A high support unit in the Health Services Executive Mid-West Area

A
HIGH SUPPORT UNIT
IN THE
HEALTH SERVICES EXECUTIVE
MID-WEST AREA

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1 Executive summary

The Social Services Inspectorate (SSI) carried out an inspection of a High Support Unit (HSU) in the Health Services Executive: Mid Western Area (HSEMWA) in March 2005. This was one part of an inspection of all 13 HSUs in the country on the theme of management of behaviour. The inspection was against five of the ten standards of the National Standards for Children's Residential Centres. These concern the unit's purpose, the management and staffing arrangements, the approach to children's rights, care planning, and care practices in the unit. These are the issues that most directly affect the unit's capacity to manage, safely and well, the behaviour of the young people placed there.

This inspection occurred shortly after a number of significant changes had taken place in the unit. There had been a change in the purpose and function of the unit so that it began to provide a service for young people who displayed sexually inappropriate behaviour. A number of young people had moved from the unit to accommodate this change, which occurred in August 2004, just eight months prior to inspection. Two young people who presented with particularly challenging behaviour were admitted. A new manager had been appointed. A new model of care had been introduced, one that was specifically designed to address the difficulties of the target client group. The main finding of this inspection, that management of behaviour did not reach the required standard, has to be seen in the context of a unit in a process of transition with all the instability and uncertainty that accompanies fundamental change.

Many of the elements that are associated with a good quality service were present. There was a good management structure in place and key elements of good management practice were also present. There was, for example, regular formal supervision and access to advice and consultation for the staff team. The standard of primary care was good. The care staff team were respectful of the young people's rights, they consulted with them about their care and listened to and endeavoured to resolve their complaints. There was good communication with the parents of the young people and with their social workers and both parents and social workers were happy with the service being provided to the young people.

Inspectors were concerned for the safety of the young people and the staff in the unit. There was a high level of assaults on staff. Many of the staff interviewed by inspectors presented as demoralised and disempowered. Of particular concern were problems in the communication between managers and staff. There was no consensus in relation to the source of the difficulties the unit was experiencing or their resolution.

At the time of this inspection, the unit was in a downward spiral. There was a relatively high level of sick leave, some of it due to the number of assaults in the unit. This led to a reliance on relief staff and others who were due to transfer to another unit. Not all of these staff had participated in the induction training for the new model of care. This put additional strain on those left behind increasing the sense of demoralisation within the staff team. Team functioning had suffered and there was little sense of a collective approach to the management of behaviour. Managers accepted that the situation was serious but believed that they were addressing the difficulties.

The unit was going through a critical period in its development at the time of this inspection. Inspectors commend the HSEMWA and its staff for endeavouring to provide an appropriate service for some of the more troubled young people in its care. Considerable resources in

terms of numbers of staff and the commitment and energy of the managers and staff concerned had been committed to the task. Much of what had been done was appropriate and good. However, the crisis in the unit needs to be addressed and a way forward found that addresses the concerns of the staff team for their own safety so that they can provide an appropriate and good quality service to the young people in their care.

2 Introduction

The Social Services Inspectorate (SSI) carried out an announced inspection of a High Support Unit (HSU) in the Health Services Executive: Mid Western Area (HSEMWA) as part of a themed inspection of all 13 designated high support units throughout the country. The aim of these inspections is to examine the approach to the management of behaviour across the various units and to draw some general conclusions in relation to good practice. There will be a report of each individual inspection. When all the inspections have been completed a composite report will be published and SSI will issue guidance notes on good practice in relation to behaviour management.

The inspection was carried out under Section 69(2) of the Child Care Act 1991. It was against selected standards taken from the National Standards for Children's Residential Centres. These concern the statement of purpose and function (Standard 1), the management and staffing of the unit (Standard 2), children's rights (Standard 4), care planning (Standard 5) and care practices (Standard 6). The overall aim of the inspection was to evaluate the unit's capacity to manage the behaviour of the young people placed there safely and well.

This inspection was conducted by Ann Ryan and Andrew Fagan (lead inspector) over three days from the 14th to the 16th of March 2005.

2.1 Methodology

During the course of the inspection, inspectors interviewed the centre manager and the regional manager for residential child care, a child care leader, seven child care workers, the young people's parents and social workers, the guidance counsellor and senior clinical psychologist attached to the regional residential child care service, and the HSEMWA's monitoring officers. Inspectors met the young people and spent some time observing practice in the unit. However, the young people declined to be interviewed.

Inspectors corresponded with the external consultant. A meeting was held, after the inspection fieldwork, with the regional manager for residential child care and her line manager, the child care manager for North Tipperary in relation to all four High Support Units in the Mid Western Area.

The following documentation and records relating to the work of the unit were examined in the course of the inspection:

- The statement of purpose and function for the unit.
- Policy documents relating to: absence without authority, staff access to the on-call manager, exposure incidents, working with young people under the influence of substances, therapeutic crisis intervention, safe care, drug and alcohol policy, and an operations manual and guide to good practice.
- Written documentation in relation to the trauma model of care supplied by the external consultant.
- The young people's care files.

- The records of sanctions, complaints, incidents and sick leave.

2.2 Acknowledgements

Inspectors wish to acknowledge the assistance of the manager and staff of the unit, the young people, their parents and social workers and the other professionals and managers who contributed to the work of this inspection.

3 Setting the scene:

3.1 Background

The unit was one of four high support units that had been established as part of a regional service that had been set up by a religious order and was handed over to the (then) Mid Western Health Board at the end of 2003.

The Board had, over a number of years, identified a need for a high support unit that would provide a service specifically designed to address the needs of boys from the mid-western area who behave in sexually inappropriate ways. This unit, which had been operating as a high support unit, was identified as the one in which this service would be provided. Young people who had been living in it were moved to other placements to accommodate the change of purpose and function. The existing staff team were given the option of remaining in the unit or transferring to another part of the regional residential child care service. As the service was seen as a new one there was an internal competition for the post of manager and a person with management experience was appointed to manage the unit. The unit closed in July 2004. There was a three week period of staff induction into the new service. This involved training the team in a new model of care, the trauma model. The new service began operation in August 2004 when two young people were admitted within a short space of time.

The two young people admitted to the new unit presented with very difficult to manage behaviour and in considering the difficulties encountered in the unit this has to be taken into account. In addition, there were some new team members and a new manager. Finally, the unit was attempting to introduce a new model of care. All of these factors contributed to the instability in the unit that was found during this inspection.

3.2 Data on young people

Young person	Age	Length of time in the unit	Legal status	Number of previous placements
#1	14	7 months	Voluntary	22 foster and residential placements
#2	15	7 months	Care Order	none

4 Standards: the findings

4.1 Statement of purpose and function

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

The unit had a written statement of purpose and function that clearly set out the service the centre was set up to provide. This was described as 'high support care within a therapeutic framework based on a trauma theory [that] is specifically focused on addressing inappropriate sexualised behaviour for adolescent boys'. The programme of care was dependant on the needs of each individual young person but was described as being for a period of up to two years. The age profile of the young people was ten to seventeen years on admission.

An integrated multi-disciplinary approach was described as critical to the model of care within which the unit operated.

Inspectors have some concerns about the inclusion of young people under twelve within the target group for residential care. However, the child care manager for North Tipperary explained that such placements would only be considered in the most exceptional circumstances and that placement with relatives of other foster carers would be the placement of choice for any young person in the mid-western area in need of alternative care.

The two young people in the unit at the time of inspection fitted the criteria for admission. However, it is important to note that while the unit was established for young people whose behaviour was sometimes sexually inappropriate, this did not imply that they had behaved in a sexually abusive manner towards other children.

There had been a number of discharges in the year leading up to the inspection. These had all been planned discharges. Though the unit could accommodate five young people, there were only two in the unit at the time of inspection. However, managers did not consider that the unit was under occupied. It was pointed out to inspectors that both of the young people presented with particular difficulties. One had a long history of placement breakdowns and, prior to admission, was being looked after by a private provider in a single occupancy centre outside of the mid- western area. The HSEMWA took the decision that it needed to take responsibility for his care and provide a service for him where he could be with other young people. It recognised that this would be costly and resource intensive. The other young person also presented with a range of difficulties that rendered the provision of a suitable service problematic. It had been decided that the unit would not accept any other referrals for at least a year for these reasons and also to give an opportunity to the staff team to become proficient in the application of the trauma model.

The statement of purpose and function described what the unit set out to do but not the manner in which the service would be provided. The statement was accompanied by policies and procedures covering child protection, the use of drugs and alcohol and others, but there was no detailed policy document setting out the trauma model of care and how it was to be put into operation. This was significant. There were problems related to the introduction of the trauma model that are detailed later in this report. Care staff and members of the regional residential service interviewed by inspectors gave differing accounts of what it involved.

These were no clarity or agreement about how the unit was to be run and, in particular, how the young people's behaviour was to be managed. Inspectors were also concerned that managers could not tell them whether the trauma model of care that they were attempting to implement in the unit had been independently evaluated.

The standard on statement of purpose and function was not met. It did not provide clarity about how the service in the unit was to be provided.

Recommendations

1. **The regional manager of residential child care should revise the statement of purpose and function to include a description of how the service is to be provided in the unit.**

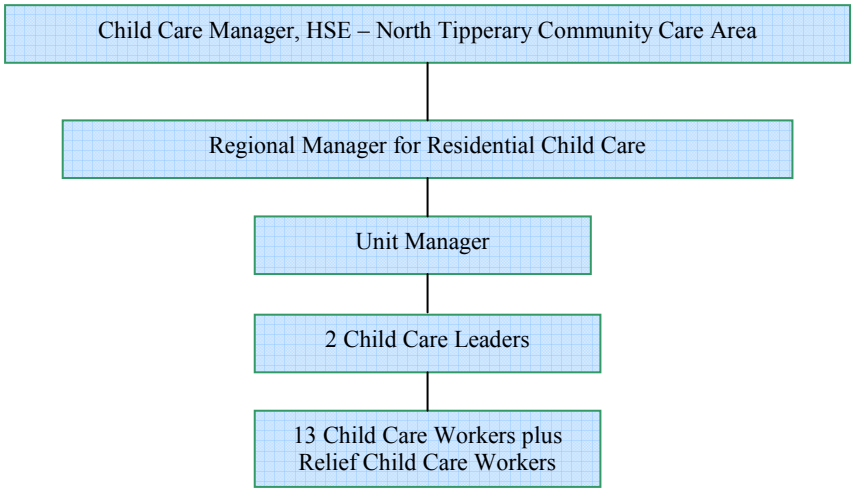
2. **The regional manager of residential care should ensure that any model of care introduced to a unit for which she has responsibility has been through some form of independent evaluation.**

4.2 Management and care staffing

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

4.2.1 Management

The management structure is outlined in the chart below.



There was a regional management structure in the HSEMWA for the residential child care service. It was headed up by a regional manager to whom each of the centre managers reported. A clinical psychologist and a guidance counsellor, both of whom worked directly with the young people in the service and provided consultancy and support to the staff teams in the units, formed part of the regional service. The regional manager reported to the child care manager for North Tipperary. The regional manager had regular formal supervision with the manager of the unit under inspection and was available, outside of these times, for informal discussion, consultation and advice. There were, in addition, regular management meetings attended by the regional manager and all of the centre managers. The regional

manager visited the unit from time to time. The centre manager in the unit found the support and direction provided by the regional manager helpful and supportive.

The principal social workers in the area attended monthly meetings with residential managers and this helped to integrate social work and residential care services. This was reflected in good working relationships between social workers and care staff detailed later in this report.

The unit manager had taken up the position at the time of the change of purpose and function and was, therefore, relatively new to the post. However, she came with four years management experience. The regional manager and unit manager were, at the time of inspection, undergoing management training along with other managers in the mid-western area.

There were two child care leaders employed in the unit. They carried certain management responsibilities. They provided formal supervision for some of the child care workers and undertook certain administrative duties. Like the manager they worked 'on the floor' alongside the child care workers and were available to them and to the young people.

There was an out of hours, on-call system in place that was operated by all of the managers of the regional service in rotation.

There was a good management structure in place and inspectors were satisfied that management practice was good in many respects. However, as discussed later in this report (4.2.4), there were problems in the communication between managers (internal and external to the unit) and staff in the unit that had serious implications for the running of the unit. Within the internal management team (manager and child care leaders) there were differences as to the appropriateness of the trauma model of care.

4.2.2 Supervision and support

All of the care staff had regular, formal supervision. The manager and one of the child care leaders had received training in supervision. The second child care leader was due to commence training shortly after the inspection. Sessions involved addressing issues raised by both the supervisor and the supervisee and there was an agreed record kept of them. Most of those interviewed by inspectors on the subject stated that they found supervision helpful.

There were regular fortnightly team meetings. Inspectors were informed that about two thirds of staff members were in attendance at any given meeting, taking account of annual and sick leave and that some staff members are on night duty at any given time.

The senior clinical psychologist and guidance counsellor undertook direct work with the young people, attended some staff meetings and were available to members of the care staff team for advice and consultation and also, at times, for support following assaults or when staff members were feeling under pressure or stressed. Staff reported to inspectors that the psychologist and counsellor were accessible to them. There was, in addition, an external consultant. This person was based in Scotland but had a contract with the HSEMWA to provide training and consultation to the staff team with particular emphasis on the implementation of the trauma model of care. He had provided three days training to the whole team on the trauma model of care and, up to the time of inspection, had had four further consultation sessions with the team.

Most of the care staff working in the unit at the time of inspection had participated in the three week training that was provided in August 2004 to induct the team into the new model of care, the trauma model. Members of the care staff team had participated in some other in service training courses during 2004 such as therapeutic crisis intervention (TCI) training, training on assessment and others.

There were good systems in place for the supervision and support of staff.

4.2.3 Care staffing

CARE STAFF EXPERIENCE, STATUS AND QUALIFICATIONS

	CARE STAFF	LENGTH OF SERVICE IN THE UNIT	EMPLOYMENT STATUS	QUALIFICATIONS
#1	Centre Manager	7 months	Permanent, full-time	National Diploma in Social Studies in Social Care
#2	Child Care Leader	4 years, 3 months	Permanent, full-time	National Diploma in Social Studies in Social Care
#3	Child Care Leader	7 months	Permanent, full-time	B.A. Applied Psychology M.A. Applied Psychology
#4	Child Care Worker	5 years	Permanent, full-time	Diploma in Applied Social Studies in Social Care
#5	Child Care Worker	4 years, 6 months	Permanent, full-time	Cert. Child Care, Cert Nursery Management
#6	Child Care Worker	5 years	Permanent, full-time	Diploma in Applied Social Studies
#7	Child Care Worker	1 year	Permanent, full-time	B.A. Applied Social Care
#8	Child Care Worker	2 years	Permanent, full-time	National Diploma in Child Care. Diploma in Social Studies
#9	Child Care Worker	3 years, 6 months	Permanent, full-time	Nurse, Diploma in Social Therapy
#10	Child Care Worker	4 years	Permanent, full-time	Certificate in Childcare
#11	Child Care Worker	2 years	Permanent, full-time	B.A. Clinical and Counselling Psychology, M.A. Psycho-social Intervention
#12	Child Care Worker	4 years, 6 months	Permanent, full-time	Diploma in Applied Social Studies in Social Care
#13	Child Care Worker	4 years	Permanent, full-time	National Diploma in Applied Social Studies in Social Care
#14	Child Care Worker	5 years, 6 months	Permanent, full-time	National Diploma in Applied Social Studies in Social Care
#15	Child Care Worker	2 years, 6 months	Temporary, full-time	B.A. Applied Social Studies
#16	Relief Child Care Worker	5 years, 11 months	Temporary, part-time	No qualifications
#17	Relief Child Care Worker	4 years, 9 months	Temporary, part-time	Diploma in Social Care
#18	Relief Child Care Worker	5 years, 9 months	Temporary, part-time	Diploma in Social and Community Studies

The staffing complement in the unit was a manager, two child care leaders, 13 child care workers, three relief child care workers, a cook and a housekeeper. There were at least three staff on duty during the day and two waking staff at night. There were two dedicated night staff and other members of the team did night duty in rotation.

There was a relatively well qualified staff team in the unit. Ten of the 15 full-time care staff had child care or social care qualifications. Two held masters degrees in related fields and two of the remaining three held some post second level educational award.

One member of staff was studying for a degree in social care. She was given one day per week off to attend college and study leave. Her fees were paid by the HSEMWA. Another staff member was given financial assistance to attend a course in psychology.

At the time of inspection, the care staff team consisted of a manager, two child care leaders, 12 child care workers and three relief child care workers who covered annual and sick leave. There were two other staff members on long term sick leave and, therefore, unavailable at the time of inspection. Staffing, therefore, was not up to complement. Managers of the service stated that there are continuing difficulties recruiting sufficient care staff despite the fact that the area had conducted numerous recruitment campaigns locally, nationally and even overseas. Included in the 12 child care workers were two workers who were assigned to a special care unit that had been closed temporarily but was due to reopen later in 2005. The unit manager stated that when these two staff return to the special care unit the staffing difficulties at the centre will become acute. These difficulties were exacerbated by relatively high levels of sick leave. Inspectors estimated that the average amount of sick leave taken by the care staff (including the centre manager and child care leaders) employed at the unit at the time of inspection was ten days over a six month period. Some of this sick leave was related to work related stress and injuries.

There were supports available to staff members who were suffering from work related stress. For example, staff members could avail of up to six counselling sessions with the clinical psychologist and a further six with an external counsellor, if recommended by the clinical psychologist to the regional manager. Further sessions could be made available on the recommendation of the occupational health unit. All were paid for by the HSE. Staff had access to alternative therapies as another support to manage stress at work. Some of those interviewed by inspectors considered that these supports worked well. For example, one person had seen the clinical psychologist after she had been assaulted and reported that this had helped her to come to terms with what had happened to her. However, others believed that these supports did not operate effectively all of the time. For example, it was intended that debriefing would be provided to a staff member after an assault but this did not always occur. One staff member reported that, while it was helpful to discuss incidents in supervision, if supervision happened weeks after an assault she did not always wish to discuss it at that point. Managers and staff were mindful of their duty of care to their colleagues but the number and frequency of assaults made it extremely difficult to offer timely and effective support.

The standard on staffing was not met. There were not enough care staff. Those that were employed to work at the unit were not always available to work there due to sick leave. Two staff had left the unit shortly after the introduction of the new model and, at the time of inspection, a third one was seeking a transfer to another unit. While there were supports available to staff who were injured or assaulted these were not always effective. This issue is given further consideration in the next section of this report.

Recommendations

3. The regional manager for residential child care should persevere with efforts to ensure that the unit is adequately staffed.

4. The regional manager for residential child care should ensure that the support systems for care staff operate effectively.

4.2.4 Training and development

There were good systems in place for the supervision, training and support of the care staff team. These were outlined in section 4.2.2 and 4.2.3 of this report. Despite the resources devoted to the development of the care staff team, however, most of those interviewed during the inspection presented as demoralised, disempowered and stressed.

The staff team was not operating effectively at the time of inspection. This was related to the changes the team had experienced in the recent past, namely, the change of manager, changes to team personnel, the introduction of a new model of care and the admission of two young people who presented with very challenging and difficult to manage behaviour.

The management perception of the difficulties within the unit was that they could be understood in developmental terms. The managers saw the team as struggling to come to terms with a new way of working with all the resistance and uncertainty that a process of change involves. They stated that there were clear strategies for dealing with the young people's behaviour that were discussed, agreed and recorded at team meetings but were not being implemented by members of the team. The regional manager told inspectors that the external consultant gave detailed advice to the staff team on the principles of the trauma model of care and its implementation.

Most of the care staff team interviewed by inspectors had a radically different perception of the difficulties being experienced by the unit at the time of inspection. They related the difficulties to the trauma model of care. Their difficulties with this model are outlined in more detail later in this report (4.5.2). One member of the regional residential child care service stated that the implementation of the new model had not been handled well. This person told inspectors that staff were given the wrong message: that they understood that they were being asked to give up on their existing practice whereas what they should have been told was to integrate some of the insights of trauma theory into their practice.

Clearly there were different perceptions as to the origin of the problems in the unit. The content of this disagreement is less important than the fact that there was little effective communication between managers and staff: there was no shared understanding of the problems nor of their solution. An example of this poor communication concerns the issue of assaults on staff.

Assaults on staff

From the time the unit re-opened in August 2004 up to the time of inspection, there were 98 incidents in the unit. Inspectors carried out a detailed analysis of all the 36 incidents that occurred from the beginning of 2005 to the time of inspection in the middle of March. Twenty three incidents involved an assault on a member of staff (sometimes two members of staff). Some incidents, that were recorded as 'disruptive behaviour' and/or 'sexualised behaviour' and involved verbal abuse, inappropriate touching and / or threats to staff, could

justifiably have been recorded as assaults. Inspectors were told that some incidents were not recorded at all. If anything, therefore, the unit records underestimated the actual number of assaults. The managers argued that not all of the young people's physical behaviour should be understood as assaultive. Staff members understood this as minimisation and as meaning that their concerns for their safety were not being heard and taken seriously.

Even if 50% of the assaults, so recorded in the unit's records, could be re-classified as something different, inspectors considered that there remained a very serious problem with violence towards staff within the unit. Some assaults were of an indecent nature and some staff members had been repeatedly assaulted over a short period of time.

In order for staff to look after the young people in their care they must have reasonable confidence in their own safety and in their capacity to discharge their responsibilities without undue hindrance. In a unit for young people with emotional and behavioural difficulties, such confidence cannot be absolute. However, in this particular unit, the level of violence was unsustainable. The unit was in a downward spiral where assaults led to high levels of staff absence due to sickness which further undermined the team's capacity to manage the young people's behaviour in a safe way.

The issue of assaults is linked to the implementation of the trauma model of care as many members of the staff team believed, perhaps mistakenly, that they did not have effective measures to manage the young people's behaviour. The different perceptions of this assaultive behaviour underlined problems in communication between managers and staff that undermined attempts to resolve the difficulties.

The implementation of the trauma model of care had not been successful. The care staff team were not managing the behaviour of the young people safely and well. The implementation of the model needs to be reviewed.

Use of consultants

Managers explained to inspectors that the use of external consultants was new to the area and that some difficulties had been encountered which they were attempting to address. The external consultant was contracted to work on the introduction and implementation of the trauma model. There were, in addition, two others within the regional residential service, the guidance counsellor and the clinical psychologist, who provided a consultation service. Inspectors consider that some clarification of roles and responsibilities is required in relation to the unit. It was not clear, for example, what authority the advice offered by the external consultant carried and, consequently, who within the agency carried accountability for actions taken on foot of it.

Recommendations

5. The regional manager for residential child care should ensure that the implementation of the trauma model in the unit is reviewed.

6. The regional manager for residential child care should ensure that effective measures are taken to ensure the safety of staff at the unit.

7. The regional manager for residential child care should review the use of external consultants in the units for which she has responsibility.

4.3 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.

4.3.1 Access to information

There was written information available for the young people about high support services in the mid west area. They were given a booklet on admission.

The young people could access those parts of their care files referred to in the unit as 'case notes'. These were the records made by unit staff on a day to day basis. They were also given copies, in advance, of the reports prepared by unit staff for the placement planning meetings and care plan reviews. For access to other parts of their care files the young people were referred to their social workers.

4.3.2 Consultation

There were a variety of means for consulting with the young people in the unit. There were young people's meetings but these often proved difficult so that the care staff found informal means to consult with the young people in their day to day interactions with them. The young people were involved in menu planning.

The young people were encouraged and facilitated to attend fortnightly placement planning meetings and regular care plan review meetings.

Care staff stated that they saw themselves as advocates for the young people, that the young people's request were taken seriously and acted on whenever possible.

4.3.3 Complaints

The regional residential service had a variety of policy and procedure documents but inspectors were not provided with a copy of a complaints procedure. The service had devised a comprehensive policy prior to the transfer from the religious order to the health board but this had not been implemented. Inspectors were informed that the matter was under active consideration within the service.

Practice in relation to dealing with everyday issues was good. Staff members listened to the young people's expressions of dissatisfaction and tried to resolve them immediately. If this did not work, or if the young people chose to do so, they were invited to fill up a complaints form. These went to the manager for resolution. There were records of seven such complaints in the six months leading up to inspection. They were recorded in a separate complaints log. One young person had made four complaints and these had been resolved satisfactorily by the unit manager. This young person also made a fifth complaint about something that allegedly happened to the other young person in the unit just before the inspection and this matter was receiving attention. The second young person had made one complaint about an incident that allegedly occurred in school and this was being addressed at the time of the inspection. The young person also made a complaint about an alleged incident in another unit and there was nothing in the complaints log to indicate whether this had been resolved.

The procedure in relation to internal resolution of complaints was clear and records indicated that it was working well in practice. What happened next was not clear, however. A young person could bring a matter to the attention of his social worker if he was not happy with the manner in which the unit had dealt with his complaint but there was no clear procedure for appealing the outcome of a complaint and there was no independent element to the procedure, at least for everyday expressions of dissatisfaction.

A young person made a complaint about the actions of a member of staff during the inspection. The regional manager carried out a risk assessment and took the decision that the staff member would remain at work while the investigation was taking place. Inspectors commend this development. It contrasted with a situation involving another member of staff who was suspended from another unit for one year on foot of an allegation that was not confirmed.

It is vitally important that young people's complaints are heard, acted on and resolved. However, it is as important for the young people as for those looking after them that such complaints are dealt with in a manner that does justice to the complainant and to the person about whom the complaint is made. There are two reasons for this. It is not helpful for young people to see the complaints procedure as a weapon to be held over staff members and there was evidence in this inspection of young people threatening to make complaints about staff. Secondly, care staff will rapidly lose confidence in a system that does not treat them fairly and this is bound to impact of their capacity to deliver a quality service to the young people. This was particularly relevant in the unit at the time of inspection as many staff members felt that their own concerns for their safety were not being given the attention they required.

Inspectors commend the approach of the regional manager to the most recent complaint.

Recommendation

8. The regional manager for residential child care should implement a regional complaints policy.

4.4 Planning for children and young people

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

4.4.1 Social work role

Both the young people had allocated social workers. The social workers visited the young people regularly. They worked in close co-operation with the staff of the unit and with the other professionals working with their clients. There were placement planning meetings every two weeks to coordinate the work of the various professionals and to ensure that the young people were receiving the appropriate interventions. The social workers reported that the care staff kept them informed of the events in the young people's lives.

The social workers had not read unit records and inspectors urged them to do so from time to time. Despite this, inspectors consider that this standard was met.

4.4.2 Care planning and review

Both the young people had care plans that were prepared or updated at or near to the time of their admission to the unit. Both were reviewed within approximately six weeks.

There was evidence of consultation with the key stakeholders in the preparation of the care plans but, in one case, a parent disputed that he had been fully consulted. He complained about this and the matter was receiving attention at the time of the inspection. The social worker expressed a willingness to amend the written care plan to take account of the parent's concerns.

The two young people in the unit at the time of inspection presented with very particular needs and attempts to meet these needs in the past had not always been successful. It was clear to inspectors that enormous efforts were being made by a network of professionals to work together to provide an adequate response to their needs. The parents of both young people told inspectors that their children were getting a good service in the unit, and one that was better than the service provided in the past.

This standard was met.

4.4.3 Emotional and specialist support

There was a keyworker system in place in the unit. The role of keyworkers, as described to inspectors, was understood in terms of co-ordination of care and advocacy rather than relationship building and planned therapeutic interventions.

Alternative therapies such as reflexology and aromatherapy were available to the young people and one of them availed of these.

As argued later in this report, the primary care in the unit was good.

The guidance counsellor and the clinical psychologist provided therapy for the young people and the external consultant met with one of them on a monthly basis.

Access to specialist services, outside of the regional residential services, was good. One young person was being seen by a psychiatrist and was on medication that was very regularly reviewed.

The standard on access to specialist support was met. However, as stated elsewhere is this report there was a significant level of assault on staff members. Some members of the care staff team interviewed by inspectors were primarily focused on avoiding getting hurt. This had a negative impact on their capacity to offer emotional support to the young people.

4.5 Care of young people

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

4.5.1 Individual care in group living

The unit was based in large domestic style premises in a rural location not far from a major urban area. The premises were well decorated and well maintained. They were based in fairly extensive grounds and there were both indoor and outdoor recreational facilities.

There was a fairly relaxed regime in the unit. The staff offices were kept locked and, from time to time, the kitchen also, but the young people had free access to all other parts of the unit.

Both young people attended a special school and there was close cooperation between teaching and care staff. For example, care staff accompanied the young people to school and were on hand if required. The young people received individual tuition, at least part of the time, and the curriculum was adapted to their needs. The parents of one of the young people were particularly positive about the education their son was receiving, stating that it was much better than anything he had received before.

The young people were given a medical examination on admission to the unit and were taken to the doctor or dentist as required. There was a general practitioner for the young people in the unit but they were encouraged to continue with the doctor they had prior to admission, where ever possible. Issues of health and sex education were dealt with by the guidance counsellor and by care staff both through formal sessions and as they arose in day to day situations. Some staff were clearly skilled at using everyday situations or television programmes to prompt such discussions. Despite this commendable practice, it was clear from this inspection that the young people needed assistance in understanding and respecting appropriate boundaries in their relationships with females, in particular.

The young people were encouraged to be involved in activities within the community and one of them was very involved in sport. This took him out of the unit a number of times during the week and gave him an opportunity to engage with peers in age appropriate activities. This is commendable.

The young people's families visited the unit. The four parents interviewed by inspectors stated that they were always made to feel welcome in the unit and that they found the care staff approachable and helpful. Care staff also facilitated contact with the families of the young people outside the unit. Both sets of parents interviewed by inspectors stated that they were very happy with the way their children were being looked after in the unit. The parents of one of the young people stated that they felt listened to for the first time and that they were involved in their son's care. They were especially positive about the placement planning meetings which they attended regularly and where, they said, their views were heard and taken into account when decisions were made. This is noteworthy and commendable.

There had been no birthdays since the change of purpose and function. However, one of the young people was due to have a birthday shortly after the inspection. A party was being

planned to which it was proposed to invite his parents and sibling. Both young people had been with parents over Christmas.

The young people were given a monthly clothing allowance. They went shopping for clothes with staff members and chose the clothes they wished to purchase.

The young people each had his own room. They could decorate their rooms according to their taste and could spend time alone in their rooms, provided that it was safe to do so. They were facilitated to make calls in private.

There was a plentiful supply and variety of food available to the young people in the unit. Their preferences were catered for in the preparation of meals. There were set meal times and care staff, including the manager, ate with the young people. The young people were encouraged to use the cooking facilities and one of them was particularly proficient at baking. They could make snacks for themselves outside of the set meal times.

The young people were asked about their religious beliefs and offered the opportunity to attend religious services. One of them had not made his Confirmation and plans were being made to facilitate this.

The primary care of the young people was very good. This standard was met.

Recommendation

9. The regional manager for residential child care should ensure that assistance is provided to the young people to help them understand and respect appropriate personal boundaries.

4.5.2 Managing behaviour

Few of those care staff interviewed by inspectors conveyed a sense of being in charge of the unit and of being able to manage the young people's behaviour safely. For six of the eight members of the care staff team interviewed by inspectors this was seen as related to the implementation of the trauma model. They referred to various aspects of the model which they found problematic, for example, they talked of a lack of structure to the model and the lack of consequences for unacceptable behaviour. They stated that they were not clear what they were expected to do in particular circumstances. They clearly felt deskilled as they believed that they could no longer use strategies to manage behaviour that they used prior to the introduction of the trauma model. Though they had regular sessions with the external consultant, they stated that they got no clear direction from these sessions. Managers, on the other hand, stated that this reflected a failure to implement agreed strategies. Whatever the explanation, here was little sense of a pro-active approach to behaviour management. Inspectors were not informed of any work being done to help the young people understand what was expected of them in terms of their behaviour and to help them to meet these behavioural expectations. The focus appeared to be on dealing with negative behaviour as it arose, rather than on promoting positive behaviour.

There was an expectation that staff would do a life space interview with a young person each time he was involved in an incident but in the first 20 incidents of 2005, only nine incidents were followed by a life space interview and two of these were not completed. Some of the interviews, as recorded in unit records, showed little evidence of the young person learning anything valuable from the incident.

Sanctions were used in the unit. For example, the sanction for an assault on a staff member was loss of a paid activity. This sanction was not consistently applied. In fact, sanctions were used very sparingly. One of the young people had been sanctioned on eight occasions since admission to the centre and not at all since the middle of November 2004. He had been involved in at least 12 incidents in 2005.
There were a number of incidents in the unit that involved both young people. Discounting these, one young person was involved in approximately five times as many incidents as the other young person during 2005. In addition, the second young person was involved in more incidents with the first young person than incidents where he was the only young person involved. A case could be made that the approach to behaviour management was effective in relation to the young person who was involved in the lesser number of incidents. However, it could equally be argued that the failure to contain the behaviour of one of the young people was having a detrimental impact on the behaviour of the other one.

There was evidence of some bullying between the two boys. The staff response was to name the behaviour, address it and provide support to the victim.

The standard on management of behaviour was not met. There was little evidence that the young people were being helped to learn how to manage their behaviour. There was some evidence that one of them was being influenced by the other to behave in unacceptable ways.

Recommendation

10. The regional manager for residential child care should oversee a review of the approach to behaviour management in the unit.

4.5.3 Physical restraint

Staff in the unit had been trained in therapeutic crisis intervention (TCI) but physical interventions were not used in the unit. They had been tried on two occasions and been found not to be effective so a decision had been made not to use them again. This was a reasonable decision to make in the circumstances.

4.5.4 Other interventions to manage behaviour

One young person was on medication to help him to manage his behaviour. This was regularly reviewed by his psychiatrist.

There was no use of single separation in the unit.

Incidents of assault were reported to the young people's juvenile liaison officer (JLO) but none of the young people had been prosecuted in relation to their assaults on staff members.

4.5.5 Unauthorised absences

There had been no unauthorised absences from the unit since it re-opened in August 2004.

5 *Summary of recommendations*

1. The regional manager of residential child care should revise the statement of purpose and function to include a description of how the service is to be provided in the unit.

2. The regional manager of residential care should ensure that any model of care introduced to a unit for which she has responsibility has been through some form of independent evaluation.

3. The regional manager for residential child care should persevere with efforts to ensure that the unit is adequately staffed.

4. The regional manager for residential child care should ensure that the support systems for care staff operate effectively.

5. The regional manager for residential child care should ensure that the implementation of the trauma model in the unit is reviewed.

6. The regional manager for residential child care should ensure that effective measures are taken to ensure the safety of staff at the unit.

7. The regional manager for residential child care should review the use of external consultants in the units for which she has responsibility.

8. The regional manager for residential child care should implement a regional complaints policy.

9. The regional manager for residential child care should ensure that assistance is provided to the young people to help them understand and respect appropriate personal boundaries.

10. The regional manager for residential child care should oversee a review of the approach to behaviour management in the unit.