An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 069

Year: 2021

Inspection Report

Year:	**2021**
Name of Organisation:	**Peter McVerry Trust**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced**
Date of inspection:	**19th,20th & 21st May 2021**
Registration Status:	**Registered 3rd of October 2019 to the 3rd of October 2022**
Inspection Team:	**Eileen Woods** **Lorraine Egan**
Date Report Issued:	**6th August 2021**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in March 2014. The centre moved to a new location in February 2021 and this was the first inspection in the new location. The centre was in its third registration and was in year two of the cycle. The centre was registered without attached conditions from the 3rd of October 2019 to the 3rd of October 2022.

The centre was registered to provide medium to long term care for up to three young people aged between twelve to eighteen years old. The centre can provide single or multiple occupancy on a needs basis and the centre aims to meet the needs of young people who may require a higher level of individualised support for a period of time. The model of care was based on trauma and attachment informed theory and included an assessment of outcomes, promotion of the young person's wellbeing and the implementation of a strength based approach. This was structured through the use of individualised planning and a high level of staff support. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those

concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 5th of July 2021 and to the relevant social work departments on the 5th of July 2021. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 16th of July 2021. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 069 without attached conditions from the 3rd of October 2019 to 3rd of October 2022 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

This centre was operating in compliance with the Children First Act 2015 and the Children First: National Guidance for the Protection and Welfare of Children 2017. The centre worked in accordance with the organisations child protection and safeguarding policies and procedures that were developed and reviewed in line with the relevant legislation and national guidance documents. The most recent review of these policies was completed in February 2021. The policies contained the terms and definitions of abuse and harm, reporting procedures and the relevant roles as identified by the national guidelines.

The additional complementary policies to guide good safeguarding were co-ordinated with the child protection policy and included whistle blowing, safe practice, complaints, bullying prevention and intervention, social media and procedures for types of reporting. The centre had developed a child safeguarding statement and had received a letter of compliance from the Tusla Child Safeguarding Statement Compliance Unit. The safeguarding statement was clearly displayed in the office and a copy was available to all parties.

Inspectors found that the staff had completed training in the form of the compulsory Tusla E-Learn module 'Introduction to Children First' and had received, and were due to receive again, internal training on the organisations child protection policies from the regulation and compliance manager. Inspectors found that through interviews and questionnaires that staff had a core understanding of the principles and practices in child protection. The additional complementary child safeguarding focused policies were less clearly understood for some staff in interview and questionnaires and the inspectors recommended that the centre management revise these with them. The roles of mandated persons and the designated liaison person, DLP, were well defined and known by the team. The centre management had implemented a child protection reporting register and across the team there was leadership and mentoring evident for skills development in identifying and reporting concerns. The centre was an identified resource for young people who may require a

higher level of support and, who may alongside this, display high risk behaviours. At the time of this inspection there were eleven entries on the child protection register related to the resident young people since February 2021. Inspectors found that the guidance on the policy and from management to staff placed an emphasis on reporting their concerns through the web portal and where it did not meet the threshold for mandated reporting to indicate this by not ticking the mandated report box. There were procedures for 'recognising where reasonable grounds for concern exist', mandated reporting and 'consequences of non-reporting' these were accompanied by relevant additional procedures to support them.

There was evidence on file and from social workers of collaborative interdisciplinary work being implemented through regular core group or professional's meetings in response to child protection concerns. The social work team leader for one young person gave feedback that they were happy with the level of child protection reporting completed, that it was proportionate and merited, and that they had implemented actions from the social work department to respond.

There was evidence that staff worked in collaboration with the child and their social worker in the identification of specific vulnerabilities and safety concerns, this commenced from the pre-admission stage and progressed through the ongoing placement in the risk and behaviour management planning and intervention documents.

The team displayed a good awareness and regard for the young people's families and communities and their current vulnerabilities. The two young people residing at the centre at the time of the inspection had key working, placement plans and behaviour and risk management plans in place geared towards targeted interventions. Inspectors found that additional complementary training and resources would be recommended to continue to add to the skills base for this specialised service, these are addressed under section 6.4 of this report, these included advanced skills in harm reduction, online safety and regularly referred to tools like 'daily life events'.

The young people were supported to speak out and there were records and conversations were recorded where a young person told staff about aspects of their life and safety issues when outside the centre. Inspectors were told by both young people that they knew the complaints system and how to use it. There was a complaints policy in place for the centre and locally resolved issues only were observed on the relevant register. There had been no formal complaints recorded. The matters raised had been addressed with the young person involved but also

highlighted ongoing vulnerabilities in their information processing and this had been noted for external clinical referral. Inspectors recommended to the management that they oversee that opportunities are afforded to young people to have access to the formal complaints procedure with ease and that local resolution not be relied upon.

One parent responded to inspectors offer to meet with them to hear their views that they declined to meet on this occasion but wanted inspectors to know that they were happy at this time with the support and work in place by the team.

Child protection was a regular agenda item on senior management meetings, internal senior meetings and team meetings and there was good evidence of policy review and discussion of procedures at these forums. The director of services had a system in place whereby all notified child protection matters were tracked to support accountability and accurate reporting to the Board of Management. They verified that data protection arrangements and confidentiality had been taken account of regarding the management and retention of this information.

The centre staff were aware of the content and purpose of the whistleblowing policy and protected disclosures.

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

The centre staff operated a policy of strengths based behaviour management and a model of care which supported an attachment and trauma informed approach to understanding behaviours that challenge. There was praise, encouragement and the linking of feelings and behaviours utilised as purposeful key working interventions. The model and policies were rooted in evidence-based theory and practices were tracked for impact. The staff team and management spoke knowledgeably about their practices in this area. The team co-ordinated their work at team meetings, supervision and in the development of key work planning. The young people had individual crisis support plans, risk management plans and suitable safety plans on file that were up to date, inclusive of the known risks and emerging risks where present. Incentives plans were utilised along with diversionary programmes to support young people with better choices.

The staff had received training in the relevant model for management of crisis behaviours, the training approach to the model had been adapted, it now took place through guidance from the experienced team leaders and manager and two monthly

consultations with the identified expert. The behaviour management approach had been audited by the external regulation and compliance manager and will continue to be audited on a regular basis given the specific purpose of the centre. External management were satisfied to date with the integration of the model of care following a change in social care manager and changes to the staff team that took place during the centres move to a new location. Additional training in one of the key intervention tools had not been revised since 2019 and should now be planned for those staff who have not received it.

Inspectors found that the staff had good knowledge of the model of behaviour support and implemented it in practice. There was supervision and structured mentoring in place from the social care leaders for newer staff that guided their development and work with the young people. The young people spoke to inspectors and neither had any issue with their care and support at the centre. One explained that the rules were fair and clear and that there were plenty of staff available should the young person wish to link in. A second young person presented as requiring ongoing support with understanding the policies in place, fro exmaple in relation to sanctions. Inspectors found that staff did seek to work with young people in accordance with their developmental stage and abilities.

There was evidence of collaborative working with other professionals in social work, addiction and mental health to develop suitable plans and also to respond to escalating crisis where they arose. There had been specialist team sessions with external professionals in preparation for admissions and several team members had completed certified training in restorative practices. Two staff were currently on a training programme running on autism.

A previous young person who recently lived at the centre experienced placement breakdown due to complex addiction issues and the management and staff stated that they had reviewed the outcome and strategies they utilised in that situation. Delays in interagency communication, referral and treatment were identified as key factors. Some of this had been further impacted by the national pandemic response and inspectors encouraged more integration of additional training to support staff in maintaining young people in placement through similar issues should they arise again.

The centre staff had a policy on restrictive practices available to them and inspectors found that this policy was not well known across the team. The team had a clear understanding of the principle of a restrictive practice but had not clearly defined

what might be understood as restrictive practices within the centre outside of one or two items like the alarming of bedroom doors at night. Inspectors found the team should review their practices and the policy to ensure that they fully evidence a rights based approach to restrictive practices. They should address what may fit the criteria for a restrictive practice and to evidence more clearly the use of risk assessment and review once a restrictive practice is introduced to assess the removal or its ongoing use.

The inspectors were informed that a restrictive practice register was being introduced and would be reviewed monthly by management with external management in support of the further roll out of restrictive practices monitoring procedures. Inspectors were satisfied that the commitment given to introduce this register and that the date for same had been identified. The social care manager must then ensure that the team review the policy and what can be a restrictive practice.

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

The centre operated in accordance with the principles and ethos of the Trust they were part of, this was evidenced in the feedback from the staff on the shared purpose and leadership in place within the centre and from the external management. The staff named that the social care manager maintained an open door policy and that they and the team promoted a culture of positive professional contributions at team meetings. The team identified to inspectors the named persons internally like the social care manager, who was also the DLP, as well the external management as persons to whom they could report any concerns or incidents. The two young people also knew the management, their key workers and were aware of external bodies like EPIC as advocacy services for young people in care. There was a young person's booklet, key working and young people's consultation schedule in lieu of a shared young people's meeting, which was the preferred option for the young people at that time.

The centre staff completed timely and suitable reporting of significant events, both challenging and positive, to their social workers, guardian ad litum and relevant professionals. The families of the young people were informed verbally in accordance with their wishes, social work department or court directions or personal circumstances. There was evidence of discussion, support and review with these parties and the views of a parent were found to be reflected on plans stemming from significant events such as the review of absence management plans.

The written reports were expressed in clear and non-judgemental language and there were efforts to verify information where it related to risks in order to be accurate. The centre manager identified significant incidents meeting the threshold for escalation and there was a system in place with the director of services regarding this. The significant event reports were read and reviewed by internal management and staff were supported to develop their skills in this area.

There was a significant event review group, SERG, mechanism at senior management team level that utilised a template to record its work. The template was partially utilised on those that the inspectors reviewed, the learning outcomes section was not completed. The immediate risk response outcomes were trackable as implemented at the centre and the centre staff also reviewed significant events on a regular basis at their weekly team meetings. For the wider learning outcomes to be clearly evidenced from the external SERG to the staff team the use of the full template and the recording of the feedback from it to the centre staff team should be better recorded.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.1**
Practices met the required standard in some respects only	**Standard 3.2** **Standard 3.3**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager must ensure that the team review the restrictive policy practice and procedure, there should be a focus on identifying what may constitute a restrictive practice.
- The management team must ensure that they generate, record and share learning outcomes from external incident reviews completed by the significant event review group.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

The centre had a social care manager and ten full time staff. Three of the staff were social care leaders and all staff were suitably qualified. The roster always allowed for three staff on duty. The staffing ratio had been agreed with Tusla to meet the purpose and function of placements for young people who required a higher level of care and support, for example when stepping down from secure care. There was also a panel of relief staff available for the centre. The Covid-19 staffing contingency plan was implemented when required.

The staff team had a mix of experienced staff who moved with the centre to its new location, the team members had the option to remain in the original location where a new service was being created. A new social care manager was recruited from within the Trust and had experience both in management of teams and complex cases. There were sufficient numbers of staff to meet the needs of the young people living at the centre, this allocation was stretched during a period of emergency respite for a previous young person staffed by the team, effectively running the service in two locations. This was in response to a risk escalation and agreed with Tusla, the impact on the team was managed at the time but would need a revised approach if it were to arise as a strategy on a recurring basis.

Inspectors found that the internal management completed workforce planning at their internal management meeting and the team meeting and rosters were created to take account of all types of leave including study leave. The staff discussed leave at their supervision and mentoring sessions and there were clear mechanisms for applying for leave. Staff were encouraged to take their leave and staffing and staff care were agenda items at the external management meetings. There was an attendance management and taking leave policy in place and staff received feedback through the manager from any senior team decisions and responses.

The staff had a staff handbook and policies and procedures which detailed the Trusts approach to staff retention. There were HR policies and procedures available and measures were outlined to highlight opportunities to develop careers, to build skills,

to positively contribute and be heard, to hold roles and responsibilities. Inspectors found that the staff were satisfied with the organisations systems in place for support, development and advice.

There was an on call service in place called 'critical on call', there was a policy and procedure for this. Inspectors found that the staff team were familiar with the arrangements in place for its use and that they kept a clear record of when they contacted on call and why. The use of on call was thereafter tracked for trends and information at the senior team level.

Inspectors were informed also of a pandemic response of a 24-hour nurse on call for Covid-19 advice.

Standard 6.2 The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

The centre implemented the Trusts recruitment and selection policy and Garda vetting policy, these were approved by the CEO and the Director of Human Resources, the policies took account of the relevant legislation in this area. The centres child protection policy and procedures referred to these recruitment, selection and vetting policies and the informing legislation also. The social care manager confirmed that they had reviewed the staff team personnel files when they took over the management post, they found these to be following safe recruitment practices. The personnel files were securely maintained by the management and made available for review by the inspectors.

The manager had participated in interview panels for the centre and was satisfied that posts had been filled with any gaps being addressed as they arose. The manager was aware of the Tusla staffing memo on qualifications and experience for the various roles within a children's residential centre and these had been fully reviewed with the Tusla inspectorate for the centres move to its new location in 2021. The manager had the necessary skills, experience, and qualifications for their role. The staff informed inspectors that they had job descriptions and contracts of employment signed for their respective roles.

There was a written code of conduct in place for staff, there had been no reported breaches of the code. The staff were aware of the expected professional conduct and guidelines in place for their role.

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

The centre staff were found by inspectors to maintain good standards in daily routines and planning. There was consistency in daily completion of handovers and diversionary plans put in place for the young people. Key working was identified in the placement plans and assigned to key workers and named staff. The manager had delegated tasks to their team leaders and to social care staff. The staff demonstrated awareness of their roles and were accountable for their practice through mentoring, supervision and team meeting's. Professional development was supported, and areas identified for improvement were acted upon. The team worked with a facilitator on a monthly basis on reflective practice and team development.

The lines of reporting and decision making within the centre were known as were the external management arrangements and personnel involved. There was evidence of ongoing contact between the management at the centre and the director of services and the regulation and compliance manager. There were regular internal and external audits in place. The manager generated regular reports from the centre to external management.

There was a policy on supervision and a policy on 'performance management, supervision and training' in place with a suite of recording templates that combined to form a performance management and supervision system. The manager was trained in supervision and performance management. The policy timeframe for the provision of supervision was six to eight weekly and the social care manager was holding the supervision responsibilities for all staff in the initial stages of their taking on of this role. Presently the social care leaders acted as mentors and this was a formal recorded monthly process for new staff and it there was a commitment to share some of the supervision duties with the social care leaders in due course.

There was evidence of team development and shared discussion and decision making, through the mentoring the team members were supported to develop their professional practices, make decisions and then reflected on the learning from that process.

The manager maintained supervision schedules and their provision of supervision had been audited by the regulation and compliance manager and director of services. The manager was in receipt of monthly recorded supervision from the director of services. At the time of this inspection the full format involved in the supervision

recording template was not being completed and some had more sections such as the 'agreed actions' completed. Supervision contracts were on file and these differed with some staff contracts stating a four to six week interval and others a six to eight week interval, these intervals did not present as related to experience levels. The current structure does not evidence regular inclusion of policy as a discussion point and training was not formally recorded as discussed. The mentoring records, which the manager oversaw, did cover policy and training but the system as a whole should be organised to allow for contracts for supervision that were consistent and a recording structure that was more flexible to highlight supervision separate to performance management if not running concurrent with each other through out a year.

The full staff team were booked to receive supervisee training. The approach to appraisal of staff performance was stated as commenced at the time of this inspection and therefore were not available for review by inspectors.

The staff team had policies in the staff HR handbook that addressed both safety, rights and responsibilities in the workplace. There was an employee assistance programme that was advertised to staff, debriefing and support from the manager and daily and monthly reflective practice opportunities.

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

The centre had an assigned training officer in place and they organised a system of training needs analysis in order to track expiry dates, renewal dates and to identify and advertise upcoming complementary training to staff. There was evidence of mandatory training being prioritised and booked to move back into face to face where the pandemic levels allowed. Training was a standing item at the weekly team meetings and the team leader monthly meetings with the manager, the training audit was discussed, and training required to be booked identified. The ongoing development and consultation sessions regarding the model of care took place every two months.

Inspectors found that as this was a specialised service that additional attention must be paid to targeted training to support the work of the team such as substance misuse harm reduction approach, safety online and training in daily life events for those staff who have not completed it.

The centre had policies on induction and probation. There was a structured recording system for inductions, and these had been audited by the regulation and compliance manager who found good levels of compliance with the policies.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1** **Standard 6.2**
Practices met the required standard in some respects only	**Standard 6.3** **Standard 6.4**
Practices did not meet the required standard	**None identified**

Actions required

- The centre manager and external management must review the supervision timeframes as stated on the contracts for supervision and clarify the current use of the supervision recording suite for best effect.
- The centre management must continue to identify further targeted training taking account of the specific purpose and function of the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure that the team review the restrictive policy practice and procedure, there should be a focus on identifying which may constitute a restrictive practice. The management team must ensure that they generate, record and share learning outcomes from external incident reviews completed by the significant event review group.	SCM has been reviewing the restrictive practice policy with team and will be further reviewed at team meeting on 21.07.21. Restrictive practice register has been developed and will be discussed and reviewed at team meetings. SERG format will be further reviewed by Under 18's service managers to ensure that feedback is recorded and brought back to the team.	Restrictive practice register will be reviewed weekly at team meetings and will be overseen by allocated team leader, reviewed by SCM as part of Audit and by Head of Services in audit also. Manager SERG reviews will continue to take place monthly and learning will be shared at team meetings. Staff member identified to oversee internal SERG process.
6	The centre manager and external management must review the supervision timeframes as stated on the contracts for supervision and clarify the	Annual Personal Performance Plan is currently being completed with all the staff team as agreed for 2021. Supervisions time frame confirmed – Supervisions to take	SCM will ensure all staff supervision contracts are reviewed to reflect confirmed timeframe. This will be reviewed by Head of Services as part of audit process. Supervision schedules will be followed.

	current use of the supervision recording suite for best effect. The centre management must continue to identify further targeted training taking account of the specific purpose and function of the centre.	place in line with current policy every 6-8 weeks. PMVT Addiction services manager visited team meeting and carried out workshop with the staff team on harm reduction on 09.06.21. PMVT continue to support staff members to have the opportunity to engage in Certificate courses run by Carlow IT. Staff members due to start courses at the end of July in Mental Health: Building resilience and promoting positive change, restorative practices and the nature and context of addiction and further areas as required.	Ongoing support from PMVT addiction services team is available with further workshops if and when needed should the need arise.