A

CRISIS INTERVENTION SERVICE (HOMELESS)

IN THE

HSE WESTERN AREA

FINAL

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1. Analysis of Findings

The Social Services Inspectorate carried out an announced inspection of a crisis intervention service in the HSE Western Area (HSEWA) under the provision of Section 69 (2) of the Child Care Act, 1991 in February 2007. The centre provided a regional crisis intervention service for the three Local Health Office areas of Galway, Mayo and Roscommon.

The centre was opened in July 2005 and was an amalgamation of two separate services which had provided accommodation services for homeless children and young people in Galway. The service was developed at a time when there was a reduction in the overall number of residential care spaces in the region. It had not previously been inspected.

The centre was located in a small housing estate close to the city. It had a capacity for six children and young people of mixed gender aged 0 – 18 years. At the time of the beginning of the inspection, there were four young people living in the centre. However, at the time of the fieldwork inspection there were two young people living there, one of whom had returned on the final day of inspection having been absent for two nights.

Since the service opened in July 2005 to the time of inspection there had been 126 admissions, ranging in age from four months to seventeen and half years. The centre's purpose and function stated that the "objective of the centre is to respond promptly to a request for a brief emergency placement (5 days) for children and young people who require accommodation on an emergency basis".

Inspectors found that the admissions to the centre under the purpose and function were so diverse that staff's capacity to provide safe care was significantly impaired. In particular the wide age range compromised the provision of safe care, and this was the consensus of all personnel interviewed during the inspection. Inspectors were concerned that the pattern and style of admissions jeopardised the viability of the centre at times.

Inspectors have, in their considerations and recommendations, taken into account the short term and emergency nature of this centre. There is an understanding that, in the initial stages of a child's placement, there may be less information available, or an educational placement may have been disrupted due to the reasons for the admission. It may be found that care planning may be less developed; however, this is not a reason to find that it has not started. Indeed, where children have had repeated admissions, there is a particular requirement that additional attention is given to issues that may get overlooked during emergencies. The same message applies to medical attention. The child who requires an emergency admission should, in particular, have a thorough medical assessment. Findings and recommendations across the standards in this report take account of the short term nature of the centre.

Practices that met the required standard

Inspectors found a commitment among centre management and staff to the children and young people in their care, despite the complexity and challenges of caring for a wide age range of children and young people. Some young people had been repeatedly admitted to the centre over the year prior to inspection. Inspectors found resilience among the staff team to persist with the young people even when they had presented with challenging and difficult behaviour.

There was an adequate management structure in place. Efforts were made to maintain a cohesive team approach. An external facilitator had been contracted to work with the staff team on issues relating to team development. The facilitator had met with the staff team on one occasion at the time of inspection and there was agreement for the work to continue. The centre manager attended monthly meetings with managers and deputy managers from the two other residential services in the county. On occasions the line manager for the three services attended these meetings. There was an on-call structure in place for out of hours and weekends which was provided by local centre managers on a rota basis. Staff received regular supervision from the centre manager and the deputy manager and were satisfied with the support they received through supervision and with the training they received from the training unit. In general administration files were well maintained but need to be reviewed to ensure better accessibility.

The accommodation was of a high standard. It consisted of two, three bedroom semi-detached houses with a combined living area and two connecting back gardens. The young people had individual rooms. Boys were in one of the houses, the girls in the other with shared living space downstairs. There was also a family bedroom in one of the houses which catered for a sibling group. Funding had been sought to construct a purpose-built play area for one of the gardens. The standard of furnishings and fittings was good. The maintenance of the centre was carried out by local contractors and response to requests for repairs was prompt and effective.

Practice in relation to consultation was good. Young people's meetings took place regularly in the centre and they were consulted and given choice in relation to shopping, choice of food and day to day activities. Young people were encouraged to read their daily logs. One of the young people stated that her views were heard and she clearly understood her rights to access information and the complaints procedure.

Specialist services were available to those young people who required them. However, formal routes to accessing specialised services should be made available.

For the most part the centre had a proactive approach in relation to contact with families. Despite the crisis nature of admissions to the centre, consistent efforts were made to contact and liaise with the children and young people's parents and carers.

Practice in relation to vetting of staff was good.

Practices that met the required standard in some respect only

External line management
Inspectors were concerned at the lack of direction and support from external management in the operation of the centre. There was evidence of a breakdown in communication. Inspectors received conflicting accounts as to whether the centre manager had knowledge of the budget allocated to the centre in the year prior to inspection. The centre manager was line managed by the child care manager. In the previous year there was confusion regarding which manager offered supervision to the centre manager and this resulted in a supervision gap from January to September. Inspectors were concerned that despite informal consultation occurring, formal supervision did not occur regularly, with seven supervisions being cancelled in the previous year. Given the purpose and function of the centre; with a large number of admissions, the emergency nature of the work, and the risks to safety for all

concerned, it is essential that the centre manager is offered supervision for the joint purposes of professional support and accountability.

Staffing/rosters
The staff team comprised the centre manager, a deputy and 10 full-time child care posts, including one child care leader post. They were assisted by an established shared relief panel of 25 staff which was available to the three residential centres in the county. A small core group from this relief panel contributed to the core staffing hours and covered for sick leave and annual leave in the centre. The staff team demonstrated patience in providing a 24 hour emergency crisis service, at times dealing with young people who presented very challenging behaviour but who were also very vulnerable.

Inspectors were of the view that at times staff were not adequately deployed to meet the safety and general needs of the children and young people in the centre. There was provision for a minimum of two staff to be rostered at all times. On reviewing the roster for the three months prior to inspection inspectors found that whilst there were three staff available for Monday, Tuesday and Wednesday evenings, in general two staff were rostered for the remaining nights and weekend periods. Staff should be deployed to ensure that experienced staff are available for times of risk. The staff roster did not allow for the attendance and participation of all staff at weekly team meetings. This did not meet the standard on effective communication, team working and accountability as there was no occasion since the service was established, that all members of the staff team were together.

Monitoring
The monitoring officer visited the centre regularly. He was available to the staff and manager for consultation and staff told inspectors that they found the role of monitoring officer supportive. He submitted comprehensive written reports to HSE managers on the standard of care of the children and young people. In a recent monitoring officer's report nine recommendations were made concerning the care of the children and young people. Specific recommendations relating to the purpose and function of the centre were made. Whilst some of the recommendations had been implemented, inspectors were concerned that the review of the purpose and function was not.

The monitoring officer made a recommendation in a monitoring report of November 2006 calling for a review of a crisis that had occurred when the centre was closed to new admissions, three months prior to the inspection. The Child Care Manager in response to this recommendation established a review and terms of reference for this review were drawn up. However, inspectors found that the terms of reference did not reflect all the concerns of the monitoring officer. Inspectors considered that it would have been more helpful if the monitoring officer was involved in drawing up the terms of reference. Inspectors received a copy of the report of the review and proposed action plans and recommend that they are also shared with the monitoring officer. The role of the monitoring officer is an important safeguarding factor and his recommendations should be given due consideration by all in management. For this standard to be met, his recommendations must be implemented in a timely fashion.

Care planning

There was a good level of contact and communication between centre staff and social workers. Social workers were aware that they could read centre records but only some of them had done so. At the time of inspection the two young people in the centre had allocated social workers who had visited and/or had daily contact with them. However, inspectors were of the view that the standard of statutory care planning and review was inconsistent. A care review was held the day preceding inspection for one of the young people who had four previous admissions to the centre in the seven months prior to inspection. Whilst some arrangements for care plan meetings were made by the centre manager and staff, care planning is the responsibility of the social workers. Inspectors found no current updated care plans for the two young people in the centre at the time of inspection. Both had previous admissions to the centre and were known to social work departments for some time. Inspectors were told the centre had experienced ongoing difficulties in ensuring that there were updated care plans in place for many of the children and young people. Inspectors are of the view that the multiple admissions of 30 children and young people over the 15 months since the centre opened are a serious indictment of a lack of overall care planning and promote drift in placement for young people. In the absence of care plans staff devised placement plans. These do not meet the requirements of the regulations.

Aftercare

Inspectors were told of a dedicated aftercare service in the region and the line manager told inspectors that there was a dedicated after care worker available to work directly with the centre. However, inspectors were told by staff, centre manager and monitoring officer that they were not aware of this arrangement. Inspectors found that no young person had availed of this service at the time of inspection.

Management of behaviour

Difficulties encountered by staff in effectively managing challenging behaviours led to the temporary closure of the centre to admissions three months prior to inspection and again on the day before inspection commenced. Staff were trained in the use of Therapeutic Crisis Intervention and used de-escalation techniques, but physical restraint was not used. Inspectors were of the view that staff required a revised framework for risk assessment in the centre as the model of risk assessment in use was not effective in managing serious, difficult and at times violent behaviours. An Garda Siochana were called to the centre on occasions to manage young people's difficult and violent behaviours. The HSE should ensure that they have their own policy guidelines on behaviour management and the need to involve An Garda Siochana should be an exceptional occurrence and not part of routine practice. The potential for serious consequences concerning the safety of all the residents when these situations occur was identified by the centre manager, staff, social workers and monitoring officer. Inspectors were told by staff and social workers that when some of the young people's behaviour was unpredictable and volatile other residents experienced emotional peer abuse. Young people were moved onto other placements quicker than was previously planned due to concerns for their safety. Line management needs to provide leadership and direction in the management of difficult and violent behaviour and this must include a review of admissions and the development of competence and confidence of the staff to effectively manage such behaviours.

Safeguarding

Whilst safeguarding principles were well understood by centre staff and management inspectors were concerned that child protection principles were not so well understood. One of the young people living in the centre who had a history of absconding was missing from the centre two days prior to inspection. Staff had activated the agreed protocol between the HSEWA and An Garda Siochana on unauthorised absences; but inspectors found that there was a lack of protective strategies outside the centre to manage the real risks for this young person which were well known to staff and social workers. Staff were confused as to how to report a child protection concern in accordance with *Children First, National Guidelines for the Protection and Welfare of Children.* A report of a child protection concern was completed on a significant event notification form, a child protection notification and/or on a HSE risk management duplicate book. A guidance document for the reporting of significant events, which included the reporting of child protection concerns, had been developed and submitted to the Local Health Manager with lead responsibility for child care in HSE West. At the time of inspection this guidance document was yet to be signed off.

Health
Practice in relation to health care was generally good. However, inspectors found few comprehensive medical histories for children and young people as required by regulations. Social Workers should arrange medicals on admission as appropriate to the emergency admission and gather medical histories from parents and carers where possible. Inspectors considered that due to the wide ranging ages, and mix of children and young people, there was a particular need for advice and guidance in areas of children and teenage health issues.

In particular, appropriate sexual health education was needed for those young people who may not have access to such information, and who had not been attending school or training on a regular and consistent basis.

Education
The centre had developed good links with local school placements. This assisted speedy placements for children and young people who moved to the centre. One of the young people was assisted by his social worker to continue to attend his school, outside the area by the provision of daily transport. However, inspectors were made aware that some of the young people who had repeated admissions to the centre were not in attendance at school or training on a consistent basis. The local HSE had access to tuition services but this was limited to six hours per week for three residential services in the area. One of the young people in the centre who had attended secondary school for approximately three full days of the school term since January 2007 to the time of inspection, could only access this tuition service for one hour per day. This is not acceptable, and the HSE should ensure that children of school age can access a range of options as appropriate to ensure they continue their education and/or training on a consistent basis.

Fire and safety
A fire safety audit was completed in September 2006. The outstanding recommendations should be implemented as a matter of priority. A Health and Safety Audit was completed in May 2006 and the outstanding recommendations should be implemented. Inspectors found it difficult to gain information concerning health and safety from the audit form and recommend a review of the forms used to complete a health and safety audit in a children's residential centre.

Practices that did not meet the required standard

Purpose and function
The purpose and function of the centre was to provide a "brief emergency placement, (five days) for children and young people who require accommodation on an emergency basis". Inspectors were told of concerns about the purpose of the centre by centre staff, social workers, HSE managers and others during the course of their fieldwork. In particular, inspectors were aware that the local HSE monitoring officer had commented on this issue at length in a monitoring report and were made aware that on the day before the inspection fieldwork began a meeting of key HSE managers and staff had begun the process of a review of the purpose and function of the centre. Inspectors advise that An Garda Siochana should be consulted by this group as it goes about its work.

Inspectors found that the standard of purpose and function was not met for the following reasons:

1. The centre was obliged to take all referrals, even where the manager thought that a new admission could put at risk the safety and welfare of children, young people and staff.

2. Due to a shortage of residential placement options in the region, as described by the manager and other professionals, children and young people stayed longer than the time as specified by the purpose and function (5 days). The monitoring officer found that five young people who had been placed in local residential centres in the 15 month period prior to his monitoring report of November 2006, had each spent an average of 99 days in the centre prior to securing a more permanent placement in a residential centre.

3. An Garda Siochana effected placements under Section 12 of the Child Care Act 1991. Of the 18 children and young people admitted since the monitoring officer's report of November 2006, 12 were admitted under Section 12. At times some of these children and young people were under the influence of alcohol or drugs and frequently did not want to stay in the centre. It was not clear to inspectors how the needs of these young people could be met in the provision of emergency accommodation that also provided accommodation for babies and young children.

4. The centre had a broad age range of children and young people, from babies to volatile, discontented teenagers. It was not possible to provide a safe and suitable environment with the mix of demands being made on the staff group. Inspectors found evidence of children being discharged prematurely due to concerns for their safety. Inspectors are of the view that a short term emergency centre is not a suitable placement for babies and young children and that the HSE should have other arrangements in place to meet this need.

Child Protection
One of the parents's interviewed by inspectors described serious differences of opinion about the safety and welfare of their child. Inspectors shared these concerns and have written to the HSE regarding the matter. The concern's relate to responses by social workers and centre staff to unauthorised absences.

2. Introduction

The Social Services Inspectorate carried out an announced inspection of a children's residential centre in the HSE Western Area. Mary Tallon (lead inspector) and Mike McNamara (support inspector) conducted the inspection over a two day period from the 15th to the 16th February 2007.

2.1 Methodology

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

- The unit's statement of purpose and function
- The unit's policy and procedures
- The young people's care files
- Questionnaires completed by Social Workers (three)
- Census forms on management and staff
- Children's census forms
- The monitoring officer's reports
- Administrative records
- Health and safety records
- Confirmation of insurance
- Details of unauthorised absences (75) and physical restraints (0) since the centre opened (16 months prior to inspection)
- A sample of the staff duty roster

In the course of the inspection, inspectors interviewed:

1. The centre manager
2. The deputy manager
3. Two child care workers
4. One young person
5. The monitoring officer, HSEWA
6. Two social workers
7. The child care manager, Galway
8. The general manager, Galway

As well as those above the lead inspector had telephone interviews with a parent and a social worker.

2.2 Acknowledgements

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

2.3 Management structure

The centre manager reported to the local child care manager who was also line manager for two other child care residential services in Galway city and county. The child care manager reported to the local general manager. The centre had a deputy manager.

2.4 Data on young people

Young Person	Age	Length of Placement	No. of previous placements
#1 (male)	14 years 5 months	14 days	1 readmission to this centre
# 2 (female)	14 years 8 months	14 days	4 readmissions to this centre 4 previous foster care placements
# 3 (female)*	16 years 11 months	3 days	1 readmission to this centre
# 4 (male)*	15 years 11 months	3 days	2 readmissions to this centre

*** = Between the time of the census and the inspection fieldwork, two young people, were discharged from the service**

3. Findings

3.1 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 young people and the manner in which care is provided. The statement is available, accessible and understood.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Purpose and function			√

Recommendations:

1. The HSE Western Area should revise the purpose and function of the centre as a matter of urgency.

2. The HSE Western Area should ensure that there are sufficient and suitable alternative placements available for babies and young children in the event that they require emergency placements.

3.2 Management and staffing

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

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

Recommendations:

3. The HSE Western Area should ensure that there is effective external management of the centre.

4. The HSE Western Area should ensure that staff are rostered in a manner that meets the needs of children for stability and safety and allow for staff to attend regular team meetings.

5. The HSE Western Area should ensure that staff receive further direction, training and support in managing out of control and challenging behaviours.

3.3 Monitoring

Standard
The health board, 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.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Monitoring		√	

Recommendation:

6. The HSE Western Area should ensure that the monitoring officer's recommendations are implemented without undue delay and to his satisfaction.

3.4 Children's rights

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Consultation	√		
Complaints	√		
Access to information	√		

3.5 Planning for children and young people

Standard
There is a statutory written care plan developed in consultation with parents and young people 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 young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Suitable placements and admissions		√	
Statutory care planning and review		√	
Contact with families	√		
Supervision and visiting of young people		√	
Social work role		√	
Emotional and specialist support		√	
Preparation for leaving care		√	
Aftercare		√	

Recommendations:

7. The HSE Western Area should ensure that children are appropriately placed and that there is a review mechanism in place to ensure that children are not repeatedly admitted nor that their length of placement in the centre is prolonged.

8. The HSE Western Area should ensure that the care planning and review process complies with statutory requirements for emergency placements, and all children and young people have access to the HSE aftercare team.

3.6 Care of young people

Standard
Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Individual care in group living	√		
Provision of food and cooking facilities	√		
Race, culture, religion, gender and disability	√		
Managing behaviour		√	
Restraint		√	
Absence without authority		√	

Recommendations:

9. The HSE Western Area should ensure that centre staff and management are provided with support, direction and guidance in the management of difficult and challenging behaviour.

10. The HSE Western Area as a matter of priority, should revise the centres' risk assessments system of managing children and young people's behaviours. Risk management plans should be monitored by external line management.

3.7 Safeguarding and Child Protection

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Safeguarding and child protection		√	

Recommendations:

11. The HSE Western Area should ensure staff consistently follow the local child protection notification policy and procedures.

12. The HSE Western Area should ensure that adequate protective strategies are in place for children and young people identified as being "at risk" when they abscond from the centre.

3.8 Education

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Education		√	

Recommendation:

13. The HSE Western Area should ensure the necessary young people who do not attend school or training on consistent regular basis have access to educational and training opportunities.

3.9 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.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Health		√	

Recommendations:

14. The HSE Western Area should ensure medicals are carried out in accordance with the Child Care Regulations, 1995 taking into account the age and consent of the children, as soon as possible following their admission.

15. The HSE Western Area should ensure there is an ongoing programme available for the young people on teenage sexual health issues.

3.10 Premises and Safety

Standard
The premises are suitable for the residential care of the young people 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.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Accommodation	√		
Maintenance and repairs	√		
Safety		√	
Fire safety		√	

Recommendations:

16. The HSE Western Area should ensure that the outstanding recommendations of the fire safety audit are completed.

17. The HSE Western Area should ensure that written confirmation of compliance to fire safety and building control requirements is provided in accordance with Standard on fire safety 10.19.

4. Summary of recommendations

1. The HSE Western Area should revise the purpose and function of the centre as a matter of urgency.

2. The HSE Western Area should ensure that there are sufficient and suitable alternative placements available for babies and young children in the event that they require emergency placements.

3. The HSE Western Area should ensure that there is effective external management of the centre.

4. The HSE Western Area should ensure that staff are rostered in a manner that meets the needs of children for stability and safety and allow for staff to attend regular team meetings.

5. The HSE Western Area should ensure that staff receive further direction, training and support in managing out of control and challenging behaviours.

6. The HSE Western Area should ensure that the monitoring officer's recommendations are implemented without undue delay and to his satisfaction.

7. The HSE Western Area should ensure that children are appropriately placed and that there is a review mechanism in place to ensure that children are not repeatedly admitted nor that their length of placement in the centre is prolonged.

8. The HSE Western Area should ensure that the care planning and review process complies with statutory requirements for emergency placements, and all children and young people have access to the HSE aftercare team.

9. The HSE Western Area should ensure that centre staff and management are provided with support, direction and guidance in the management of difficult and challenging behaviour.

10. The HSE Western Area as a matter of priority, should revise the centres' risk assessments system of managing children and young people's behaviours. Risk management plans should be monitored by external line management.

11. The HSE Western Area should ensure staff consistently follow the local child protection notification policy and procedures.

12. The HSE Western Area should ensure that adequate protective strategies are in place for children and young people identified as being "at risk" when they abscond from the centre.

13. The HSE Western Area should ensure the necessary young people who do not attend school or training on consistent regular basis have access to educational and training opportunities.

14. The HSE Western Area should ensure medicals are carried out in accordance with the Child Care Regulations, 1995 taking into account the age and consent of the children and to be carried out as soon as possible following their admission.

15. The HSE Western Area should ensure there is an ongoing programme available for the young people on teenage sexual health issues.

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