



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Inspection of a High Support Unit in the HSE Dublin North East

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1. Introduction

The Health Information and Quality Authority (the Authority or HIQA), Regulation Directorate carried out an unannounced inspection of a high support unit (HSU) in the Health Service Executive Dublin North East Area (HSE DNE) under Section 69 (2) of the Child Care Act, 1991. Maeve O'Sullivan (lead inspector) and Bronagh Gibson (co-inspector) carried out the inspection on the 1 and 2 October 2013.

The high support unit (HSU) had been previously inspected by the Regulation Directorate in September 2012. During the inspection, eight recommendations were made. This report can be accessed on the Authority's website www.hiqa.ie as inspection report 578.

Of the eight recommendations made in the last inspection, inspectors found that seven had either been completed or were ongoing, and one recommendation had been partly completed. The partly completed recommendation concerned the development of a programme of works to ensure the structural and decorative order of the centre.

1.1 Description of the service:

The HSU provides residential care and high support to children, boys and girls, aged between 12 and 17 years on admission, who are experiencing some difficulty in their lives and need additional support.

The HSU is a large purpose-built facility located a short distance from a north Dublin town. The facility is divided into three accommodation units; there were children living in two of these units, while the third unit was being used by a clinical support team. The HSU had a school on site, a gym and outdoor recreational facilities. At the time of inspection there were four children living in the centre, three girls and one boy, aged between 13 and 17 years of age. Inspectors were informed during the inspection that plans were underway for the national reconfiguration of High Support and Special Care Services (NHSSCS). The acting HSU director and the Acting Manager NHSSCS told inspectors that the HSU was to change to a special care unit in early 2014.

1.2 Summary of this inspection:

Inspectors found that there continued to be a good standard of care provided to children in many areas. A committed management team coupled with a cohesive and motivated staff team ensured the delivery of a child-centred service. However, outcomes for some children living in the HSU were poor due to their complex needs not being met and overall management of risk taking behaviour. There was evidence of a high number of unauthorised absences from the HSU and children placed themselves at risk of harm and this emerged as a central theme to this inspection. Overall, this meant that the HSU could not meet several of the standards. For example, the high level

of unauthorised absences impacted on children's attendance at school and potentially this could undermine positive educational outcomes for children.

The policies and practices sanctioned by the National Office for Children and Family Services did not fully promote children's rights. Whilst children's safety is of paramount concern, some practices used to respond to risk taking behaviour, for example the units being locked routinely at 20:00hrs until 08:00hrs, had become institutionalised. The inspectors were unable to establish the legal remit for restricting children's freedom of movement. The HSE Children and Family Service did not have sufficient special care beds available. This meant that the HSU staff team were providing a service to some children who required a different resource to meet their needs in terms of their high risk behaviours. Such children were not suitably placed in an open residential setting at this time. Although the HSU made every effort to meet children's needs safely it was not always possible or sustainable to do this.

1.3 Methodology

In addition to mandated standards, regulations and legal frameworks, the Authority also focuses on children's rights as part of its monitoring process, in the context of the UN Convention on the Rights of the Child. It takes a risk based approach to children's safety and is also concerned that children in the care of the State achieve positive outcomes as a result of this intervention.

Inspectors' judgments are based on an analysis of findings verified from several sources including evidence gathered through direct observation of practice, interviews, examination of records and documentation, and an inspection of accommodation.

The inspectors met with three children. Inspectors also interviewed the acting director, the acting deputy director, the acting national manager of the National High support and Special Care Services (NHSSCS), one acting unit manager, one deputy unit manager, six residential childcare workers, three social workers, the Mater Support Team (MST), psychiatrist and clinical psychologist and the school principal. Inspectors also conducted telephone interviews with three parents.

The inspectors had access to the following documents:

- The HSU's statement of purpose and function
- the HSU's policies and procedures
- the HSU register
- the children's care plans and care files
- census form on staff
- census form on children
- staff personnel files
- administrative records

- details of unauthorised absences for the previous twelve months
- details of physical interventions for the previous twelve months
- one of the four units' fire register and fire safety certificate
- building insurance
- health and safety documents
- previous inspection reports
- the monitoring officers' reports
- Department of Education and Skills Inspection Report.

1.1 Acknowledgements

The inspectors wish to acknowledge the cooperation of the children, parents, the management and high support unit staff, external professionals and others who were involved in this inspection.

1.2 Management structure

The HSU was managed by a team of six people. An acting Director reported to the acting National Manager of the NHSSCS. The acting Director of the HSU was supported by a management team that consisted of an acting Deputy Director, two acting Unit Managers and two Deputy Unit Managers. The Deputy Director reported directly to the Director. The Unit Managers were responsible for the day-to-day running of the units they managed. They reported to the Deputy Director. Both units had five shift coordinators, care staff, Chefs and a part-time Domestic Assistant. They reported to the Manager of their unit. Administration staff, campus assistants and maintenance staff reported to the acting Director of the HSU.

The HSU had access to specialist services. A part-time Child and Adolescent Mental Health support team (CAMHs/MST) worked directly with children and provided support to the staff team. The MST team members participated in management team meetings, but had no management role in the HSU.

The school principal and staff reported to and were inspected by the Department of Education and Skills.

There was a HSE Monitoring Officer with responsibility for high support and special care units who monitored the HSU and reported to the National Specialist for Quality Assurance, Children and Family Services.

1.3 Data on children

<i>Young Person</i>	<i>Age</i>	<i>Legal Status</i>	<i>Length of Placement</i>	<i>No. of previous placements</i>
# 1	13	Full Care Order	13.5 months	One residential care placement
# 2	17	Full Care Order	7 months	Six foster care placements One special care unit placement Three residential care placements
# 3	15	Full Care Order	5.5 months	One foster care placement One residential care placement
# 4	14	Full Care Order	3.5 months	Three foster care placements One residential care placement

2 Summary of Findings

Practices that met the required standard

Register

This standard was met.

The HSU had a register of all children admitted to the centre. Inspectors found that the register was up-to-date and maintained in accordance with the Regulations. The register showed that five children were admitted to and six children were discharged from the HSU in the 12 months prior to inspection. The register recorded the discharge dates and follow-on placement details of all six children.

Notification of Significant Events

This standard was met.

There had been a high number of significant events in the past 12 months. Inspectors found that significant events were documented in accordance with the standards and regulations.

Care files showed that significant event notifications were made to family members and professionals identified for each child. There were 682 significant event notifications made about 11 children in the year prior to inspection. These included children absent at risk, missing from care, assaults on staff and assault threats on other children, and a child locked in a corridor following an episode of abusive or aggressive behaviour. Inspectors noted that significant events were recorded in each child's file in accordance with the HSE policy and were discussed regularly at daily handover and staff meetings. This was supported by entries in the handover log and meeting minutes.

Complaints management:

This standard was met.

The centre had a complaints process in place, which was supported by a policy for the management of complaints and grievances. The deputy director was the nominated complaints officer. Inspectors reviewed the complaints register which showed that two complaints had been made since the last inspection. There was evidence that the complaints were managed in a timely manner, with feedback to the complainant documented. Three children confirmed that they knew how to make a complaint. Records indicated that complaints were notified to the relevant social worker.

Administrative Files

This standard was met.

The HSU had recently introduced a new daily recording system for children. The system ensured that records were organised and maintained to facilitate effective management and accountability. There was evidence of quality assurance checks of records being carried out by managers on a regular

basis. Inspectors observed unit managers and shift coordinators holding staff accountable for completing records and following up on information where required.

The administrative files were accessible and staff records facilitated good communication across the team. Each unit had a system for managing petty cash.

Contact with Families

This standard was met.

The HSU promoted contact between the children and their families, where it was in the child's best interest. Inspectors found, through interviews with children and staff, a review of the children's care plans and daily logs that contact with families was encouraged, facilitated and documented in-line with the child's care plan. Parents told inspectors that they were made feel welcome in the unit and could visit their child whenever they wished. Most children said that they could speak to and meet with their family in private. Details of contact with family members were maintained on each child's daily log.

Children's Care Records

This standard was met.

Each child had a secure individual care file that contained all the statutory required information, including daily, weekly and monthly updates, individual therapeutic plans and key work sessions. Good quality information was collected on children by their social worker and care staff, and this ensured a consistent approach to care based on each child's needs and wishes. A weekly report for each child was developed and submitted to the NHSSCS office. The HSU had a policy on report writing and record keeping, a policy on handovers and a policy on confidentiality. Inspectors found through interviews and a review of daily unit records that staff were familiar with these policies. Children's daily logs showed good systems of recording, reporting and communication across the staff team and with professionals.

Social Worker Role/Supervision and Visiting of Children

This standard was met.

Inspectors found that social workers carried out their role in accordance with the standards and regulations. Each child living in the HSU had an allocated social worker. Children's record books recorded social worker visits to the unit and all telephone contact. The children knew who their social worker was and knew how to contact them if necessary. Through reviewing centre records and interviews with children and staff, inspectors found that social workers visited the children regularly, met with them in private, and reviewed their files. The required professional and statutory obligations were fulfilled for all four children by their allocated social worker. The social workers interviewed told inspectors that they had a good relationship with the management team and staff and were notified in a timely manner of significant events, updated crisis management plans and child protection issues. Social workers said that

they were satisfied that children received a good standard of primary care in the HSU. However, one social worker acknowledged that the HSU was unsuitable for a child, and that their needs could be better met in an alternative type of service. Inspectors found evidence of the work carried out by social workers in researching and visiting alternative placement options for the child, when a decision had been made that the current placement was not meeting the child's needs.

Statutory Care Plans and Reviews

This standard was met.

Inspectors found that all children in the HSU had a care plan that was developed within the statutory timescales. Care files showed that three children's care plans were updated by child in care review reports. One child had a child in care review in the month prior to inspection and a report was awaited by the unit. Up-to-date statutory care plans were in place for all four children living in the centre. Each child and their parents, where appropriate, had been consulted in the process of drawing up the care plan. Inspectors found that children's care plans were reviewed regularly in accordance with the Standards and Regulations. Placement plans reflected the objectives in the statutory care plans for three children.

Preparation for Leaving Care

This standard was met.

Children and young people were well prepared for leaving care. Key workers worked in partnership with young people in preparing them for leaving the HSU. Records reviewed by inspectors demonstrated the life skills sessions that young people had with their key workers.

Discharge

This standard was met.

The HSU had a policy on discharges. Inspectors found that when discharges took place, they were planned.

Food and Cooking Facilities

This standard was met.

Inspectors found that the food provided by the HSU was of a good standard. Main meals were prepared by a chef in each unit and children said they could have access to the kitchen when they required. They also said that they liked the food and were encouraged to cook from time to time. Inspectors shared an enjoyable meal with the children and the staff during the inspection. The two kitchens were clean and fridges were well stocked. Menu boards in unit dining rooms described the day's bill of fare. Some children's daily log books recorded what the children ate, or if the child chose not to take part in a meal.

Race, Culture, Religion, Gender and Disability

This standard was met.

The HSU had a policy on recognising diversity. Staff interviewed told inspectors that they were aware of the policy. They said that there was an established culture of respect within the HSU that benefited the children.

Practices that met the required standard in some respect only

Purpose and function

This standard was met in part.

The statement of purpose and function stated that the centre provided residential care to boys and girls aged 12–17 who were experiencing difficulty in their lives and needed some extra help. The statement was up-to-date. An accompanying mission statement described the type of care that a child could expect to receive. Inspectors found that staff were aware of the purpose and function and that some day-to-day operations of the HSU reflected this.

It is noteworthy that this standard was found to be met in the last inspection. However, on this inspection it was found to require review and change. The statement did not adequately refer to key policies that guided care practice. This was particularly pertinent to the use of environmental restraints, locking of doors and sanctions which might impact on children's rights. The HSU used the national policies Management of Serious and Immediate Risk policy and Preventing Young People from Leaving the High Support Unit and/or Area of the High Support Unit and Placing Themselves or Others at Risk policy but these were not referenced in the statement of purpose. In the context of the Authority's focus on children's rights and outcomes for children in care this inspection found that there were opportunities to ensure the HSU functioned in a way that was in accordance with an open residential setting as it did not do so consistently.

Management

This standard was met in part.

The HSU was well managed on a day-to-day basis, but improvements were required in the management of quality assurance systems and risk to ensure better outcomes for children.

The HSU was managed by an acting director who was suitably qualified. The acting director managed all staff working in the centre and was assisted by an acting deputy director. There were two unit managers who also reported to the deputy director. The centre operated an on-call system that ensured a named member of the management team was contactable at all times in the event of an emergency. HSU managers and staff interviewed by inspectors were clear about their roles and responsibilities and lines of accountability. There was good communication between management and staff that ensured information dissemination and continuity of care for children. Other key professionals such as the school principal and the mental health support team told inspectors that communications with the management team were very good, and that this was facilitated by regular meetings. Weekly management meetings took place. The meetings were attended by the deputy director, unit managers and deputy unit managers and addressed issues such as significant events, school attendance and clinical issues. The acting director informed inspectors that they attended fortnightly national managers meetings

coordinated by the acting national manager of the NHSSCS. Inspectors found that these meetings positively affected the day-to-day management of the HSU.

The acting director informed inspectors that all managers had a role in quality assurance. Inspectors reviewed a quality improvement action plan that had been developed by the deputy director in October 2012. The criteria covered in the plan were very broad and the suggested recommendations were not specific to the centre. The deputy director maintained an evidence file, which documented meetings such as the SERG group (Significant Event Review Group), and action plans which tracked progress on recommendations from Authority and monitoring officer reports. The purpose of the SERG group is to ensure that practice in the HSU relating to significant events and their management is compliant with national standards.

The acting director told inspectors that they had overall responsibility for analysing all data collected in the units in relation to significant events. This included the implementation of any changes and/or controls to manage significant events or reduce risk. They also told inspectors that data were gathered and analysed on a case by case basis. However, inspectors found that in the absence of an aggregated regular review, analysis and trending of significant events, opportunities to initiate changes in the way that staff worked with children were diminished. The notification system in place did not initiate changes to address and reduce serious risks to the children. The acting director acknowledged that the analysed data was not aggregated, which if combined could potentially improve the overall service delivery at the HSU.

Inspectors found evidence of some risk management systems used by managers, such as reviewing and signing off on significant report forms and risk assessments. However, the overall system of managing risk was not adequate. Inspectors reviewed an accident and near miss register maintained on each unit with entries mainly relating to incidents involving staff. These were recorded and responded to in a timely manner. The acting director said that risks to specific children were managed through individual risk assessments and at a number of different local and national meetings such as the SERG, SIRG (Significant Incident Review Group) reviews, child-in-care reviews, professionals meetings, formulation and response meetings. A sample of reports viewed by inspectors recorded meetings that managers held with staff after significant incidents to share information and clarify care approaches. However, this did not lead to any action which reduced risk or resulted in improvements in the service.

There was a corporate risk register in place but records showed that no risks were reported through this system by the acting director. The acting deputy director provided inspectors with a copy of the policy that guided practice with regard to managing risk. The document was a one page appendix document entitled 'HSE Risk Impact Table'. Inspectors found that managerial

oversight of all risks in the centre was lacking and key HSE policies did not direct the management of risk. Additionally, there were no criteria to define what constituted a 'serious' risk, and consequently the seriousness of some risks could be overlooked.

Supervision and Support

This standard was met in part.

The HSU had well documented systems in place to support staff but supervision of staff was not always provided within the frequency outlined in the HSU's supervision policy. Staff team meetings were held on a regular basis. Agendas covered information dissemination and discussions on recent events in the units. Meeting minutes demonstrated a child-centred approach and guidance being provided by unit managers. Members of the MST team informed inspectors that they attended weekly clinical meetings with care workers in each of the units. Issues discussed included children's placement objectives, key working and therapeutic interventions. Inspectors were informed by staff and managers that new policies were presented and discussed at team meetings and written copies of policies were issued to all staff.

The HSU had introduced the new national policy on staff supervision in July 2013 which stated that supervision should be provided every four to six weeks.

The director informed inspectors that they received regular four to-six-weekly supervision from the acting national manager. The supervision focused on the needs of the children, on staff accountability and professional development. The majority of staff informed inspectors that they found the supervision beneficial. However, a sample of staff files read by inspectors showed that supervision occurred on a six to-ten-weekly basis which was not in-line with their national policy.

Children's Rights

This standard was met in part.

This standard states that the rights of children should be reflected in all care policies and practices. Inspectors found that children were aware of their right to complain, to be consulted and to access information held about them. Staff were familiar with the policies that supported these rights. Two of the children interviewed by inspectors said that they felt consulted about their care and decisions made in the HSU. Inspectors reviewed minutes of meetings and key working sessions held with children and found that they were regular and child centred. The children told inspectors that they received pocket money and a clothing allowance. However, children's rights were not fully promoted by all HSU practices and or policies.

At the previous inspection this standard was met. In August 2012 the HSE national office finalised, signed off and fully implemented two national policies^{1 2}. However at this inspection it was found that practice did not follow these policies in that the locking of unit doors was not based on individual risk assessment and thus was not compliant with the policy.

For example, the statement of purpose and function stated that the HSU's front door was routinely locked from 20.00 to 08.00 hrs. **It was reported by staff** that these measures were taken not only to prevent unauthorised access to the overall campus, but to prevent children, who were deemed at risk, from leaving the unit they lived in.

Inspectors found that this applied to all external doors of individual units where children lived and the main entrance to the whole campus. Additionally, inspectors found that children were confined to different areas of the HSU when staff deemed this necessary to maintain the child's safety or the safety of others. This meant that children experienced a second level of restriction further impacting on their rights, despite high levels of staffing including waking night staff and night staff in the administrative building. In effect, children were detained in the centre during this period of time and could only leave the centre in a planned way. This practice has been authorised and confirmed by the Director of Children and Family Services but was not supported by national policy.

Although HSU managers took steps to inform social workers that the HSU was routinely locked at night time, some social workers interviewed by inspectors said they were unaware of this practice. This meant that children's rights were restricted and their social workers who are in *locus parentis* were not aware.

The Authority fully acknowledges the challenge in keeping some children safe and in certain instances it may be necessary to prevent children from leaving the unit. However, practices such as the routine locking of doors impinges on the children's rights and detains children in a way that is not within the legal remit of the HSU. Children may only be detained by a High Court order or a sentence relating to children's offending behaviour. The Authority has previously reported their concerns in relation to these practices in a previous inspection (see Report ID number 344).

Access to Information and consultation

This standard was met in part.

The centre had an accessible children's booklet that outlined its purpose and function, unit living and children's rights. Children told inspectors that they had been informed about the various services that were available to them,

¹ HSE Management of Serious and Immediate Risk

² HSE Preventing Young People from Leaving the High Support Unit and/or Area of the High Support Unit and Placing Themselves or Others At Risk.

including EPIC (Empowering People in Care). There was evidence that staff consulted children about their day, and documented the child's voice or views in their daily record book.

Children were consulted and had access to most information. However, children could not easily access records held on them in the centre. Access to their care files was restricted and could only be accommodated through their social worker. Children told inspectors that although they could read their daily log books, access to their care files required their social worker to be present. Therefore it was not clear what information could or could not be shared with children without the presence of a social worker.

Restraint

This standard was met in part.

There was good practice in relation to many aspects of the use of restraint. There was a policy in place and data provided as part of this inspection showed that all care staff had received up-to-date training on the use of physical restraint. Records showed that the use of physical restraint/intervention was comprehensively documented and all relevant stakeholders were notified promptly. This was confirmed to inspectors by social workers. The acting director told inspectors that they monitored and reviewed physical restraints/interventions and called a SERG meeting to review cumulative use of restraints for individual children when required.

Inspectors found that children's individual crisis management plans were reviewed and promptly updated after each incident. Children told inspectors that they understood why restraints were used. Staff told inspectors that as far as possible they used other methods to try and de-escalate a situation before using physical restraint. This was confirmed through a review of a sample of significant event documentation and also observed on site by inspectors.

At the previous inspection of 2012 this standard was met. However, at this inspection concerns were identified that the HSE must address to improve practice. For example, inspectors found that although physical restraints were carried out in-line with HSE policy and reported accordingly, there was a need to improve the use of data and information on all restraints to improve the service and manage risk effectively. There were 37 reported incidents of physical restraint and 49 reported incidents of physical intervention in the last 12 months. The management team informed inspectors that they reviewed individual incidents of restraint and physical intervention and all were deemed appropriate in terms of the individual incident, type and duration of restraint/intervention. However, inspectors found that local HSU managers did not routinely analyse information and data on all restraints over specific periods of time so that emerging trends could inform day to day practice improvements and risk management strategies.

Individual care in Group Living

This standard was met in part.

There was evidence that the children in the HSU were well cared for and respected. One child told inspectors that they liked living in the unit. Staff worked with children on establishing positive relationships and promoted change in behaviours. Throughout the two days of the inspection, inspectors observed respectful interactions between the children and the staff working in the units. Daily and weekly plans for children were developed and displayed in the staff office. Interviews with staff demonstrated that they had an in-depth knowledge of the children and their needs. Children's care files reviewed by inspector's demonstrated good direct work carried out with each child. Staff demonstrated some methods of working with the children, particularly in relation to encouraging choice.

While children were offered opportunities to take part in activities within the HSU or their communities, there was little evidence in the weekly plans that demonstrated that children were being encouraged to develop and use their talents and explore their interests external to the HSU. Children interviewed by inspectors spoke about their daily routine and indicated that they did not have enough activities or enough choice.

Absence without Authority

This standard was met in part.

At the previous inspection this standard was met. However, at this inspection, inspectors found that though there were systems in place to report children who were absent at risk, they were concerned about the number of absences.

The HSU had policies on unauthorised absences and children missing from care and these policies were followed. There was a register of all absences and all incidences were clearly recorded in the children's care files, along with the actions taken. There were 134 reported unauthorised absences in the past 12 months. This represented 16 reported episodes of children 'missing from care', 55 reported episodes of children 'being at risk' followed by missing from care, and 63 reported episodes of children being absent and at risk. The level of absences was not reduced by the locking of the doors as children absconded at other times of the day. Current strategies in place had not reduced the overall rate of absconding from the unit.

Inspectors reviewed the documentation and management of the absences. They found that staff took proactive steps when absences occurred. For example, in cases where it was considered that ongoing absences and missing from care posed a risk for a child, regular meetings were held with An Garda Síochána, an absence management plan was developed for the child and they were assigned an An Garda Síochána case manager. However, one child told inspectors that the sanctions imposed on them post-absconding were minimal and did not change their behaviour.

Not all social workers interviewed by inspectors were aware of the details of all absences, including times when children were absent without permission but not necessarily at risk. Therefore, they did not know the full extent of the risk to which children were exposed and for whom they had responsibility.

In addition it was reported that these absences had been notified to the national office and the acting manager for the NHSSCS. However, at the time of this inspection there was no evidence provided to confirm that strategies and interventions had been put in place to address this issue.

Emotional and Specialist Support

This standard was met in part.

Children had access to specialist services. The HSU had on-site part-time access to a psychiatrist, a clinical psychologist, and a speech and language therapist. Inspectors found, through a review of meeting notes and case file reviews, that this team attended weekly clinical meetings with the care staff to discuss the children's progress and were available to meet and work with the children when required.

Members of the MST team told inspectors that when children chose not to avail of their professional advice and assistance, the care team worked with them and were receptive to learning new ways of working with children and managing behaviours that challenged. However, due to the continued high level of children's absences from the HSU, opportunities for care staff to work with children and consistently address their mental health and emotional needs were limited. Continued absences meant that some children did not receive the close supervision they required as recommended by other professionals, in order to promote their safety and emotional wellbeing.

Monitoring

This standard was met in part.

A monitoring system was in place. The monitoring officer carried out regular monitoring visits to the HSU, reviewed data and met with children. However, the monitor's reports did not identify the risks associated with the high number of significant events and unauthorised absences of the children.

The monitoring officer for the HSE's Children and Family Services had visited the HSU in April and July 2013. During the April 2013 visit the monitoring officer reviewed the centre's progress in responding to recommendations made following the Authority's inspection in September 2012. The monitoring officer found that some progress had been made with regard to the majority of recommendations, but actions relating to four of the eight recommendations were ongoing. The monitoring officer also recommended the development of a policy to inform and support appropriate intervention and management of unauthorised absences where the child was not deemed to be at risk. However, there was no timeframe identified for implementation

of this recommendation.

During the July 2013 visit, the monitoring officer met with children recently admitted to the centre. In addition, they reviewed the children's files and daily reports, followed up on historic child protection referrals and reviewed progress with regard to recommendations from the Authority's September 2012 inspection. The acting director told inspectors that the monitoring officer was always accessible to the HSU and provided support to the staff team. Centre records demonstrated that the monitoring officer was notified of all significant events, and that there was effective communication between them and the HSU.

Inspectors found that during the most recent monitoring visit, the monitoring officer did not report any findings or recommendations in relation to the ongoing high number of significant events and unauthorised absences, which included children missing from care and at risk.

Staffing

This standard was met in part.

Inspectors found a committed team of experienced staff. However, not all staff were appropriately qualified.

Inspectors found that the HSU had a long standing experienced team, who cared for the children. The HSU employed a total of 49 staff which represented 47.75 WTE (whole-time equivalent) staff. In addition to the director and deputy director, there were two unit managers and two deputy unit managers, 32 residential childcare support workers, two chefs, one part-time maintenance person, 4.5 campus assistants, one domestic worker and 1.75 administrators.

A review of a sample of personnel files by inspectors showed that all staff were appropriately Garda vetted. As with the last inspection, not all files reviewed contained evidence of staff members' qualifications. Since the last inspection, all staff members had been encouraged and supported to undertake further education and acquire relevant qualifications.

The HSU had one WTE residential childcare support worker vacancy. There was some use of agency staff. For social care staff, inspectors found evidence that the same agency staff were used. All social care staff had received a formal induction and for agency staff who had worked in the HSU for 100 hours or more, supervision was provided. The acting director confirmed to inspectors that not all non care agency staff had received an induction.

Staff training and development

This standard was met in part.

Training such as report writing and first aid was provided to staff. However, staff members' ongoing training and development needs were not informed by a training needs analysis.

The staff team demonstrated skills and knowledge while working with children in the units. Inspectors found evidence of the MST team providing training and advice to the care staff in different aspects of behavioural management. Staff interviewed by inspectors confirmed that training was available to them. However, due to an escalation in significant events and children's challenging behaviour in the past 12 months, inspectors found that a review of staff training and skills set was required to support staff. The acting director confirmed to inspectors that a training needs analysis for staff had not been undertaken. Considering the high number of significant events and restraints reported in the HSU in the past year inspectors recommend that a training needs analysis of managers and staff is carried out to ensure that all staff are appropriately qualified, trained and sufficiently skilled to meet the needs of the service and the children. This should inform the ongoing training programme for the centre.

Education

This standard was met in part.

Inspectors found that although education was given high priority by the HSU and school staff, attendance by some children was sporadic and this impacted on their capacity to receive an adequate level of education while living in the HSU. Children told inspectors that they enjoyed school and there was a homework folder for each child in the units. Regular school reports were provided for children's placement reviews and where required educational psychology reports were secured.

The school principal told inspectors that unit staff met regularly with them to discuss children's progress and update them on the child's ICMPs (Individual Crisis Management Plans). This ensured a consistent approach when working with children in reinforcing positive behaviour and managing behaviour that challenged.

Staff told inspectors that school attendance for two of the four children currently living in the HSU fluctuated and that this was due to a significant number of unauthorised absences. Social workers also expressed their concerns about school attendance to inspectors. This was supported by entries in the child's daily record books. However, despite care staff and teachers making every effort to encourage school attendance, ongoing absences were impacting negatively on the children's educational outcomes. This was acknowledged by the school principal, staff and managers.

Health

This standard was met in part.

Health outcomes for children were positive, but not all children's files contained information on their immunisation status, though care staff had made several efforts to contact social workers regarding this issue. The HSU had a policy on general health, on drugs and alcohol and on sexual health. All children living in the HSU had a medical card and had access to a general

practitioner. Information on various aspects of health was maintained on file for each child as well as details of appointments attended. Evidence of a medical assessment on admission to care was evident in all children's files. Medication was safely stored in a locked cabinet in each unit and medication administration was properly administered in line with HSU policy. There was evidence of medical consent being sought from parents where appropriate and a medical event and contact form was maintained on each child's file. Records in children's files documented the appointments that they had with additional specialist supports such as optician and dental services. Children interviewed confirmed that they had access to a medical practitioner when required.

Aftercare

This standard was met in part.

Accessing aftercare services for all children remained a challenge. One young person who was 17 years of age had been recently referred to the aftercare service. Monthly meetings with the aftercare worker were occurring and a 'preparation to leave care' plan had been developed. Inspectors reviewed the work documented to date and noted that further one-to-one work and planning meetings were required to ensure that the young person was sufficiently prepared to live independently. The acting director and care staff told inspectors that due to limited resources in the aftercare team not all children were able to access the service in a timely manner.

Accommodation

This standard was met in part.

The units were homely but required redecoration. Each child had their own bedroom with en suite facilities. The children informed inspectors that they could choose to have their bedroom door locked during the day while they were at school if they wished. The living and dining room areas of both units were nicely furnished and pleasant home cooking smells filled the air around meal times. Each unit had a small room that was used for private meetings for the children to meet with their families. The buildings and grounds were well maintained and a gym was occasionally used by the children. The HSU managers told inspectors that the painting of the units was planned as part of the overall refurbishment and change of the HSU to a special care unit. However, at the time of inspection there was no refurbishment and redecoration plan in place.

Maintenance and Repairs

This standard was met in part.

The HSU had an effective system in place for routine daily maintenance, but a programme of works for ongoing maintenance was not developed. The HSU had a part-time maintenance person. Inspectors found the maintenance log in each unit detailed maintenance requests made to and addressed by the HSE maintenance department. Maintenance requests were prioritised, appropriately recorded and noted when completed. However, as at the last inspection, there was no programme of works to address the structural and

decorative requirements of the HSU. The acting director informed inspectors that considering the plans to build a special care unit on the premises and change the current units into special care units, the development of a programme of works was on hold until such time as the building and restructuring work got underway. There was a requirement for a temporary programme of work to be put in place so that the HSU was pleasant for the children living there, and safely maintained.

Practices that did not meet the required standard

Safeguarding and Child Protection

This standard was not met.

This standard was met in part in 2012 and inspectors found that the systems to report child protection concerns had improved since the last inspection. However, safeguarding systems to protect children when they were absent from the HSU were not always effective, and therefore there were occasions when children were not safe.

The HSU had written policies on safeguarding and child protection. Staff interviewed by inspectors were familiar with these policies and gave examples of how they ensured a child was kept safe. All care staff had attended Children First (2011) briefings, but other staff such as chefs and campus assistants had not. Staff were familiar with the concept of protected disclosure and told inspectors that there was a culture of openness and accountability in the unit and they were encouraged to question and express their concerns and they felt safe in doing so.

Inspectors found that all child protection concerns were managed in line with Children First (2011) guidance. The acting director was the designated child protection officer, and children's records and a child protection referral schedule demonstrated good, timely management and monitoring of child protection concerns. Social workers informed inspectors that they were notified of all relevant child protection concerns in the HSU. The acting director told inspectors that in cases where a child had been discharged from the HSU, feedback, where appropriate, on the outcome of an investigation was not always received in a timely manner by the HSU.

The continuous risk taking behaviours of children that included fire setting, substance misuse when absent from the unit and behaviours that included bullying and physical threats toward other children and staff reflected the complex needs of the children, but also demonstrated that the systems in place to protect children and keep them safe were not effective.

Managing Behaviour

This standard was not met.

This standard had been met in previous reports but inspectors found that at the time of this inspection there were some poor outcomes for children due to risks posed by their behaviour.

The HSU had a policy on behaviour management which was known and understood by staff interviewed. It used a specific model of behaviour management and records showed that all care staff were up to date in training in this model. Staff used positive reinforcement of acceptable behaviour and a rewards system for improvements in behaviour. There was a system of sanctions in place which had not proved to be effective when children's behaviour escalated. Clinicians on campus provided support and advice in relation to specific behaviours and individual children.

Staff told inspectors that they were confident in managing children's behaviour and inspectors found evidence that some children's behaviour was well managed at particular times. However, inspectors found that the model of behaviour management used was not always effective, for example a supportive interaction with the child after an unauthorised absence and a plan being developed to reduce the likelihood of a reoccurrence, did not always have a long-lasting positive impact on the children's risk-taking behaviour.

A review of children's records and staff interviews showed that individualised risk assessments and plans were developed and routinely updated following a significant event or when a risk was identified. Risk assessments read by inspectors showed that their quality varied. Some assessments did not adequately identify risks to children, were unrealistic in safety measures to be taken and therefore, were not effective.

Each child had an Individual Crisis Management Plan (ICMP) which guided staff on how to respond to challenging behaviour and these were reviewed following specific events. The ultimate aim was to support the child to manage their own behaviour but this was not a common outcome as children continued to put themselves at risk and social workers confirmed this to be the case. The process of carrying out risk assessments and developing risk management plans needed to be reviewed. However, the inspectors found through review of documentation that appropriate training was not provided to staff and managers to ensure the development of quality risk assessments and plans, and to analyse root causes of absences at risk, so as to reduce risk for children and promote safer outcomes.

The practice of restricting children's liberty was used to manage behaviour. Records examined by inspectors showed that in the majority of incidents, the intervention entailed restricting a child to an area of a unit, such as a corridor or a room. Inspectors found that this was frequently used by HSU staff, often several times in one day for one particular child and for protracted periods of time. Inspectors also found examples of when corridor areas were locked

when a child was in bed in their bedroom although the level of risk had reduced. This was not in compliance with national policies^{3 4}. However, all of these incidents had been reviewed by managers and were all found to be appropriate. Confining children to specific areas of the HSU was an issue raised in a previous inspection report (see SSI report ID Number 344), and this practice had not changed since then.

Records showed that there were a significant number of reports related to bullying incidents between children. These included verbal threats and physical assaults. Records reviewed by inspectors showed that individual and group work was carried out directly with children in relation to bullying and that these incidents were appropriately reported to relevant parties. The individual behaviours of the children were monitored by staff teams and close supervision of children when bullying was suspected or happening was promoted. This included careful consideration of the mix of children in each unit. Interventions were well documented in the child's file and incidents of bullying had reduced overall. In spite of these strategies some children told inspectors that although the staff intervened in such circumstances, they did not feel safe all of the time. Additionally, it was unclear from the unit records reviewed how social workers responded to accumulating reports of suspected or actual bullying of individual children within the centre.

Children, managers, unit staff and social workers acknowledged that the main risks to children arose when they were absent in the community. The acting national manager of the NHSSCS told inspectors that they were currently reviewing how persistent absences at risk could best be managed. The objective of these review meetings was to develop systems of support to staff in managing the risks and meet the needs of the children. Inspectors found that unit managers and managers at national level had held meetings to discuss individual children's cases and agree on the most appropriate methods of managing the behaviours that challenged. Documents showed the decisions and actions to be taken to reduce the behaviour that challenged. However, there was limited evidence to demonstrate that these actions had been effective, that their effectiveness had been reviewed or that the actions had decreased the level of unauthorised absences and incidents of missing from care. The children's behaviour was not reassessed to see if the service could continue to meet their needs.

The significant event notification system did not result in a reduction in the risks or incidents of harm to children. A review of the significant event register identified incidents of fire setting, ranging from minor to more serious episodes. Inspectors reviewed a sample of significant event forms which reported on these incidents. The forms documented the immediate actions which had been taken and the plan to manage this behaviour going forward.

³ HSE Management of Serious and Immediate Risk.

⁴ HSE Preventing Young People from Leaving the High Support Unit and/or Area of the High Support Unit and Placing Themselves or Others At Risk.

However, these plans were ineffective as the fire setting behaviour continued. Children spoke to inspectors about a recent fire which had been set in one of the units and said that it had upset them. The significant event register also recorded incidents of threatening behaviour and assaults on other children and on staff, as well as episodes of children abusing substances when absent from the HSU.

In spite of the high level of staffing, inspectors reviewed unit reports which showed that staff called An Garda Síochána on a number of occasions to provide assistance. Children's behavior had deteriorated to a point at which staff did not feel safe to physically intervene due to the level of threatening behavior. Whilst inspectors found that it was appropriate to call An Garda Síochána in these circumstances they were concerned that the service was unable to meet children's needs in these circumstances.

There were continuing high levels of significant events occurring within and outside of the unit, incidents of absences at risk and missing from care. Social workers, the acting HSU director and the acting national manager of the NHSSCS acknowledged that the systems in place to manage children's behaviour were not always effective for all children living in the unit.

Suitable Placement and Admissions

This standard was not met.

Inspectors found that not all children were suitably placed; therefore their needs were not being fully met.

The transition and admission process for children was in accordance with the HSU's admission policy. Some children told inspectors that they knew why they were in the HSU and the purpose of their placement. Inspectors found evidence of interagency placement plans for children, detailing their needs, goals, responsibilities, emotional and developmental needs, education, aftercare and review dates.

Inspectors found that children were appropriately admitted to the unit. However, as some children's needs changed staff were not always able to provide the care required. Consequently the placement ceased to be suitable. One child had been referred to special care and the child was deemed to meet the criteria but no bed was available since May 2013 and no other arrangements had been made to meet this child's needs. Records showed that this had a negative impact on the child, particularly in terms of their behaviour and this was a concern for their social worker. As a result, the child remained in an unsuitable short term placement which resulted in poor outcomes for him/herself and other children living in the unit.

The social worker for another child expressed their concerns in relation to the suitability of their placement due to the ongoing risk that they continued to place themselves at when absent from the HSU. This had continued for some time without improvement. The social worker told inspectors that a

professionals meeting was now due to be held to discuss the child's placement and to identify any protective measures and explore alternative placements for this child in order to manage risk in this context.

The lack of suitable and timely onward placements for children moving on from the HSU generally was raised by the acting director of the HSU and acknowledged by the acting national director (NHSSCS). The acting national director (NHSSCS) told inspectors that there were an insufficient number of special care unit placements to meet current demand. He/she further outlined the NHSSCS restructuring plan that will result in a total of 35 special care unit places in the country. This plan is due to be rolled out in 2014. However, the immediate impact on children requiring such a resource is of concern to the Authority and will be addressed with the Children and Family Agency.

Safety and Fire Safety

This standard was not met.

Fire safety checks had improved since the last inspection, but the systems in place to safeguard against the risk of fire were not adequate. Additionally, evidence of fire safety compliance was not available for the centre.

The HSU had a health and safety statement, and inspectors observed health and safety policies displayed in staff offices in the units. The HSU had a health and safety committee and meetings were held regularly. Inspectors reviewed the fire safety registers on the two accommodation units and observed that staff were carrying out and recording fire safety checks daily. A shift coordinator confirmed to inspectors that it was their responsibility to check that daily fire safety checks were carried out and records maintained. There was an interlinked fire alarm system between the main office and the units. A contract was in place with an external specialist to ensure all fire alarms and sensors were checked every three months. Inspectors observed records that demonstrated that fire alarm checks were happening quarterly.

Records reviewed by inspectors showed that seven fire drills had been carried out in all units since 1 January 2013, but not all staff and children had participated in the fire drills. All seven fire drills had been held between the hours of 09.45 and 12.50hrs. No fire drill had taken place at night-time since the practice of locking the doors at 20:00hrs had occurred. Details of the number of children involved in each fire drill were recorded. Also recorded was whether a child refused to participate in a fire drill and remained on in the unit. The HSU acting director told inspectors that the procedure relating to instances where a child refused to leave a unit during a fire drill involved notifying the child's social worker. Inspectors noted the communication sent to a social worker when a child refused to participate in a recent fire drill. Some staff told inspectors that they had not participated in fire drills in the past year. The HSU director confirmed to inspectors that there was no system in place to record staff's participation in fire drills.

Fire training was not up to date for all staff. The deputy director told

inspectors that fire prevention and evacuation training was scheduled for the remaining staff in October 2013 and this was supported by a fire prevention and evacuation training schedule located in the two units' staff office.

Written confirmation from a chartered engineer stating that all statutory requirements relating to fire safety and building control had been complied with was available for the education unit only. Written confirmation for the remaining units was requested during the inspection. Although the HSU had communicated with the Authority since the inspection outlining their difficulty in securing the required compliance documentation, the written information to confirm compliance with fire safety and building control was not available at the time of writing this report.

The HSU had a fire safety statement and a fire risk assessment. However, the fire risk assessment did not take into account the fact that all external doors were locked from 20:00hrs. Neither did it consider the increased risk of fire due to the profile and behaviours of the children currently living in the HSU.

Inspectors reviewed documentation relating to a fire that had occurred in a unit in the month prior to inspection. Staff confirmed and unit records outlined the various mitigating actions taken by managers and staff to effectively manage potential risk after the fire, which included conducting a fire drill two days after the fire. Documentation relating to the recent fire incident viewed by inspectors did not provide details of the evacuation process and the timeframes involved. Therefore it was not possible to establish how long it took the staff team to contain the fire and ensure that all children and staff were safe. The HSU's fire risk assessment had not been updated following the incident. The fire risk assessment, dated March 2013, did not document the fact that in the event of smoke or a fire being detected, the external doors do not automatically unlock. Staff identified, when interviewed by inspectors, that they had a master key that opened all doors in each unit, they also had a key for the fire panel which they carried with them at all times. Inspectors did not consider that there was a sufficiently robust fire safety system in place. There was no HSU-wide risk assessment report on the current precautions taken against the risk of fire, the behaviours of children that result in fire setting and an examination of the provision of adequate means of escape in the event of a fire. This was a significant omission because:

- There had been a number of incidents of children setting fires in the units
- the external doors were locked from 20:00 to 08:00hrs
- the fire alarm system was set in such a way that when the alarm sounded there was no automatic release system of the external doors
- the external doors remain locked until opened by staff with a key.

3. Findings

1. Purpose and function

Standard
The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for children and the manner in which care is provided. The statement is available, accessible and understood.

	<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		√	

Recommendation:

1. The HSE national high support and special care service should ensure that the HSU's statement of purpose and function lists the key policies that guide care practice, and that all persons with a legitimate interest in the work of the HSU are aware of the statement and its contents.

2. Management and staffing

Standard
The centre is effectively managed, and staff are organised to deliver the best possible care and protection for children. There are appropriate external management and monitoring arrangements in place.

	<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 (including vetting)		√	
Supervision and support		√	

Training and development		√	
Administrative files	√		

Recommendations:

2. The HSE national high support and special care service should develop a centre-specific quality assurance plan and processes to promote accountability, enhance compliance and improve the quality of outcomes for all children residing in the centre.

3. The HSE national high support and special care service should ensure that all data including significant events are aggregated for analysis and review, and that actions taken post analysis are monitored and reviewed on an ongoing basis to ensure service improvements and improved outcomes for children.

4. The HSE national high support and special care service should put in place a robust system to manage risk both at an organisational and operational level, including such issues as managing behaviour and fire safety.

5. The HSE national high support and special care service should review the process of carrying out risk assessments and the development of risk management plans to ensure that staff and managers are appropriately trained to develop and review quality risk assessments and risk management plans.

6. The HSE national high support and special care service should ensure that development work is carried out with managers and staff to promote a robust risk management culture.

7. The HSE national high support and special care service should ensure that all formal supervision is in line with HSE policy.

8. The HSE national high support and special care service should ensure that all personnel files contain a record of staff members' qualifications.

9. The HSE national high support and special care service should carry out a training needs analysis of all staff to ensure that they are appropriately trained and skilled to meet the ongoing and changing needs of the children in the centre, and that this informs the training programme.

10. The HSE national high support and special care service should ensure that all staff are supported to achieve appropriate professional qualifications.

11. The HSE national high support and special care service should ensure

that an induction programme is in place and that all new staff, including agency staff, are appropriately inducted to the unit.

3. Monitoring

Standard
The HSE, for the purposes of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the health board to monitor statutory and non-statutory children’s residential centres.

	<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		√	

Recommendations:

12. The HSE national high support and special care service should ensure that the monitoring function is carried out in accordance with the standards.

13. The HSE national high support and special care service should ensure that recommendations made in monitoring reports include a timeframe, where appropriate.

4. Children’s rights

Standard
The rights of children are reflected in all centre policies and care practices. Children and their parents are informed of their rights by supervising social workers and centre staff.

	<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>
Consultation		√	
Complaints	√		
Access to information		√	

Recommendations:

14. The HSE national high support and special care service and acting director of the HSU should, in line with relevant policies, review the routine practice of locking doors at night. There should be an ongoing process to monitor the effectiveness of this practice to ensure that it results in improved outcomes for children.

15. The HSE national high support and special care service should review the process of children's access to their care files, to ensure easy and safe access.

5. Planning for children and young people

Standard
There is a statutory written care plan developed in consultation with parents and children that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of children and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

	<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>
Suitable placements and admissions			√
Statutory care planning and review	√		
Contact with families	√		
Supervision and visiting of children	√		
Social work role	√		
Emotional and specialist support		√	
Preparation for leaving care	√		
Discharges	√		
Aftercare		√	
Children's case and care files	√		

Recommendations:

16. The HSE national high support and special care service should ensure that, in line with the admissions policy, an onward placement is identified for each child in a timely manner.

17. The HSE national high support and special care service should ensure that where the preferred onward placement option for a child is temporarily unavailable, a suitable alternative service should be secured as a matter of priority.

18. The HSE national high support and special care service should ensure that the aftercare service is sufficiently resourced to meet the needs of children placed in HSUs.

19. The HSE national high support and special care service should review and revise the way it delivers emotional and specialist supports to children, particularly those who continuously abscond.

6. Care of children

Standard
Staff relate to children 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.

	<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>
Individual care in group living		√	
Provision of food and cooking facilities	√		
Race, culture, religion, gender and disability	√		
Managing behaviour			√
Restraint		√	
Absence without authority		√	

Recommendations:

20. The HSE national high support and special care service should prioritise work with children to identify and develop their talents and interests both within and external to the HSU.

21. The HSE national high support and special care service should carry out ongoing reviews and analysis of restraints/physical interventions to assess its effectiveness in relation to decreasing the need for and number of physical restraints and/or interventions.

7. Safeguarding and Child Protection

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

	<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>
Safeguarding and child protection			√

Recommendations:

22. The HSE national high support and special care service and the director of the unit must as a priority review the effectiveness of the systems currently used to manage children's behaviour, including the management of unauthorised absences, so as to ensure better and safer outcomes for children.

23. The HSE national high support and special care service should ensure that all non care staff attend Children First (2011) briefings.

24. The HSE national high support and special care service should ensure that the status and outcome of all child protection referrals and investigations are feedback to the HSU by the relevant social worker where appropriate, in adherence with Children First (2011) guidance.

25. The HSE national high support and special care service should ensure that the policy and procedure on bullying is discussed with staff and children on an ongoing basis and that social workers take appropriate action and record their response to ongoing reports of suspected or actual bullying.

8. Education

Standard

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

	<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:

26. The HSE national high support and special care service should ensure that, in compliance with the standards, it makes every effort to encourage and facilitate the children to attend school and reach their educational potential.

9. Health

Standard

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

	<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>
Health		√	

Recommendation:

27. The HSE national high support and special care service should ensure that the files of all children contain a complete record of their immunisation history.

10. 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. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 & 13 of the Child Care Regulations, 1995.

	<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>
Accommodation		√	
Maintenance and repairs		√	
Safety		√	
Fire safety			√

Recommendations:

28. The HSE national high support and special care service should develop a temporary programme of work to ensure that the HSU is pleasant for the children living there, and safely maintained.

29. The HSE national high support and special care service should ensure that the HSU provides written confirmation from a qualified architect/certified engineer stating the centre is suitably compliant with the statutory requirements relating to fire safety as a matter of priority.

30. The HSE national high support and special care service should undertake a risk assessment of the safety system in place to ensure fire safety compliance, and develop mitigating actions as required. The risk assessment should consider the following factors:

- that there has been a number of incidents of children setting fires in the units
- that the external doors are locked from 20:00 to 08:00 hrs
- that the system is set such that on the alarm sounding there is no automatic release system to the external doors
- the external doors remain locked until opened by staff with a key (which they should carry at all times).

31. The HSE national high support and special care service should ensure that all staff participate in fire prevention and evacuation training.

32. The HSE national high support and special care service should ensure that all children and staff participate in fire drills and that all fire drills are recorded.

4. Summary of Recommendations:

1. The HSE national high support and special care service should ensure that the HSU's statement of purpose and function lists the key policies that guide care practice, and that all persons with a legitimate interest in the work of the HSU are aware of the statement and its contents.
2. The HSE national high support and special care service should develop a centre-specific quality assurance plan and processes to promote accountability, enhance compliance and improve the quality of outcomes for all children residing in the centre.
3. The HSE national high support and special care service should ensure that all data including significant events are aggregated for analysis and review, and that actions taken post analysis are monitored and reviewed on an ongoing basis to ensure service improvements and improved outcomes for children.
4. The HSE national high support and special care service should put in place a robust system to manage risk both at an organisational and operational level, including such issues as managing behaviour and fire safety.
5. The HSE national high support and special care service should review the process of carrying out risk assessments and the development of risk management plans to ensure that staff and managers are appropriately trained to develop and review quality risk assessments and risk management plans.
6. The HSE national high support and special care service should ensure that development work is carried out with managers and staff to promote a robust risk management culture.
7. The HSE national high support and special care service should ensure that all formal supervision is in line with HSE policy.
8. The HSE national high support and special care service should ensure that all personnel files contain a record of staff members' qualifications.
9. The HSE national high support and special care service should carry out a training needs analysis of all staff to ensure that they are appropriately trained and skilled to meet the ongoing and changing needs of the children in the centre, and that this informs the training programme.
10. The HSE national high support and special care service should ensure that all staff are supported to achieve appropriate professional qualifications.
11. The HSE national high support and special care service should ensure

that an induction programme is in place and that all new staff, including agency staff, are appropriately inducted to the unit.

12. The HSE national high support and special care service should ensure that the monitoring function is carried out in accordance with the standards.

13. The HSE national high support and special care service should ensure that recommendations made in monitoring reports include a timeframe, where appropriate.

14. The HSE national high support and special care service and acting director of the HSU should, in line with relevant policies, review the routine practice of locking doors at night. There should be an ongoing process to monitor the effectiveness of this practice to ensure that it results in improved outcomes for children.

15. The HSE national high support and special care service should review the process of children's access to their care files, to ensure easy and safe access.

16. The HSE national high support and special care service should ensure that, in line with the admissions policy, an onward placement is identified for each child in a timely manner.

17. The HSE national high support and special care service should ensure that where the preferred onward placement option for a child is temporarily unavailable, a suitable alternative service should be secured as a matter of priority.

18. The HSE national high support and special care service should ensure that the aftercare service is sufficiently resourced to meet the needs of children placed in HSUs.

19. The HSE national high support and special care service should review and revise the way it delivers emotional and specialist supports to children, particularly those who continuously abscond.

20. The HSE national high support and special care service should prioritise work with children to identify and develop their talents and interests both within and external to the HSU.

21. The HSE national high support and special care service should carry out ongoing reviews and analysis of restraints/physical interventions to assess its effectiveness in relation to decreasing the need for and number of physical restraints and/or interventions.

22. The HSE national high support and special care service and the director of the unit must as a priority review the effectiveness of the systems currently used to manage children's behaviour, including the management of unauthorised absences, so as to ensure better and safer outcomes for children.

23. The HSE national high support and special care service should ensure that all non care staff attends Children First (2011) briefings.

24. The HSE national high support and special care service should ensure that the status and outcome of all child protection referrals and investigations are feedback to the HSU by the relevant social worker where appropriate, in adherence with Children First (2011) guidance.

25. The HSE national high support and special care service should ensure that the policy and procedure on bullying is discussed with staff and children on an ongoing basis and that social workers take appropriate action and record their response to ongoing reports of suspected or actual bullying.

26. The HSE national high support and special care service should ensure that, in compliance with the standards, it makes every effort to encourage and facilitate the children to attend school and reach their educational potential.

27. The HSE national high support and special care service should ensure that the files of all children contain a complete record of their immunisation history.

28. The HSE national high support and special care service should develop a temporary programme of work to ensure that the HSU is pleasant for the children living there, and safely maintained.

29. The HSE national high support and special care service should ensure that the HSU provides written confirmation from a qualified architect/certified engineer stating the centre is suitably compliant with the statutory requirements relating to fire safety as a matter of priority.

30. The HSE national high support and special care service should undertake a risk assessment of the safety system in place to ensure fire safety compliance, and develop mitigating actions as required. The risk assessment should consider the following factors:

- That there has been a number of incidents of children setting fires in the units
- that the external doors are locked from 20:00 to 08:00 hrs
- that the system is set such that on the alarm sounding there is no automatic release system to the external doors
- the external doors remain locked until opened by staff with a key (which they should carry at all times).

31. The HSE national high support and special care service should ensure that all staff participates in fire prevention and evacuation training.

32. The HSE national high support and special care service should ensure that all children and staff participate in fire drills and that all fire drills are recorded.



Health Information and Quality Authority

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Action Plan ID 655

**Regulation Directorate
Action Plan for Inspection No. 655**

Centre ID: 257

HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
1	The HSE national high support and special care service should ensure that the HSU's statement of purpose and function lists the key policies that guide care practice, and that all persons with a legitimate interest in the work of the HSU are aware of the statement and its contents.	The HSE and National High Support and Special Care Services will ensure that the statement of purpose and function list the key policy areas and that all with a legitimate interest are informed. This will be signed by the Director.	Director	20.12.2013
2	The HSE national high support and special care service should develop a centre-specific quality assurance plan and processes to promote accountability, enhance compliance and improve the quality of outcomes for all children residing in the centre.	The HSE and National High Support and Special Care Services will ensure that a comprehensive review of the quality assurance plan will be undertaken in the unit with a view to improving the quality of outcomes for children and young people.	National Manager, Director, DD and Monitor.	31.03.2014

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
3	The HSE national high support and special care service should ensure that all data including significant events are aggregated for analysis and review, and those actions taken post analysis are monitored and reviewed on an ongoing basis to ensure service improvements and improved outcomes for children.	The HSE and National High Support and Special Care Services will ensure that all data will be aggregated and charted on a monthly basis and reported to the national manager along with a plan if there is increase in risk taking behaviour for any young person. This plan will be devised on the units, steered by the unit manager and deputy unit manager with the care team and in consultation with the Mater Support Service and the Social Worker for the individual young person department and family if relevant.	Director Unit Managers	To begin in December 2013 and reviewed every three month thereafter beginning end 31.03.2014

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
4	The HSE national high support and special care service should put in place a robust system to manage risk both at an organisation and operational level, including such issues as managing behaviour and fire safety.	<p>The HSE and National High Support and Special Care Services will ensure that a robust system will be put in place to manage risk both at an organisational level and operational level. Locally the centre will continue to work with stakeholders to ensuring that risk is identified and managed through the systems that are currently in place (SIRG, SERG, Care approaches, risk management plan, ICMP). These risks will be reviewed regularly and include such issues as behaviour management and Fire Setting, will be aggregated and charted on a monthly basis and reported to the national manager along with a plan if there is increase in risk taking behaviour for any young person.</p> <p>To ensure that positive change is taking place, and the system will include all stakeholders to ensuring that the risk can be reduced. All of above intervention will be used in order to identify and management the risk, and/or implement a course of action</p>	Director Unit managers	December 2013 and review every three month thereafter beginning end 31.03.2014

		<p>that requires change, which will include time frames, and what the centre can achieve. Targeted key working sessions will take place with the young people to address these behaviours.</p> <p>The Director of the centre will also keep the national manager abreast of any risks identified within the centre. These risks will be discussed with the National Manager and an agreement will include the following: Risk reduction/additional controls required, resources requirements, timescales for implementation, review date, completion date, performance measures and reporting and monitoring the requirements of the risks.</p> <p>Any serious risk will be identified through the National Managers Risk Register and also the centre's serious risk register.</p>		
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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
5	The HSE national high support and special care service should review the process of carrying out risk assessments and the development of risk management plans to ensure that staff and managers are appropriately trained to develop and review quality risk assessments and risk management plans.	<p>The HSE National High Support and Special Care service will deliver targeted workshops on risk management and assessment to managers and staff/care teams.</p> <p>This will enable the managers and teams to better identify risk factors and develop plans for each individual young person, as well as aggregating data, monitoring trends and sector developments.</p> <p>This will enhance the standard approach to risk assessment for each young person admitted thereafter.</p> <p>The management team will begin this process in early December so that it is rolled out by end 31.03.31.</p>	National Manager, Director Deputy Director Unit Managers.	20.12.2013 to end 31.03.2014

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
6	The HSE national high support and special care service should ensure that development work is carried out with managers and staff to promote a robust risk management culture.	<p>The HSE and National High Support and Special Care Services will map out an improved and consistent approach to risk Management.</p> <p>Standard Operating Procedures will indicate appropriate stages and tasks associated therewith and Join up actions between IRMP, ICMP's, Unit Risk Registers and H S & W Statements and a National Special Care Risk Register.</p> <p>Such SOP's will be quality assured each 6 months initially following implementation.</p>	National Manager Director Deputy Director Unit managers	14.02.2014 And Quality Assured @ 6 months x 2 initially following implementation.
7	The HSE national high support and special care service should ensure that all formal supervision is in line with HSE policy.	The HSE and National High Support and Special Care Services will ensure that staff continue to receive supervision in line with the new HSE policy. This will require an additional resource allocation.	Director Deputy Director Unit Manager Deputy Unit Manager	From November 2013

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
8	The HSE national high support and special care service should ensure that all personnel files contain a record of staff members' qualifications.	The HSE and National High Support and Special Care Services will ensure that all staff who have received qualifications post employment will provide the centre with a copy of their qualification within 6 weeks of a written request. The director will write to those who have yet to provide this requesting same. Once received these will be placed on the individual's personnel files.	Director Deputy Director	31.03.2014
9	The HSE national high support and special care service should carry out a training needs analysis of all staff to ensure that they are appropriately trained and skilled to meet the ongoing and changing needs of the children in the centre, and that this informs the training programme.	The HSE National High Support and Special Care Service & the unit will undertake a new training needs analysis. This will identify gaps in training on the whole but also areas specific to the needs and profile of the current young people. The identified training will be sourced from the following areas; MST, School, Workforce Development and any personnel on site who have a specific area of expertise. A plan will be developed to made to deliver this to the care team. The analysis will be completed by the Director, Deputy Director and unit mangers by 20.12.13 and the training rolled out from January 2014. Reviews of progress with training will take place on a monthly basis at managers meetings.	Director Deputy Director Unit management	Analysis by 20.12.2013 Training to commence by Jan 2014

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
10	The HSE national high support and special care service should ensure that all staff are supported to achieve appropriate professional qualifications.	The HSE and National High Support and Special Care Services will identify those staff who have not gained the appropriate qualifications. They will be informed that both DIT and ITB will cease running the In service degree in Social Care in 2014 therefore if they will be required to attend education on a full time basis if they are to achieve a qualification. As a release from duty will not be possible for some this will not likely be taken up by many staff. The staff will also be advised to clarify with CORU what the likelihood of their registration prospects will be at a future date. They may wish to consider an alternative route thereafter.	Director Deputy Director Supervisors All Staff	Informed by end December 2013 in writing.

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
11	The HSE national high support and special care service should ensure that an induction programme is in place and that all new staff, including agency staff, are appropriately inducted to the unit.	<p>Specific induction packages already exist for care staff and agency care staff. Any new member of care staff coming to the centre inclusive of those from an agency care will be assigned to an Induction programme as now.</p> <p>In addition any new agency ancillary staff will also receive an appropriate induction programme.</p> <p>Persons with the responsibility for providing same will include the Director, Deputy Director, Unit managers, Deputy Unit Managers and Co-ordinators/ experienced members of staff.</p> <p>The director will oversee the development and delivery of all induction packages specific to care, agency and non care staff and one unit manager and co-ordinator will oversee the updating of the induction package for care staff.</p>	Director Deputy Director Unit Managers Deputy Unit Managers Co-ordinators	January 2014

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
12	The HSE national high support and special care service should ensure that the monitoring function is carried out in accordance with the standards.	<p>In November 2013 a new monitor was appointed.</p> <p>Since her appointment the monitor has met with the national manager and the director and deputy director, the unit managers and some of the care team.</p> <p>In this meeting the focus of the monitors purpose and role in service has been clarified to ensure the function is to monitor service to ensure good quality care and compliance with the National Standards. The Director and Unit managers are awaiting confirmation of dates for the next audit.</p>	National Manager and Monitor Director Deputy Director	Completed to date however this process will be reviewed following the next audit.

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No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
13	The HSE national high support and special care service should ensure that recommendations made in monitoring reports include a timeframe, where appropriate.	<p>At the end of each audit and Quality Assurance Visit, the Director, Deputy Director and Unit managers will agree appropriate and achievable timeframes for response to recommendations.</p> <p>The director will then respond to the with an action plan; and designate responsibility to the relevant members of the team in order to respond too each aspect of the action plan in a timely manner.</p> <p>Both recommendations and the action plan developed from these will be forwarded to the National Manager.</p> <p>The Director will use the HIQA action plan as a starting point for the work of the new monitor. On her first visit.</p>	Monitor Director Deputy Director Unit Managers	16.12.2013 and following this on receipt of the initial feedback from the next Quality Assurance Visit

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No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
14	<p>The HSE national high support and special care service and acting director of the HSU should, in-line with relevant policies, review the routine practice of locking doors at night. There should be an ongoing process to monitor the effectiveness of this practice to ensure that it results in improved outcomes for children.</p>	<p>The centre has as part of practice has locked the centre door at 20:00 hours until 08:00 since it opened. The practice of routinely locking the door, allied with individual risk assessment, is a safeguarding measure.</p> <p>In line with the recommendation the practice will be reviewed again.</p> <p>A clearer process of ongoing monitoring of the effectiveness of this practice will be introduced to ensure that it results in improved outcomes for children and young people.</p> <p>At Unit level, in each unit the unit manager will take on responsibility to oversee that each current young persons absence record will be analysed to evaluate the reasons for their absence and if the locking of the front door at night contributes to the frequency, length and times of their absences.</p> <p>A standard Risk Analysis matrix will be used to evaluate this.</p> <p>This information will be then fed back to the National Management team.</p>	<p>National Manager Director, Deputy Directors, Unit Managers, Deputy Unit Managers MST and Key workers.</p>	<p>31.03.2014</p>

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No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
15	The HSE national high support and special care service should review the process of children's access to their care files, to ensure easy and safe access.	Currently the young people are allowed to access, and facilitated to access their files. It is not necessary that a young person does this in the presence of their social worker. This practice for allowing young people access to their files in the unit is to continue.	Director Unit Managers Deputy Unit Managers Key workers Care team	A clear record will be kept each time a YP access their file.
16	The HSE national high support and special care service should ensure that, in line with the admissions policy, an onward placement is identified for each child in a timely manner.	<p>In order to progress this matter the Director will meet with the CRC for area specific to each young person currently in the centre.</p> <p>The director will also write to the Principal Social Workers for each young person to inform them of the agreed discharge date for each young person currently in the centre.</p> <p>A commitment will be sought from the Area regarding onward placements. If this is not forthcoming the matter will, again be escalated to the National Office.</p>	Director, Unit Managers, Social Worker Principal Social Worker	Meeting and commitment by 10.12.2013 Escalations for these YP by 20.12.2013

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No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
17	The HSE national high support and special care service should ensure that where the preferred onward placement option for a child is temporarily unavailable, a suitable alternative service should be secured as a matter of priority.	The HSE National High Support and Special Care Services will endeavour to ensure that when a preferred onward placement option for a child or young person is temporarily unavailable a suitable placement should be secured as a matter of priority. The Director will convene a meeting with the CRC for the area specific to the young person. The director will write to the Principal social worker for each young person to inform them of the agreed discharge date for each young person currently in the centre. If a young person requires alternative placement and this is not available within the NHSSCS that a meeting will be organised with all stake holders to identify any alternative placement for the young person. The outcome of the meeting will be documented to ensure that all options have been identified and risk assessments carried out to ensure the suitability of the alternative placement is in line with the care plan.	Director, Unit Managers, Social Worker Principal Social Worker	10.01.2014 Escalations for these YP by 30.01.2014

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
18	The HSE national high support and special care service should ensure that the aftercare service is sufficiently resourced to meet the needs of children placed in HSU's.	<p>All young people close to or over 16 years of age will have 'Aftercare' as an agreed goal for their placement.</p> <p>The key workers and unit managers will continue the practice of referring the young person for an Aftercare service to their Social Work Teams/Areas who hold the responsibility for the resource in this area.</p> <p>Aftercare update meetings will be convened on a monthly basis with the relevant Social Work/Area teams for the relevant young people and records of these, decisions made and actions required will continue to be stored in the Aftercare Section of each young person's files.</p>	Unit Managers Deputy Unit Managers Key workers Social Work/Area Teams	20.12.2013

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
19	The HSE national high support and special care service should review and revise the way it delivers emotional and specialist supports to children, particularly those who continuously abscond.	<p>The HSE National High Support and Special Care Services will consult with the MST, SW and other clinical professionals in the arena (ACTS) to take an Overview of needs in care approach adopted to address such absences from a Behaviour management and support standpoint.</p> <p>Individual care approach plans will be reviewed at weekly meetings and at managers meetings to consider its appropriateness as the young person continues through their placement. The MST will also review any documentation on the young person's absences and offer their opinion on trends, reasons etc. and professional guidance regarding changes to interventions and support approaches.</p> <p>A record of this opinion will be recorded on the Risk Analysis form and will also inform specific actions and approaches of care teams and care planning.</p>	<p>National Manager Director Deputy Director Unit Managers Deputy Unit Managers SW MST ACTS</p>	<p>Overall consultation 31.03.2014</p> <p>Specific individual updates by 20.12.2013</p>

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
20	<p>The HSE national high support and special care service should prioritise work with children to identify and develop their talents and interests both within and external to the HSU.</p>	<p>The unit managers will again focus on ensuring that as part of the admission process, any hobbies are identified for each young person.</p> <p>An assessment will be made by the key workers and the unit manager about how to develop and promote these interests for each individual young person and what if any clubs/ classes are available to them and the level of support they might require to attend.</p> <p>Motivational approaches to engagement will be more specifically utilised and recorded as well as the outcomes of said interventions per motivation.</p> <p>Once the young person becomes involved, their progress will be monitored and documented.</p> <p>The Director will ensure an assessment is made of centre progress and improvements in this area and collate evidence indicating same by end Q2.</p>	<p>Unit Managers & key workers.</p> <p>MST</p> <p>Director</p>	<p>20.12.2013</p> <p>Evidence of improvements by end Q2</p>

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
21	The HSE national high support and special care service should carry out ongoing reviews and analysis of restraints/physical interventions to assess its effectiveness in relation to decreasing the need for and number of physical restraints and/or interventions.	<p>Any significant events recording physical restraints continues to be forwarded to the Director for his review and initial feedback which is recorded on the SERG Documentation.</p> <p>Once the SERG has taken place, any outcomes will be fed back into the young persons risk assessments, ICMP's and individual staff supervision.</p> <p>An analysis of any increase or reduction in physical restraints per individuals will be completed and documented on the SERG records.</p> <p>An aggregation of data will also inform individual, unit and sector strategies (see 3)</p>	National Manager Director Deputy Director Unit Manager	01.11.2013

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No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
22	The HSE national high support and special care service and the director of the unit must as a priority review the effectiveness of the systems currently used to manage children's behaviour, including the management of unauthorised absences, so as to ensure better and safer outcomes for children.	In each unit the unit manager will take on responsibility to oversee that each current young person's absence record will be analysed to evaluate the reasons for their absence length and times of their absences. And any trend emerging. A Risk Analysis template will be devised to evaluate this. This information will be then fed back to the National Management team.	Director, Deputy Director Unit Managers	15.01.2014
23	The HSE national high support and special care service should ensure that all non care staff attend Children First (2011) briefings.	The Director will deliver Children First briefings (2011) to all non Care staff and a record of their attendance will be placed on their personnel file.	Director	14.02.2014

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
24	The HSE national high support and special care service should ensure that the status and outcome of all child protection referrals and investigations are fed back to the HSU by the relevant social worker where appropriate, in adherence with Children First (2011) guidance.	All HSE National High Support and Special Care services have currently a process, however, because of the delay in receiving information. The Child Protection Officer will deal with child protection referrals through the Children First 2011 – however, if a young person is discharged from the centre and there are still is a concern which is outstanding and being investigated, the Child Protection Officer will: in the first instances write to the social worker, if nothing is resolved in two weeks, the Child Protection Officer will write to the social worker and their team leader, again two weeks will be given, if nothing is received following two weeks, the social worker, team leader and the principal social worker will be written to. Finally if nothing is heard that National Office will be contacted and they will contact the area manager of the area	Director Social Workers	01.11.2013

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
25	The HSE national high support and special care service should ensure that the policy and procedure on bullying is discussed with staff and children on an ongoing basis and that social workers take appropriate action and record their response to ongoing reports of suspected or actual bullying.	The unit managers have a robust and direct approach to managing incidents of bullying behaviour and have evidenced that the relevant social workers are happy with the outcome. The centre will promote an anti bullying culture which does not just respond to it but works towards preventing it on a continuing basis. This is done through immediately identifying the behaviour and in proactive individual work with the young people. It is supported by the team who are receiving training in Bullying which has been rolled out since April 2012 and will continue as a major part of the training for staff in the centre,.	Director Deputy Director, Unit Managers Deputy Unit Manager who has a specific knowledge in this area MST	01.11.2013

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
26	The HSE national high support and special care service should ensure that, in compliance with the standards, it makes every effort to encourage and facilitate the children to attend school and reach their educational potential.	<p>The HSE and National High Support and Special Care Services will work with the school the educational coordinator has created IEP's with consultation with key workers and unit managers. IEP's are designed to support and encourage young people reach their full potential in school and create opportunities to engage young people who have difficulty in attending school.</p> <p>Cognisance will also be taken of risk taking behaviour which leads to absences and efforts combined to and reduce the level of absences due to be Missing or absent at risk.</p>	Unit Managers, Key Workers and school and MST	<p>01.11.2013</p> <p>Review improvements in School Attendance stats at end of 31.03.14</p>
27	The HSE national high support and special care service should ensure that the files of all children contain a complete record of their immunisation history.	<p>The HSE and National High Support and Special Care Services will now be able to access a data base dated back to 1997 (DOCYA)</p> <p>This data base documents all immunisation records. At the pre-admission stage of each placement the unit manager will work with the assigned social worker to get this information.</p>	Deputy Director Unit managers Social Workers	01.11.2013

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No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
28	The HSE national high support and special care service should develop a temporary programme of work to ensure that the HSU is pleasant for the children living there, and safely maintained.	<p>Minor works needed will be scheduled out and costed.</p> <p>If a budget is allocated minor works will be completed.</p> <p>In 2014 there is capital investment available for a refit for special care.</p>	National Manager Director Deputy Director Unit managers	20.12.2013
29	The HSE national high support and special care service should ensure that the HSU provides written confirmation from a qualified architect/certified engineer stating the centre is suitably compliant with the statutory requirements relating to fire safety as a matter of priority.	The HSE and National High Support and Special Care Services is in liaison with Technical Fire Service regarding same fire compliance certificates.	National Manager, Director and HSE Estates. HSE Fire Officer	14.02.2013

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No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
30	<p>The HSE national high support and special care service should undertake a risk assessment of the safety system in place to ensure fire safety compliance, and develop mitigating actions as required. The risk assessment should consider the following factors:</p> <ul style="list-style-type: none"> • that there has been a number of incidents of children setting fires in the units, • that the external doors are locked from 20:00 to 08:00 hrs, • that the system is set such that on the alarm sounding there is no automatic release system to the external doors, • the external doors remain locked until opened by staff with a key (which they should carry at all times). 	<p>The deputy director for the centre has completed a fire plan and it has been submitted to the Fire officer for Signature.</p> <p>The National Management team will be notified of this once it is received.</p>	Director and Deputy Director	<p>Submitted to Fire Officer</p> <p>2nd December 2013</p> <p>Sign off requested by 16 December 2013</p>

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HSE Area: HSE DNE

No.	Recommendation	Action to be taken	Person Responsible	Implementation Date
31	The HSE national high support and special care service should ensure that all staff participate in fire prevention and evacuation training.	The HSE High Support and Special Care service in conjunction with the Health and Safety Committee has completed an audit of the last 18 months of fire drills to evaluate who had not attended these drills, since October 2013 fire drills has taken place to ensure participation of staff who hadn't or haven't for a period of time participated in fire drills. The centre has completed three fire safety training on 16 th October 2013, 5 th November 2013 and 3 rd December 2013. Due to sick leave and annual leave there are 3 members of staff outstanding to complete this training.	Director Deputy Director Health and Safety Group	3 December 2013 and 31.03.2014
32	The HSE national high support and special care service should ensure that all children and staff participate in fire drills and that all fire drills are recorded.	All Fire drills are recorded, and any issues that arise from these drills are recorded and followed through on. Fire drills have since taken place at different times during the day and including in the evening time. If a young person refused to participate in the fire drill, contact is made with the young person social worker, they are informed of their refusal. Work would take place with the young person to ensure that they understand the importance of these drills.	Director Deputy Director Health And Safety Committee	01.11.2013