



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

**Social Services
Inspectorate**

BALLYDOWD SPECIAL CARE UNIT

In the

HEALTH SERVICE EXECUTIVE

DUBLIN MID-LEINSTER REGION

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13th, 14th & 18th August 2009**

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1. Introduction

The Health Information and Quality Authority (HIQA) Social Services Inspectorate (SSI) carried out a triggered inspection of Ballydowd Special Care Unit (SCU) in the Health Services Executive Dublin Mid-Leinster region (HSEDML) under Section 69 (2) of the Child Care Act 1991, on the 24th – 25th June 2009. This was on foot of concerns about care practices in the unit brought to the attention of HIQA SSI in May 2009. The inspection was carried out by Michael McNamara, lead inspector and Bronagh Gibson co-inspector. The inspection assessed compliance with standards on management, complaints and safeguarding. As part of its round of annual inspections, the SSI also carried out an announced inspection of the SCU on the 13th, 14th and 18th August 2009. This inspection was carried out by Michael McNamara, lead inspector and Sharron Austin, co-inspector. This report is based on findings from both inspections.

Ballydowd provides secure residential accommodation for up to 12 boys and girls with serious emotional and behavioural difficulties, aged between 11 and 17 years on admission, who are detained under a High Court Order for their safety and welfare. The campus comprises an administration block, a school, a gymnasium, and three accommodation units. At the time of this inspection only two of the accommodation units, with a capacity for six children in each, were operational. The buildings are arranged in a semi-circle around a central green used for outdoor recreation that includes a quad-bike track. The whole SCU campus is overlooked by a recent development of apartments immediately beyond the perimeter fence.

1.1 Methodology

Over the course of the two inspections, inspectors' judgements are based on evidence verified from several sources gathered through direct observation, examination of relevant records and documentation, an inspection of accommodation, and interviews with nine children, the director of the SCU, the acting SCU director, the deputy SCU director/head of care, the HSE monitoring officer, two unit managers, a team co-ordinator, one parent, four staff, a guardian-ad-litem, two members of the national special care and high support team, and the local health manager with responsibility for special care. Telephone interviews were carried out with two clinical psychologists, two parents, one member of staff, one social worker and one guardian-ad-litem. Inspectors also had access to the following documents:

- A copy of the unit's register
- Information on the children in the SCU
- Nine questionnaires completed by children
- Twelve questionnaires completed by supervising social workers
- Three questionnaires completed by parents
- Two questionnaires completed by guardians-ad-litem
- Children's care files
- Children's care plans
- The unit's policy on complaints
- Details of unauthorised absences since September 2008 (31)
- Details of physical restraints since September 2008 (186)
- Details of single separation since September 2008 (163)
- Details of non-school attendance from September 2008 to June 2009 (20%)
- Details of other notified significant events since September 2008.

1.2 Acknowledgements

The inspectors wish to acknowledge the co-operation of the children, their relatives, the director, acting director and staff of the SCU, the HSE managers and all the other professionals who participated in this inspection.

1.3 Data on Children

Since the inspection in September 2008 there had been 21 admissions and 20 discharges. At the time of the inspection in August 2009 there were twelve children resident in the unit, six girls and six boys aged 13 to 17 years. Details are shown in the table below.

Data on Children in Ballydowd SCU – 13th August 2009

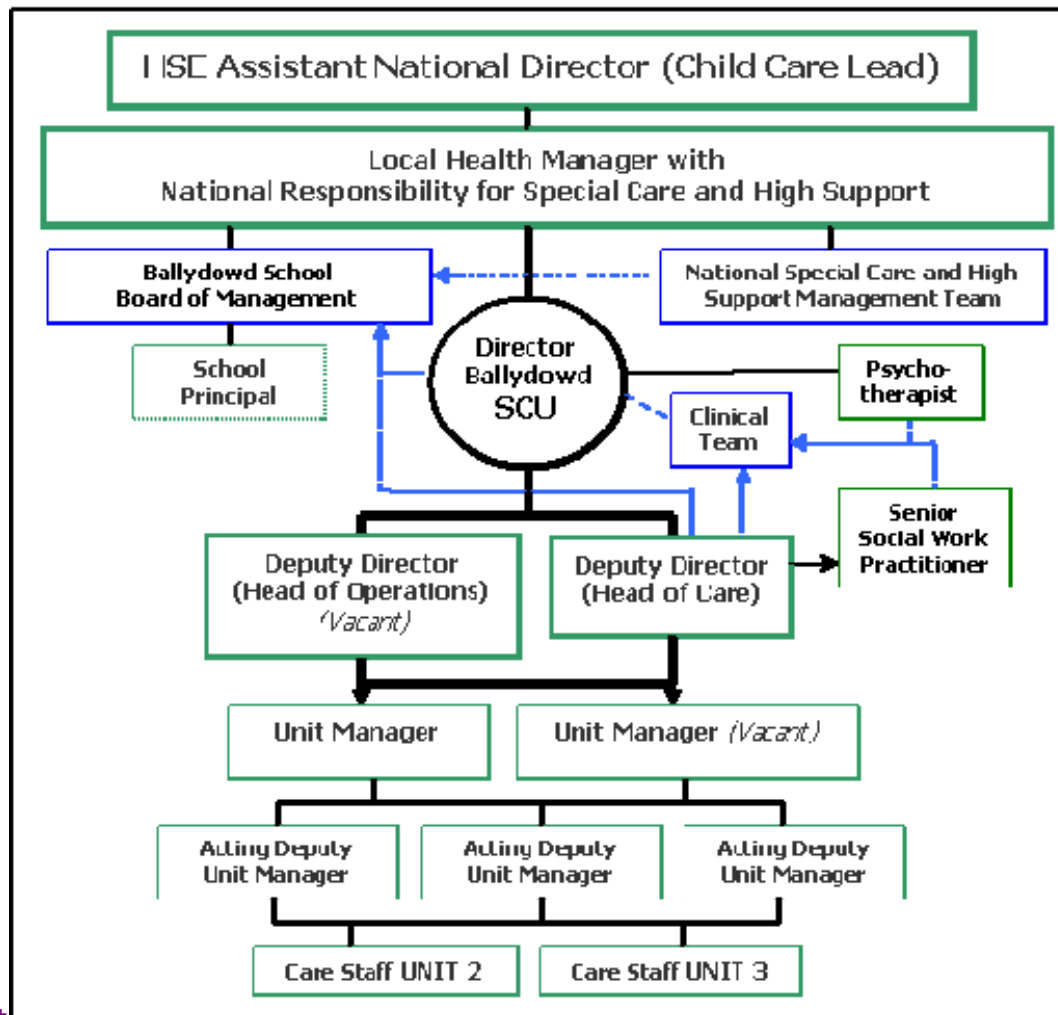
<i>Child</i>	<i>M/F</i>	<i>Age</i>	<i>Placing HSE Area</i>	<i>Length of Placement</i>	<i>Number of previous placements</i>
# 1	M	15 years 7 months	Dublin City South	9 months 3 weeks	5 foster placements 4 residential placements 1 high support placement
# 2	M	14 years	Dublin West	8 months	1 foster care placement 1 residential placement 1 high support placement
#3	M	13 years 10 months	Dublin South East	7 months	3 residential care placements 1 high support placement
#4	M	16 years 4 months	Laois/Offaly	5 months 2 weeks	6 residential placements 2 special care placements 1 foster care placement 2 respite placements
#5	F	14 years 11 months	Dublin South West	5 months 2 weeks	Out of Hours Service
#6	F	17 years 2 months	Kildare/West Wicklow	4 months	1 residential placement
#7	F	16 years	Dublin City South	10 weeks	1 residential placement
#8	F	14 years 1 month	Dublin North East	2 months	4 foster placements 2 residential placements
#9	M	13 years 6 months	Dublin North East	1 month	1 high support placement
#10	M	13 years 10 months	Dublin North Central	1 month	3 residential placements 1 foster placement
#11	F	16 years 9 months	Dublin North East	3 weeks	11 foster care placements
#12	F	15 years 3 months	Dublin North Central	1 week	1 residential placements Out of Hours Service

Listed in order of length of placement

1.4 Management structure

At the time of the inspections, Ballydowd SCU was managed by an acting director as the director was on leave. The director was available for part of the two inspections and was interviewed on both occasions. The acting director was supported by an acting deputy director/head of care, and reported to an HSE local health manager with national responsibility for special care and high support.

Management Structure in Ballydowd SCU – 13th August 2009



There were three key developments in the management of Ballydowd since the 2008 inspection: the establishment of a board of management for the school; the establishment of a campus consultation forum intended to improve the relationships between the staff of the SCU's care and education facilities; and the commencement of meetings under the National Consultative Partnership Forum to discuss human resources and industrial relations issues. This last initiative was in response to long-standing difficulties in the SCU which had, from time to time, impacted on the capacity of the managers and staff to deliver a high quality service to children.

A clinical team met once a week to consider therapeutic interventions, and a critical incident review group met monthly to review a range of serious incidents including physical restraints, unauthorised absences, and single separations.

The national special care admissions and discharges committee approved admissions to all three SCUs in the state.

2. Summary of Findings

Inspectors found examples of good practice. There was evidence that intensive work was done to address the problems of some of the children, and some of those interviewed by inspectors spoke well of their keyworkers. The unit had had a busy year offering a special care service to a large number of children. Standards of admissions, care planning, health and social work were met for the most part. However, difficulties in the management of staffing and the physical environment, evident in previous years, caused inspectors to have serious concerns for the ongoing welfare of the children. Additionally, (and this requires action as a matter of urgency,) the physical environment had deteriorated and was no longer an acceptable premises in which to detain children. In view of findings set out below, inspectors recommended that urgent attention is required to address these concerns. Between the field work and publication of this report inspectors met with external managers to monitor progress.

Practices that met the required standard

Register

Inspectors were provided with a print-out of the unit's electronic register. It showed that in the year between the two annual inspections there had been 21 admissions and 20 discharges, and that in the three months prior to the inspection the SCU was running to its agreed capacity of 12 children.

Legal and court work

All of the children had guardians-ad-litem. All cases were judicially reviewed by the court each month.

Health

The standard on health was well met. All the children were able to access services as required.

Referral and placement of children

Referrals to special care in all three of the states SCUs were processed by a national committee. Inspectors were told by the director that as a consequence of reduced capacity in the special care units nationally Ballydowd was taking cases of extreme complexity. There was an added pressure in the court's direction in some cases to extend the placements of some of the children. Inspectors recommend that the HSE resolve this situation as soon as possible so that there are greater options available to the admissions committee.

Practices that partly met the required standard

Purpose and function

The SCU had a statement of purpose and function consistent with its national role as a residential centre in which boys and girls at risk aged 11 – 17 years on admission were detained under orders from the High Court. However, a major concern for the placing social workers was that the SCU was unable to fulfil expectations in terms of the provision of some aspects of its therapeutic service. Ballydowd's statement of purpose and function clearly states that children referred to the unit should be assessed as suffering from severe emotional/behavioural disturbance. It also makes reference to the unit providing a safe therapeutic milieu, and specifies psychiatric assessments and therapies among its functions. The HSE should ensure that the scope and limitations of Ballydowd's therapeutic provision are clearly explained to referring social workers.

Training and Development

Twenty-six staff had attended a briefing session on *Trust in Care*, nine had attended training on dignity at work, and all managers had received training in children's rights provided by the Irish Association of Young People in Care (IAYPIC) since the last inspection. Others received training in attendance management, partnership training, financial accounting and risk assessment. Four of the staff were supported by the HSE to gain a qualification in social care.

Inspectors were told that all staff had training in child protection. However, six care staff did not have training in *Children First: National Guidelines for the Protection and Welfare of Children*. This deficit should be remedied as soon as possible. Inspectors recommend that managers provide training in Children First for the care staff who have not received it, and training in supervision for those at director and unit manager level who are required to provide staff supervision.

Administrative files

During the last full inspection in September 2008 inspectors found archived records stored in the unit that was not in use. Files were not secure and were found in disarray. A recommendation was made to ensure that all care files were stored in a private and secure manner. During the follow-up inspection in April 2009 the inspector noted that while significant work had been carried out on archiving files to date the recommendation was only partly met. During the August inspection, inspectors found that the protection and security of archived files in unit one was still outstanding and was a serious concern. The HSE should address this as a matter of priority.

Monitoring

The SCU had an HSE appointed monitoring officer. She visited the SCU frequently both in her capacity as monitoring officer and as member of the critical incident review group. Since the last annual inspection in September 2008, she had carried out 11 monitoring visits, visited the accommodation units seven times, and attended six critical incident review meetings. She had written two monitoring reports, one an annual report for the calendar year 2008 as required by the standards, and the other in April 2009 reporting on compliance with her recommendations. While some recommendations were met, inspectors found no formal record of a response to the monitoring officer by either on-site or external managers. The inspectors were of the view that the monitoring officer's role should be strengthened in a unit that caters for a transient population of extremely vulnerable and at times volatile children. Although visits were regular and frequent, the infrequency of reports meant that the situations of some of the children were not represented until long after they had left the unit. This was discussed with the monitoring officer who agreed that reports would be produced more frequently.

Statutory care planning and review

The 12 children had care plans, and they were subject to regular, monthly review. In questionnaires and interviews social workers and guardians-ad-litem for three of the young people expressed serious concerns that the decisions made at reviews were not adhered to, and that in two cases children were given information by the SCU that ran counter to an agreed plan. There were differences of opinion between the professionals involved in two cases and the SCU about the right way forward, and in one case the positions were directly opposed. The overall responsibility for the care planning process rests with the placing social workers. It is essential that the social workers, the SCU managers and staff and all other professionals involved in the care plan reviews work in partnership in the best interests of the child.

In the 12 children's questionnaires received by inspectors ten said that they were aware that they had a care plan, nine said that they attended the review meetings, seven said that the care plan and reviews were discussed with them. However, only three thought that they had a say in decisions made at the review meetings where the plans were discussed. This needs to be addressed, and the social workers and SCU should aim to have full attendance of each child at the meetings, and give due weight to their views.

Most of the children in the SCU were aware of the plans for them to move on after the expiry of the detention order. However, two of the children who had been in the SCU for several months said that they were unaware of the plans for their moving on. Interviews with the social workers and guardian-ad-litem confirmed that there was no moving-on plan in place for them. The HSE should ensure that there are clear moving-on plans in place for all the children placed in special care and that everyone involved collaborates to the highest standard of partnership in the best interests of the child.

Contact with families

The standard on access to and contact with families was mostly well met. Children who completed the questionnaires and those interviewed acknowledged that they were encouraged and facilitated to make contact, could speak to known family members in private, and were able to receive visits from them. Parents who completed questionnaires or spoke with inspectors confirmed that they were treated with respect and kept informed of their child's progress. The problems encountered in access in one case are referred to in the section on child protection below.

Social work role - supervision and visiting of children

All but one of the children was assigned a supervising social worker, and four of them visited weekly, and one fortnightly. The other six visited monthly when they attended review meetings. It is essential that all social workers visit children in special care frequently, interview them in private, and satisfy themselves that they are safe and have an opportunity to discuss any worries or concerns. The child without a social worker was allocated to a social work duty team leader. This was not satisfactory since the resignation of the social worker was known for some time, and a planned transfer should have taken place. The supervising social workers told inspectors that the SCU provided a safe service for the children placed there, and this was reflected in the views expressed by the children in the questionnaires.

Child Protection

Since September 2008 there had been allegations (8) arising from one incident. Six specific allegations were made between late April and May 2009, four were referred to SSI, and the other two were referred to the Ombudsman for Children and the Minister for Children and Youth Affairs. The HSE carried out investigations into the allegations. It concluded that the allegations were malicious.

During the August inspection it was clear to inspectors that staff interviewed were aware of how to raise a child protection concern, but they were not confident about using the written procedure, and those interviewed said they were not sure who they would contact if the safeguarding concern involved a member of the senior management team. Views were expressed about how they would be dealt with, or that actions would be taken against those who made allegations or complaints.

The deputy director/head of care, who had responsibility for processing complaints, said that a child care manager independent of the line management system of the SCU had been to the unit and discussed her role with him, but it had not been explained to staff. As a consequence of both inspections, inspectors were of the view that the systems in place for bringing child protection concerns to notice promptly were not sufficiently robust to be used confidently by the children and staff. Inspectors recommend that the system be changed to ensure that the independent child care manager that already exists in the system is used in future to deal with allegations and complaints that concern senior managers of the unit, as well as an independent arbiter when an appeal is made against the outcome of an investigation of a complaint.

In one case a child protection matter concerning a person outside the unit, unresolved for six months, had an impact on an access arrangement in which there was confusion about the level of contact and the need for supervision. The HSE should issue clear guidelines on the management of access, and principal social workers and the external managers of the SCU should ensure that they are properly implemented. Changes in conditions of access should be the consequence of a risk assessment and all those with an interest in the case should be consulted before they are enacted, unless a decision is prompted by an emergency or is a direction of the court.

Access to information

Inspectors found that young people were aware of their right to access to information, and that access in practice was mostly limited to log books on the units. They recommend that this right is more proactively promoted and facilitated, and that staff are enabled to be confident in putting it into practice.

Meals

Inspectors were assured by staff that the children were well catered for, and on two of the days of both inspections, inspectors saw good quality meals being provided to the children. However, several children told inspectors that the standard and quality of their meals was poor. Inspectors were also told of difficulties in the provision of good quality food prior to June; this issue had been dealt with at that time. During the inspection staff were unable to produce menus to show the quality of food being offered to children. Inspectors recommend that the managers and staff of the SCU should enter into discussion with the children in order to elicit the children's views and act accordingly.

Education

The SCU's on-site school provided education based on individual education plans. Since the last annual inspection, the HSE has put in place a committee, the Campus Consultation Forum, to support an improvement in all aspects of the relationship between care and education in the SCU. A board of management for the school was also established. During the school year prior to the inspection, between September 2008 and June 2009, the majority of children attended school. This is a notable achievement given that many of the children in the unit have had serious disruptions in their education and find school attendance extremely difficult.

However, there had been problems of non-school attendance, and these have led to significant problems in the management of behaviour. For the total of 19 children who were in the unit over that period, out of a possible 1313 school days, there had been 268 (20%) absences, few of which were due to illness. This is unacceptable. The absences in turn resulted in a practice of confining to their bedrooms or locked parts of the unit children who refused to attend school.

Special care units have legal authority to use single separation for the management of risk. However, in the case of non-school attendance, separation was used to effect compliance and was not consistent with the conditions of the SCU's authority to use the measure. The separations were not recorded as such because they were defined as being outside the agreed definition owing to the fact that the child confined in his/her bedroom could make a choice to leave. At the time of the June inspection the practice had ceased following a directive from the external HSE managers.

Complaints

Inspectors found that all the children, both those interviewed and those who completed questionnaires, had a clear understanding about the SCU's complaints procedures and understood that they could refer a complaint to people outside the unit such as their social worker or guardian-ad-litem. They expressed confidence in the director dealing with verbal complaints brought to her by the children. Of those named outside the unit to whom they could direct their complaints, none of the children mentioned their social worker.

In the period between the two annual inspections there had been 16 complaints. Inspectors note that 13 were dealt with promptly and in accordance with procedures. One complaint made nine months ago remained outstanding. The person against whom the complaint had been made had been on sick leave and has since left the service and the young person who made the complaint was no longer resident in the SCU. There were two further complaints arising from episodes of physical restraint, made by a young person living in the unit at the time of the August inspection, which had neither been dealt with nor notified in accordance with procedures.

Inspectors recommend that the SCU's complaints procedure be reformed so that it is clear that there is one system for the whole operational area of the SCU – management, care units and school, and that the procedures are clearly set out in writing and can be followed by anyone with a bona fide interest. The role of the independent external element in the process should also be explained in writing, and the procedures should include clear timescales to ensure that all matters are dealt with expeditiously, and strict guidelines on notification.

Practices that did not meet the standard

Management

Serious difficulties of trust between management and staff impacted negatively in the unit and presented itself as a crisis of confidence and authority on the management of the challenging and high risk behaviour, the rate of absconding and security, issues regarding recording and notifications of significant incidents, and a confidence in using the complaints procedures or raising concerns about care practices.

There has been a history of difficulties in the SCU and despite significant efforts to improve the situation inspectors had evidence from a range of sources that these difficulties had worsened. The difficulties described to inspectors represented a reciprocal lack of trust between senior managers and many staff. Issues to be resolved include:

- Formal external accountability for senior management
- Regular formal supervision for all staff
- Inclusion of representatives of the clinical and school's team in unit team meetings
- Clarity about who is in charge when the Director is on leave.

Staffing

Inspectors were told there were 47 staff of whom four were part-time, and several others were on leave owing to maternity leave, sick leave, and administrative leave, and the SCU had recently drafted in extra staff from a mainstream children's centre in the Dublin Mid-Leinster region. Given the absences and difficulties within the management and staff team as described to the inspectors, there were not enough staff to run the unit consistently and safely. It was not clear on the second day of inspection whether the unit could be safely staffed over the coming weekend. Figures given to inspectors of those due to be on duty looking after a challenging group of 12 highly vulnerable children varied from six to nine.

There were eight staff disciplinary processes between September 2008 and August 2009. Two were protracted procedures commenced in May and October 2007. Of the other six matters, two were dealt with promptly, and four others, initiated one month prior to the inspection, had yet to be resolved.

Impact of staffing problems on the children

Children and staff told inspectors that there were often insufficient staff on duty to facilitate supervised outings from the SCU. A dangerous incident occurred during the inspection when one member of staff took three children out on 'group mobility'. During the outing all three absconded in a manner posing serious risk to themselves and the staff member. Inspectors were concerned that such a high risk practice occurred.

Notification of significant events

In the last two annual inspections inspectors found that the standard on prompt notification of significant events was well met. However, in these inspections inspectors found that there had been a significant change in practice and the standard was not met. Many supervising social workers and guardians-ad-litem told inspectors of delays in receiving written information about serious incidents, and the records examined by inspectors supported this. In the August inspection, one young person made allegations that on two occasions he was hurt during restraints. At the time of the inspection, two weeks afterwards, these had yet to be reported through the notification system. To meet the standard the HSE should ensure that the SCU

notifies all significant events to relevant parties without delay, and that each is provided with detailed reports about the incident as required. External managers of the SCU should monitor the notification system to ensure that it provides the safeguards for which it is established.

Children's individual files

The quality of recording was poor. Inspectors read eight care files and two serious incident files. Examining closely the accounts of some significant events, inspectors found that care records did not give clear accounts of what actually happened and who made decisions. They found that overall the quality of reporting cast the reliability of the system into doubt. In a report brought to the attention of inspectors by the director and acting deputy director a simple matter of fact concerning the member of staff who wrote it was in dispute, and the truth of the matter could not be confirmed, raising doubt about the credibility of the whole report. Staff interviewed by inspectors acknowledged that training was required in this and that it had been requested from senior management. The HSE should address this issue as a matter of priority.

Promoting good order

Inspectors examined records and were told in interviews of incidents in which children were beyond the control of staff. These included two children climbing on the roofs of the unit several times, and escaping from the campus. There were assaults on staff, and in the view of children and some staff, some of the children were from time to time beyond the control of staff. The managers of the SCU, in consultation with other professionals involved in the placement of children in the unit, should review all the systems in place to manage behaviour and promote good order as a matter of priority.

Restraint and single separation

In the previous annual inspection inspectors made several recommendations regarding the use of single separation, most of which were met by the time of the April 2009 follow-up inspection. From September 2008 to August 2009 there were 186 instances of use of physical restraint, and 163 of single separation, involving 19 children. Between inspections, inspectors were in contact with the managers of the special care service about the use of single separation when children refuse to attend school. This is not included in the figures; see the section on education above. All physical restraints and separations were reviewed by the serious incident review group to ensure that they were carried out in accordance with unit policy and procedure. While the SCU was operating at its full capacity for a short period of time, throughout most of the year the incidence of the use of both measures, remained constant, but of particular note is the fact that nearly a third (30%) of restraints and nearly a quarter of single separations (23%) took place during the seven weeks between the June and August inspections when there were four changes at director level.

Absence without authority

In the year since the 2008 inspection there had been 31 unauthorised absences. Taking into account the increase in the number of children placed in the SCU this figure represents a decrease in the incidence of absconding. However, 41% of these absences took place in the seven weeks between the June and August 2009 inspections. Also, whereas in the past unauthorised absences were from outings, some of these were from the campus itself and entailed escape from the SCU. These constitute a serious breach of security. In order to meet the standard fully the managers of the SCU should address the capacity of some children to escape from the campus, and make whatever adjustments necessary to the physical environment to improve the security of the unit.

Location and design

The SCU was originally built in the grounds of a hospital. Most of the rest of the hospital site has been developed and the units are now overlooked by new apartments. The monitoring officer has brought her concerns about the impact of being overlooked to the attention of HSE managers. Inspectors acknowledge that the conditions in which the unit was built have changed and that the apartments impact on the privacy and living space of the children adding to the unsuitability of the location for the purpose and function of the SCU.

Accommodation – general

Inspectors could see clearly that the SCU was in disrepair in many areas, that it generally was not fit for purpose, and that managers and staff were struggling to maintain any standard in its physical condition. One of the three units on campus was already out of commission, and parts of its internal structure were being recycled to make repairs in the units that were still in operation. As indicated in the report of the 2008 inspection, there was a plan to move to more suitable premises, but at the time of the inspection in August 2009 there was no clear timescale for the move. The general standard on accommodation was not met on two counts: there were areas of the buildings that were either in need of repair or decoration and had been in that condition for some time. For example, in one of the unit staff offices the floor was bare concrete with the remains of adhesive after removal of a carpet in anticipation of replacement with a wooden floor. In other areas where a persistent problem with drains, graffiti, scratched perspex and broken panelling on roofs, and the depositing of large items of refuse and litter in some of the outdoor spaces gave the SCU an appearance of not being cared for.

Accommodation – individual children

The standard on accommodation for individual children was not met. The bedrooms were of a poor structural standard and there was evidence that, while deliberate damage had been repaired, the overall condition of several of the rooms was poor, and several of the rooms provided a bleak and severe environment for vulnerable children.

Maintenance and repairs

Inspectors found evidence that the in-house maintenance service carried out repairs that arose because of rough use, wear and tear, and damage to property. However, there was also evidence of a significant deterioration in the overall condition of the physical environment since the last annual inspection in 2008, and that severe restrictions in the budget assigned for maintenance meant that some items, such as inner sheets of reinforced glass in a double-glazed window, were not replaced. In some instances parts of unit one, including doors and door frames, were used for repairs in the two units that were still in use. Although this is clearly understood by inspectors to be a necessary response to budgetary constraints, nonetheless, the standard on maintenance and repairs was not met because, in spite of the work carried out, the overall condition of the SCU was unacceptable. The standard requires the managers of the SCU to have a programme of rolling maintenance and repair in place to ensure that the children are cared for in a high quality environment that reflects their worth and the values of those caring for them. Inspectors recommend that, as a matter of urgency, the HSE addresses the fact that the SCU is no longer fit for purpose, and that the maintenance service is not in a position to meet the considerable demands to make fundamentally unsuitable accommodation good. Inspectors recommend that the HSE gives urgent consideration to finding a suitable location for the special care unit with accommodation both fit for purpose and of a high standard for the detention of vulnerable children.

Security

The standard on security was not met. Since the last annual inspection there had been several incidents in which the security of the SCU had been compromised by children accessing the roofs of buildings, scaling walls and fences, and escaping. This compromises the SCU's ability to comply with the court's order to detain children in order to keep them safe and defeats the general purpose of the unit to provide vulnerable children with a secure environment. The HSE should carry out an assessment of the premises and staff practice with a view to reducing to an absolute minimum the potential for children to escape from the SCU.

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 partly met the required standard</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.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Management Systems			√
Register	√		
Notification of significant events			√
Staffing			√
Supervision and support			√
Training and development		√	
Administrative files		√	

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 partly met the required standard</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 partly met the required standard</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			√

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 partly met the required standard</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			√

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 partly met the required standard</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			√

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 partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Education		√	

4. Recommendations

The HSE should ensure that:

1. the therapeutic provision of the unit described in the unit's statement of purpose and function is explained in detail to referring social workers,
2. it carries out a root-cause analysis of the policy and practice issues that gave rise to the complaints brought to the attention of the SSI,
3. the quality of relationships of the managers, staff and disciplines involved in the SCU reflects the highest standard of professional partnership,
4. formal supervision in Ballydowd is implemented in accordance with HSE policy for all staff and that the director is supported and accountable through a formal arrangement,
5. the frequency of monitoring visits is reflected in regular reports, and that all recommendations of the monitoring officer receive a timely formal response from external HSE managers,
6. the SCU's system of notification is prompt in accordance with the standard,
7. the standards on recording, maintaining files and archiving are improved significantly,
8. all access arrangements are appropriately risk assessed and implemented as agreed,
9. the children's right of access to information is fully promoted and facilitated,
10. all complaints receive a prompt and thorough response and that complaints concerning senior managers are dealt with by the independent child care manager,
11. at the earliest opportunity suitable premises that are fit for purpose as a special care unit are sourced for the SCU.