

## Health Information and Quality Authority Regulation Directorate

Monitoring Inspection Report Special Care Centres  
under Section 69 (2) of the Child Care Act 1991  
as amended by the Child Care Act (Amendment)  
2011



<b>Type of centre:</b>	Children's Special Care Unit
<b>Centre name:</b>	Coovagh House
<b>Centre ID:</b>	OSV-0004219
<b>Type of inspection:</b>	Unannounced Full Inspection
<b>Inspection ID</b>	MON-0017927
<b>Lead inspector:</b>	Sharron Austin
<b>Support inspector (s):</b>	Patricia Sheehan;Tom Flanagan

## **Children's Special Care Unit**

About monitoring of children's special care services

The purpose of monitoring is to safeguard vulnerable children of any age who are receiving child protection and welfare services. 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 lives.

The Health Information and Quality Authority (the Authority or HIQA) is authorised by the Minister for Children and Youth Affairs under Section 69 (2) of the Child Care Act, 1991 as amended by the Child Care(Amendment) Act 2011 to inspect children's special care services provided by 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.

Monitoring inspections assess continuous compliance with the Standards, and can be announced or unannounced.

## Compliance with National Standards for Children's Special Care Units

### The inspection took place over the following dates and times:

From:	To:
23 August 2016 09:30	23 August 2016 18:00
24 August 2016 08:30	24 August 2016 15:30

During this inspection, inspectors made judgments against the *National Standards for Children's Special Care Units*. 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
<b>Theme 1: Child - centred Services</b>	
<b>Standard 1:1</b>	Meets standard
<b>Standard 1:2</b>	Meets standard
<b>Standard 1:3</b>	Requires improvement
<b>Standard 1:4</b>	Requires improvement
<b>Standard 1:5</b>	Meets standard
<b>Standard 1:6</b>	Meets standard
<b>Standard 1:7</b>	Requires improvement
<b>Theme 2: Effective Care</b>	
<b>Standard 2:1</b>	Requires improvement
<b>Standard 2:2</b>	Requires improvement
<b>Standard 2:3</b>	Significant risk identified
<b>Standard 2:4</b>	Requires improvement
<b>Standard 2:5</b>	Requires improvement
<b>Theme 3: Safe Services</b>	
<b>Standard 3:1</b>	Meets standard
<b>Standard 3:2</b>	Meets standard
<b>Standard 3:3</b>	Requires improvement
<b>Standard 3:4</b>	Meets standard
<b>Theme 4: Health &amp; Development</b>	

<b>Standard 4:1</b>	Requires improvement
<b>Standard 4:2</b>	Requires improvement
<b>Standard 4:3</b>	Meets standard
<b>Theme 5: Leadership, Governance &amp; Management</b>	
<b>Standard 5:1</b>	Meets standard
<b>Standard 5:2</b>	Requires improvement
<b>Standard 5:3</b>	Meets standard
<b>Standard 5:4</b>	Meets standard
<b>Theme 6: Use of Resources</b>	
<b>Standard 6:1</b>	Requires improvement
<b>Theme 7: Responsive Workforce</b>	
<b>Standard 7:1</b>	Requires improvement
<b>Standard 7:2</b>	Requires improvement
<b>Standard 7:3</b>	Requires improvement
<b>Standard 7:4</b>	Requires improvement
<b>Theme 8: Use of Information</b>	
<b>Standard 8:1</b>	Requires improvement
<b>Standard 8:2</b>	Requires improvement

## Summary of Inspection findings

Coovagh House special care unit is one of three special care units. It has capacity for up to four children of mixed gender, aged between 11 and 17 years on admission. The purpose of Coovagh House special care unit is to provide a short-term period of care in a safe and secure environment. At the time of the inspection, there were 3 children living in the centre.

During this inspection, inspectors met with or spoke to 2 children, 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.

In addition, inspectors spoke with social workers, guardians ad litem, the Child and Family Agency Monitoring Officer and members of the assessment, consultation and therapy service (ACTS) who provided multidisciplinary interventions to children placed in special care.

Inspectors found that the staff and management team were caring for children with multiple complex needs which had resulted in two of the children being cared for in

single occupancy arrangements due to the identified risks. Considerable property damage and serious assaults on five staff had occurred in the months and weeks preceding the inspection. Despite this, the service was providing adequate care for children within an environment that required further restriction to ensure safety.

Children's rights were respected and they had appropriate contact with advocacy services, social workers and legal representatives.

Children were admitted to the special care unit subject to the relevant legislation and guided by a programme of special care. The components of which were maintained in a number of plans to support the care of the children but it was not evident that these were collectively reviewed.

Safe care practices were implemented in line with Children First: National Guidance for the Protection and Welfare of Children (2011). There was a system to ensure managerial oversight of restrictive practices; however, a collective monitoring approach was not in place to ensure the special care programme was fit for purpose and to track and analyse significant events to ensure improved outcomes for children.

The health and development of children was promoted and children had timely access to medical and other specialist health services as required. The special care unit had access to a psychiatrist on a consultative basis only. In the event of an emergency, access to psychiatric services was sought through the accident and emergency department in the local hospital or through the local Child and Adolescent Mental Health Services (CAMHS) team. However, the provision of a robust psychiatric service and ongoing psychiatric review of children in the special care unit required further development. Some medication administration practices required improvement.

The special care unit was well managed and staffing levels were adequate. There were a number of systems in place to ensure that the service provided was safe. The reporting of significant event notifications had improved and communication and accountability was good. However, there was no up-to-date risk management policy in place to consistently guide the practice of staff in managing risk.

Significant risk was found in relation to the living environment. Significant damage had been caused to several areas of the unit resulting in a number of rooms that were out of commission. Two children were being accommodated in single occupancy arrangements based on risk, and this impacted on the third child in terms of access to other areas within the unit. Access to appropriate indoor and outdoor recreational areas were also impacted due to the single occupancy arrangements.

This report makes a number of findings which the provider is required to address in an action plan. The provider's action plan is 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.

Children's rights, privacy and dignity was respected and guided by policy and procedures consistent with the provision of safety and security. Children were facilitated in accessing their social worker, legal representation, guardian-ad-litem services and advocacy services. Assistance and support was provided to children through key working sessions and building relationships with staff. Children were encouraged to participate in decision making about their lives. There was a system in place to manage complaints but the recording of complaints required improvement.

### **Standard 1:1**

The rights and diversity of each child are respected and promoted.

### **Inspection Findings**

Children's rights were respected and guided by policy and procedures consistent with the provision of safety and security. Children were facilitated in accessing their social worker, legal representation, guardian-ad-litem services and advocacy services. Assistance and support was provided to children through key working sessions and building relationships with staff. Children were encouraged to participate in decision making about their lives.

Information on rights was provided to children and they were supported in exercising them. Children that met with the inspectors were aware of their rights and had been given a copy of a child friendly information booklet. The information booklet also promoted rights in relation to diversity. It outlined that the child would be supported and facilitated to partake in activities that were important to their culture, to practice their religion and to develop their identity. There were no children from a diverse cultural background in the special care unit at the time of inspection.

Independent advocates visited the special care unit regularly and children interviewed were aware or had met these advocates. A review of unit records and discussions with staff and management demonstrated that the team had a good understanding and were respectful of children's rights.

**Judgment:** Meets standard

### **Standard 1:2**

The privacy and dignity of each child are respected.

## **Inspection Findings**

The privacy and dignity of each child was respected by staff and was guided by policy and procedures consistent with the provision of safety and security.

Room and clothing searches were carried out based on risk and in accordance with policy. Significant event notifications and risk assessments were in place, which evidenced the decision and need for such an intervention based on risk.

Bedrooms were never locked when a child was in their room and this was good practice. A child's room could be locked so as to protect their belongings at the request of the child when they were not in their room.

A closed circuit television (CCTV) system was in place which allowed for the remote monitoring of key strategic areas of the special care unit, including internal and external doors. Staff were cognisant of privacy issues for the children and were aware of the policy in place. The use of CCTV was in line with policy and respected children's privacy.

**Judgment:** Meets standard

### **Standard 1:3**

Each child exercises choice and experiences effective care and support as part of a programme of special care.

## **Inspection Findings**

Children exercised some choice in areas such as the food, meals and the activities they participated in and were encouraged to attend their review meetings. Through interviews with social workers, examples were given whereby the views of children were respected in terms of who would attend their review meetings.

Children were encouraged to exercise choice and to participate in decision making about their daily living. One of the deputy managers outlined that children's views were sought through consultation on an individual basis when a group setting could not be facilitated. Data provided to HIQA after the inspection indicated that 106 children's meetings had been held since the last inspection. However, inspectors could not comment on the effectiveness of this type of consultation as records of these meetings could not be located during the inspection. A review of staff meeting minutes did not evidence decisions made and feedback given to children on issues they had raised.

Two of the three children who met with inspectors reported that they were bored, with very little to do. Inspectors saw weekly planners and support plans which showed leisure and recreational activities on-site and in the local community. However, due to assessed risks and consultative decision making in the interests of safety and security, choices available to one child in particular were limited.

Children had opportunities for supervised activities consistent with the provision of safety and security. The special care unit had secure outdoor green areas for children to use, however, recreational equipment was limited. Staff and managers told inspectors that there were plans to develop the gym area and outdoor space area.

Children’s achievements were acknowledged by staff. It was evident in a review of staff meeting minutes when discussions took place on each child, that any progress or positive behaviours were recognised and acknowledged.

**Judgment:** Requires improvement

**Standard 1:4**  
Each child has access to information, provided in an accessible format that takes account of their communication needs.

**Inspection Findings**

Information was appropriately provided to children in line with policy. The information booklet provided to each child required updating as some information pertaining to named persons in the service were incorrect. Children had an awareness of how to access their information through the detail contained within the information booklet. Children who met with the inspectors were aware of how to access their information. A policy regarding access to information was in place and children who met with inspectors had an awareness of how to access their information. There was no evidence of children accessing their care records or daily logs in records reviewed by inspectors.

Assistance and support was provided to children through key working sessions, records of which supported this when viewed by inspectors. The standards for special care units were mentioned in the children’s information booklet in reference to inspections undertaken by HIQA. However, children were not provided with an accessible copy of the standards.

**Judgment:** Requires improvement

**Standard 1:5**  
Each child participates in decision-making, has access to an advocate, and consent is obtained in accordance with legislation and current best practice guidelines.

**Inspection Findings**

Children were encouraged to participate in decision making about their lives and had access to advocacy services. From a review of records, it was evident that the voice of the child was captured in staff’s preparation with children for their child in care reviews. Children were encouraged and facilitated to express their views to the court either via their guardian ad litem or, in one case where the child spoke with the judge on the phone. Children were supported to complete a review form prior to their review meeting and supported to attend their review meetings and to read out their form if they wanted to.

Children had access to their social worker, legal representation, guardian-ad-litem services and advocacy services which provided opportunities for children to access services that protected their rights and best interests. Children spoken with confirmed this with inspectors.



Inspectors saw a number of good quality key working sessions with individual children. External professionals noted that these sessions facilitated the building of good relationships with staff members and provided opportunities for children to be consulted about important issues in their lives.

**Judgment:** Meets standard

**Standard 1:6**  
Each child develops and maintains positive attachments and links with family, the community and other significant people.

**Inspection Findings**

Each of the three children residing in the special care unit had been placed outside of their own community. However, contact and visits with family and friends was encouraged and facilitated by staff where possible, consistent with the provision of safety and security. This was done through phone calls in the special care unit, facilitating children to visit family members and having members of the family visit the unit. Records of contact were maintained on contact sheets on care files and placement plan decisions. While children spoke of their contact with their various family members, they said they would like more contact. The special care unit had a visitor’s room in the main administration block; however, due to property damage, adequate space to ensure children had private space to meet with their families, friends and social workers within the special care unit was limited. This was being addressed at the time of inspection.

**Judgment:** Meets standard

**Standard 1:7**  
Each child’s complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.

**Inspection Findings**

There was a system in place to record, manage and resolve complaints. Information regarding the right to make a complaint was outlined in the children's information booklet in an age appropriate manner but it did not outline an appeals process if the child was not satisfied with the outcome. The booklet required updating as key people named as persons to speak to were no longer in their respective posts. A policy to guide the management of complaints was in place. This contained detail about the procedure to follow regarding receipt of formal complaints and information about the appeals process. However, it did not outline the process to follow should a complaint require investigation by the social work department or external personnel.

Children were very clear about their right to complain and they told inspectors that they knew how to make a complaint and who to make it to. A review of the central complaints folder found that 24 complaints were made by five children since the last inspection in June 2015. Eighteen of these related to three children who had since

been discharged from the special care unit. Six related to one child currently in the unit. The complaint form was user friendly and there was clear evidence of the steps taken to address the complaint and when the matter was resolved. A significant event notification was completed on foot of a complaint made by a child and the complaint form was then attached to the notification.

Children’s satisfaction or dissatisfaction with the outcome of their complaint was not clearly recorded. Inspectors found that the complaints officer had met with children individually following their concerns and in the majority of cases this was within the timeframes required by the policy. However, the central complaints log did not evidence a system to monitor and review complaints on a regular basis to establish if there were reoccurring trends or to track the overall timeliness of the management of complaints.

**Judgment:** Requires improvement

**Theme 2: Effective Care**  
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.

Each child was placed in the special care unit, in accordance with their identified needs and subject to the relevant legal authority. Interventions with children were underpinned by a programme of special care. Positive outcomes were identified for some children, but no formal process was in place to gather and analyse this information for the purpose of driving improvement. The living environment was not fit for the purpose of providing safe and effective care at the time of inspection. Access to appropriate indoor and outdoor recreational areas were impacted due to the single occupancy arrangements based on risk.

**Standard 2:1**  
Each child is placed in special care, in accordance with his or her identified needs and subject to the relevant legal authority.

**Inspection Findings**

Children were admitted to the special care unit subject to the relevant legislation and in accordance with their identified needs. An admissions policy and procedure was in place and referrals for a special care placement were processed by a national committee. A review of children’s care records found sufficient referral and admission information to inform the committee. Each child was subject to a high court order which was on file. Managers and staff interviewed outlined that information received prior to admission was generally good. However, despite this information one child presented with more significant difficulties that were not known to any of the professionals involved at the time of admission. Inspectors were told that shortly after admission, it became apparent to staff and managers that the complex needs of the child required a specific intervention which was facilitated under the guidance of the appropriate professionals. For two of the children this was their second admission to a special care unit. One child had transitioned to a residential facility within four months of admission to the unit. This onward placement broke down and the child returned to the special care unit. One child was admitted to the unit as a place of safety pending a move to an alternative

placement that was more appropriate to meet his complex needs.

Both children who met with inspectors understood the reason for their placement in special care, but were unhappy that they were still in the special care unit. On admission to the unit, children were given age appropriate information about the special care unit. A review of this booklet found that it required revision as information was outdated and named persons were incorrect.

**Judgment:** Requires improvement

**Standard 2:2**

Each child has a programme of special care which details their needs and outlines the supports required to maximise their personal development.

**Inspection Findings**

All interventions in the special care unit were underpinned by a programme of special care. This programme was made up of several components which included the child's care plan, placement plan, placement support plan, individual education plan, and individual therapeutic plan and where a child required the services of a psychiatrist, an intervention plan was included. A review of care files demonstrated the involvement of children, family members, and relevant professionals in the process, but not all components of the programme of care were consistently in place for each child. Staff, managers and external professionals reported that some elements of the programme of care were not necessarily warranted for individual children and was dependent on their assessed need and circumstances. Since the 1 August 2016, a child in care review and a multidisciplinary meeting were held every four weeks, both within two weeks of each other. Where the level of risk changed for a child or progress was poor, a review was undertaken to discuss the appropriate steps required to help the child in the management of their behaviour. Decisions and recommendations from child in care reviews were not always evident on care files.

Individualised care for the three children involved either specialist professionals from the Assessment Consultation and Therapeutic Service (ACTS) team or other external professionals and this was seen on care files.

A centre governance reporting system was in place which included data on the care experience of children on a monthly basis. This had been developed to support managers in the performance of their duties and to ensure the national office were aware of and responded to identified deficits/issues arising in the special care unit. The service had not developed a system to consider outcomes for children. Although, managers could identify positive outcomes for some children, no formal process was in place to gather and analyse this information for the purpose of driving improvement.

**Judgment:** Requires improvement

**Standard 2:3**

The special care unit is homely and promotes the welfare, dignity and safety of each child, consistent with the provision of safety and security.

## **Inspection Findings**

The living environment was not fit for the purpose of providing safe and effective care at the time of inspection. Some significant damage had been caused to several areas of the unit resulting in a number of rooms that were out of commission. Two children were being accommodated in single occupancy arrangements based on risk, and this impacted on the third child in terms of access to other areas within the unit. While each child had access to a bedroom and bathroom facility, access to other communal areas had to be juggled between children. The living space was not stimulating and furnishings were minimal given the extent of the various complex behaviours presented by each child. The decision to have children in such arrangements were carefully considered following a risk assessment. A review of records and interviews with staff, managers and external professionals all indicated that the level of risk that each child presented to each other could not be effectively managed in a more open setting. The extent to which the physical structure had been damaged required substantial maintenance. Inspectors saw maintenance work being carried out throughout the inspection; this in itself required coordination by the social care leader on shift and supervision consistent with safety and security. Access to appropriate indoor and outdoor recreational areas were also impacted due to the single occupancy arrangements. While these spaces were secure, two children could not access these areas at the same time.

While the unit had a part-time housekeeper, it required the services of an external cleaning company to ensure safe infection control practices. Training in infection control had been identified for staff and was to be rolled out shortly. A walk through of the premises found that clinical waste was inappropriately stored in a staff toilet. The premises had suitable heating and lighting throughout, but improvements in ventilation were required. The unit had an up-to-date health and safety statement dated April 2016 and the required policies and procedures were in place. Health and safety audits reviewed by the inspector found that deficits were clearly identified, but the action plan to address the deficits was not fully completed. Evidence of adequate insurance for the building and contents was in place, however a copy of the centre's insurance against accidents or injuries to children placed in the unit was not available at the time of inspection.

The unit had access to two vehicles which were insured, maintained and were equipped with appropriate safety equipment. Service records were not kept by the unit but were held by the garage that carried out servicing as per the lease agreement in place.

The special care unit complied with the requirements of fire safety legislation, relevant building and health and safety regulations. There were adequate precautions in place for the prevention of fire. A fire safety register was in place and there were sufficient numbers of fire extinguishers which were regularly serviced. Emergency lighting checks were not undertaken and the fire safety management plan was dated 2012 and had not been subject to review since that time. Procedures were in place to ensure a safe evacuation but were not on display due to property damage. Inspectors found there were adequate means of escape with due regard to secure nature of the accommodation and all fire exits were unobstructed and in working order. A review of training records found that the most recent fire safety training was completed in April

2016. The fire safety register held records of fire drills, fire alarm tests and servicing of fire equipment. A personal emergency evacuation plan (PEEP) was not in place for each child. Fire drills were carried out on a monthly basis and records evidenced who took part in these. Staff and children confirmed their participation in fire drills.

**Judgment:** Significant risk identified

**Standard 2:4**  
Children are actively supported in the transfer to and/or from special care and all transitions occur in a timely manner with a discharge plan in place to assure continuity of care.

**Inspection Findings**

The special care unit had policy and procedures in relation to the preparation for moving on and transition from the unit. A review of care records demonstrated that there were detailed transition plans on file for two of the children. Both transitions were implemented but were not successful. This was outside of the control of the special care unit. Inspectors found that good consideration and planning was carried out for future transitions for each child. Onward placements had not been identified for all children, however, staff and managers worked in partnership with each child’s social worker to advocate for and facilitate access to supports and aftercare services. External professionals interviewed reported that while the placements were suitable from a safety point of view, the sourcing of appropriate onward placements was difficult which resulted in children remaining in special care when they no longer required it.

**Judgment:** Requires improvement

**Standard 2:5**  
Special care units have a care record for each child.

**Inspection Findings**

Each child’s care record was held in accordance with legislative and best practice requirements. The special care unit had a policy in relation to record keeping. Care records viewed by inspectors were detailed, however, they were arranged in such a way that it was difficult to determine if all the required records were maintained. Not all records were signed and dated.

**Judgment:** Requires improvement

**Theme 3: Safe 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.

Safe care practices were implemented in line with Children First: National Guidance for the Protection and Welfare of Children (2011). There was a system to ensure managerial oversight of restrictive practices; however, a collective monitoring of

restrictive practices was not in place to track and analyse significant events to ensure improved outcomes for children.

**Standard 3:1**

Each child is safeguarded from abuse and neglect and their protection and welfare is promoted.

**Inspection Findings**

There were measures in place to safeguard children from abuse in line with policy. Staff members interviewed were vigilant in relation to the protection of children against bullying, to the extent that single occupancy arrangements were in place to protect children from each other and were subject to regular review.

Safe care practices were implemented and staff were appropriately trained. Policies and procedures to safeguard children were in place in line with Children First. Staff were vigilant and protected children against bullying. Areas of vulnerability were identified and individual safeguards were put in place and recorded in children's care records. This was reflected in practice as the complex needs of each of these children had resulted in environmental restrictions of children.

Staff followed procedures when children went missing from care or absconded. There had been 23 absconds since the last inspection. A review of significant event notifications demonstrated appropriate recording and reporting of these incidents.

There were policies and procedures in place for the protection and welfare of children including a child protection policy, bullying and whistleblowing. Staff interviewed had a good understanding of child protection and were knowledgeable of the policies and procedures in place to safeguard children. Social worker's interviewed were satisfied that they were appropriately notified of concerns affecting the safety and/or welfare of the children living in the special care unit.

All allegations and concerns were appropriately managed in accordance with Children First. The deputy manager who was the designated person in place, maintained a central record of all child protection and welfare concerns. A review of this record found that 35 concerns were reported to the respective social work departments since the last inspection in June 2015. Seventeen concerns were reported in relation to five children from July to December 2015 and the remainder were reported in 2016 to date in relation to six children. A review of these records demonstrated that the majority of the allegations related to alleged incidents outside of the special care unit, two related to staff members and two related to alleged mistreatment by the Gardai in the management of incidents involving the child. In each case the child protection concern was written up as a significant event and in consultation with respective social workers, a standard report form was completed where required and attached to the significant notification record. The inspector found that each concern was appropriately recorded and reported. A trust in care process was initiated on foot of an allegation against a staff member. The records demonstrated the steps undertaken in line with policy. Acknowledgements from social work departments on receipt of concerns were not always in place. The inspector viewed a sample of more comprehensive correspondence

from social workers in some instances regarding the status of the reported concern.

Risk was generally well managed in the special care unit. There were individual risk assessments in place to safeguard children and interventions to protect their safety and welfare was good. Risk assessments were subject to review or as concerns arose. External professionals reported that there were adequate policies and procedures in place to ensure the safety of children.

**Judgment:** Meets standard

**Standard 3:2**

Each child experiences care that supports positive behaviour and emotional wellbeing.

**Inspection Findings**

The special care unit had a written policy and procedure on the provision of behavioural support to children. Inspectors found that the staff and management team were caring for children with multiple complex needs which had resulted in all three children living very separate lives within the special care unit. Two children were in single occupancy arrangements for some time due to the identified risks. A third child was being primarily maintained in the special care unit for safety only pending his transfer to a therapeutic facility. Each child had an individual crisis management plan in place. A review of these found that they contained good quality information and detail which assisted staff in their engagement with children to support them to manage their behaviour. Inspectors reviewed records of key working sessions and meetings with children after incidents and found that staff supported children to reflect on their behaviour.

An Garda Siochana were called on five occasions to support staff in the management of some incidents of behaviour that challenged. A review of a sample of records where this occurred found that the rationale for contacting An Garda Siochana was evident.

Staff had not received training on each child's specific complex need, but training in the management of behaviour and approaches, recommended by the ACTS team involved with children, was provided. Specialist interventions were evidence based and implemented in accordance with policy and with the informed consent of families or person acting on their behalf. The child's programme of care clearly identified the supports and interventions required for children in the special care unit and the service was adequately resourced to ensure this was provided. Staff had the relevant information required to assist them in supporting children with complex behaviours and had access to specialist advice and appropriate supports.

**Judgment:** Meets standard

**Standard 3:3**

Children are not subjected to any restrictive procedure unless there is evidence that it has been assessed as being required due to a serious risk to the safety and welfare of the child or that of others.



## **Inspection Findings**

The use of restrictive practices was in line with policy and procedure. Restrictive practices were used as an emergency intervention following a risk assessment or as a last resort. Since the last inspection, there had been 51 incidents of physical intervention, 49 incidents of single separation and 39 incidents of structured time away involving six children. A review of this information found that they were carried out appropriately in response to behaviours that challenged. Two children were in a single occupancy arrangement at the time of inspection, due to identified risks. This environmental restriction had been used for one child since January 2016, shortly after admission to the unit, over a period of three months but not on a continuous basis. Following a new admission to the unit in June 2016 and another child being readmitted as a result of placement breakdown, single occupancy arrangements were established again to protect these children from serious risk.

Tusla's policy on the use of special care was a short-term, stabilising intervention so as to deliver safe therapeutic care in a secure environment and that the restriction of a child's liberty would always be limited to the shortest possible time. Cognisant of this, inspectors were informed of the current living arrangements in the unit for the three children and the decisions that had to be made which placed further restriction of children's liberty. Managers outlined that these decisions were carefully considered, and in consultation with all relevant professionals were taken in the best interests of the children. This had resulted in two of the children being cared for in single occupancy arrangements; however, one of these children could at times mix with a third child. Appropriate staffing ratios were in place to support these arrangements. From a sample of records of significant events, inspectors noted that the decision to restrict children within their immediate environment was appropriate due to the complex behaviours and the immediate risk of harm to themselves or others. Single occupancy was reviewed at multidisciplinary meetings as demonstrated in records viewed by inspectors. The rationale for the continuation of single occupancy was based on immediate risk of harm to the child or others; however, the recording of these was not consistent. The deputy manager confirmed that this was a deficiency that required action.

Inspectors were concerned that due to significant property damage, the areas where children were accommodated were reduced as maintenance was being carried out on a number of rooms.

There was a system to ensure managerial oversight of all restrictive practices. The special care unit reviewed and monitored the approach to managing behaviour on an individual basis and information was shared with relevant persons, as well as with the national office via the centre governance reporting system. However, a collective monitoring of restrictive practices was not in place to track and analyse significant events to ensure improved outcomes for children.

**Judgment:** Requires improvement

### **Standard 3:4**

Incidents are managed and reviewed in a timely manner and outcomes inform practice at all levels.



## **Inspection Findings**

There were policies and procedures in place for the notification, management and review of incidents. One of the deputy managers had responsibility for the review of all significant event notification records. This was done on a daily basis for the previous day's events and feedback given to staff or follow up required was addressed via the supervisor. An initial notification email was sent to relevant persons that required to be notified and a full report was generally sent out within 24 hours. External professionals interviewed were satisfied that the notification of significant events had improved and was now done in a more timely manner. A review of staff supervision files demonstrated where feedback or follow up was required with a staff member; this was discussed in supervision and actions identified. Fourteen serious incident review group meetings had been held since the last inspection. Staff interviewed outlined that learnings from these reviews were shared with them.

There was a policy and procedure on whistle blowing and protected disclosure. Staff were aware of who they should report concerns to and that they could do so without fear of adverse consequences to themselves.

**Judgment:** Meets standard

### **Theme 4: 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.

The special care unit had sufficient information regarding the health needs of children and the necessary supports and resources were in place to meet these needs. However, the provision of a robust psychiatric service and ongoing psychiatric review of children in the special care unit required further development. Medicine management practices required improvement.

### **Standard 4:1**

The health and development of each child is promoted.

## **Inspection Findings**

The health and development of children was promoted and facilitated by the special care unit in line with policy. Staff had facilitated timely referrals to mental health and substance abuse services where appropriate. Staff interviewed demonstrated good working knowledge of healthy lifestyles. This was also evident in a review of key working sessions where children were provided with information on diet and nutrition, substance misuse, smoking cessation, exercise and physical health.

Children had limited access to leisure and recreational activities. This was based on assessed risk particularly for one child who could not leave the special care unit. Recreational equipment was also minimal and not readily accessible. There were

limitations to the degree of choice available to the children in what activities were appropriate and available consistent with the provision of safety and security.

**Judgment:** Requires improvement

**Standard 4:2**

Each child receives an assessment and is given appropriate support to meet any identified need.

**Inspection Findings**

There were appropriate arrangements in place for timely access to medical and other specialist health services as required. A service agreement was in place for the provision of medical services by a general practitioner (GP) to the special care unit. A review of care files found that children's health care needs were assessed following admission and, where required specialist appointments were made or had been attended by the child.

A national specialist service responsible for the provision of a clinical assessment, consultation and therapeutic service (ACTS) was in place for children in the special care unit. This was a Child and Family Agency multi-disciplinary team. Children could access speech and language therapy, addiction counselling/psychotherapy, therapeutic social work, social care and psychological services from this team. The special care unit had access to a psychiatrist on a consultative basis only who was based in Galway. The managers told the inspector that this person attended on request. The frequency of input from this professional was based on the number of children actively under the care of the consultant and their presenting needs. Under the special care processes, the consultant psychiatrist has a responsibility to participate in professional meetings (in person or by teleconference) so as to have a collective review of individual children. In the event of an emergency, access to psychiatric services was sought through the accident and emergency department in the local hospital or through the local Child and Adolescent Mental Health Services (CAMHS) team. Managers reported that the consultant psychiatrist had met their obligations under the requirements of the special care processes. The national manager of ACTS and members of her team told the inspector that they had some concerns with aspects of the new special care processes which they have raised with the national office, one of which was psychiatric input for the special care unit. Agreement by all contributors to the programme of special care required further consideration to ensure effective implementation of the special care processes.

A review of care records demonstrated input from members of the ACTS team in relation to assessment and the development of individual therapeutic plans for two of the children and these were subject to regular review.

There were written policies on the administration, storing and disposal of medication but a new medication management policy was still at draft stage with the National Office, as outlined by the unit managers. Some medication administration practices were unsafe. A review of medication administration records found that the prescription for one child was illegible and when transcribed by staff onto a further page, was given

the incorrect name.

Following the findings of a gap analysis report, an office space within the unit was being converted for the purposes of the storage and administration of medication. It had a secure locked space for the safe storage of medication, but was not completed as the installation of a hand wash basin and refrigeration space were not finalised. This room was also going to store the care files for each child which should allow for the contemporaneous recording of the administration of medications and reduce the potential for errors.

Medical records demonstrated children's access to medical and other specialist services as required; however, they were not comprehensive and lacked information pertaining to the child's medical and vaccination history. Children's medical cards were kept in the staff office. Signed consent for medical treatment was not evident on all care files and there was no record of consent for children aged 16 years and over.

The three managers and six staff had received training on the safe administration of medicines in February 2016. Further training was scheduled for the end of the year for the remaining staff. There was no evidence of audits to ensure appropriate medicine management practices and this was confirmed by the centre manager.

One pilot medication audit had been undertaken in May 2016. There were nine improvements required with a time frame of August 2016. These were still outstanding at the time of this inspection as there was no action plan update to assess any progress in addressing the improvements. While nightly medication counts were undertaken, there was no evidence of further medication audits to ensure the safe administration of medication and to address deficits.

**Judgment:** Requires improvement

#### **Standard 4:3**

Educational opportunities are provided to each child to maximise their individual strengths and abilities.

#### **Inspection Findings**

Educational opportunities were encouraged and provided to each child within the special care unit. Two of the children had been in the special care unit during school terms and one child was only admitted during the summer. The inspection took place while children were still on their summer break from school and inspectors could not ascertain the views of the education staff.

With the exception of one child, educational records reviewed by inspectors were comprehensive. Two of the children had individual educational plans in place which outlined their educational needs and how best these could be met as part of their programme of special care. One of the children had participated in a summer programme run by the staff of the onsite school. Staff and external professionals interviewed reported that while education was actively encouraged, children's engagement with school was a struggle. The children who spoke with the inspectors

said that they liked vocational subjects in school.

Managers outlined that the principal of the school participated in the child in care review meetings and provided an update on each child's educational progress and achievements as part of the new special care processes. A review of care records and staff meeting minutes demonstrated discussion on children's educational placement and needs.

**Judgment:** Meets standard

### **Theme 5: 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.

The special care unit was well managed. There were clear lines of accountability and authority but systems for monitoring and auditing practices required improvement. There was no up-to-date risk management policy in place to consistently guide the practice of staff in managing risk.

### **Standard 5:1**

The special care unit performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect each child and promote their welfare.

### **Inspection Findings**

The special care unit operated in accordance with relevant legislation, regulations and standards. Staff interviewed were knowledgeable of relevant legislation, policies and procedures and standards appropriate to their role. During interview, the unit manager outlined the appropriate steps being taken to achieve compliance with the relevant legislation and standards. A gap analysis commissioned by the national office to assess if special care units were prepared for the commencement of special care regulations was carried out by an external service provider in February 2016. A report was finalised in April 2016 and feedback was given to the managers of the special care unit. The unit manager could not confirm if a formal action plan in response to the findings of this report was in place. She outlined that she had carried out two actions based on feedback from that report. These included a revision of the statement of purpose and the completion of an audit of the medication record. A copy of this was given to the inspector and it demonstrated that an audit improvement action plan was formulated with a completion date of August 2016. The centre governance report from July 2016, provided to inspectors, contained information on the number of outstanding actions completed and those outstanding following inspections of the special care unit. This outlined that 12 of 23 actions were completed arising from the previous inspection completed by HIQA. These reports were discussed at supervision with the acting national manager and the unit manager with a broader discussion at regional

management meetings.

**Judgment:** Meets standard

**Standard 5:2**

The special care unit has effective leadership, governance and management arrangements in place with clear lines of accountability.

**Inspection Findings**

There were management and governance systems in place with clearly defined lines of authority and accountability. Day-to-day operations were the responsibility of a unit manager who reported to the national manager for special care. The unit manager was supported by two deputy managers. Each manager was in an acting position for the past three years. Each manager had specific roles and responsibilities and clearly outlined these during interview. Staff were aware of the governance structures in place and clearly outlined their role and responsibilities.

There were systems in place to ensure that the service provided was safe and appropriate to children's needs. Staff stated they were supported by management and that communication was generally good. Managers interviewed demonstrated accountability for the service delivered and had a great understanding of the needs of the children currently residing in the special care unit.

A briefing meeting was held each morning between the deputy manager and social care leader. These meetings facilitated the sharing of contemporaneous information on children, sharing the details of each child's day and how staff experienced them. This forum ensured that managers were kept informed on each of the children on a daily basis. The meeting observed by the inspector went into great detail and the deputy manager picked up on any issues of concern that needed to be risk assessed or communicated to other professionals or to the rest of the staff team. In the initial meeting with inspectors on the first day of inspection, the deputy managers demonstrated detailed knowledge of each of the three children, their needs and future care options.

There was evidence of some quality assurance systems in place to monitor the quality of the service. The unit manager outlined that she had good oversight of centre records. File audits were undertaken and a review of same by inspectors found deficiencies which included no signature of the person auditing or when it was reviewed by management. The findings from the audit were not actioned and therefore were not followed up and rectified.

The special care unit was monitored by a Child and Family Agency monitoring officer who carried out regular visits and maintained good phone contact with the service. HIQA had received two monitoring reports since the last inspection from the previous monitoring officer dated May and June 2016. The theme of safe services was audited by the monitoring officer at that time and attendance at the multidisciplinary team meeting and the staff meeting was the purpose of the latter visit. Four actions were required on foot of the findings in relation to safe services, some of which were

reflective of findings in this inspection. The monitoring officer reported that the staff were co-operative and the management team presented as united and open to improving the service for children in the unit. She was satisfied that the reporting of significant event notifications had improved and that the unit was very responsive to feedback.

There were some good systems in place for risk management to identify, assess and manage risk, such as the management of individual risks to children. While they had a risk register, this was in fact a folder of risk assessment forms. Two of the assessment forms were actually descriptions of events that took place. This meant that the oversight of collective or overall risks were not adequately managed. Managers and staff interviewed demonstrated a good knowledge of risks posed by the complex needs of each child. However, there was no up-to-date risk management policy in place to consistently guide the practice of staff in managing risk.

**Judgment:** Requires improvement

**Standard 5:3**  
The special care unit has a publicly available statement of purpose that accurately and clearly describes the services provided.

**Inspection Findings**

The special care unit had an approved written statement of purpose which described the service provided and the population it catered for as a secure environment for up to four children. The statement was undated and did not accurately reflect the new special care processes. However, these had only been in place since the 1 August 2016. It included its basis in legislation, statutory functions, service objectives and the model of service delivery. A clear organisational structure was evident with information on the management and staff employed in the special care unit. Staff interviewed were familiar with the content of the statement and this was reflected in day-to-day practices.

**Judgment:** Meets standard

**Standard 5:4**  
Appropriate service level agreements, contracts and or other similar arrangements are in place with the funding body or bodies.

**Inspection Findings**

A service level agreement was not required for this special care unit as it was funded and managed by the Child and Family Agency. There were formalised agreements in place for services sourced externally which clearly defined the relationship, roles and responsibilities of the service provider. These included the services of a private security company which had been in place for a number of years and the services of a general practitioner. Inspectors viewed the agreement in relation to the medical practitioner and found that it was appropriately detailed and monitored.

**Judgment:** Meets standard

**Theme 6: Use of Resources**

The effective management and use of available financial and human resources is fundamental to delivering child-centred services and supports that meet the needs of children.

The use of available resources is planned and managed to provide child-centred, effective and safe services to children.

**Standard 6:1**

The use of available resources is planned and managed to provide child-centred, effective and safe services to children.

**Inspection Findings**

The management team demonstrated an understanding of the levels of need for the delivery of a service to children in the special care unit. The unit manager reported that they were sufficiently resourced in relation to staffing levels. The three managers were all in acting positions for the past three years and this required action.

A centre development plan dated 2016 was provided to the inspectors. This outlined the proposed development of special care services as provided by the unit during 2016 and the intention to ensure that the centre was compliant with the new national standards for special care units and proposed regulations for special care units.

**Judgment:** Requires improvement

**Theme 7: Responsive Workforce**

Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children's services recruit and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.

Staff and managers were caring for children with extreme complex needs and demonstrated appropriate knowledge and skill to respond to the needs of children. Staff understood their roles and duties and demonstrated a good understanding and awareness of policies and procedures to be followed. Mandatory training requirements were being delivered, however, there was no training needs analysis and review of training to inform a service training plan.

**Standard 7:1**

Safe and effective recruitment practices are in place to recruit staff.

**Inspection Findings**

Staff were recruited and vetted according to the recruitment policy. Six new staff had been recruited since the last inspection. A review of 18 staff files demonstrated that appropriate references and checks were in place for the majority of staff, but not all files were up-to-date. Staff files did not evidence formal induction and probation



processes and were not up-to-date. A written code of conduct for staff was in place.

**Judgment:** Requires improvement

**Standard 7:2**  
Staff have the required competencies to manage and deliver child-centred, effective and safe services to children.

**Inspection Findings**

Inspectors found that the staff and managers were caring for children with extreme complex needs which required children to be placed in single occupancy arrangements. This impacted on the ratio of staff to each child determined by the assessed risk each day. Managers reported that there were a sufficient number of staff to meet the needs of these children, however short term sick leave hindered this on occasions and a review of staff rosters reflected this. In the weeks preceding the inspection, five staff had been seriously assaulted and staff interviewed did not consider the staffing levels to be adequate at times to ensure the safety of the individual children within the unit.

The staff team comprised 27 whole time equivalents which included an acting unit manager, two acting deputy managers, five social care leaders and 17 social care workers. The special care unit had 10 whole time equivalent agency staff in use, these were kept to a minimum with a consistent group of staff used. There were five staff vacancies at the time of inspection. The unit also had a full-time clerical staff, two part-time chefs and one housekeeper. Inspectors reviewed the rota and found that staffing levels were in line with the ratios needed to maintain a safe level of care but acknowledged that this was difficult given the current single occupancy arrangements.

Of the 18 personnel files reviewed, 15 staff had the relevant recognised social care qualification. Three staff were recorded as not qualified, but had another relevant qualification. These included the acting unit manager and two social care workers. This was also demonstrated on the centre governance report provided to the inspector which had a total of six tusla staff and three agency staff with other relevant qualifications. These included the acting unit manager and two social care workers.

A review of care records demonstrated good input from keyworkers. Key work records evidenced detailed accounts of conversations or specific sessions with children on relevant issues. External professionals spoke positively of individual key workers and the work undertaken by them with respective children.

The unit manager demonstrated competence in her role and while classed as not qualified, she held a degree in social science, a diploma in business management and administration and had completed a certificate in quality improvement processes. She had been in her current post for the past three years. Staff and external professionals spoke positively of her role as unit manager.

**Judgment:** Requires improvement

**Standard 7:3**



Staff are supported and supervised to carry out their duties and promote and protect the care and welfare of children.

### **Inspection Findings**

Staff interviewed understood their roles and duties and understood the accountability and reporting relationships in place. They also demonstrated a good understanding and awareness of policies and procedures to be followed.

Supervision was not provided regularly in line with policy for all staff. Managers were trained in supervision and a number of staff had attended training in supervision processes. A review of 12 supervision records found that deficiencies in the frequency and evidence of accountable decision making. There were periods of months between supervision sessions for a number of staff and the records did not always record the reason for this. While some discussion in relation to professional development, support and training were evident, there was no evidence of professional development plans to support this. There was no consistent performance appraisal carried out on an annual basis. Group supervision records were also evident on files but similar deficiencies were found in relation to these records.

While there was some discussion on children's cases, supervision records did not adequately reflect that sufficient time was given to reviewing the interventions undertaken by staff and key workers within the supervision process to ensure practice was safe and of good quality.

**Judgment:** Requires improvement

### **Standard 7:4**

Training is provided to staff to improve outcomes for children.

### **Inspection Findings**

Staff received a number of mandatory training modules to meet the needs of the children. A training passport was compiled for each staff member but these were not all up-to-date. The training records demonstrated that modules in relation to the new policies and procedures, manual handling, fire safety, restrictive practices, behaviour management, supervision and understanding self harm were completed in 2016 to date. Nine staff had completed training in the safe administration of medication and the three managers had completed a quality improvement process in March 2016.

Managers outlined that mandatory training requirements were being delivered and updated on an ongoing basis.

There was no training needs analysis and review of training to inform a service training plan.

**Judgment:** Requires improvement

### **Theme 8: Use of Information**

Quality information and effective information systems are central to improving the

quality of services for children. Quality information, which is accurate, complete, legible, relevant, reliable, timely and valid, is an important resource for providers in planning, managing, delivering and monitoring children's services. An information governance framework enables services to ensure all information including personal information is handled securely, efficiently, effectively and in line with legislation. This supports the delivery of child-centred, safe and effective care to children.

Information governance arrangements were in place. File auditing systems required improvement as there were clear deficiencies in the recording of same.

#### **Standard 8:1**

Information is used to plan and deliver a child-centred, safe and effective service.

#### **Inspection Findings**

Relevant information and data in relation to each child was comprehensively recorded and reviewed at management meetings, team meetings and multidisciplinary meetings. This supported the team in terms of decision making and planning for the children. The unit manager outlined that she submitted a weekly report to the national manager on the status of the special care unit. Weekly statistics were also maintained for all significant events. However, it was unclear how this information was utilised as there was no formal systems in place to gather information from children on outcomes, and use it to drive continuous improvement.

**Judgment:** Requires improvement

#### **Standard 8:2**

Information governance arrangements ensure secure record-keeping and file management systems are in place to deliver a child-centred, safe and effective service.

#### **Inspection Findings**

Information governance arrangements were in place and records required for the effective and efficient running of the unit were a good quality and up to date. The privacy of each child's personal information was protected and respected and held in accordance with regulatory and best practice requirements. Inspectors found file audits to evaluate record keeping and file management; however, this auditing system required more robust managerial oversight as there were clear deficiencies in the recording of same.

Children interviewed were aware they had access to their information. Minutes of management, team and children's meetings were recorded but they did not clearly demonstrate decisions made or actions to be followed up.

The unit maintained an electronic register in line with statutory requirements detailing the relevant information in respect of each child who resided in the special care unit. A review of same found that there were some inaccuracies pertaining to children that had been discharged in respect of contact details and placements discharged to. This was rectified by the administrator at the time of the inspection.

The inspector found a full copy of a significant notification about a child on a staff member's supervision file and queried if any consideration was given to data protection issues in relation to this. The unit manager outlined that this was practice within the centre in order to address findings or deficiencies, but had not considered the impact of this at that time. She indicated that steps would be taken to address this.

**Judgment:** Requires improvement

### **Acknowledgements**

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