Children's residential services inspection report

Health Information and Quality Authority Regulation Directorate monitoring inspection report on children's statutory residential centres under the Child Care Act, 1991

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of region:	Dublin North East	
Centre ID:	130	
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Lead inspector:	Una Coloe	
Support inspector(s):	Paul Tierney	
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Inspection ID:	**725**	

About monitoring of children's residential services

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.

The Authority inspects services to see if the National Standards are met. Inspections can be announced or unannounced.

The Authority has decided to carry out a number of themed inspections during 2015 which will specifically look at how behaviour is managed in residential centers. The purpose of the inspections is to take a closer examination of how behaviours that challenge are managed in these settings as well as identifying what approaches and models are most effective.

This inspection report sets out the findings of a monitoring inspection against the following themes

Theme 1: Child-centred Services	☒
Theme 2: Safe and Effective Services	☒
Theme 3: Health and Development	☐
Theme 4: Leadership, Governance and Management	☒

1. Inspection methodology

As part of this inspection, inspectors met with children, 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.

During the inspection, the inspectors evaluated the:

- quality of care and safety of the service
- organisation and management of the centre
- safeguarding processes
- effectiveness of interagency and multidisciplinary work
- outcomes for children.

The key activities of this inspection involved:

- the analysis of data
- reviewing local policies and procedures and minutes of various meetings
- reviewing three children's case files
- meeting with two children and three parents
- meeting with the centre manager
- meeting with three centre staff
- meeting with four external professionals, including three social workers and a guardian ad litem
- observation of the day-to-day life in the centre.

Acknowledgements

The Authority wishes to thank the children, parents, staff, managers, and other professionals in the service for their cooperation with this inspection.

2. Profile of the service

2.1 The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency, which is overseen by the Department of Children and Youth Affairs. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency has responsibility for a range of services including:

- child welfare and protection services, including family support and residential services to children
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- service response to domestic, sexual and gender-based violence.

Children's residential services are managed nationally by a Director of children's residential services and four interim regional managers. These regional managers line manage nine service managers, who in turn manage the individual residential centres.

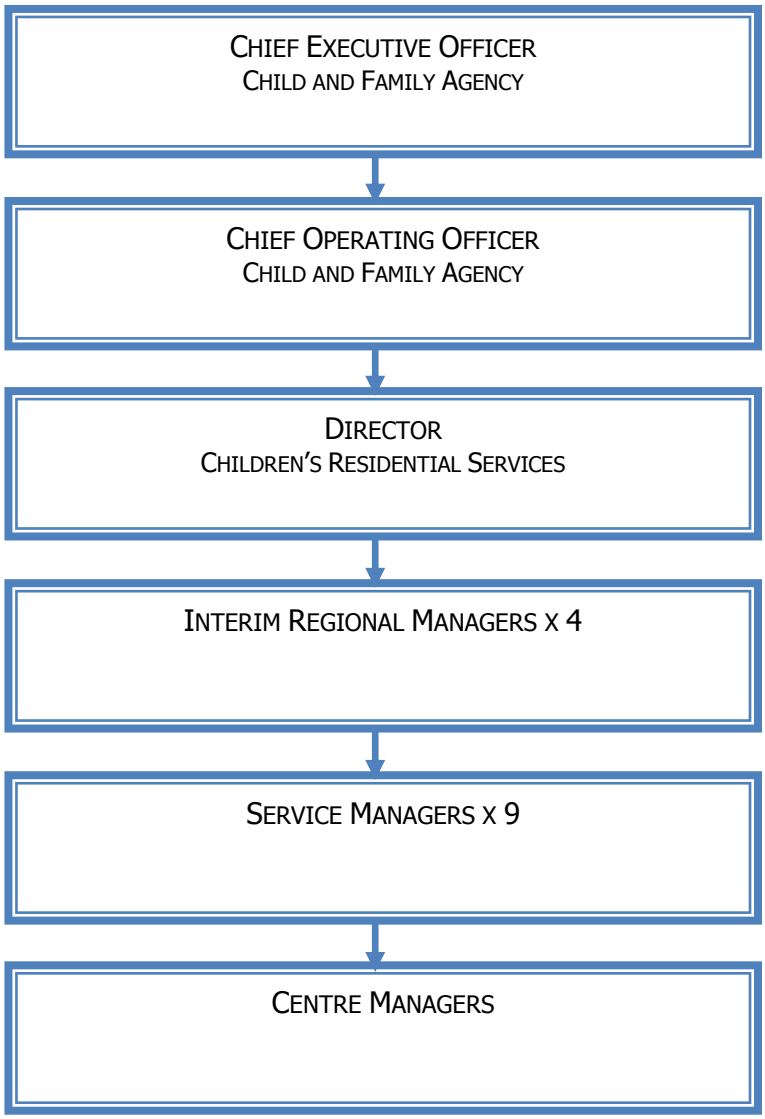
This centre was situated in the Dublin North East region of the Child and Family Agency.

2.2 The Centre

The centre was based in a three-storey building on a quiet housing estate. It had a small garden to the rear of the house and had large green areas close by. The centre had access to local amenities such as schools, shops and public transport. The centre provides places for males and females from the age of 12 to 18 years. At the time of the inspection, there were 2 children living in the centre.

The organisational chart in figure 1 describes the management and team structure as provided by the centre.

Figure 1: Organisational Structure of the children's residential service[*]



[*] Source: The Child and Family Agency

Summary of inspection findings

Children who are placed in residential centres often endure a range of difficult experiences in their early years of life. They may be distressed and display behaviours that challenge those who care for them in these settings. The Child and Family Agency has statutory responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Children in residential care require a high quality service which is safe and well supported by social work practice.

During this inspection, inspectors focused solely on how the needs of children who display behaviours that challenge are met. The inspection looked at the individual needs of children in this regard, how effective the service was in meeting those needs and the leadership provided by managers in managing this issue. The main resource for meeting these children's needs is through the interventions and interactions provided by staff members. For these inspections, judgments are made against each standard solely in relation to behaviours that challenge.

This report reflects the findings of the inspection, which are set out in Section 5. The provider is required to address a number of recommendations in an action plan which is published separately to this report.

In this inspection, the Authority found that of the 8 standards assessed:

- No standards were exceeded
- No standards were met
- 4 standards required improvement
- significant risks were identified in relation to 4 standards.

The centre had experienced a significant number of behaviours that challenged in the last year, some of which placed the children at risk. This inspection found that the centre worked in partnership with the Child and Family Agency social work department and other professionals, however the systems to manage risks to the children were not effective in all cases.

The model of care in use at the centre was not documented and the approach to the management of behaviours that challenged required review. There was a lack of oversight of the care and support provided in the centre and the effectiveness of risk management systems to keep children safe required review.

The governance and management systems in the centre were not rigorous. The leadership and support provided to the staff team regarding the day-to-day care and management of behaviours that challenged was not adequate. There were no systems in place to monitor the quality of responses to behaviour that challenged and significant events were not collectively reviewed.

Care programmes were limited and the information contained within children's files was not always up to date or sufficient to guide good quality care of the children.

The staff team were positive in their approach and were aware of the children's needs but children's rights were not sufficiently promoted. Children were not adequately consulted in their care planning or management of behaviours. The motivation and morale within the team was impacted by the extent of behaviours that challenged in the service. There were a large number of significant events in the centre and some of the children were at risk due to their behaviours that challenged. One child was admitted to the centre that was deemed as unsuitable and was at significant risk during his/her placement. Therefore the Authority requested written assurances that the risk management strategies and plan for the child were sufficiently robust to address the complex needs of the child.

3. Summary of judgments under each standard and or regulation

During the 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.

National Standards for Children's Residential Centres	**Judgment**
Theme 1: Child-centred Services	
Standard 4: Children's Rights	Requires improvement
Theme 2: Safe and Effective Services	
Standard 5: Planning for Children and Children	Requires improvement
Standard 6: Care of Children	Significant risk identified
Standard 7: Safeguarding and Child Protection	Significant risk indentified

[+] Please refer to Appendix 1 for full listing of standards and regulations for children's residential centres.

Standard 10: Premises and Safety	Requires improvement
Theme 4: Leadership, Governance and Management	
Standard 1: Purpose and Function	Significant risk identified
Standard 2: Management and Staffing	Significant risk identified
Standard 3: Monitoring	Requires improvement

4. Findings and inspection 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.

Summary of inspection findings under Theme 1

Children's rights were not sufficiently promoted in the centre. Children were aware of their rights but there was a need to ensure the right to a safe environment was not compromised by behaviours in the centre. The children were not consulted with adequately regarding their care and day-to-day lives. The system to record and manage complaints was not effective and some issues were dealt with on an informal basis and not recorded as a complaint.

Children's rights

Communication and consultation with the children and the systems to promote children's rights within the centre required improvement. There were some systems in place to ensure children were aware of their rights and consulted regarding their care but due to difficulties in the centre, this was not consistent and not viewed as a priority by staff. The centre provided written information to children about the centre and their rights whilst living there. Inspectors reviewed documentation provided to the children on admission which included information on how behaviour was managed, sanctions and children's rights. However, it was not evident that rules or consequences were revisited following an admission to the centre. There were no records to show a set of house rules, sanctions or consequences to behaviour. The centre would benefit from having clear boundaries in relation to managing behaviour especially if the children were consulted in the creation of rules and consequences.

Staff were aware of the rights of the children but there was little evidence in the files reviewed that rights were promoted and there was no reference to children's rights displayed in the centre.

Staff and management in the centre told inspectors that children's rights were promoted through participation in children's meetings but inspectors found that there had been no children's meetings held in the last 12 months. Children's views and their requests were discussed and considered during team meeting in relation to activities for

example but there was no system to formally consult with the children. One child told inspectors that staff made decisions in the centre. The child told inspectors that the staff team made the decisions in relation to meals provided for the children.

Children were not consistently consulted with or encouraged to participate in decision making about their lives. Discussions with the children were reactive and there was an absence of proactive approaches to assist the children to express opinions about how behaviour was managed. Inspectors read key working records and although the sessions were held with the children regularly, there was no formal structure to key working sessions. It was apparent that behaviour was discussed after an incident but inspectors did not see evidence of consultation with the children to obtain their views on how behaviour was managed or consequences resulting from their behaviour.

Inspectors reviewed care plans, individual crisis management plans and individual absence management plans and the children were not consistently involved in the development of the plans. This meant that the children may not have had sufficient awareness of the expectations of them in terms of their behaviour or the structures in place to guide their care.

One child in the centre had access to an advocacy group for children in care and it was documented in staff meeting minutes that the child had a meeting with an advocate. However, it was not evident that all children had access to such a service. One child had a guardian ad litem and inspectors met with her during the inspection while she was visiting the child.

Complaints

Children were aware of how to make a complaint, but the system to manage, record and resolve complaints was not robust. There was a complaints policy for the centre but this was not fully adhered to. The recording of complaints was poor and not all complaints were recorded as a complaint. There was a complaints register, a complaints log and a grievance book but the centre manager told inspectors that many issues relating to complaints were resolved informally and not formally recorded. There were two complaints listed on the complaints register. One complaint was not dated and had not been signed off as concluded. Inspectors reviewed the details of the complaints which were logged on the register. An investigation had taken place regarding one complaint but inspectors found that only part of the second complaint had been followed up with. It was not documented that the child was satisfied with the outcome.

There were no complaints formally recorded regarding behaviours that challenge but not all complaints were formally recorded on the complaints register. Inspectors

reviewed the minutes from team meetings and spoke with social workers; there was a level of dissatisfaction regarding the impact of behaviour on other children in the centre. Inspectors saw reference to complaints by children in the minutes of a serious event review group, but these complaints were not recorded in the centre's complaints log.

Judgment against standard, in respect of behaviour that challenges

Standard	National Standards for Children's Residential centres	Judgment
Standard 4: **Children's Rights**	The rights of children are reflected in all centre policies and care practices. Children and their parents are informed of their rights by supervising social workers and centre staff.	**Requires improvement**

Theme 2: Safe and Effective Services

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.

Summary of inspection findings under Theme 2

Not all children were appropriately placed at the time of their admission and the policy on admissions was not fully adhered to. Staff were committed to the care of the children, however they were overwhelmed at times by the presenting needs and behaviours of the children which included criminal behaviour. There was a need to review how behaviour was managed in the centre to establish a safe structured environment that supported the children. Care planning and review processes required additional work to ensure appropriate and up to date guidance was in place for the children.

Admissions and discharges

Admissions to the centre came through a central admissions panel and were based on assessments of each child's needs. There was a detailed policy in place to guide practice in relation to both planned and unplanned admissions however inspectors found that the policy was not adhered to in all instances. Comprehensive pre admission risk assessments were completed to help determine the suitability of a placement. However, one child was inappropriately placed in the centre. A pre-admission risk assessment was completed and the outcome of this found that the centre was not a suitable placement for the child but the recommendations from the social care manager were not followed. The needs of the child were not being met adequately and the child was deemed at significant risk due to behaviours. The level of risk for this child had escalated since admission to care and although risk and strategy meetings were held, they were not effective in terms of ensuring the child was safe. Staff, management and the child's parent did not feel the child was safe in the current placement but the child remained at risk.

The centre's admission and discharge register gave an overview of the required information but it was not always clear where children were discharged to. The centre manager advised inspectors that there had been no unplanned discharges and no discharges as a result of behaviour that could not be managed. There were five children listed, from the last 12 months, three of whom had been discharged. There was no information in respect of one child who was absent temporarily from the centre. It was

not documented when this child was admitted to the centre. There had been no unplanned discharges from the centre but the centre's register did not clearly state where the children were discharged to. Inspectors were told that one child was discharged to an aftercare service as appropriate and another child was discharged home.

Assessment and care planning

The service did not consistently fulfil its statutory requirements in relation to children. Care plans were not up to date for some children and inspectors found that some recent care plans were stored on a computer rather than in the children's files. This meant that up-to-date information may not have been available for the staff team.

Good quality care plans were not in place. There were two children in the centre during the inspection and one child was temporarily placed in another centre, but was due to return in September. Two of the three children had care plan reviews completed recently but one of the plans was not placed in the child's file. Staff members and the centre manager attended the review meeting so they knew what changes had been made to the plan. However, there was a risk in the absence of the record that not all staff would be aware of the plan.

The quality of recording required improvement. It was difficult to ascertain from the care plans reviewed the extent of behaviours and the interventions required to support the children. One child had significant behaviour that challenged and a high number of missing from care episodes but this was not reflected adequately in the care plan. One child's care plan was not reviewed since admission to the centre in April 2015 and therefore the plan was not effective to guide the placement. The children did not consistently participate in their care plan reviews or in meetings regarding their care and it was not apparent that the children had read their files. One child told inspectors that s/he would like to be involved in his/her care plan review. On one care plan reviewed, the child was not consulted about their views and did not attend the review. The minutes of care planning meetings read by inspectors outlined that one of the children had contributed to their plan but further work was required to ensure the children were consulted adequately in their care planning.

Placement plans were not on file for two of the children. One placement plan was reviewed which contained information regarding the child's needs relating to health, relationships, education and emotional and behavioural needs. There was sufficient details to guide some areas but the guidance in terms of the child's behavioural needs were not comprehensive. The child had a significant number of missing from care events but this was not reflected in the plan. Aggressive behaviour and the adverse

effect of behaviour on other residents was highlighted as an issue but the tasks identified to manage this were not sufficient. Interventions and strategies to support the child required review as the tasks identified were open to interpretation and not specific. Therefore additional information was required to ensure the placement plan would improve outcomes for the child.

Each child had an allocated social worker. A child told inspectors that their social worker was due to visit the evening of the inspection and another child told inspectors that his/her social worker follows up on requests. The social care manager advised that social workers regularly visit the centre and both staff and social workers confirmed that there was open communication between the two services.

Children received the physical care they required on a day-to-day basis but the children's emotional and psychological needs were not adequately assessed. External support agencies were available but not all of the children chose to avail of these. This meant that children's emotional and psychological needs were not assessed and children were without adequate supports.

Quality of care

The model of care provided in the centre was not specified. Staff and management did not know the model of care and it was not clearly documented on the statement of purpose. This impacted on the approach and quality of care provided to the children. Inspectors observed appropriate interactions between staff and the children which were respectful even when faced with behaviour that challenged.

Children in the centre did not receive the care and support they required to manage the behaviours of concern. There was a policy on the management of behaviour but not all aspects of the policy were fully adhered to. There were negative outcomes for the children in terms of engaging in risky behaviour. There were a high level of significant events in the centre and the management of behaviour that challenged was complex and difficult for the team. There were inadequate supports for the children in terms of their complex needs. There was evidence that the team tried to engage the children with psychology and mental health services and programmes to develop their interests but the children refused to engage and as a result had limited support in relation to their complex needs.

There were 386 significant events in the centre in the past twelve months. Children had engaged in various types of behaviour including property damage, self injurious behaviour, missing from care, violence and aggression and substance misuse. Some of the children were involved in criminal and other risky behaviour in the community. Staff attempted to provide a nurturing environment in the centre and advocated for services

for the children. Inspectors spoke with staff who expressed care and concern about the children and spoke about them in a respectful manner. Attempts had been made by the staff team to engage the children in a daily plan and in activities of interest to the children. Inspectors viewed key working activities completed with the children but there was not a structured plan in place for each child to learn and develop from their behaviours.

The centre followed a recognised model of behaviour management but it was not always documented what interventions and strategies were employed with the children. The strategies that were implemented were not effective. The main strategy to manage behaviour as identified by the staff members and management was supervision of the children. Staff spoke about the requirement to supervise the children constantly and how the children were followed when they changed location in the house. However, rules, boundaries and routines were not clear. Inspectors were advised that the children's pocket money was reduced as a response to behaviour on a regularly basis but staff and management told inspectors that this was not effective. Inspectors reviewed key work sessions and noted that the children were spoken to about the money they owed in relation to taxi fares. There was no log in the centre of sanctions, consequences or interventions used with the children and it was difficult to ascertain what was in place for individual children. One child told inspectors that she did not "mind them" when asked about rules in the centre.

There was a lack of interventions and strategies in place to help the children to understand their behaviours and the centre lacked a framework to guide the work with the children. Boundaries and limits to ensure a safe nurturing environment were not evident. There was a reactive approach taken with the children and there was a lack of clear structured interventions completed with the children according to the presenting needs. There were limited measures in place to ensure the risks to children were managed. For example, inspectors reviewed documentation and spoke with staff about risks to a child in the community which impacted on safeguarding and the child's health. The behaviour was discussed with the child in key work sessions but a reactive approach meant that learning and change for the child did not happen. Inspectors reviewed significant event logs and de-escalation techniques had not been consistently implemented and not documented on the forms. Life space interviews, a technique to support the management of behaviour after an incident did not take place as recommended in the training attended by the team. There was minimal use of physical interventions recorded. Inspectors viewed records and found that this section was not consistently completed. On one occasion a moving technique was used to deescalate a situation, as appropriate.

The children had complex needs relating to emotional, mental and sexual health but the majority of the staff team had not received training to inform their practice in managing

such needs. A minimal amount of staff had training in managing self-harm but this was not sufficient given the extent of such concerns in the unit. Although the children's care was discussed by staff on a bi-weekly basis, there was no indication that there were changes to practice or a reduction in the number of behaviours that challenged.

There were no systems in place to identify or analyse children's behaviours. This meant that children's behaviour went unaddressed and misunderstood. Significant events were not collectively reviewed. An Garda Síochána were often called to the centre as a result of property damage. There was also a process in the centre where criminal charges were brought against the children should property damage occur. The centre manager advised that this had not brought about a change to behaviour but the process was supported to ensure there were realistic consequences for the child involved. Inspectors reviewed significant event notifications and it was not evident that all necessary interventions were employed before the Gardai were called. On one occasion it was noted that the child was agitated and caused some damage to a unit in his bedroom. There was no record of the strategies that were implemented with the child to deescalate the situation before the Gardai were called. Interventions with the children following an incident of behaviour that challenged were limited to a discussion with the child. Inspectors did not see any documentation to reflect that life space interviews had taken place or other programmes to help the child to reflect on their behaviour, how it needed to change and who had responsibility to make this happen.

Documentation to inform and guide the care of the children required review. There were individual crisis management plans (ICMP) and individual absence management plans (IAMP) in place for the children however additional work was required to ensure they were up to date and current for each of the children. There were a number of significant events and missing from care episodes in relation to one child but the ICMP had not been updated since November 2014. On another ICMP reviewed there were examples of behaviour displayed by the child, but the information provided to manage the behaviour was not comprehensive. One child in the centre had a high amount of absences without authority but the IAMP reviewed by inspectors found that the plan had not been updated since October 2014. Inspectors reviewed risk assessments in the files sampled but the risks were not always related to the child and in one case the risk assessed related to the staff, even though the child was at risk from the same issue.

Parents interviewed as part of the inspection told inspectors that they did not feel their children were safe in the centre. A social worker discussed the extent of behaviours in the centre and outlined the difficulties of ensuring there were appropriate consequences.

There were difficulties in the centre in managing relationships between the children and there were concerns regarding the nature of relationships. Staffing levels were increased in the centre to manage this previously, with a waking night staff to observe at all times. Alarms were fitted on the doors of the children's bedrooms which alerted staff at night if the children left the room. Supervision was the main strategy to manage relationships between the children. Although staff spoke with the children about the nature of the relationship, inappropriate relationships between the children was a reoccurring difficulty and had occurred on two separate occasions in recent months.

Child protection and safeguarding

The children in the centre were presenting with difficult behaviours and although staff attempted to implement safe care practices, they were not effective to keep the children safe. Policies and procedures were followed when children went missing but there were incidents of bullying that were ongoing in the centre. Inspectors reviewed incidents of intimidation recorded on logs. Staff members confirmed that at times there was abusive behaviour between the children in the centre. It was evident from team meeting minutes that this was discussed and a complaint form offered to the child but it was not clear if changes were made to practice in terms of how staff controlled the situation.

Children First: National Guidance for the Protection and Welfare of Children (2011) was implemented in the centre. Management and staff members followed national policies when responding to allegations or concerns about the children in their care. There had been 12 referrals made to the Child and Family Agency social work department in relation to child protection and welfare concerns in the past year. Concerns were appropriately referred but there was no documentation that the concerns were concluded. There was no indication that changes were brought about for the children as a result of the referrals. This meant the concerning issues for the children were not resolved in a timely manner and the children remained at risk. The training records reviewed by inspectors outlined that training in Children First (2011) was provided but there was no record that this had been provided to three of the staff members listed.

There was one allegation made in relation to a staff member. This was managed in a timely way and was referred to the social work department. This had not been concluded at the time of the inspection but the internal investigation found that there was no evidence of an abusive interaction having taken place.

There was no system of audit to review incidents or significant events involving the children. Serious incidents were discussed at a serious incident review group but the

documentation regarding these meetings were not of good quality. The minutes of these meetings contained limited information in terms of recommendations for a change to practice following the review. The storage of information regarding such reviews was not adequate or up to date and this meant that the staff may not have had sufficient information to guide their practice. The centre manager said that feedback was provided to the team verbally but there were no changes to how behaviour that challenged was managed. The centre manager said there had been no collective review of significant events in the centre. Children remained at significant risk in the centre and effective processes to review and effect change, to improve outcomes were not in place.

There was one child living in the centre who was at significant risk. Although there had been a number of meetings to discuss the child and his/her situation, the risk remained for the child. Inspectors reviewed a number of strategy meetings and risk management meetings between the centre and external professionals including the allocated social worker. However, the meetings were not effective in terms of instigating change to ensure the child was safe in the placement. The child was at risk due to behaviours that challenged in the centre and in the community. Risk assessments were completed and inspectors found that the child was not permitted to travel in the centre's vehicle. The child was transported in a taxi to ensure staff could sit either side of the child to ensure his/her safety while travelling. Inspectors spoke with the social work team leader and were advised that there was a plan to move the child in the near future. Inspectors also spoke with a parent of the child's who expressed dissatisfaction with the child's care and stated that the child was unsafe in the placement. The placement was not meeting the needs of the child and inspectors requested assurances in relation to the case following the inspection.

The national policy on children missing from care was followed and staff reported appropriately when children went missing but work with the children to prevent or reduce further incidences required improvement. There were some incidences of bullying in the centre. Staff had taken actions to eradicate or reduce the incidences but they continued to occur in the centre.

Health and safety

The centre required refurbishment and the storage of fire extinguishers required review to ensure there was easy access to the equipment if required. There was significant damage to the centre as a result of behaviours that challenged. Inspectors observed temporary wall surfaces in place to cover extensive damage in the centre. The decor was not child friendly and the centre was in urgent need of refurbishment.

Inspectors were advised of one incident of fire setting behaviour in the unit and this was managed with the assistance of An Garda Síochána who were present in the unit at the time. Inspectors observed a number of fire extinguishers stored in locked rooms which were not easily accessible. The reason for this storage was due to threats from the children to harm staff or property with the fire extinguishers. However, this meant that extinguishers were not readily available at all locations within the centre if they were needed.

Effective processes were in place with regard to fire safety. Inspectors viewed a fire and house register and information relating to fire evacuations and fire alarms. Fire drills were completed every quarter and detailed the names of the children and staff who participated. The fire alarm was regularly serviced and the fire extinguishers were serviced recently. There was regular health and safety audits of the centre. The deputy manager was satisfied that all soft furnishings in the centre were fire retardant. Inspectors reviewed documentation to evidence that the curtains in the centre were flame retardant.

Judgment against standard, in respect of behaviour that challenges

Standard	National Standards for Children's Residential centres	Judgment
Standard 5: Planning for Children and Children	There is a statutory written care plan developed in consultation with parents and children 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 children and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.	**Requires improvement**
Standard 6: Care of Children	Staff relate to children in an open, positive and respectful manner. Care practices take account of children's individual needs and respect their social, cultural, religious and ethnic identity. Staff interventions show an awareness of the impact on children of	**Significant risk identified**

	separation and loss and, where applicable, of neglect and abuse.	
Standard 7: Safeguarding and Child Protection	Attention is paid to keeping children in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.	**Significant risk identified**
Standard 10: Premises and Safety	The premises are suitable for the residential care of children and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care (Placement of Children in Residential Care) Regulations, 1995.	**Requires improvement**

Theme 4: Leadership, Governance and 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.

Summary of inspection findings under Theme 4

The statement of purpose was not adequate and did not outline the model of care to be provided in the centre. Management systems required review to ensure there was effective oversight of practices in the centre and to ensure leadership and support was consistently provided to the team. Quality assurance systems were not robust and there was a significant number of incidents that had not been reviewed or trended to inform changes to practice. The staff team were not trained in key areas of concern that related to behaviour that challenged. The supervision process was not in line with the centre's policy.

Statement of purpose

The statement of purpose and function did not adequately describe the service. The model of care was not stated on the statement of purpose and staff and management in the centre were not clear on the model of care to be provided. It did not outline the services and facilities to be provided. The statement of purpose did not set out the basis in legislation and statutory function of the service, service objectives and the model of service delivery, particularly around managing behaviour. The statement of purpose was not adequate and as a result children could be inappropriately placed in the centre.

Management structures and systems

There was a clear line of authority in the centre and managers were aware of their role. However, management systems required improvement to ensure the service provided was safe and appropriate to children's needs. The system to ensure effective oversight of the centre's management of behaviour that challenges was not robust. Inspectors found that there was a need for stronger leadership and guidance for the staff team with clear expectations of the children.

The manager of the centre was qualified for the role and had significant experience working in the area. The centre manager was supported in the role by two deputy managers and there were social care leaders and social care workers carrying out the day-to-day practices in the centre. There was an experienced team who were supported by agency staff on a daily basis but the systems to ensure the service was safe and effective required review. The centre manager was managed by a regional manager. Inspectors reviewed minutes of management meetings and records of the centre manager's supervision; however, ongoing support provided to management in the centre was not evident. There were some discussions relating to the behaviour of the children but the records did not detail the extent of the difficulties in the centre. This meant that more senior line managers may not have had the awareness or oversight of what was happening in the centre which would impact on the provision of a safe effective service.

Quality assurance systems in relation to managing behaviour that challenged needed to be improved. The centre manager and deputy manager advised that incidents were reviewed at team meetings but there was no collective review of significant events. Inspectors reviewed records of team meetings and it was noted that the children were discussed regularly. Although inspectors noted that behaviour was discussed, it was not a collective review and the measures and actions identified to improve the outcomes for the children were not effective. There were no mechanisms to trend and identify patterns and there was no evidence that changes to practice had been made as a result of serious incidents.

The monitoring of the service and systems to ensure changes to practice was not of good quality. There were no mechanisms to monitor the quality of responses to behaviour that challenges. The centre manager said that she read the significant event notification forms and signed them to evidence that she had read them but there were no initiatives to instigate change or drive improvements. It was not evident how management in the centre were monitoring service delivery and improvements in the centre were minor. Inspectors found that important documentation such as care plans were not always present in the child's file. Inspectors also noted that not all significant events recorded on the centre's log had a corresponding significant event form in the child's file and there was no central record of all significant events that occurred in the centre. Individual crisis management plans and individual absence management plans were not reviewed on a regularly basis. In some cases the actions required following a significant event warranted a review of such plans but this was not completed consistently.

Relationships and morale in the centre were impacting on outcomes for the children. The centre manager said that the morale in the centre was poor and stated that there had been no positive changes in recent times and felt the culture in the centre needed

to change. The centre manager stated that the centre need to regroup and consider the way the service was provided into the future.

There was a prompt notification system for significant events but they were not trended to ascertain patterns of behaviours. They were not proactively used to improve outcomes for children. The centre manager advised that external managers received the notifications and some risks had been escalated to external managers. However, it was not evident that any change had occurred as a result, and risk to the children due to behaviours that challenged remained in the centre. There was a serious incident review group that met on a monthly basis to review significant events across a number of centres. It was evident through speaking with management in the centre (and from review of the minutes) that a small number of significant events were reviewed at these meetings. However, Inspectors were advised that the records of these meetings were not up-to-date and therefore staff did not have access to this information. The manager told inspectors that she passed information on verbally to the team following reviews but this did not include changes to practice and there was no reduction in the number of significant events.

There was an integrated risk management policy that guided the management of risk in the centre. Despite requests to view this document, inspectors were not provided with a copy to review. There were risk assessments and a risk register in place but they were not comprehensive to address all risks posed by incidents of challenging behaviour. Inspectors reviewed risk assessments of centre specific risks. The control measures in place were poor and there was no review dates listed. Risk assessments had not been updated since May 2015 even though there had been a significant number of incidents that posed a risk to staff and the children. The risk register was not effective in terms of highlighting priority or high rated risks in the centre.

The Child and Family Agency's monitoring officer had recently completed a monitoring report of the centre and there was evidence of documentation that was reviewed during that process. Not all of the recommendations from the monitoring officer's report had been incorporated into practice at the time of the inspection. Outstanding issues that were highlighted in a recent monitoring report required attention. Some actions which had been provided to the Authority (following an update to the action plan submitted after a previous inspection by the Authority) were not in place. For example, inspectors were advised that the resources panel was not assessing if the placements were meetings the children's needs as outlined in the action plan responses provided to the authority in January 2015.

Sufficient staff and skill mix

The centre was sufficiently staffed to meet the needs of the children living there. At the time of the inspection there were two children residing in the centre. There were three staff on duty during day and night shifts. There was also a manager and deputy manager on duty during core hours on a daily basis. Inspectors found that the staff team were mostly qualified and well experienced in providing residential care. The use of agency staff had increased in the centre to provide additional cover for the management of behaviours in respect of one child in particular. Inspectors reviewed rota's and the overview of use of agency staff. Inspectors found that 74 shifts were covered by 11 agency staff since March 2015. The rotas were difficult to read and therefore it was difficult to ascertain the skill mix of experienced staff on duty on a daily basis. One staff remained unqualified for the role and the team lacked some specialised knowledge and training in terms of dealing with the extent of behaviours and need in the centre. Staff files did not contain all of the required information including for example evidence of the person's identity, full employment history and the position the person holds.

Supervision and support

There were systems in place to support staff but a formal system was required. The centre manager told inspectors that formal supervision provision was poor and advised that support was provided on an informal basis.

Inspectors viewed records of supervision provided to the staff team and found that supervision was not provided in line with the centre's policy. The supervision contracts on file outlined that supervision should be provided every four to six weeks, however in three of the four records sampled, the staff members were supervised once in a twelve month period. One staff member had supervision three times in the same period; however the records of supervision were not adequately detailed to determine the quality, specifically in relation to behaviour that challenged. In the absence of a good quality supervision system, staff accountability for practice was not monitored sufficiently and support mechanisms for staff were minimal. Inspectors reviewed supervision records for the centre manager. Supervision did not occur according to the supervision policy and there were significant gaps in the provision of this support to the centre manager.

There were no appraisals for the staff team and there was no system to review cases within the supervision process to ensure practice was of good quality. The children

were at risk in the centre as a result of behaviours that challenged but there was no formal process to ensure accountability for practice.

Training

The staff team did not receive sufficient training, to meet the needs of the children who displayed behaviours that challenged. Staff were provided with some training that linked directly with behaviours that challenged but there were gaps in the training needs of the staff team to manage the complex needs and associated behaviours of the child who lived in the centre.

Inspectors reviewed training records and found there were gaps in the training provided to the team. The entire staff team required refresher training in the behaviour management technique adopted in the centre and for six staff the refresher training was overdue by over 3 months. Training in Children First National Guidance for the Protection and Welfare of Children (2011) was provided to the team but there was no record that this training was provided to three staff members. The centre manager told inspectors that this was up to date for all staff but this was not reflected in the training records reviewed by inspectors.

There was a training needs analysis completed in October 2014. This required additional work to ensure it was specific to the needs of the staff team in the centre. It did not reflect areas of training required that were directly relevant to the centre in areas such as sexual health and mental health. There was a large amount of incidents of self-harm in the centre, but staff were not adequately trained. A limited number of staff had completed training in mental health or specific self-harm training but this training was a priority given the complex needs of the children in the centre. There was no evidence that the team were developed in a way to improve service delivery or outcomes for the children.

Judgment against standard, in respect of behaviour that challenges

Standard	National Standards for Children's Residential centres	Judgment
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 children and the manner in which care is provided. The statement is available, accessible and understood.	**Significant risk**

Standard 2: Management and Staffing	The centre is effectively managed, and staff are organised to deliver the best possible care and protection for children. There are appropriate external management and monitoring arrangements in place.	**Significant risk**
Standard 3: Monitoring	The Health Service Executive[1], 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.	**Requires improvement**

[1] Formally the Health Service Executive at time of writing Standards, now thesefunctions are the responsibility of the Child and Family Agency.

Appendix 1 – Standards and Regulations for Children's Residential Services

National Standards and Regulations for Children's Residential Centres
Theme 1: Child-centred Services
Standard 4: Children's Rights The rights of children are reflected in all centre policies and care practices. Children and their parents are informed of their rights by supervising social workers and centre staff.
Theme 2: Safe and Effective Services
Standard 5: Planning for Children and Children There is a statutory written care plan developed in consultation with parents and children 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 children and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care. ***Child Care (Placement of Children in Residential Care) Regulations, 1995*** *Part IV, Article 23 Care Plans* *Part V, Articles 25 and 26 Care Plan reviews* *Part III, Article 8 Contact with families* *Part IV, Article 24 Supervision and visiting of children* *Part IV, Article 22 Case records* *Part III, Article 9 Emotional and specialist support*
Standard 6: Care of Children Staff relate to children in an open, positive and respectful manner. Care practices take account of children's individual needs and respect their social, cultural, religious and ethnic identity. Staff interventions show an awareness of the impact on children of separation and loss and, where applicable, of neglect and abuse. ***Child Care (Placement of Children in Residential Care) Regulations, 1995*** *Part III, Article 11 Provision of food and cooking facilities* *Part III, Article 10 Religion*

Standard 7: Safeguarding and Child Protection

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

Theme 2: Safe and Effective Services

Standard 10: Premises and Safety

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

Child Care (Placement of Children in Residential Care) Regulations, 1995

Part III, Article 7 Accommodation
Part III, Article 12 Fire Precautions
Part III, Article 13 Safety Precautions

Theme 3: Health and Development

Standard 8: Education

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

Standard 9: Health

The health needs of the child are assessed and met. They are given information and support to make age-appropriate choices in relation to their health.

Child Care (Placement of Children in Residential Care) Regulations, 1995

Part III, Article 9 Health care
Part IV, Article 20 Medical examinations

National Standards and Regulations for Children's Residential Centres
Theme 4: Leadership, Governance and Management
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 children and the manner in which care is provided. The statement is available, accessible and understood.
Standard 2: Management and Staffing The centre is effectively managed, and staff are organised to deliver the best possible care and protection for children. There are appropriate external management and monitoring arrangements in place. ***Child Care (Placement of Children in Residential Care) Regulations, 1995*** *Part III, Article 5 Care practices and operational policies* *Part III, Article 6 Staffing* *Part IV, Article 21 Maintenance of Register* *Part III, Article 15 Notification of Significant events* *Part III, Article 16 Records*
Standard 3: Monitoring The Health Service Executive[2], 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. ***Child Care (Placement of Children in Residential Care) Regulations, 1995*** *Part III, Article 17 Monitoring of Standards*

[2] Formally known as Health Service Executive at time of writing Standards, now known as The Child and Family Agency.