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

The Authority is authorised by the Minister for Children and Youth Affairs under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011, to inspect children's residential care services provided by the Child and Family Agency.

The Authority monitors the performance of the Child and Family Agency against the National Standards for Children's Residential Services and advises the Minister for Children and Youth Affairs and the Child and Family Agency. In order to promote quality and improve safety in the provision of children's residential centres, the Authority carries out inspections to:

- assess if the Child and Family Agency (the service provider) has all the elements in place to safeguard children
- seek assurances from service providers that they are safeguarding children by reducing serious risks
- provide service providers with the findings of inspections so that service providers develop action plans to implement safety and quality improvements
- inform the public and promote confidence through the publication of the Authority's findings.

Compliance with National Standards for Children's Residential Services

The inspection took place over the following dates and times:

From:	To:
04 July 2016 10:00	04 July 2016 19:00
05 July 2016 09:00	05 July 2016 14:30

During this inspection, inspectors made judgments against the *National Standards for Children's Residential Services*. They used four categories that describe how the Standards were met as follows:

- **Exceeds standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

The table below sets out the Standards that were inspected against on this inspection.

Standard	Judgment
Theme 1: Child - centred Services	
Standard 4: Children's Rights	Requires improvement
Theme 2: Safe & Effective Care	
Standard 5: Planning for Children and Young People	Requires improvement
Standard 6: Care of Young People	Requires improvement
Standard 7: Safeguarding and Child Protection	Significant risk identified
Standard 10: Premises and Safety	Requires improvement
Theme 3: Health & Development	
Standard 8: Education	Requires improvement
Standard 9: Health	Requires improvement
Theme 4: Leadership, Governance & Management	
Standard 1: Purpose and Function	Requires improvement
Standard 2: Management and Staffing	Requires improvement
Standard 3: Monitoring	Meets standard

Summary of Inspection findings

The centre provided medium to long term care for up to five boys and girls aged between 13-17 years old on admission. It is located in the Midlands region. At the time of the inspection, there were 5 children living in the centre.

During this inspection, inspectors met with or spoke to 4 children, 1 parent, managers and staff. Inspectors observed practices and reviewed documentation such as statutory care plans, child-in-care reviews, relevant registers, policies and procedures, children's files and staff files.

Inspectors also spoke with the monitoring officer, five social workers, two aftercare workers and two guardians ad litem.

In general, children had a good quality of life. There were good relationships and attachments formed between staff and children and children said that they liked the staff team. Children met with friends and family and participated in interests and hobbies similar to their peers. However, children's child in care reviews did not always occur as required by the regulations and not all children had an up-to-date care plan available to them. Children's rights were not always promoted as some children were not in fulltime education. In the absence of full time education, there were no formal plans in place to ensure children reached their academic potential. In addition, complaints made by children were not always responded to in a timely way. Children had raised issues in relation to the maintenance of the house but these issues had not been responded to. The maintenance of the premises was not adequate and a number of issues required prompt repair.

Safeguarding practices were not effective to protect children from abuse. Inspectors found that a safety plan in place to protect the children living in the centre was not fully implemented. In addition, the safety plan in place did not consider all risks in order to ensure the plan protected children's safety. This posed a risk to all of the children and inspectors escalated this concern to the Principal Social Worker of the relevant social work department. The Principal Social Worker responded to HIQA with the steps she had taken to address the risk including the immediate convening of a strategy meeting and the development of a revised safety plan.

Governance and management arrangements of the centre were not robust. Deputising arrangements in the absence of the Centre Manager were not always effective. There were a number of management systems in place some of which worked satisfactorily but others, such as risk management and monitoring and oversight required improvement to ensure the quality and effectiveness of the service for children.

There was a well established and experienced staff team. The majority of staff were qualified and had up-to-date training. However, some training needs had been identified in order to meet the needs of the current cohort of children, but had not been provided at the time of inspection.

Inspection findings and judgments

Theme 1: Child - centred Services

Services for children are centred on the individual child and their care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use services.

Standard 4: Children's Rights

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

Inspection Findings

Children's rights were generally respected and promoted. Children were aware of their rights and had been provided with child-friendly information packs when they were first placed in the centre, relating to the centre, advocacy groups and their rights. The Centre Manager was in the process of updating information and material relating to rights, and children were consulted in the design of the new information booklets.

Children told inspectors that they were aware of advocacy groups. The advocacy group, Empowering People in Care (EPIC), which is a national agency that advocates for children in care, had visited the centre to meet with the children. Children had also contacted EPIC in order to seek advocacy. Guardians ad litem had been appointed to two children to advocate on their behalf. However, not all children who may have benefited from a guardian ad litem had been considered for this service.

Children's right to education and to access their own records was not consistently promoted. Some of the children were not in fulltime education and were not being sufficiently supported to reach their educational potential. While some children's requests to view information on their records were appropriately responded to and supports were provided to children to access this information, not all children had access to their information. A formal freedom of information request was identified as a route for a child to access some information about themselves during a child-in-care review and the Centre Manager was identified to follow-up on this. Records did not indicate if the child was supported or facilitated further in relation to this request. On review of records, it was not clear that there were compelling reasons that the child should not review this file or if the child's social worker had explored these issues further with the child.

Children were encouraged to participate in decision-making about their lives. Staff and social workers supported children to be involved in the care planning process and the children attended all or some of their child-in-care reviews. Children knew that they had a care plan and what was in that plan, though some were not in date. Staff were

observed to take the time to talk to children on an individual basis about important issues, including the dynamics within the house, future opportunities in relation to college, hobbies and interests.

There was some consultation with children about the day-to-day running of the centre. Children told inspectors that they had been consulted in the design of their bedrooms and inspectors observed staff asking children about the meal plan for lunch and dinner on the days of inspection. There were community meetings held weekly in the centre, which were attended by children and staff. On review of these meetings minutes, inspectors found that there was good attendance by both children and staff. However, children had mixed views of the value of these meetings. While some children felt that they liked the community meetings and everyone had their voice heard, other children did not like these meetings. Inspectors found that community meetings were chaired by staff members and records did not reflect that children suggested items for discussion at these meetings or that opportunities were taken at these meetings to consult with children about the running of the centre.

Not all complaints were effectively managed. Children were aware of how to make a complaint, they were informed of the complaints process and were encouraged to make a complaint if they were dissatisfied with any aspect of the service. Complaints were recorded on a complaint log. There were eight complaints in the 12 months before the inspection, all of which had been made by children. However, children told inspectors of issues which they had raised six months previous which had not been recorded as a complaint, for example issues relating to maintenance. One complaint made in 2015 was recorded as being open and on-going. While staff told inspectors that this matter had been dealt with and closed, this was not reflected on the complaints log. Inspectors saw no evidence of follow up of this issue and whether there was resolution of this complaint. While there was evidence of recording of the outcome of most complaints, not all complaints recorded whether the child had been satisfied with the outcome of the complaint.

Judgment: Requires improvement

Theme 2: Safe & Effective Care

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs.

Standard 5: Planning for Children and Young People

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. This 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.

Inspection Findings

All children had an allocated social worker and were visited regularly, in line with the regulations. Children told inspectors that they were happy with their social workers and the level of contact they had with them. While social workers spoken with told inspectors that they reviewed children's files when they visited the centre, there were gaps on children's files in recording visits by social worker to the centre.

Care plans were in place for all children, but they were not all up to date and their quality varied. Two of the care plans reviewed were of good quality and reflected the needs of the children but two of the other plans reviewed did not. One child's care plan on file reflected their previous placement and though a child-in-care review had taken place two months before the inspection in relation to their current placement, neither the care plan nor minutes of the meeting had been made available to the social worker, staff in the centre, the child or their parents. As a result, the staff team had no up-to-date information which outlined the child's needs or information about areas that the staff team could work on to achieve positive outcomes for the child. Although the Centre Manager had made contact with the social worker seeking a copy of the most up-to-date plan, this had not led to receipt of same. Inspectors wrote to the relevant Principal Social Worker in Tusla, following the inspection, in relation to this and the Principal Social Worker responded identifying that copies of the care plan and minutes were circulated to the social worker, residential care staff, the child and parents on 20 July 2016. The other plan reviewed did not reflect the child's current needs, particularly in relation to safeguarding and educational needs. Inspectors spoke with the child's social worker who acknowledged that parts of the care plan were out of date.

Not all child-in-care reviews had occurred as often as required by regulations. Children, parents, staff and relevant professionals participated in the planning and review process. While some reviews were held in line with regulations, for example, one child was having monthly child-in-care reviews in order to closely monitor the child's progress, others were not. Not all minutes of child in care reviews were provided to the centre staff in a timely manner. As a result, the staff were not fully informed of decisions made at these reviews. One child's circumstances had changed significantly, but this had not prompted a child-in-care review. The child's social worker told inspectors that the child-in-care review was scheduled annually, (for later in the year) and it was difficult to reschedule reviews at the current time as no reviews were taking place in her social work area for five weeks over the summer. Inspectors wrote to the relevant Principal Social Worker in Tusla, following the inspection, in relation to this review and the Principal Social Worker responded identifying that in light of the changed circumstances that the child-in-care review would be brought forward by two months. However, in relation to the child's educational needs this review would not be timely to ensure the child was accommodated in a suitable educational setting for the 2016-2017 school year.

The quality of placement plans varied as not all placement plans were informed by up-to-date care plans. Placement plans which were informed by up-to-date care plans were of good quality and were regularly reviewed. Placement plans outlined goals and daily routines to support children's progress and guided staff in ensuring positive outcomes were achieved for children. However, inspectors found that some placement plans were

not completed in full and did not sufficiently guide staff.

Children maintained positive relationships with their parents, siblings and significant others. The staff team facilitated children to visit their family and friends in line with children's care plans in order to maintain links with their own communities. On the day of inspection, one child was visiting her family. Inspectors observed staff helping to arrange children's visits with family members and friends.

The quality of emotional and physical care provided to children was generally good. Inspectors observed staff interacting respectfully, warmly and appropriately with children. Each child had a number of key workers who completed individual work with them and provided emotional support when they were experiencing difficulties in their lives. Inspectors observed staff providing emotional support to young people. Children were referred and some were attending appropriate services in order to assist them in their emotional and physical development. Examples of these services included, psychology, speech and language and occupational therapy. However, when children declined to attend appointments, staff did not always encourage children to attend in order to meet their best interests. Inspectors spoke with a child's social worker who had not been made aware by the residential staff team that the child did not intend to go and had not attended a specific appointment in line with their care plan.

Preparation for young people leaving care required improvement. Children over the age of 16 were referred to aftercare services and children were assigned aftercare workers appropriately. Children were involved in aftercare planning in order to prepare for their future. An aftercare worker who advocated for one young person had successfully secured various grants in order for them to live independently. However, not all young people had aftercare assessments on file and the quality of aftercare plans was poor. Inspectors found that plans were not sufficiently detailed to ensure that there was a plan for development of independent living skills and that all options on leaving care, for example, accommodation and on education/training on leaving care were explored and were attainable.

The development of independent living skills was not integrated into day to day life. Three of the young people living in the centre were over the age of 16, but plans did not clearly identify good preparatory work to develop independent living skills. The staff team and the young people's key-workers' completed some good one-to-one sessions in areas such as budgeting, using public transport, cooking, and preparing for a young person's driving test. However, these plans had not been integrated into day-to-day living. Staff were observed vacuuming the house, doing laundry and preparing and cooking meals and none of the young people were involved in these activities which would have developed these skills and supported them when they left care.

Children living in the centre were appropriately placed. All admissions were approved by the Central Referrals Committee of which the interim Service Manager was a member. The Centre Manager and staff team were consulted as part of the admission procedure to determine a child's suitability to the service. Inspectors found that information relating to children was provided to the staff team prior to their placement in the centre.

While children were admitted to the centre in line with its statement of purpose, there

was no record of a collective risk assessment on the impact of an admission on the other children already living in the house. The absence of a collective risk assessment meant that some children may end up being admitted to the centre who could not live compatibly with the other children living there and the child's placement may have to end. The Centre Manager and interim Service Manager told inspectors these risks were discussed at the referrals committee meeting but there were no records to support this.

There were two discharges of young people from the centre in the 12 months prior to the inspection. On review of files, inspectors found that the staff team had made efforts to ensure that the discharges were as planned as possible.

Judgment: Requires improvement

Standard 6: Care of Young People

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

Inspection Findings

Children were cared for in a manner that respected choice and recognised achievements. Staff interacted warmly with children and children knew that staff were available to support them. Children were encouraged to pursue their own interests and to try new activities in order to develop self confidence. Children's achievements and significant events were celebrated. Inspectors found that staff and children arranged social events which included birthday parties and graduations. On the day of inspection, staff and children planned to buy a gift for another young person's birthday. Photographs and memorabilia were kept safe on children's files.

Care practices did not take into account children's individual religious identity. While children's religion was noted on their care plans, there was no record of children's wishes with regard to the practice of their religion. One child told inspectors that religion was not something that was celebrated with them in the centre.

Records of children's nutritional intake were not adequate. Children were involved in buying and preparing some meals, but inspectors found that this was not completed in a systematic way. There were no consistent records relating to meal planning. Some children's care plans identified their needs in relation to healthy eating. Inspectors saw evidence of the staff team, in consultation with children, making a decision to limit takeaways in recent months in order to encourage a healthy lifestyle. However, children's eating habits had not been consistently monitored to ensure children had healthy diets. Meal times were observed to be positive sociable events.

Some children had complex needs and displayed behaviour that challenged. Incidents of behaviour that challenged were well managed and staff made considerable efforts to support children. Children's behaviour support plans identified the supports required. However, not all behaviour support plans were reviewed and updated in line with

children's needs. While staff were trained and skilled to provide care for children with complex needs, further training was required in order to meet children's individual needs. Staff were aware of underlying causes of behaviour that challenged and strived to ensure that practice supported children to manage behaviour.

Physical restraint was not used in the centre. However, there were some restrictive practices used which were not always recognised as such. There were some doors and windows which were locked during the inspection. There were also sharp knives which were locked away. While some of these practices were in place due to identified risks, it was unclear why others were in place as there were no risk assessments in place. The staff team did not recognise these as restrictive practices. There was no central log to record any restrictive practices in order to ensure effective oversight of these practices.

Consequences and incentives were reasonable and appropriate. However, oversight and monitoring of the use of consequences required improvement in order to promote consistency among the staff team. There was a consequences log which recorded both positive and negative consequences. Consequences and incentives were also recorded on individual young people's files. There was a total of 81 consequences in the previous 12 months. However, inspectors found that the central log was not complete as some incentives were not recorded. In addition, there was a lack of recording of the reason children received positive consequences and staff were not always aware of the reasons for positive consequences. This lack of recording could lead to inconsistency among the staff team in relation to practice.

Absence management plans were in place, but did not always provide clear guidance to staff. These plans took into account the age and personnel circumstances of the children. There were three incidents of children missing from care in the previous 12 months. Inspectors found that in those incidents, staff followed national policy and took appropriate steps to ensure the children's safety. Staff reported appropriately when a child was missing in care. However, inspectors found that some absence management plans lacked sufficient detail in relation to steps to take should a child go missing from care. For example, plans did not outline clear timeframes for when staff should contact An Garda Síochána.

Judgment: Requires improvement

Standard 7: Safeguarding and Child Protection

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.

Inspection Findings

Safeguarding measures were not always implemented to protect children from abuse. While there were some measures in place to safeguard and protect children, five child protection concerns related to one incident of peer to peer abuse had not been consistently managed. Inspectors found that a strategy meeting was held between all relevant social workers and the staff team following the event. However, inspectors found that some risks associated with this child protection concern had not been risk

assessed. While there was a safety plan in place, inspectors were not assured that all known risks to the children had been explored collectively and on the day of inspection, not all aspects of the safety plan were implemented. This posed a risk to all of the children and inspectors escalated this concern to the Principal Social Worker of the relevant social work department. The Principal Social Worker responded to HIQA with the steps she had taken to address the risk including the immediate convening of a strategy meeting and the development of a revised safety plan.

Child protection concerns were managed in line with Children First: National Guidance for the Protection and Welfare of Children (2011). There were 12 child protection and welfare concerns in the previous 12 months. Five child protection concerns remained open and were under investigation at the time of the inspection. Inspectors found that all child protection concerns were appropriately referred to the relevant social work department. There was a good level of communication between staff and social workers in relation to these concerns. The Centre Manager followed up with the social work department in relation to the outcomes of social work investigations.

Staff were aware of the whistle-blowing policy. However, not all staff were aware of the steps to take should they wish to report any concerns relating to the service.

Judgment: Significant risk identified

Standard 10: Premises and Safety

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

Inspection Findings

The health and safety of children, staff and visitors was not always promoted or protected in suitable accommodation. The centre had policies and procedures relating to health and safety and there was an up-to-date health and safety statement. All staff were trained in first aid, the centre was adequately insured, and vehicles were suitably equipped, insured and maintained.

However, the centre was not in a good state of repair. Children had space in the centre in which they could store their personal belongings and receive visits from friends, family members. However, some children told inspectors that they did not like bringing friends to the house due to the state of disrepair. Inspectors walked around the premises and found that it was poorly maintained. Staff and children told inspectors that some parts of the house could be cold and that there was not an adequate heating system. There was damage to some kitchen presses, bedroom and communal area walls. Staff and children identified that some of this damage had occurred over six months ago. While children and staff had raised these maintenance issues, there was no timely responses to these requests.

There was a record of maintenance requests and repairs but the record contained gaps. Inspectors found that maintenance issues were recorded but the records did not clearly

indicate that the maintenance issue had been addressed appropriately. Some actions taken and the date of repairs were not recorded. This meant that the Centre Manager could not oversee trends in delays in maintenance issues being addressed. Some issues were re-requested but others were not. The Centre Manager reviewed and signed the maintenance book on a monthly basis but this did not lead to these gaps in repairs and recording being addressed. In addition, the recording issue was identified by the interim Service Manager in previous months, but had not led to amendments.

While medicines were safely stored in a secure cabinet, the cabinet was overstocked. On the first day of inspection, inspectors found that there were some medicines stored which were out of date or no longer prescribed. On day two inspectors found that the staff had reviewed the medicines in the cabinet and medicines were stored in a more orderly manner.

There were adequate precautions against the risk of fire, but some improvements were required in fire safety. There was written confirmation from a certified engineer that the centre complied with fire safety and building requirements. Staff were trained in fire safety, but required refresher training. There was suitable fire safety equipment which was appropriately serviced. There was a nominated fire safety officer among the staff team, and daily, weekly and monthly checks of fire fighting equipment. There were adequate means of escape and staff knew what to do in the event of a fire and where the fire assembly point was. However, there was no signage in this area to identify it as the assembly point.

Not all staff had participated in regular fire drills in line with the health and safety policy. There were three fire drills recorded in the previous 12 months. All children had participated in a fire drill. Records of fire drills included the names of those who participated in fire drills and the time of the fire drill. However, not all records had recorded the duration of the fire drill and whether or not there had been any difficulties during the fire drill in order to promote learning among the staff team. In addition, inspectors found that there were duplicate records of fire drills in the centralized logs.

Judgment: Requires improvement

Theme 3: Health & Development

The health and development needs of children are assessed and arrangements are in place to meet the assessed needs. Children’s educational needs are given high priority to support them to achieve at school and access education or training in adult life.

Standard 8: Education

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 education facilities.

Inspection Findings

Not all children were in full-time education. Children were encouraged to complete state examinations in order to reach their potential and a number of the children in the centre had completed both junior and leaving certificate exams. Inspectors saw certificates of achievements and school reports on children's files.

Where possible, children were facilitated to maintain their own school placements following admission to the centre. If this was not possible, staff sought to enrol children in schools in the vicinity of the centre. Where children were attending school, inspectors found that there was a good level of communication between the staff team, professionals and educational establishments in order to ensure positive outcomes for children's education.

Three of the children were not in full time education, though some of this was due to personal circumstances. Two of these children were 15 years or younger. There were no educational assessments on these children's files nor was there an individual educational plan to ensure these children reached their academic potential. In addition, there was no up-to-date care plan in place for two of the three children. While a social worker and staff told inspectors that there was a proposal to get one of these children additional tuition hours for the 2016/2017 school year there was no formal plan in place. For the other two children, efforts made had not been effective at improving their educational outcomes. Some social workers identified that while proposed educational placements were not the optimum plan for the particular child, due to the child's current circumstances the proposed option of youthreach or home tuition would continue their education, at a minimum while they worked on other options.

There was no non attendance at school policy in place. Staff told inspectors that they worked on social skills and one to one work when children were not attending school. However, there was no formal guidance in place to ensure an appropriate routine was maintained when children were not in fulltime education.

Judgment: Requires improvement

Standard 9: Health

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.

Inspection Findings

Children's healthcare needs were adequately assessed and met. Children had timely access to a general practitioner (GP), therapeutic supports and specialist services. Children were referred to ophthalmic, orthodontic and occupational therapy as appropriate. However, not all children's medical records, for example children's immunisations records, were on their files.

Healthy lifestyles were encouraged by the staff team. Staff promoted children's health and encouraged exercise and a healthy diet. One child had completed a smoking cessation programme. However, four out of five children smoked. Files reflected that staff used one to one key working sessions with the children to discuss areas such as smoking, alcohol, sexuality and relationships.

Medication administration practices were good. Medicines were labelled appropriately and administration of prescribed medicines was recorded on an administration sheet in the child's file. Where parental consent was required prior to administering newly prescribed medications, this was appropriately recorded in a child's file.

Judgment: Requires improvement

Theme 4: Leadership, Governance & Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed. The system is subject to a rigorous quality assurance system and is well monitored.

Standard 1: Purpose and Function

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.

Inspection Findings

The centre's statement of purpose adequately described the service provided to children in the centre. However, the statement was dated January 2015 and had not been reviewed as per the review date on the statement. Day to day practice reflected the statement but there was no child-friendly version available.

Judgment: Requires improvement

Standard 2: Management and Staffing

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.

Inspection Findings

There was a defined management structure in place but it was not always effective. Social care leaders deputised for the Centre Manager in her absence and were also shift leaders. The Centre Manager reported to the interim Service Manager who in turn reported to the Regional Manager for residential care. However, inspectors found over the course of the inspection that the arrangements for covering the Centre Manager's leave required improvement to ensure the centre was managed appropriately. Inspectors found that information relating to children had not been communicated to the relevant social worker in the manager's absence and safety plans were not being monitored to ensure they were implemented appropriately.

Management systems required improvement. While policies and procedures were in place to guide staff, some of these policies were old. Staff were aware that revised policies and procedures were in the process of being developed at a national level.

Communication between centre staff and other relevant stakeholders varied. Inspectors found some good communication systems in place including regular staff meetings, a daily handover meeting and a handover book for staff. However, inspectors also found that some key information in relation to the children was not always communicated in a timely way to relevant parties. Team meeting minutes reflected good discussion about the children, decisions made, the person responsible and agreed timescales for actions but there was not always a record that the agreed actions were discussed at the next meeting. Inspectors also found that not all information had been recorded in the handover book which could result in inconsistency in practice among the staff team.

Regional management meetings were held regularly with good attendance by the Centre Manager. Items discussed at these meetings included health and safety, fire registers, new admissions, training, complaints and significant events. Inspectors found that information was shared at these meetings and there was good guidance for centre managers in relation to practice. However, there was no standing items for discussion at these meetings.

The risk management system was fragmented and did not always control risks. While there was a risk register in place and some risk assessments had been completed, there was no risk management policy and the Centre Manager and staff had not received training in risk management. The risk assessments completed included risks to individual children and environmental risks in the centre. Inspectors reviewed the risk register and found that the residual risk grading for some risks was not appropriate as some of the measures identified as in place to control the risk were not. In addition, there was no implementation date identified for any additional controls required. As previously identified some controls, for example safety plans, were not being implemented appropriately.

There was a prompt notification system for significant events which had occurred in the centre. Inspectors reviewed significant events notifications which included child protection notifications, complaints and conversations of note. Inspectors found that significant events were responded to appropriately by the staff team. The Centre Manager also reviewed significant events and provided feedback to the staff team to promote learning. Records showed that all significant events were forwarded to the relevant social work departments, monitoring officer and the significant events review group (SERG). SERG reviewed these events and, as appropriate, feedback was provided through meeting minutes and discussion at team meetings. The interim Service Manager also completed an analysis of significant events to identify patterns of behaviour of children. However, it was not evident how feedback from this had been provided to the team to promote learning and improve outcomes for children.

Monitoring systems were not effective in improving the quality and effectiveness of services and outcomes for children. There was little evidence of a quality management system as there were no audits, evaluations or reviews undertaken by the Centre Manager. Daily logs were signed by the Centre Manager, but inspectors found gaps in recording on children's logs which had not been addressed. The Centre Manager used a

governance reporting tool to report up the National Director of Residential Care on a range of issues including children's care plans and risks on a monthly basis. Inspectors found that maintenance and health and safety issues were only recently included in this report by the Centre Manager though they had been raised as an issue by children five months previous to this. Inspectors also found that this reporting tool was a one way communication system as deficiencies reported through this tool were not responded to. For example, the absence of an up-to-date care plan for children had been reported but no external manager had responded to this.

External managers also had monitoring mechanisms in place, but these were not always effective. The interim Service Manager visited the centre regularly, completed supervision, audits, observed practice and attended some team meetings. She carried out audits including children's care, placement support plans, central logs and health and safety. However, issues identified by the interim Service Manager such as, recording of maintenance requests and complaints and gaps in the centre register had not been addressed by the Centre Manager and had not been followed up by the interim Service Manager. In addition, some of the recommendations made in the Tusla monitoring report from February 2015 were outstanding. For example, a recommendation in relation to the refurbishment of the centre and a review of maintenance arrangements had not been implemented in line with the action plan.

The register of children was not complete. There were gaps in recording of dates of young people's discharges or where young people were discharged to. This meant that young people who may request this information in the future would not have access to full and accurate records. Staff told inspectors that there were two logs where they recorded this information. As a result, there was a lack of clarity among the staff team in relation to the recording of this information.

Records were held securely but there were gaps in some records. Files were stored in a locked cabinet and there was a system in place to archive old files. Inspectors found that some information was difficult to find as procedures in relation to filing were not always followed by the staff team. Some records, for example in relation to the children, and the register were not completed in full.

There was a financial management system in place, but it was not robust. A number of staff members held procurement cards, but there was not always a staff member on a shift who had a procurement card. Staff told inspectors that petty cash was to be used for some purchases or they would hold off on buying items until there was a staff member on duty who had a card. Inspectors reviewed the petty cash and procurement card records and found that while most of the records were in place in relation to the procurement cards, the petty cash record did not match the petty cash. In addition, the petty cash expenditure record had sticky tape covering errors in records which was not in line with Tusla's records management policy.

Staff members had been recruited in accordance with legislation, standards and policies. There was a sufficient number of staff in place to deliver the service. There was a Centre Manager, five social care leaders and 14 social care staff. While the majority of staff were qualified, for the small number that did not hold a qualification they had many years experience.

The quality of supervision was mixed and some supervision arrangements were not effective. The Centre Manager and social care leaders provided supervision and had been trained in supervision. The majority of supervision records sampled showed that supervision was regular, there was good discussion about the children and staff were encouraged to develop new skills and improve their practice. Some staff told inspectors that they found supervision supportive and that it provided them with clear guidance and accountability for their workload, but other staff identified that there were not always opportunities to reflect on and discuss challenging practice issues and receive appropriate guidance. Inspectors found that there was some duplication of the supervision role as the Centre Manager told inspectors that if there were performance issues with staff who were supervised by a social care leader, she addressed these issues separately.

Staff training needs had been identified but had not always been provided in a timely manner to meet the needs of the children. A training needs analysis had been completed and had been informed by the needs of the children, the risk register and staffing skills and knowledge. A training plan had been identified from the training needs analysis and included training in sexual health and self-harm in order to meet the needs of individual children. However, this training had not been provided up to the time of the inspection. Some updated training was required in fire safety and child protection.

Judgment: Requires improvement

Standard 3: Monitoring

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

Inspection Findings

The centre had an assigned monitoring officer whose role was to monitor the centre on a regular basis to ensure compliance with the regulations, standards and best practice. The monitoring officer had visited the centre in June 2016 and February 2015. The monitoring report from the most recent visit in June 2016 had not been completed at the time of the inspection.

However, as previously identified some actions from the previous monitoring visit had not been actioned in a timely manner.

Judgment: Meets standard

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

