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Children's Residential Centre

Item Type	report
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Citation	Ruadhan Hogan, Patricia Sheehan, 'Children's Residential Centre', [report], Health Information and Quality Authority, 2016-11-29, Children's Residential Centre (CRC), Monitoring Inspection Report on children's statutory residential centres under the Child Care Act, 1997
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-03-13 14:59:37
Link to Item	https://hdl.handle.net/20.500.14765/81366

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 South CRC
Centre ID:	OSV-0004650
Type of inspection:	Unannounced Full Inspection
Inspection ID	MON-0017923
Lead inspector:	Ruadhan Hogan
Support inspector (s):	Patricia Sheehan, Erin Byrne

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:
30 August 2016 09:00	30 August 2016 18:00
31 August 2016 09:00	31 August 2016 17:00
01 September 2016 09:00	01 September 2016 13:00

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	Significant risk identified
Standard 7: Safeguarding and Child Protection	Significant risk identified
Standard 10: Premises and Safety	Significant risk identified
Theme 3: Health & Development	
Standard 8: Education	Meets standard
Standard 9: Health	Meets standard
Theme 4: Leadership, Governance & Management	
Standard 1: Purpose and Function	Meets standard
Standard 2: Management and Staffing	Significant risk identified
Standard 3: Monitoring	Requires improvement

Summary of Inspection findings

The centre was located on a large campus style facility which provided a range of services to young people and families. Three residential units provided care for up to 15 boys aged 12 to 16 years on admission. The centre was located on the outskirts of a large town. Additional facilities on campus included an on-site school, a two-bed roomed cottage which was used as an independent living facility for young people aged 16 years and over, a sports complex, administration buildings, and extensive grounds which were used for various activities, for example soccer pitches and horse stables. The centre had a facility to provide accommodation for family visits. The campus on which the centre was located also accommodated other Tusla services.

The centre provided residential care for up to 15 boys aged 12 to 16 on admission whose safety and care needs could not be adequately met within the community. The statement of purpose had been revised to reflect the approach taken to its practice. At the time of the inspection, there were 9 children living in the centre.

During this inspection, inspectors met with or spoke to 5 children, 3 parents, 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.

While there were nine children on the centre register, five were staying in the centre at the time of inspection. The other four children were on access or other arrangements. Inspectors also spoke with other professionals including Social Workers and a Guardian Ad Litem (GAL). The centre appropriately met children's education and health care needs. Children were able to form good quality relationships with staff. Children were aware of their rights and were treated with respect. Each child had an allocated social worker. The management of care planning and review processes was good.

The centre was last inspected by HIQA in July 2015. The 2015 inspection was a themed inspection, which focused on behaviours that challenge. A full inspection of the centre, including the layout and premises, was last carried out in October 2013. Since that inspection, changes had been made to the campus so that additional Tusla services were now accommodated alongside the centre. On this inspection, inspectors found the layout of the centre within the campus was found to be unsuitable and contributed to children being placed at risk.

Since the 2015 inspection, inspectors found that the centre had gone through a period of crisis. There had been significant deficits in managing behaviour that challenges and appropriately safeguarding children. These issues were compounded by a failure to

maintain effective management systems to ensure the service was safe. Systems of communication, risk management, monitoring and supervision were ineffective. This resulted in children sometimes experiencing significant harm and frequently being placed at risk of significant harm.

As a result, the centre was found to have significant risk against the standards: 6: Care of Young People, 7: Safeguarding, 10: Premises and safety and 2: Management and Staffing. Following the inspection, inspectors met with the Regional Manager for Tusla Residential services to discuss these findings. In addition, the significant risks were formally escalated to senior management in Tusla, and assurances on what was being done to address these failings was provided to HIQA, prior to the completion of this report.

Recommended improvements are outlined in an action plan published separately to this report.

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

The centre had systems in place to ensure children were aware of, and supported to exercise their rights. Children were given a booklet when they were first admitted to the centre. The booklet outlined information about rights, how to make a complaint and other information about what to expect when staying at the centre. Children had the opportunity to visit the centre prior to their admission with their families. Social Workers said this helped them settle into the centre.

Inspectors reviewed files and found that children's rights were upheld in relation to access to information and advocacy. Children were provided with information about an independent advocacy agency, the Ombudsman for Children and the UN declaration of rights. Children told inspectors that they were aware of their rights as they had been given information on rights. Inspectors also spoke with children's Guardians Ad Litim, Social Workers and parents who all said that children were able to exercise their rights.

Other practices facilitated and promoted children's rights. Each child had their own room and bathroom. Staff respected children's privacy and right to bodily integrity by knocking on the door and waiting for permission to enter a bedroom. Children who talked with inspectors said they felt their privacy and confidentiality was respected.

Some practices in the centre were institutional and impacted on children's right to privacy and bodily integrity. A HIQA inspection carried out in July 2015 found that the centre carried out routine night-time checks of children without risk assessing these practices to justify the infringement. Since that time, the centre implemented a policy on night-time checks that stipulated risk assessments were to be completed. The policy was that when children were first admitted, hourly night-time checks were completed for the first two weeks. Following this, night-time checks were to be carried out three times per night. On this inspection, inspectors found that risk assessments completed were of poor quality as they did not justify why routine checking of all children continued to take place.

Children had access to advocacy, for example one child had a Guardian Ad Litem (GAL) who met this child regularly. Children said they were aware of advocacy services including an independent agency providing advocacy for children.

From a review of centre files and interview's with children, parents, the children's Social Worker and GAL, children were communicated with in a respectful manner. Children were consulted with through the children's meetings held in each of the unit's. The meetings were held regularly and records showed that staff recorded children's views and wishes in the respective unit team meeting book. For example, children told inspectors that they could choose activities they liked.

Children had opportunities to participate in decision-making. Children were consulted and encouraged to participate in decision making in their child care reviews. These meetings looked at their care plan and involved the significant people in care planning for a child such as their parents, Social Worker, GAL, centre staff and other professionals. Children told inspectors that they were given the opportunity at these meetings to ask questions and say what they thought. The children's extended family were also consulted about leaving care arrangements.

Complaints, when classified correctly, had been responded to in a timely manner and outcomes were clear. However, the oversight of the complaints system was ineffective. Inspectors found that some complaints were actually child protection concerns and not complaints. The centre had a policy for the management of complaints. Children were told that they could exercise their right to complain by contacting their Social Worker or staff to make a verbal complaint or fill in a form with help from staff. The centre held separate complaints logs for each of the units. Inspectors reviewed all complaints logs and found that 16 complaints had been recorded over the previous 12 months. Complaints were satisfactorily investigated and addressed. The log did not record if children were satisfied or not.

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

The admissions process was in line with the policy for the referrals, admission and planning of placements. An admissions committee was in place which comprised of the Interim Service Manager, Residential Manager, Deputy Director, Centre Psychologist, Care Manager(s) and local area Social Work Team Leader. At the time of inspection, nine children were resident in the campus with five children present on the days of inspection. Over the course of the 12 months prior to inspection, two children had been admitted and referrals on 20 children had not progressed to an admission. This indicated that gatekeeping on admissions was good quality.

Reviews of a number of children's files found that their admissions process was robust. Children were appropriately admitted in line with the admissions process. They were given age appropriate information about the centre and visited prior to admission. The centre had all the necessary information on children prior to admission. Children spoken with said they knew why they were in the centre. Inspectors spoke with professionals such as supervising Social Workers, Social Work Team Leaders and GAL's about the appropriateness of children's placements. Some professionals said that children were appropriately placed and were provided a good standard of care. Some professionals told inspectors that placements for some children were not appropriate.

Social Workers were clear that they should have been notified of any new placements so they could assess any risks to the child whom they were responsible for. However, they were not notified when a new child was admitted to the centre, in order to make this assessment. The Monitoring Officer also said he was not notified of new admissions. Centre management acknowledged that the relevant persons should be notified and consulted about new admissions.

Children were discharged from the centre in a planned and appropriate way. Six children had been discharged over the 12 months prior to inspection. Records showed that overall, discharges of children were in line with their care plans. A small number of children had been discharged outside of their care plan. This had been agreed with the Social Workers, GAL's and parents.

From a review of the children's files, inspectors found that the Child and Family Agency had fulfilled all of its statutory requirements. Children in the centre had an allocated Social Worker. The social work visits were carried out within the time frames laid out in the regulations. Centre records showed that some Social Work visits took place far more frequently than the regulations stipulated, and often happened every two weeks. Records also showed that Social Workers were in contact by phone with children. Child in care reviews were held within time frames laid out in the regulations and records showed that these also were often held more frequently than these time frames.

The centre held copies of up-to-date care plans on some children's files. Where care plans had not been circulated to the centre following the child in care review, the Residential Manager had sent a letter to the relevant social work team requesting a copy. The care plans reviewed by inspectors identified the purpose of the placement and listed specific actions to meet specific needs. They were comprehensive and contained relevant information. Records showed that children and families were consulted and contributed to their care plans.

The centre held regular reviews of children’s placements that included reports from unit staff, school personnel, the nurse and psychology. They were written in placement folders held in each of the units. Inspectors reviewed the placement plans and found that actions to address identified needs were not described comprehensively. They included one line descriptions of the issue identified and generic actions to address them. Staff told inspectors that verbal discussions led interventions with children. The outcome was that, for some children who were in crisis, this process was not effective at managing their behaviour.

Children could maintain relationships with their families. Some children in the centre were placed within their own community. The centre placed sets of siblings together where appropriate. When children were placed outside of their community, the centre facilitated access and helped with transport. From a review of records and interviews, visits with families were encouraged and facilitated. One child’s parent visited the centre with the child prior to the placement beginning. The centre had accommodation on the campus in the event that parents stayed overnight. Records showed that children’s parents stayed over at the centre as part of access arrangements. Social Workers said that family visits to the centre visits helped children settle into their placement.

Children told inspectors that they had a good relationship with staff and in particular with their key workers. Social workers and GAL’s also said that children had good relationships with staff in the campus. Records did not show that staff wrote up formal key working sessions with children. A Care Manager said that as the centre was in crisis, regular one on one sessions with children were not prioritised. The outcome was that in the absence of focused work with children, they could not effect positive changes of behaviour for children in crisis.

Children were supported and prepared for leaving care. Two of the units in the centre were allocated for older children who may be eligible for an aftercare service. One child stayed at the centre during the week to go to the school located on the campus. At weekends, they returned to another Tusla children’s residential centre. This child was entering their last year of school and had plans for further education. This child said they were happy with their living arrangements. Records showed another child was allocated an aftercare worker, the worker had visited the child and written a report. The centre provided supported living accommodation for children aged 16 and over. One child was living there at the time of inspection. The centre had specific arrangements agreed with this child. Records however did not consistently show that specific leaving care and aftercare plans were on the children's care files.

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

During this inspection, inspectors found that over a significant period of time, a number of children were engaged in a wide range of high risk behaviours. Several staff and managers in the campus, along with external professionals and parents told inspectors that the campus was in crisis during that period of time. Inspectors were not assured that any of the methods for managing behaviour at that time were effective in changing this dynamic.

Inspectors reviewed a sample of significant event notifications over the 12 months prior to the inspection and found that 472 incidents had been reported by staff in the campus. 63 of these were recorded as positive events, the remaining 409 were recorded as significant events which related to; for example, sexualised behaviour, missing from care, at risk behaviours, physical restraint, alcohol and substance misuse and other behaviours that challenge.

ICMP's were written and held on children's personal plans. Inspectors reviewed practices and incidents in the centre to see how effective these methods were in responding to children's needs and managing behaviour that challenges. The centre Psychologist also contributed to and had oversight of individual crisis management plans (ICMP's). The effectiveness of ICMP's however was not seen to improve outcomes for some children. Where children were settled in the centre and not involved in the crisis, inspectors found these methods were effective at promoting positive behaviours. These children had positive outcomes. Where children were engaged in the crisis behaviour, the campus strategies were ineffective at preventing escalation in behaviours.

Inspectors found that, where children were in crisis:

- The response from the campus to the crisis was reactionary and there was little evidence of a planned, timely and coordinated response to the crisis particularly through the significant event review group meetings.
- Records showed children were given sanctions yet patterns of negative behaviours continued. The sanctions and ratings system was ineffective at managing behaviours that challenge and encouraging positive behaviours during the crisis period.
- ICMP's were brief and listed generic information. They didn't always reflect current behaviours. They didn't show any new interventions being tried despite significant changes in circumstances and behaviours of children. Some ICMP's stated that there was nothing to preclude physical restraint being used where children had contra indicators listed to physical restraint.
- Recommendations from Social Workers to manage specific high risk behaviours were given to the campus management. However, they were not incorporated in children plans in the centre.
- Records did not show that key working and life space interviews were effectively used to address behaviours with children after incidents.
- Records did not show adequate managerial oversight of Significant Event Notification's and follow on actions to address them.
- There were 277 incidents of children being absent from the centre in the 12 months prior to the inspection. This was a marked increase from the previous year, since the HIQA inspection in July 2015 found 10 incidents of children being absent from

the centre over a similar time period.

- Absence management plans were generic, had brief details and were ineffective at managing risk when children left the centre.

The outcomes as a result for children were poor.

- There was an increase in highly inappropriate sexualised behaviours, alcohol and drug use, criminal activities and incidents of violence.
- Some children were exposed to behaviours and situations that were higher risk than the situations they were removed from. One child was remanded to a children's detention centre as a result of behaviours engaged in while at the centre.
- A number of children were returned for access to their homes more frequently, to remove them from risk in the centre.
- One child was subsequently placed under constant supervision while in the centre as a measure to reduce risk. Professionals said this was disproportionate to the child's behaviours and not in their best interests.

Staff used a recognised model for intervention with children including restraint. Inspectors found that physical restraint had been used on a few occasions. Incidents of physical restraint were reviewed at the Significant Event Review Group (SERG) meetings. Where practice issues were identified, there was appropriate review with recommendations for improvements in practice.

Meal times in the centre were institutional and not similar to a family environment. Each of the units had cooking facilities. However, children's food here was limited to snacks such as fruit, cereals, noodles and bread. Children ate breakfast in the units. Children from all three units ate lunch and dinner in the campus canteen, at separate tables with staff from their respective units. Administration, maintenance and other staff, who were working or visiting the campus, also ate at these times in the canteen. Pre set menus were sent around the campus in the morning. Some children said they liked the food in the centre. Other children said that food choices were repeated. For example, every Friday fish and chips was the option provided. Therefore children had little choice in the meals offered.

Inspectors observed lunch on one of the days of inspection and saw a large amount of people in the canteen. Everybody queued up to collect food and drop off dishes after the meal. There were little opportunities to get involved in cooking the meals and washing dishes. While interactions between staff and children were generally light hearted, some rules enforced were institutional. Inspectors observed one child approach a member of staff who was having lunch. Another member of staff told the child that that staff was not on duty and discouraged the child from approaching them. The staff member told inspectors that it wasn't fair on the staff to be approached when off duty.

Children were provided with opportunities to get involved in leisure activities, holidays and interests and were encouraged to do so by staff. Records showed children had a choice of activities and the centre was creative at finding activities. For example, some children were offered unique and specialist activities and went on extraordinary activities such as mountain biking. Children could also avail of facilities in the campus such as gardening, stables, swimming pool and gym.

Children's achievements were recognised. Positive events were recorded in the significant event notices. However, the centre units did not display children's individual achievements in communal areas. This was not akin to living in a home environment.

Children's right to maintain culture was promoted while in the centre. There was a small church located on the campus. The centre also had a Pastoral Care Officer who was available to children if appropriate.

Judgment: Significant risk identified

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

The systems in place for safeguarding and child protection in the centre were not effective in keeping children safe from the risk of significant harm particularly during periods of crisis.

The centre did have a specific policy in relation to safe care practices. However, it did not guide staff on safeguarding practices. Inspectors found that some practices carried out in the centre were not safe. For example, the Residential Manager said that children had, on occasion, gone to the homes of staff to complete chores such as gardening activities in exchange for an allowance. Records did not show that these arrangements had been identified and written down on the children's individual placement plans or care plans. In addition, they were not consistently recorded in the unit daily logs. These practices were not risk assessed despite being sanctioned by the centre management. Social workers interviewed by inspectors were unaware of this also. Inspectors found that children had been placed at risk of significant harm during some of these arrangements. The Residential Manager said that staff had subsequently been directed to stop these practices. Inspectors were not assured that all practices in the centre had been reviewed to ensure that they were safe, and in line with good safeguarding practice.

Safeguarding practices during periods of crisis were ineffective. The residential manager said that, during crises that occurred both on and off the campus, managers were based in the centre. They were physically available between the hours of 8am and 12 midnight and on-call the remainder of the time. Care managers recorded their version of events in a separate Care Manager log. Inspectors reviewed these logs and found that decisions and actions were not adequately recorded. Good quality safety plans were in place for one child where significant risk had been identified. This consistency in quality was not seen across all children's files. Inspectors reviewed SENs and found that staff had followed children during incidents when children were engaged in serious at risk behaviours. Records showed that staff did not intervene during some of these very serious incidents and observed from a distance while children engaged in at risk behaviour.

The centre did not have a current policy for the safe use of phones. The sanctions guidelines stipulated that children had access to their phones depending on the sanction given to them. If children were not being sanctioned, they had full access to their phones. Some children had their own mobile devices that had full access to the internet. Staff were unable to remove phones from children and effectively supervise safe use of mobile devices. Staff and parents told inspectors that children used devices late into the night. In these circumstances, children could access unsuitable internet content on phones. They could also potentially coordinate leaving the centre without permission which led to escalations of risk behaviour.

According to the campus specific child protection policy, staff were required to fill out a child protection officer (CPO) referral form along with a significant event notice when they found a child protection concern. The Residential Manager then completed a standard report form (SRF) which was sent to the respective social work department. Social Workers told inspectors that these SRFs were responded to in an urgent manner. The SENs were responded to with much lesser urgency. Staff told inspectors they were not confident that the referrals were being appropriately forwarded to the respective social work department.

At the time of inspection the campus records showed a total of 34 child protection referrals were made to social work departments. In addition a Principal Social Worker with responsibility for child protection had reviewed files of two children in the centre and found a number of concerns that had not been reported to the respective social work department. These totalled 22 further referrals. The Regional Manager for the centre said these had been further reviewed and were likely to be a lower number than 22. Inspectors spoke with Social Workers, Principal Social Workers and a GAL who gave conflicting responses on how the centre management reported child protection concerns. Some concerns were over reported while some did not, in the opinion of a Principal Social Worker, constitute a child protection referral. Other serious incidents were not reported as child protection referrals and a Social Worker subsequently requested for specific SRFs to be submitted retrospectively. Inspectors were not assured that the centre management had an understanding of the threshold for child protection concerns and knew the correct procedures for reporting child protection concerns. This was further exacerbated as the majority of staff in the centre did not have up-to-date child protection training. The Residential Manager said that providing this training was a priority.

Three separate child protection allegations had been made against staff over the 12 months prior to inspection. Inspectors reviewed these and found one had been appropriately investigated by the area child protection team and had subsequently been closed. Another had been incorrectly classified as a complaint. From the review of the information on the complaint log and from information provided by the Social Worker, the social work team and the centre had carried out an appropriate investigation which was subsequently closed. The Residential Manager subsequently updated the social work department with a letter and SRF. A third allegation against a staff member was under investigation at the time of inspection and was being managed appropriately.

The centre had a whistleblowing policy in place. Staff told inspectors that the policy had been posted to a notice board. Inspectors did not see any evidence in centre records

that whistle-blowing and protected disclosures were discussed. Despite poor safeguarding practices having been identified, the failure of other staff to report this did not appear to have been addressed.

Inspectors found that management in the centre did not maintain systems to an adequate level to ensure these concerns were recognised and timely action was taken. Given the seriousness of the risk that were found over the course of this inspection, these issues were escalated to senior management in Tusla.

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 design and layout of the centre was in line with the centre's statement of purpose. However, the layout was unsuitable and did not always ensure that children's safety could be maintained. The campus on which the centre was located also accommodated other Tusla services which included: the regional residential services team, an outreach team, a fostering team and an access team. A school linked to the centre and public services such as a swimming pool were also located on the campus. The buildings associated with the centre including the accommodation were not separated and secured from these services. On the day of inspection, inspectors observed a large number of people on the campus grounds. It was not possible to tell who were Tusla employees and members of the public. Centre management did not have a system to verify the identity of people in the centre. Staff also told inspectors that the campus was not secure and there were too many people coming and going.

A public river walk also ran adjacent to the campus. Inspectors reviewed incidents at the campus and found that when children absconded, they frequently went to the river bank. On some of these occasions they were under the influence of alcohol. Parents told inspectors that they were very worried for their child's safety during these incidents. Inspectors read other incident reports where children interacted with members of the public by the river and this resulted in serious incidents. Given the number and type of incidents, and the mix of children, inspectors were not assured of the suitability of the layout of the centre and that children could be kept safe.

The layout of the campus had significant institutional features. The campus grounds were extensive and had excellent facilities for children to avail of, for example, stables, soccer pitches and a growing garden. Aspects of the living in the centre were institutional due to the set up of the units. The statement and purpose described the units as domestic type dwellings. Inspectors found they the units were dormitory type buildings that were connected to each other to allow night supervisors to access all parts. This was not akin to living in a home environment.

The centre units did not have a homely feel and children's bedrooms were similar to a boarding school. The units were well lit and had adequate lighting and heating. The communal areas were generally in good condition. However, they had little personalised or homely elements, for example, plants, cushions and the use of colour. There were adequate private spaces for children. Each child had their own bedroom. One child told inspectors they liked the space in the unit as they came from a large family.

The centre operated a closed-circuit television system (CCTV) at night time in the corridors of the units. There was signage alerting people to the presence of the CCTV system. There was a CCTV policy in place. Night supervisors were employed and stationed in CCTV rooms which were located in the connections between the units.

Centre vehicles were well maintained, appropriately taxed, insured, and had NCT certificates where applicable. Not all vehicles were equipped with safety equipment. A Care Manager had been assigned responsibility for the centre vehicles, to ensure they met all the required safety standards. This included a log which was checked regularly in relation to any issues that arose regarding the vehicles and the issues were addressed in a timely fashion.

The centre had a designated maintenance team, which was managed by a maintenance manager. All maintenance requests were completed by each unit on a daily basis and given to the maintenance manager, who then prioritised requests accordingly.

The centre had a health and safety policy and a safety statement in place. There were precautions against the risk of fire in place in the centre. There were sufficient numbers of fire extinguishers and records showed they were regularly serviced. Inspectors reviewed the fire check log and found the fire equipment to be well maintained. The emergency lighting was adequate and along with the fire alarms, had been serviced regularly. Fire exits were unobstructed and there were records of fire drills carried out with both staff and children. Fire exit procedures were clearly displayed throughout the centre. A fire compliance certificate was in place. Over half of the staff complement had not received up-to-date fire safety training.

Medicines management practices were not robust. The centre had a policy that was last reviewed in October 2013. Medicines was managed by the Nurse Specialist and all medicines were stored securely in a locked cabinet in each of the individual units. One of the unit cabinets had loose, unlabelled, over the counter medication belonging to staff that had been left behind. Records of the administration of medication were maintained in diaries held in the units. The centre did not use administration sheets, instead using unit diaries. The Nurse Specialist updated each individual unit diary with daily pharmacy stickers. Staff signed when medication was administered to children and included any comments. If the Nurse was absent, the relevant Care Manager could access the medical cabinet in the nurse's office for the children's medicines information. The staff had not been trained in the management of medicines. Overall this was not good practice and there was a risk of error in administration.

Judgment: Significant risk identified

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

Children received appropriate education and were supported and facilitated to attend relevant educational and training placements. The campus had a school situated on-site which children attended. Education was highly valued throughout the centre. Reviews of children's files found that they contained school reports and certificates. Educational needs were outlined in children's care plans. Some children's files also contained reports from an educational psychologist. Inspectors spoke with the deputy principal and staff who said that communication between the school and centre was of good quality. The school provided reports for reviews and placement meetings.

Inspectors found mixed educational outcomes for children. Some children had made progress in school. Social Workers said that the centre staff made significant efforts to engage children in education. When children did not engage with their educational placement, records showed that a tailored programme was developed to re-engage in practical subjects.

Judgment: Meets standard

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 health care needs were appropriately assessed and met. The centre had its own Nurse Specialist who was responsible for the overall management of the medical and health needs of the children. Records showed that children had medical examinations upon admission to the centre, by a local General Practitioner who attended the centre specifically for this purpose. Children had medical cards. Their files contained reports from other health professionals. Efforts were also made to ensure vaccination and other medical details were obtained for the children's care files. The records showed good external liaison between the centre and outside medical professionals when necessary. Children were supported in relation to health education programmes such as alcohol/substance misuse and smoking cessation. Staff encouraged children to engage in exercise and to become involved in community activities that promoted a healthy lifestyle. For example, one child was encouraged to

participate in a five kilometre run. Another child who spoke with inspectors said that they used the gym and swimming pool in the centre.

Judgment: Meets standard

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 had a Statement of Purpose that was up-to-date. It accurately defined what service was carried out and to whom it was aimed at. The statement adequately defined the statutory and legislative functions and listed the key policies and their availability to staff, children, families and other persons. The purpose and function set out in the statement reflected the day-to-day operation of the centre. The staff and managers at the centre were clear about the purpose and function of the centre. Inspectors found that there had been deficiencies in the implementation of systems in the centre, specifically in relation to behaviour management and safeguarding.

Judgment: Meets standard

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

Inspectors found that, over the 12 months prior to inspection, there had been a failure to maintain effective management systems to ensure the service was safe. Deficits were seen in the systems of monitoring, risk assessment, communication and supervision. This led to a collective failure, across several different levels of management, to adequately recognise and appropriately respond to children in crisis. Inspectors escalated a number of significant concerns, in relation to the quality and safety of care provided to children, to senior management in Tusla and a response was received prior to the completion of this report.

The campus had a governance structure in place which identified clear lines of authority and accountability. However, they were not effective in implementing good governance arrangements. An Interim Resident Manager was accountable for management of the entire centre since the 1 July 2015. He reported to an Interim Service Manager who reported to the Regional Manager. In turn the Regional Manager reported to the National Director for residential services for Tusla. The National Director for residential services reported to the Chief Operations Officer for Tusla. The Interim Resident Manager was experienced, qualified and had management training and coaching. He was supported by five Care Managers as part of the overall management team. During interviews with inspectors, centre staff were aware of their roles and responsibilities. Three Care Managers managed each of the three units in the centre. A further two Care Managers were responsible for other areas in the centre such as premises, facilities and finance. One of these Care Managers was rostered at all times and available on the centre 'on call' phone should an emergency arise.

Communications systems in the centre were in place. However, they were ineffective at managing periods of crisis. The staff carried out handover meetings when new staff started their shift. Inspectors observed a meeting and saw that good quality information was shared. The recording of these meetings did not reflect the same quality of information being consistently shared. Each individual unit held team meetings. Centre management meetings also took place. Inspectors reviewed a sample of the minutes and found a range of issues were discussed. The minutes did not show a consistent structure and decisions and actions were not explicit. These records did not show that issues were carried forward to the next team meeting. Therefore accountability for decisions was not transparent. The 'on-call' Care Managers recorded their version of significant events in a Care Managers log. Inspectors reviewed this log and found that decision-making during some of these incidents was poorly recorded. The justification for actions was also not clearly described. Records did not show management oversight of this log. This led to ad hoc and crisis led interventions rather than planned and effective actions.

Inspectors found that significant events were not consistently notified to person(s) external to the centre and senior managers were not aware of the risks in the centre. Staff recorded significant events involving children and reported these to the Residential Manager who was also the designated person for child protection (DLP). Where it was thought that these events included child protection concerns, an additional form was completed and given to the DLP. A standard report form (SRF) was then completed and sent to the respective social work department by the Residential Manager. Social Workers and Social Work Team Leaders told inspectors that the Residential Manager did not notify all adverse events and incidents through the required mechanisms or in a timely way. This affected care arrangements that were overseen through the Court as inspectors were told the Court did not receive up-to-date information. This meant that the children's care plan's were not updated with the children's current needs.

Risk management was not robust and issues of high risk were not escalated in a timely manner. Inspectors reviewed children's files and found that individual risk assessments were completed for children. For example, the risk of violence from a child to another child. Some of these risk assessments had oversight from the child's Social Worker yet inspectors found that recommendations from a Social Worker were not implemented into the child's records. Risk registers were held in each of the units. These registers

listed specific risks for individual children. Some risks such as night checks were not adequately justified. Other risks referenced the ICMP's as control measures and were dependent on the quality of ICMP's. General risks such as self harm and children under the influence of alcohol were also identified and control measures were listed. The Residential Manager also held a centre risk register which was overseen by the Interim Service Manager. These included risk behaviour such as sexual assault, exposure to criminal behaviour and alcohol and drug use. Critical risks such as those seen during periods of crisis were not adequately identified in this register. For example, absconding to the public river walk and consuming alcohol, or absconding to local shops and engaging in criminal activity.

Systems for auditing, monitoring and learning had been developed. However, in some instances inspectors found they had been poorly implemented. Inspectors reviewed the significant event review group meetings (SERG). The terms of reference stated these groups were to be held monthly and review all incidents of physical restraint, child protection concerns and atypical events that take place. Five meetings had taken place over the 12 months prior to inspection. These meetings did not address the behavioural and child protection issues and the centre management had missed an opportunity to formally review and address or escalate if necessary. There was also a lack of monitoring of systems to manage behaviour including the quality of key working, life space interviews with children and ICMP's. Management review of SEN's did not take place and hence practice issues during incidents were poorly monitored.

Supervision of staff was of poor quality. On the day of inspection, the majority of records were not available for review as the staff that held keys to the records were on leave. From the review of a sample of supervision records, details were brief and recommendations and actions were not adequately recorded. Supervision was held every 10 weeks. Considering the issues that were ongoing in the centre, this was not sufficient. Inspectors spoke with the Regional Manager for the service after the inspection who acknowledged that supervision of staff across levels of management was also poor.

Centre governance reports were completed by the Residential Manager and submitted to senior management. Inspectors reviewed a sample of these reports that the centre completed. These reports monitored aspects of the centre through checklists of areas such as children's records, staffing and training. The reports did not audit the quality and effectiveness of the services provided by the centre. Records did not reflect oversight of these reports from senior management.

The centre maintained a register of admissions to and discharges from the centre in line with the Child Care (Placement of Children in Residential Care) Regulations, 1995 – Regulation 21. The register held all the appropriate details on children. The centre's administration files were well organised and information was relatively easy to locate during the inspection.

The centre was staffed by professionally qualified staff who were sufficiently experienced to deliver the service. At the time of inspection there were 40.25 whole time equivalent staff posts for the centre and 49 persons employed. The staff absenteeism rate was 3.5%. There were eight staff vacancies in the centre. The staff gender mix was varied. However, the majority of staff had been in the centre for a long

time. The Regional Manager said that a national recruitment had begun following several years of a recruitment moratorium. The Residential Manager said that eight agency staff were used to ensure there was sufficient numbers on the staff rota and the use of more recently qualified staff had brought a freshness to the staff team. Inspectors reviewed the rota and found that staffing levels were in line with the ratios needed to maintain a safe level of care. A Care Manager was consistently 'on-call'. Inspectors reviewed a sample of staff records and found that they were appropriately vetted by An Garda Síochána, had references, copies of qualifications and details of previous employment.

The centre had an on-going training programme for all staff. Staff had received up-to-date training in dealing with behaviours that challenge. However, the majority of staff required up-to-date training in core areas such as children first, manual handling, supervision, first aid and trust in care.

Judgment: Significant risk identified

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

At the time of the inspection the Child and Family Agency monitoring officer had visited the centre in line with the Child Care (Placement of Children in Residential Care) Regulations, 1995 – Regulation 17. During interviews, the monitoring officer said they had taken over as the monitoring officer for the centre in April 2015 and had visited the centre three times over the past year. One monitoring report was written in January 2016 relating to a monitoring visit in November 2015. This report did not identify any behavioural issues. The report addressed a number of key areas in the centre and made recommendations. Inspectors reviewed the report and found that issues from a previous HIQA inspection and issues identified by the monitoring officer were being addressed on an on-going basis, such as risk assessment regarding night supervision and up-to-date care plans. Another report was in the process of being written at the time of inspection.

There was a lack of a formal response from the monitoring service to ensure the service was compliant with regulations and standards during the period of crisis. The Monitoring Officer said he had received all notifications over the crisis period in the centre. He said he had been in weekly phone contact with the Residential Manager. He also said that line management for the monitoring service had been updated during this time. The Monitoring Officer said he had satisfied himself that through regular phone calls and through four visits to the centre that the service was compliant with the standards and regulations. However, a formal escalation of concerns had not been made. Inspectors found there had been no overall analysis of the SEN's. As a result the significant increase in incidents during the crisis period was not escalated in order to provide a more robust and urgent response.

Judgment: Requires improvement

Acknowledgements

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