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Ballydowd Special Care Unit

Health Service Executive

Dublin Mid-Leinster

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1. Introduction

The Health Information and Quality Authority Social Services Inspectorate (SSI) carried out the seventh inspection of Ballydowd Special Care Unit (SCU) in the Health Service Executive's Dublin Mid-Leinster region under *Section 69(2) of the Child Care Act, 1991* which provides authority for the inspection of the social service functions of Health Service Executive areas, including special care units. The inspection took place over 16th and 18th October 2007. SCU's are inspected annually under the *National Standards for Special Care 2001*.

Ballydowd Special Care Unit is a purpose built secure residential facility opened in September 2000 to cater for the needs of young people with serious emotional and behavioural problems detained by a High Court Order. It was established to provide a safe and secure environment where boys and girls aged between 11 and 17 years on admission deemed a risk to themselves or others could be provided with short-term intervention at a time of severe crisis to ensure their safety and well-being in a secure setting. The campus comprises three accommodation units, an administration block, a school and a gymnasium. The buildings are arranged in a semi-circle around a central green that provides opportunities for outdoor recreation. The centre was situated adjacent to a psychiatric hospital. The recent sale of the hospital land and subsequent recent development has resulted in the unit being overlooked by new apartments. This was brought to the attention of inspectors by the monitoring officer and others as a matter of concern in terms of its impact on the privacy of the children living in the unit.

At the time of the inspection, there were 12 children aged between 13 and 16 years in the unit. The average age of young people on admission since the last inspection was constant at 14.5 years. The unit's register showed that from January to September 2007 there were 23 admissions and 13 discharges, and that seven of those were readmissions. All of the children had assigned social workers and guardians-ad-litem, and all but four had solicitors. Two were from Cork and one from Galway. The other 20 were from the HSE Dublin North East or Dublin Mid-Leinster regions.

Over the years, Ballydowd Special Care Unit has experienced difficulties in the establishment of a stable team. At times this impacted on the unit's capacity to provide an optimal service. At the time of this inspection only two of the three units were operational owing to difficulties in recruiting and retaining staff.

1.1 Methodology

In this inspection, inspectors' judgements were based on analysis of findings verified from more than one source of evidence gathered through information provided by the SCU prior to the inspection and through questionnaires and census forms, interviews with relevant HSE staff members and managers, interviews with young people, observation of practice, examination of relevant records and documentation, and an inspection of accommodation. Details of sources of evidence are listed below.

The inspectors had access to the following documents during the inspection:

- The unit's statement of purpose and function,
- The unit's policies and procedures manual,
- The young people's care files,
- Questionnaires completed by social workers and teachers,
- Reports of notifications of other significant events,
- A register of complaints, allegations and staff disciplinary matters
- The monitoring officer's reports (4),

- Previous inspection reports,
- Details of staff qualifications and training,
- Staff rosters,
- Health and safety assessments,
- Evidence of insurance.
- Census forms on staff,
- Administrative records, including the unit's register and details of sanctions,
- Reports of the use of physical restraint (109), use of single separation (42), and unauthorised absences (20), in the previous 10 months

In the course of the fieldwork inspectors interviewed ten young people, one parent, the director, deputy director (child care), unit's senior social work practitioner, unit manager, acting deputy unit manager, four team coordinators, two care workers, and three psychiatrists (one by telephone interview). Inspectors met with the principal of Ballydowd special school, the HSE's monitoring officer, and the national manager and project manager from the national special care and high support management group. Inspectors also interviewed the professionals involved with the case management of the children including two guardians-ad-litem, ten social workers and one social work team leader.

1.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the young people, managers, staff and all other professionals involved in this inspection.

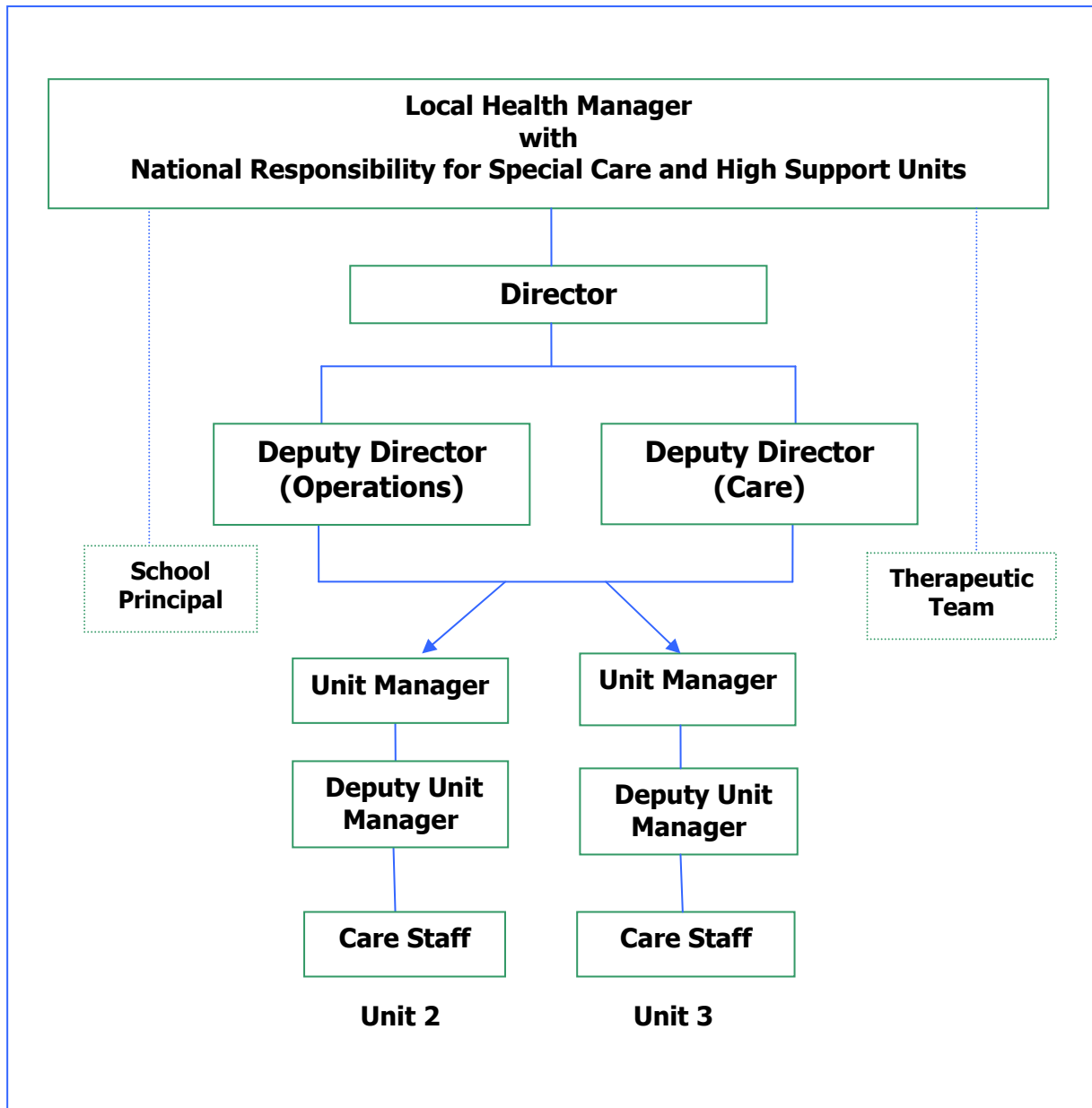
1.3 Management structure

Ballydowd SCU is a national facility, managed by a director who is supported by a deputy director (head of operations) and a deputy director (head of care). The two units in operation on the campus are each run by unit managers, with the assistance of deputy unit managers and shift co-ordinators.

The director reports to a HSE local health manager in his role of National Manager for Special Care and High Support. The national manager is supported by a National Special Care and High Support project management team, and also chaired the national admissions and discharges group for all children referred for special care.

This structure was a significant change from that found by inspectors in the 2006 inspection. A consequence of the change was that Ballydowd no longer had a management advisory board. The structure is shown in the diagram below.

Organisational Structure in Ballydowd SCU – October 2007



1.4 Data on young people

Listed in order of length of placement

Young person	Age	Placing HSE region	Length of placement	Number of previous placements
#1 girl	15 yrs	Dublin North East	9 months	2 short-term residential care
#2 girl	14 yrs	Dublin Mid-Leinster	8 months	None
#3 girl	15 yrs	Dublin Mid-Leinster	7 months	4 relative foster care, 6 foster care, 4 Out of Hours Service, 5 residential care, 2 Special Care Unit (21)
#4 boy	13 yrs	Dublin North East	6m 2w	1 hospital, 1 foster care, 5 residential care, 1 High Support Unit
#5 boy	14 yrs	Dublin North East	4m 2w	2 short-term foster care, 3 residential care
#6 girl	13 yrs	Dublin Mid-Leinster	3 months	2 relative care, 3 foster care, 7 residential care, 1 Special Care Unit
#7 boy	14 yrs	Dublin North East	3 months	None
#8 girl	15 yrs 11 m	Dublin North East	2 months	1 foster care, 1 Out of Hours Service, 1 emergency residential care
#9 girl	16 yrs	Dublin Mid-Leinster	1 month	5 foster care, 1 residential care, 1 High Support Unit, 1 Special Care Unit
#10 girl	15 yrs	Dublin North East	1 month	4 relative foster care, 5 hospital, 5 short-term residential care, 5 short-term foster care, 3 Out of Hours Service, 3 Special Care Units, 2 High Support Units (27)
#11 girl	15 yrs	Dublin North East	1 month	3 foster care, 1 residential care, 1 High Support Unit, 1 Special Care Unit
#12 girl	14 yrs	Dublin Mid-Leinster	1 month	1 relative foster care, 1 Out of Hours placement

2. Analysis of findings

Practices that met the required standard

Purpose and function

The 2006 inspection report recommended that the HSE revise the statement of purpose and function to reflect the therapeutic aspects of the care of young people. Inspectors found that this recommendation had been met. The unit has capacity for 18 young people to be detained, but operates at a maximum of 15 owing to the nature of the severe problems of some of the young people.

The statement describes the main elements of care in the unit as health care, individual psychotherapy, and specialised school and recreational programmes. The SCU's ethos emphasises inclusion of young people in their families and communities of origin, and accessing community-based agencies and services even when they are in the unit under a special care order.

There was evidence of a shared understanding of the purpose and function of Ballydowd between staff members, social workers and young people. The provision of individual psychotherapy was facilitated by the recent establishment of a team of psychiatrists who had been introduced since the last inspection and who assessed every young person placed in the unit. The emphasis on assessment and treatment and on young people reaching a state of readiness to move safely to an open setting meant that the length of placement was becoming longer in some cases. At the time of the inspection the average length of placement was five months, with a range of one to 15 months.

Of the 12 young people in the unit at the time of the inspection, two were in their second special care placement, one was in a third, and another in a fourth. Some staff members interviewed by inspectors said that the change of ethos may have resulted in more young people with mental health problems being referred to the unit. This may also reflect the fact that the unit has started offering in-house psychiatric assessment and treatment.

Two of the young people had experienced severe disruption even when in care, both having over 20 placements before admission to Ballydowd, and both were re-admitted to special care.

Therapeutic services

Inspectors found that a number of young people in the unit had difficulties of a psychiatric nature as evidenced by the levels of self-harm. In the 2006 inspection report inspectors expressed serious concern about the possibility that some young people were being detained in special care due to a lack of access to suitable mental health adolescent services. At the time of this inspection the unit no longer had the service of an on-site senior clinical psychologist but had increased availability of psychiatrists and psychologists who had dedicated time to visit the unit regularly and carry out a systematic programme of assessment. Inspectors recommended that the HSE should review all admissions to determine if the primary reason for admission is to access mental health services.

In this inspection the managers, social workers and psychiatrists said that while all children were detained in Ballydowd primarily for their own safety, nonetheless several had mental health problems for which there were insufficient community-based services, and particularly secure child and adolescent in-patient facilities.

Keyworking

As in previous inspections, inspectors found the standard on keyworking well met. Young people said that they had faith in their keyworkers and saw them as someone they could speak to if they had worries about anything.

Children's rights

There was a good awareness of children's rights in the SCU. All the young people interviewed by inspectors said that they were consulted about daily living in the unit. There were young people's meetings; and the majority attended the whole of their review meetings. The recommendations of the 2006 inspection that all young people are given the children's booklet on admission and are made aware of their right to information on their care files and how to access them were met. However, staff should proactively assist children exercising their right to access their files.

Health

The standard on health was well met. At the time of inspection Ballydowd had a service agreement with a local general practitioner which had both male and female doctors. The SCU also had a dedicated dental service. Practice in the administration of medication had been changed after a recommendation was made by the monitoring officer following an error in dosage. Since then all medication has been administered from blister packs prepared by the pharmacist. Young people who remained registered with their own GPs were facilitated in attending appointments; and all the young people who had specialist medical need were referred and quickly accessed appropriate medical attention. The unit also fitted out a clinical room in a building separate from the school and accommodation as so that children could keep appointments with the GP's, psychiatrists, and the dentist in a private and relatively quiet space. At the time of this inspection there were four children who had been prescribed psychotropic medication.

Vetting

All staff employed at Ballydowd had Garda clearance, and staff employed since the last inspection had been appropriately vetted prior to the commencement of employment.

Notification of significant events

The 2006 inspection report recommended that all relevant parties should be expeditiously notified of all significant events, and that incidents of attempted self harm be clearly notified in their own right. In this inspection inspectors found that both recommendations had been met, a system of notification by e-mail had been introduced, and the monitoring officer, and the social workers interviewed by inspectors were satisfied that they received adequate information promptly, as required by the standard.

Unauthorised absences

During the year prior to inspection there were 20 unauthorised absences. All were appropriately recorded and interviews during inspections indicated that those who should be notified were happy with the method and promptness of notification. Absences varied from short absences of 15 minutes duration to long periods of up to 17 days. Most of the young people were returned to the unit by Gardai. Inspectors found that the recommendation of the 2006 inspection that each care file had up to date, sensitively obtained recent photograph of the child, had been implemented.

Administration and care files

The 2006 inspection recommended that the HSE should review record keeping with a view to streamlining the care files, and ensure that there is a complaints register held in the unit. This had been met.

Monitoring

The standard on monitoring was well met. The monitoring officer visited the unit regularly and was a member of the critical incident review group which met monthly. She also produced detailed reports and wrote to external managers bringing matters of concern to their attention. Inspectors found evidence of changes in practice that had come about as a result of the findings of the monitoring officer.

Training

The recommendation of the 2006 inspection that there be an increase in the number of first aid trained staff was met. There was a good standard of training and the majority of staff had been trained in *Children First: National Guidelines for the Welfare and Protection of Children*, fire safety and other topics relevant to the work of the unit. The managers and staff of the SCU are commended for the good standard of training. Inspectors recommend that the outstanding refresher training in TCI for a small number of staff should be provided as soon as possible.

Insurance

Inspectors were given written confirmation of the SCU's current insurance for public and employer's liability, renewable on 1st January 2008.

The standard on contact with families was well met. Inspectors commend the managers and staff for their efforts in this area. Additionally, the service provided by social workers including the supervision and visiting of young people, and preparation for leaving the SCU and transition to onward placements were all well met.

Practices that met the required standard in some respects

Staffing

The standard on staffing was partly met. At the time of this inspection there were 82 staff in total. This number did not include teaching staff. At the time of inspection one unit was closed owing to care staff vacancies, and other staffing difficulties such as extended leave and absences due to sickness.

Of the 63 care staff posts, 35 were permanent and 28 were temporary. All but four of the staff were full-time. There was a gender balance of 23 men to 40 women, and the average length of service was three years two months within a range of one month to just over seven years. The majority of staff had third level qualifications; 18 had qualifications in social care; 13 had no qualifications, and the HSE supported another six who were at various stages of qualification training.

Inspectors recognise the continuing difficulties faced by the HSE in providing the SCU with a stable, qualified, experienced and confident staff team, and commend the steps taken to support those attending qualification training. Inspectors recommend that a strategy be drawn up between the managers of the unit and the HSE human resources department to provide a structure for recruiting and particularly sustaining suitable staffing levels.

Register

The unit had a register which provided the majority of information required by the standards except the addresses of parents and social workers.

Complaints

In the last inspection it was recommended that the unit had a complaints register. This recommendation was implemented. Each unit had a complaints box into which young

people could post complaints. The box was checked regularly and a record kept of the complaints in a book on each unit.

There had been 35 complaints during the 10 months between inspections, 12 of which had been made by children and the remainder by social care professionals. Sixteen of these were about unprofessional conduct or other matters and are referred to later in the report.

The remaining complaints were expressions of dissatisfaction with an aspect of care or referred to safeguarding or child protection. Inspectors were satisfied with how complaints were dealt with however there were two areas for improvement. Some complaints took several months to investigate. In two instances there was a delay in receiving responses from social workers who had interviewed children who had made two separate complaints 10 months previously, and the member of staff against whom one complaint was made had not been told of the reason for the delay. Inspectors were also concerned that in two complaints brought against teachers, young people were interviewed twice under two different procedures and that there was no resolution of the complaints. The HSE should review practice of dealing with complaints so that, from the point of view of the young people and those against whom complaints are made, there is a clear, prompt system for responding to them. The school's system for dealing with complaints and child protection concerns should be consistent with that of the SCU, and should be approved by the HSE.

Single Separation

The 2006 inspection recommended that records of episodes of single separation should record the time it commenced and its duration and this was implemented. During the 10 months between inspections there had been 42 instances of use of single separation. They varied in length from a few minutes to six hours, averaging just over one hour. Some were authorised by the director, and others were authorised by unit managers or deputy unit managers. The HSE should review the SCU's practice to determine who may authorise single separation. Inspectors recommend that single separation should be authorised by senior SCU managers only in line with *National Guidelines on the Use of Single Separation*.

Inspectors observed young people being confined to areas of the unit, with use of a corridor and room. Staff explained that there are circumstances in which this is routine practice, for example, when young people are sent back to the residential unit from the school for misbehaviour. Staff and young people also explained that sometimes when there is 'time out' a door of a section of the unit may be locked restricting a young person's access to the rest of the unit. This is single separation, and should be used only in response to serious immediate risk, and should be authorised, reviewed, recorded and notified in accordance with national guidelines.

Admissions and discharges

From January to September 2007 there were 19 admissions of 16 children, and 14 discharges. Eleven of those who had been admitted during that time were present in the unit at the time of the inspection. All of the children had assigned social workers and guardians-ad-litem, and all but four had solicitors. One was from Cork and one from Galway. The other 17 were from the HSE Dublin North East or Dublin Mid-Leinster regions. The average length of placement was four and a half months.

Eight of them were readmissions, with four being in special care for the second time, two for the third time, and two for the fourth. In 2006 inspectors expressed concern about the discharge of young people from SCUs, and said that it required the sustained attention of senior HSE managers. They recommended that a formal individual care planning review is called in cases where a child is re-admitted to special care. Inspectors found that in essence these were happening either through statutory review or monthly review in the courts, but the readmissions were happening nonetheless.

Inspectors are concerned that the pattern of re-admissions represents a serious deficit in discharge planning and the provision of suitable community care facilities for vulnerable young people. Inspectors recommend that the HSE analyse the discharges of children who were subsequently re-admitted and use this information to inform a national strategy to avoid the repeated detention of children.

Management of behaviour

The unit had a policy that emphasised the importance of relationships with young people in managing behaviour. Inspectors found that sanctions were used sparingly, and there was a positive approach to managing behaviour. However, the children interviewed by inspectors were clear that the principle means of management of behaviour centred on decisions regarding mobilities – supervised, and occasionally unsupervised access to the community. Inspectors also found that ‘time out’ was used within the units to separate disruptive children from their peers. The staff should have a range of options within the units to assist them in dealing with challenging and sometimes dangerous behaviours but practice should be closely monitored. More serious measures such as ‘time out’ and restricted mobility should be clearly associated with the management of risk rather than misbehaviour.

Physical restraint

In the ten months between inspections there had been 109 instances of use of physical restraint. This was a reduction on the numbers of restraints reported in the previous inspection. The monitoring reports showed that there had been concerns about physical restraint, and about the recording of incidents. In particular, the monitoring officer noted that in some incidents of restraint the antecedent factor was verbal aggression. She also noted that some children, who refused to go to their bedrooms when requested, were physically escorted. Therapeutic Crisis Intervention (TCI), the only method of restraint approved for use in the SCU, does not have provision for escorting. In June 2007 a young person who was subject of an escort lodged a formal complaint that was subject of an external investigation.

The monitoring officer was also concerned that the number of staff involved in a restraint sometimes exceeded the three allowed for in the TCI model. As a consequence of her concerns a Critical Incident Review Committee was established. It met once a month, and membership, among others, included the local child care manager, a psychiatrist, and the monitoring officer. Inspectors had concerns however, that escorting was still being used at the time of the inspection to enforce compliance to requests, when physical intervention can be used only to ensure the immediate safety of a child. While inspectors commend the unit for introducing the review committee all physical interventions should be continuously closely monitored by managers.

Self harm

There had been several incidents of self harm and attempted self harm among some of the young people in the unit since the last inspection. In the 2006 inspection report it was noted that there needed to be greater awareness and training in the management of self harming behaviour and further training in first aid. As indicated in the section on training above, the SCU had made progress in meeting this recommendation. There was also a wider range of consultation about the management of self-harm as a result of the introduction of a range of therapeutic specialists to the unit. However, inspectors were concerned that the assessment of the building in terms of the potential for self-harm carried out in response to a recommendation of the 2005 inspection report had not been followed-up with appropriate actions, and recommend that the HSE give this priority.

Care planning

The standard on care planning was mostly well met. All the young people had comprehensive care plans that showed evidence of extensive consultation and they were reviewed at a frequency well within the statutory timescales. The 2006 inspection report noted that there were difficulties regarding invitations to the school principal to attend all care reviews, and recommended that he should attend all review meetings. The difficulties, primarily of communication, were found in this inspection. Inspectors recommend that they be resolved, that the principal or a representative attends the reviews, and that a copy of the written reports presented by the school at each review meeting be kept on individual children's care files.

Children's views of their care

Children interviewed by the inspectors said that they were consulted about their daily lives, and there were several aspects of life in the SCU that they enjoyed. These included access to open space and recreational facilities on the campus, relationships with keyworkers, and access to their families, individual and group outings. During the summer they had gone on outings to the beach as a group, and found these enjoyable and memorable. However, they were unhappy with inequities between what they received in Ballydowd and what they would receive in other special care or high support units. There were differences in practice between units regarding: access to written records, purchasing clothing, pocket money, how complaints are dealt with, school work, restriction of movement, and the Ballydowd policy on smoking, (which was a zero tolerance policy). The HSE should review the differences of practice and determine to what extent a consistent policy across units is appropriate and practicable.

Safeguarding

As in the 2006 inspection, inspectors found that policy on safeguarding in Ballydowd was good, and staff demonstrated an understanding of good safeguarding practice, but the two issues of concern remain; elements of poor communications between managers and staff and allegations of unprofessional conduct. While acknowledging that training in safeguarding and protection has been extended to more staff, inspectors recommend that external managers closely monitor safeguarding practice to ensure that the needs and interests of the children are paramount in all staff and inter-professional interactions.

Education

Ballydowd had a written policy in relation to education that stated its aim was to deliver an education of the highest quality in order to raise achievement and reduce inequality. There was evidence that each child had an individual education plan outlining objectives achievable within the timescales of the placements, and that a key part of the SCU's educational service was to make plans and prepare each child for the intended educational setting after Ballydowd. Some of the children enjoyed school and were working on the FETAC general education certificate courses and receiving individual tuition to support them in literacy and numeracy skills. However, there were difficulties in ensuring continued attendance for some of the children, either because of unacceptable behaviour in the units or the school. The external managers should give attention to the difficulties faced by the school, and ensure that an appropriate level of integration and partnership with care management and staff is achieved.

Fire safety

The standard on fire safety was mostly met. There was written confirmation from a suitably qualified person confirming compliance with fire safety and building control legislation, as required by the regulations. The fire safety system was subject to annual checks. However, at the time of the inspection inspectors found that some fire extinguishers were either missing or out of place and that only two fire drills had taken place in the unit since the last inspection. While acknowledging the problems fire drills pose in a special care unit,

inspectors are of the view that, given the turnover of staff and children, there is a case for having fire drills more frequently. At the time of the inspection, a total of 31 staff had received training in fire safety. Inspectors recommend that fire safety training be extended to more staff.

Practices that did not meet the standard

Primary care

Inspectors found that overall, the standard of primary care was not met due to deficits in the accommodation and the provision of meals in one unit.

The 2006 inspection recommended that staff continue with their attempts to make the units more homely. Inspectors found that this recommendation had not been met and that the standard of accommodation, although it was better in one unit, generally in terms of décor, maintenance, cleanliness, tidiness and presentation was below standard. Inspectors were told that structural defects were becoming apparent as vigorous wear and tear began to take its toll on the fabric of the buildings. The bedrooms of several of the young people were of an unacceptable standard and required immediate attention to bring them up to a basic level of comfort.

In one of the units a decision not to replace a cook resulted in industrial action being taken by the staff. For just over two weeks before inspection staff had ceased cooking full meals, but provided convenience foods to the young people in the unit without a cook, and in both units there had been no cleaning or daily housekeeping.

Partnership between management and staff

Inspectors found that there were serious differences between management and staff across a range of issues, and that these differences impacted on the standard of care provided to the young people.

Nearly half of complaints shown to inspectors were either staff grievances about employment issues or staff disciplinary matters regarding unprofessional conduct. When interviewed by inspectors staff did not show an understanding of the procedures for dealing with grievances. Several staff said that they would talk to the unit manager in the first instance, and then talk to the union. The principle of local resolution that is found in the HSEA's grievance procedure for health services did not feature in their description of procedures.

The National Special Care Management Group acknowledged the differences and has sought advice on dealing with them. Inspectors urge speedy resolution to the differences in the best interests of the young people.

The HSE, external to Ballydowd, should provide the director and external managers with support to clear the backlog of outstanding investigations into allegations, complaints and grievances. The HSE should also ensure that its policies on child protection, complaints and grievances are understood by all staff members. The role of the director in dealing with disciplinary issues and grievances should be reviewed and support should be provided by the HSE Human Relations Directorate.

The channels of communication that are needed for good routine working relationships should be re-established and developed, in particular, senior management meetings including the school principal, formal staff meetings with the director, and a rigorous system of staff supervision.

3. Findings

3.1 Purpose and function

Standard

The unit has a written statement of purpose and function that accurately describes what the unit sets out to do for children and the manner in which care is provided. The statement is available, accessible and understood. The unit's role in relation to the wider child care services (including regional and national) is clearly set out by the Health Services Executive.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Purpose and Function	√		

3.2 Management and staffing

Standard

The unit 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. There is an adequate number of staff who are sufficiently experienced and qualified to enable the unit to achieve its purpose and function and to meet the needs of the children. There is an adequate number of staff who are sufficiently experienced and qualified to enable the unit to achieve its purpose and function and meet the needs of the children.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Management		√	
Register		√	
Notification of significant events	√		
Staffing		√	
Supervision and support		√	
Training and development	√		
Administrative files	√		
Vetting	√		

Recommendations:

1. The HSE should prioritise the resolution of staff issues with the unions.

2. The HSE should ensure that the wider HSE system supports the SCU director in dealing with disciplinary actions and staff grievances.
3. The HSE should ensure there are formal systems of communication in place, including senior management meetings that include the school principal, formal staff meetings with senior management, and a rigorous system of staff supervision.
4. The HSE should revise the format of the register to meet all the requirements of the regulations.
5. The HSE should ensure that all staff members receive regular, formal supervision.

3.3 Monitoring

Standard

The Health Services Executive, for the purposes of satisfying itself that the Special Care Regulations and Standards are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person on its behalf to monitor statutory and non-statutory children's residential units.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Monitoring	√		

3.4 Planning for children and families

Standard

There is a written care plan to promote the welfare of each young person, which is developed in consultation with parents and children and subject to regular review. It stresses and practically supports contact with families, and preparation for adulthood. It promotes education and health needs and addresses the emotional and psychological needs of the children. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care. Supervising social workers have clear professional and statutory obligations and responsibilities for children in residential care. All children need to know that they have access on a regular basis to an advocate external to the unit to whom they can confide any difficulties or concerns they have in relation to any aspects of their care.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Referral and placement of children		√	
Statutory care planning and review		√	
Legal and Court work	√		
Contact with families	√		
Supervision and visiting of children	√		
Social work role	√		
Emotional and specialist support	√		
Preparation for leaving care and after care	√		
Children's individual files	√		

Recommendations:

6. The HSE should examine discharges and re-admission of children to the centre to inform a national strategy to avoid the repeated detention of children.
7. The HSE should ensure that the school principal or a representative attends care plan review meetings, and that a copy of the written reports presented by the school at each review meeting be kept on individual children's care files.

3.5 Care of children

Standard

Children are cared for by staff who can relate effectively to them in an open, positive and respectful manner. Care practices take account of the children's individual needs and respect their social, cultural, religious and ethnic identity. Children have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on children of separation and loss and, where applicable, of neglect and abuse. Day-to-day care is of good quality and provided in a way that takes account of the individual needs of children in relation to age, race, culture, religion, gender and disability.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Protection		√	
Staff relationships	√		
Race, culture, religion, gender and disability	√		
Health	√		
Access to Information	√		
Consultation	√		
Privacy, Dignity and Individuality		√	
Meals			√
Personal Appearance	√		
Leisure Activities	√		
Promoting good order		√	
Restraint and single separation		√	
Complaints		√	
Absence without authority	√		

Recommendations:

8. The HSE should review the SCU's practice of dealing with complaints so that there is a clear, prompt system for responding to them.
9. The HSE should ensure that all staff have a detailed understanding of the policies and procedures for dealing with grievances and complaints.

10. The HSE, external to Ballydowd, should provide the director and external managers with support to clear the backlog of outstanding investigations into allegations, complaints and grievances.
11. As a matter of priority, the HSE should upgrade the units generally and the children's bedrooms in particular and ensure the provision of freshly cooked meals.
12. The HSE should ensure that all physical interventions are closely monitored by managers, to ensure they adhere to best policy and practice.
13. The HSE should ensure where possible that there is an equitable system in place for the provision of pocket money and clothing and review the differences of daily practice between the SCU's and high support units to determine to what extent a consistent policy across units is appropriate and practicable.
14. The HSE should review the SCU's policy and practice of the use of sanctions.
15. The HSE should ensure the SCU's practice of single separation is in line with National Guidelines.

3.6 Premises and Safety

Standard

The premises are suitable for the residential care of the children and their use is in keeping with their stated purpose as a special care unit. The unit's buildings and associated outdoor areas are designed to prevent unauthorised entry or exit. They facilitate supervision and minimise opportunities for self-harm while providing accommodation that is, in so far as it is practicable, appropriate to its designation as a children's unit. The unit is properly maintained and furnished. It has adequate arrangements to guard against the risk of fire and other hazards.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Risk Assessment		√	
Location and design	√		
Accommodation general			√
Accommodation individual children			√
Maintenance and repairs			√
Safety and fire precautions	√		
Security	√		

Recommendations:

16. The HSE should support the director and senior managers in providing accommodation of a high standard.

17. The HSE should ensure that maintenance requests are responded to promptly and that the repairs carried out are completed.
18. The HSE should take steps to promote an ethos whereby staff and children in the SCU take care of the environment in which they work and live.
19. The HSE should give priority to meeting the recommendations of the assessment of the building in terms of the potential for self-harm carried out in response to a recommendation of the 2005 inspection report.
20. The HSE should ensure that the SCU have fire drills more frequently, and that fire safety training be extended to more staff.

3.7 Education

Standard

All children have a right to education. Education is seen as an integral part of the care of the young person. The education of each young person in the unit is actively promoted by all involved. Supervising social workers and unit management ensure each young person in the unit has access to appropriate educational facilities. Where appropriate, and as far as it is practicable, children over the age of sixteen should be offered a programme of vocational preparation, training and work experience or transition to further education.

	<i>Practice met the required standard</i>	<i>Practice met the required standard in some respects only</i>	<i>Practice did not meet the required standard</i>
Education		√	

Recommendation:

21. The HSE should review and approve the school's system for dealing with complaints and child protection concerns, ensuring that it is consistent with that of the SCU.

4. Summary of Recommendations

1. The HSE should prioritise the resolution of staff issues with the unions.
2. The HSE should ensure that the wider HSE system supports the SCU director in dealing with disciplinary actions and staff grievances.
3. The HSE should ensure there are formal systems of communication in place, including senior management meetings that include the school principal, formal staff meetings with senior management, and a rigorous system of staff supervision.
4. The HSE should revise the format of the register to meet all the requirements of the regulations.
5. The HSE should ensure that all staff members receive regular, formal supervision.
6. The HSE should examine discharges and re-admission of children to the centre to inform a national strategy to avoid the repeated detention of children.
7. The HSE should ensure that the school principal or a representative attends care plan review meetings, and that a copy of the written reports presented by the school at each review meeting be kept on individual children's care files.
8. The HSE should review the SCU's practice of dealing with complaints so that there is a clear, prompt system for responding to them.
9. The HSE should ensure that all staff have a detailed understanding of the policies and procedures for dealing with grievances and complaints.
10. The HSE, external to Ballydowd, should provide the director and external managers with support to clear the backlog of outstanding investigations into allegations, complaints and grievances.
11. As a matter of priority, the HSE should upgrade the units generally and the children's bedrooms in particular and ensure the provision of freshly cooked meals.
12. The HSE should ensure that all physical interventions are closely monitored by managers, to ensure they adhere to best policy and practice.
13. The HSE should ensure where possible that there is an equitable system in place for the provision of pocket money and clothing and review the differences of daily practice between the SCU's and high support units to determine to what extent a consistent policy across units is appropriate and practicable.
14. The HSE should review the SCU's policy and practice of the use of sanctions.
15. The HSE should ensure the SCU's practice of single separation is in line with National Guidelines.
16. The HSE should support the director and senior managers in providing accommodation of a high standard.
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18. The HSE should take steps to promote an ethos whereby staff and children in the SCU take care of the environment in which they work and live.
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20. The HSE should ensure that the SCU have fire drills more frequently, and that fire safety training be extended to more staff.
21. The HSE should review and approve the school's system for dealing with complaints and child protection concerns, ensuring that it is consistent with that of the SCU.