An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 067

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Peter Mc Verry Trust (PMVT)**
Registered Capacity:	**Five young people**
Date of Inspection:	**6th and 7th October 2020**
Type of Inspection:	**Announced**
Registration Status:	**Registered from 31st December 2020 to 31st December 2023**
Inspection Team:	**Linda Mc Guinness** **Eileen Woods**
Date Report Issued:	**8th December 2020**

Contents

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 monitor the on-going regulatory compliance of this centre with the aforementioned standards and regulations and the operation of the centre in line with its registration. The centre was granted their first registration under the current organisation in 2005. At the time of this inspection the centre was in their fifth registration were in year three of the cycle. The centre was registered without attached conditions from 31st December 2017 to the 31st December 2020.

The centre's purpose and function was to accommodate a total of five males, five of whom would be aged between 12 and 17 on admission on a medium to long-term basis in the residential centre and the sixth aged 18, accommodated in a semi-independent but attached apartment on a medium term basis. The centre had recently moved to a new model of care in consultation with the Tusla Child and Family Agency. This model was based in 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. There were six domains under which outcomes were assessed and measured, these being that young people are; safe and protected from harm, active and healthy, achieving economic security & opportunity have hope and are connected, respected and contributing to their world.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe care and support.	3.1, 3.2, 3.3,
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors looked 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 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 and to the relevant social work departments on the 9th of November 2020. 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 23rd November. 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: 067 without attached conditions from the 31st December 2020 to the 31st of December 2023 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.

Inspectors found that the centre was operating in compliance with the relevant policies and legislation as outlined in Children First: National Guidance for the Protection and Welfare of Children, 2017. The policies and procedures were reviewed in October 2019 and inspectors found that the child protection policies in place were compliant with legislation, regulations and guidance.
A review of personnel files found that policies in respect of vetting practices were adhered to and all files contained the required documents.

A child safeguarding statement was in place and displayed appropriately, and there was written confirmation dated July 2019 from the Tusla Child Safeguarding Statement Compliance Unit that it met the required standard. There was a risk assessment as required, and policies in place to mitigate against risks occurring were outlined.

Inspectors were satisfied that there were systems in place to monitor and audit compliance with child safeguarding policies and practices. However, inspectors found that the risk relating to harm by another young person including risk of bullying, required further action and should have been highlighted in centre audits.

The inspectors examined the register of child protection concerns and were satisfied that issues arising had been reported and managed appropriately. Inspectors found evidence that while the manager followed up with social work departments to determine the outcome of reported concerns, a significant number of these were still open. The centre must establish an escalation process with Tusla when responses are not forthcoming to ensure that all reported concerns are brought to conclusion.

Staff training records evidenced that each staff member had completed the Tusla E-Learning module: Introduction to Children First, 2017. Inspectors found from interviews and questionnaires that while staff were familiar with child protection reporting procedures and their statutory obligations as mandated persons under the

Children First Act, 2015 they were less familiar with the child protection policies guiding their practice. There was no specific training in respect of the organisations' child protection policies and procedures and this is recommended. Where child protection concerns arose they were reported without delay and strategy meetings were convened with supervising social work departments. Information relating to child protection was included in manager's monthly audits but inspectors found that there could be greater evidence in centre records that child protection was discussed in staff team meetings, management meetings and through the supervision process.

There was a policy in place to address all forms of bullying in line with Children First and relevant legislation. The centre also had a written policy on young people's use of electronic equipment and procedures were in place to monitor the young people's use of the internet and social media.

There was evidence across centre records that the management and team had worked collaboratively with young people's placing social workers to promote their safety and wellbeing. The social workers were sent copies of risk assessments and safety plans. Appropriate records were maintained of all family and professional contacts. Inspectors spoke with the parents/carers of all young people placed in the centre. All spoke highly about the care being provided, that they were involved in planning and that there was excellent communication with the centre. Parents identified that exposure to risks outside the centre and complex individual needs would determine if the centre would be able to continue to meet the needs of their young people. There were agreed procedures in place to inform parents of allegations of abuse.

There was evidence of some strategies in place to support young people and promote safety. The young people's risk assessments and safety plans were reviewed by the inspectors and while there was evidence that they addressed individual areas of vulnerability there were deficits in respect of safety planning relating to free time and risks outside the centre. The free time permitted to young people outside the centre was not proportionate to their age and risk profile. For example young people aged 14 and under years had were permitted up to 5 hours unsupervised free time outside the centre and had come to the attention of the Gardaí.. While there was evidence that keyworkers were supporting young people to develop self-awareness and skills needed for self-care and protection this must be balanced against appropriate boundaries for younger children.

The centre had protected disclosures policy to facilitate staff to raise concerns or disclose information relating to poor practice. Inspectors found in interviews that staff members were familiar with the policy and would report concerns without fear of adverse consequences.

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

The centre had a policy on supporting positive behaviour and management of challenging behaviour. All staff had received training in the recognised model of behaviour management in use however some refresher training had been delayed due to the Covid 19 pandemic. This was being rescheduled at the time of the on-site inspection. Interviews with staff and review of records showed that staff were aware of the underlying causes of behaviours of concern and they were particularly attuned to the needs of young people coming into the care system during the Covid 19 pandemic. There were individual crisis management plans (ICMP) in place to assist and support staff and the young people to manage difficult behaviour. Each young person had an up to date ICMP and there was evidence of regular review of these documents. Inspectors found that these documents did not always highlight safety considerations in respect of physical interventions as required. Keyworking records evidenced that staff used their relationships with young people to support them to manage their behaviour. Social workers and parents interviewed during the inspection process all stated while the team were working hard to support young people there were risks relating to the current group that posed significant challenges.

During inspection interviews the staff team were aware of the impact of trauma, neglect and abuse and how these can impact on behaviours of young people. Training had been provided in relation to the care framework and inspectors found that there was guidance and direction from the consultant to the team to support them in their work with young people. There was much evidence of planned and opportunity led proactive keyworking and relationship based individual work with young people.

While there were policies on bullying inspectors found that they were not entirely effective and staff could be more alert and responsive to issues of peer to peer abuse/violence in the centre. Inspectors found that there were complexities associated with the current mix of young people and that one young person who was significantly younger than the others had come to harm in the centre following

assaults by other young people on a number of occasions. This was reported to Tusla as a child protection and welfare concern.

Risk assessments took place and the requirement for high levels of staff supervision was highlighted. There was evidence that individual safety plans and daily programmes were implemented with increased staff supervision and the staff roster had been altered to respond to the safety needs of the current group. Notwithstanding this, inspectors found that these incidents were not managed in line with centre policies to protect young people from harm. It was noted that there also was a concern that the young person was giving money to older peers. Inspectors recommend that management review all occasions and responses where this young person has come to harm in the centre and assess if centre policy was followed to ensure provision of safe care.

Keyworking sessions, keyworking and individual work had taken place with the young person however inspectors found while there was some exploration of feeling unsafe it did not evidence a robust focus on the impact of bullying or being targeted by other young people. While there was evidence of work with young people to develop their understanding of behaviour that challenges, inspectors found that there could be a more effective focus on impact of behaviours that impinged upon the rights of others.

Inspectors met with one young person and while they were unhappy with some limitations placed on them due safety planning, they were satisfied with the care being provided and stated they liked the manager and staff team.

Review of the significant event register found that there had been increasing levels of absences from the centre with various identified risks to young people in the community. There were also episodes of self-harm, suicide ideation, property damage and violence amongst peers. While there was good evidence of communication with all relevant people, strategy meetings, updates to risk management and other plans and review at the significant event review group (SERG) there was little evidence of improvement. The situation was being monitored closely internally and by all social work departments and consideration was been given to referrals for alternative placements if risks could not be managed.

Inspectors found that while there was an emphasis on rewarding positive behaviour there was also a reliance on the sanction of removing pocket money on a daily basis from young people. This measure was often not related to the behaviour and there

was little evidence that it was successful in affecting change. Inspectors found that this team had been used to dealing with older young people and that this transition to managing younger children posed some challenges. There was evidence that the team were adjusting to transitioning to a new model of care with internal and external support.

Inspectors found that there could be improvements in discussions relating to behaviour management approaches at team meetings and through supervision. Staff interviewed during inspection felt that there could be more effective analysis of behaviour management. It was felt that there could be further exploration of strategies with the whole team to support change and manage risk. The director must ensure that there is an effective audit and analysis of behaviour management to highlight any deficits and take timely remedial action.

Each young person had an up to date individual absence management plan which was required under the *Children Missing from Care: A Joint protocol between An Garda Síochána and the Health Services Executive, Children and Family Services, 2012'*. Inspectors found that these required review to ensure they were age appropriate and relevant to individual risk profile. Inspectors found that often children were not being reported in line with the agreed national protocols and this was placing them at further risk. There was an over reliance on reporting young people aged 14 and under absent at risk when it would be more appropriate to report them missing in care, so that there was appropriate risk escalation to higher levels of Tusla and An Garda Síochana in line with the protocol.

There was a policy in respect of the use of restrictive practices which inspectors found was fully understood by the staff team. There had been no use of physical interventions in the 12 months prior to this inspection. Other restrictive measures such as limitations on mobile phones and door alarms were appropriately recorded and reviewed. It was noted that removal of young people's pocket money was not recorded as a restrictive practice and should be considered as such.

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

Inspectors found that an open culture was promoted in the centre and staff members who were interviewed were confident that they would challenge each other's practice if required.

There was evidence that the staff and management team were in regular contact and worked closely with social workers, advocates for young people and family members where appropriate. Mechanisms in place for these people to provide feedback on the care being provided and to identify areas of improvement were not yet fully developed, however they were part of the current service improvement plan.

The inspectors found that the centre had a written policy and procedure for the recording and notification of significant events. There was evidence that these notifications were sent in a timely manner to supervising social workers. There was evidence that the social care manager and director of child and family services had oversight of significant events that occurred in the centre.

Significant events were initially reviewed at local level between the manager and those involved in the incident, and this included staff debriefing. They were also reviewed at team meetings and in staff supervision. There was a significant event review group (SERG) in place which was attended by all social care managers for the under 18's services in the organisation. While there was some evidence of feedback to the team meeting, inspectors found that there was some level of disconnect between this process and the staff team who did not describe it as a particularly helpful process. Managers decided which events to review but inspectors found that some higher level significant events or patterns of behaviour which were serious in nature had not been reviewed at this forum. Management must review this process to ensure that review of events is used to determine actions required and inform the development of best practice in the centre.

Compliance with Regulation	
Regulation met	**Regulation 16**

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

Actions Required

- The director must ensure that training is provided in respect of the organisations' child protection and safeguarding policies.
- The director must ensure establish an escalation process with Tusla to ensure that all reported child protection concerns are brought to conclusion.
- The centre manager must ensure that safety plans and individual absence management plans are appropriate to young people's age, risk profile and stage of development.
- The centre manager must formally review the centre response to one young person being targeted by others. This review should place a specific focus on the management of bullying in the centre and implementation of centre policy.
- The director must ensure that there is evidence that complaints and issues relating to child protection are discussed at team and management meetings.
- The director must ensure that there is an audit and analysis of behaviour management and ensure that there is evidence of exploration of strategies to support change and manage risk.
- The director must ensure that there is a review of the significant event group to ensure that all incidents are analysed for antecedents, interventions and outcomes and that any learning is communicated to the staff team.
- The director must ensure that there are mechanisms in place to receive feedback from significant people in young people's lives to identify areas for service improvement.

Regulation 5: Care practices and operational policies
Regulation 6: (1) and (2): Person in charge

Theme 5: Leadership, Governance and Management

Standard 5.1 - The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

The centre had updated their policies in October 2019 to ensure they were compliant with the requirements of Children First; National Guidance for the Protection and Welfare of Children 2011, and the National Standards for Children's Residential Centres 2018 (HIQA). Inspectors found that some polices such as the risk

management and complaints policies required further updating. Centre management had already scheduled a review of policies to take place in November 2020.

In interviews, inspectors found that the manager and staff were aware of centre policies and procedures and relevant legislation including Children First and how these informed practice in the centre. There was limited evidence of discussions relating to centre policies and procedures at team and management meetings.

There was a system in place to identify gaps in compliance and the audit framework was broadly aligned with the National Standards for Children's Residential Centres, 2018 (HIQA).

Standard 5.2 - The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-cantered, safe and effective care and support.

There was evidence of good management and leadership within the centre. A qualified and experienced centre manager had been in post for seven years. In interview staff members stated that they were supported by and expressed confidence in the centre manager. Supervising social workers who provided feedback to inspectors were satisfied that the centre was well managed and there was good communication with the centre manager. Social workers commended the commitment of the manager and the team to support the current group of young people despite many challenges. Oversight of the leadership in the centre was provided by the director of child and family services through monthly management meetings and regular contact with the centre manager. The staff team confirmed that the director visited the centre and was accessible and available to them. The social care manager also received professional supervision appropriate to their role from the director.

Inspectors reviewed a range of records including significant events, supervision records and team and management meetings. While it was clear that there was a focus on quality, safety and learning inspectors found that there could be better evidence of this across centre records.

There were clearly defined governance arrangements and structures in place with clear lines of authority and accountability. Each staff member had a job description appropriate to their position and they displayed a good understanding of their

specific roles and responsibilities. The centre manager was the person in charge with overall executive accountability for the delivery of service and there was evidence of their oversight in centre records and in monthly reports to management.

There was a service level agreement in place with the Child and Family Agency and meetings took place regularly. There was evidence of effective and regular review of policies and procedures to assess compliance with regulatory requirements taking account of national standards and guidelines.

Inspectors found that with the exception of follow up to child protection reports, there was a process for the escalation of risk within the centre and the organisation and externally to Tusla if required. Following escalation, the centre manager and regional manager also met with social workers for young people to discuss strategies for managing risk. The alternative care manager for the Tusla area where the centre was located was in regular communication with centre management and also attended some strategy meetings. While issues relating to risks were discussed with supervising social work departments and mitigating measures were implemented where possible there was a lack of evidence that the risks for young people were discussed at senior management meetings within the organisation.

At the time of inspection, a comprehensive risk management framework was not yet in place but inspectors were provided with a proposed new risk management framework which included a matrix and other supporting structures. This was part of the service development plan and was in the early stage of implementation at the time of inspection. The director stated that training would be provided to the staff team to facilitate the assessment, identification and management of risk and the effective implementation of the model. A risk register was in place but was evolving at the time of inspection to include separate individual risks and centre risks.

Inspectors assessed the organisation's response to the management of risks posed by the Covid 19 pandemic. There were comprehensive protocols, contingencies and control measures in place to manage identified risks. These were frequently updated in accordance with guidance from National Public Health Emergency Team (NPHET) and government guidance. There were robust cleaning schedules in place and procedures to safely manage visitors to the house. There were adequate supplies of cleaning equipment, anti-bacterial products, and personal protective equipment on site. There were contingency plans in place to manage staffing with a panel of relief workers who would provide cover in the event of a shortfall of staff due to an outbreak of the Covid-19 virus or a requirement to self-isolate.

One of the four social care leaders deputised when the manager was absent from the centre and while the same person generally stood in, that was not always the case. They did not have a specific responsibility as a deputy manager and had not been inducted into all aspects of the management role. While the director was available to support during times the centre manager was absent, inspectors recommend that consideration is given to the appointment of one person with an enhanced dedicated role to act up in the manager's absence. This person would have specifically delegated tasks and responsibilities to ensure clarity and consistency. There was an on call system in place to support staff at all times to manage incidents and risks in the centre. There was an appropriate record of calls made to the on call person and the direction and guidance provided.

The requirement to have a system in place to record managerial duties delegated to other appropriately qualified members of staff was highlighted during inspection. The management team took immediate action to address this with the implementation of a new centre record.

Standard 5.3 - The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The centre had a detailed statement of purpose that outlined the aims, objectives and ethos of the service, the management and staff employed in the centre, and the range of services provided to support and meet the care needs of the young people. The centre had recently adopted a new model of care which was due to be included in the review of the statement of purpose in November 2020. There was evidence that this new model was a good fit with the ethos of the centre and their approach of focusing on positive outcomes for young people. Staff interviewed during inspection demonstrated knowledge of the model and they were being provided with on-going support to assimilate the model into their practice. The language of the model of care was evident across centre records.

Social workers interviewed by inspectors were satisfied that the statement of purpose was reflected in the day-to-day operation of the centre. Information on the statement of purpose was available to those who required it including young people, social workers and family members and this was being updated alongside the policy review to incorporate the new model of care.

Standard 5.4 - The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Inspectors found that while the quality, safety and continuity of care provided to young people within the centre was regularly reviewed, some issues relating to safety of young people required a more robust and rapid response. There was evidence the centre manager monitored the quality of care in the centre through oversight of all records, observation of staff practice, through staff supervision and daily contact with the young people. The centre manager reported directly to the director and there was evidence of regular management meetings however, the quality of these records were not up to the required standard to evidence good governance. Inspectors found that the quality assurance audits had identified some areas requiring attention however the audit tool could be improved to include commentary by the auditor on the quality of the information assessed. An acting quality assurance and compliance officer had been appointed for 28 hours per week in the months prior to inspection. While full implementation of their revised auditing system was impacted by the Covid 19 pandemic this was a positive development intended to improve governance.

Inspectors found that the complaints policy did not account for monitoring or analysis of complaints for learning purposes. There was a lack of evidence that complaints were discussed and reviewed in team and management meetings to identify any trends to inform service improvements. The complaints policy did not make reference to the Tulsa Tell Us complaints policy. While all formal complaints were recorded and managed appropriately other lower level complaints which were resolved locally were not recorded on the register.
From interview with one young person during inspection it was not clear that they understood the internal complaints process but they did know they could complain to their Tusla social worker.

The centre management were aware of the requirement for the registered provider to conduct an annual review of compliance of the centre's objectives to promote improvements in work practices and to achieve better outcomes for young people. Work had commenced on this at the time of inspection.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.1** **Regulation 6.2**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 5.1** **Standard 5.3**
Practices met the required standard in some respects only	**Standard 5.2** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions Required

- The director must ensure that the records of management meetings are improved to evidence all aspects of governance highlighted in centre audits.
- The director must ensure that the complaints policy is updated and that all complaints are recorded, monitored and analysed for learning purposes and service development.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The director must ensure that training is provided in respect of the organisations' child protection and safeguarding policies.	A training workshop on PMVT Child Safeguarding and Protection Policy has been developed and will be delivered to staff team in December 2020.	Training is scheduled for December 2020. The centre manager will also maintain the focus on child protection discussion in team meetings.
	The director must ensure establish an escalation process with Tusla to ensure that all reported child protection concerns are brought to conclusion.	The Director has agreed an escalation process with the alternative care manager (ACM) of the Tusla Dublin North East Region. This involves stages of written escalation to social worker, social work team leader principal social worker and to regional manager if no conclusion is reached within agreed timeframes.	This will be monitored as part of the centre manager's audit and reviewed by compliance and regulation manager. It has also been added into the policy and procedure review. The centre manager will maintain the focus on child protection discussion in team meetings and ensure that timelines for escalation are adhered to.
	The centre manager must ensure that safety plans and individual absence management plans are	The centre manager is working on an on-going basis with the team and allocated social work teams to ensure that young people's absent management plans are age	The centre manager will continue to review safety management plans and individual absence management plans with team, and allocated social work teams. This will also

	appropriate to young people's age, risk profile and stage of development.	appropriate and in line with the young people's risk profile and development. Completed and on-going.	be subject to review in centre audits by the compliance and regulation manager and with director of services.
	The centre manager must formally review the centre response to one young person being targeted by others. This review should place a specific focus on the management of bullying in the centre and implementation of centre policy.	Centre manager was in the process of reviewing all young people's placements and sourcing an alternative, more appropriate option for resident. Risk management strategies and supports were in place prior to the young person transitioning. This young person has now transitioned positively to an alternative placement and continues to be offered outreach support by the Balcurris staff team also. Staff team have reviewed and will review again the Bullying Prevention and Intervention Policy.	Completed. This will be monitored as part of audit process.
	The director must ensure that there is evidence that complaints and issues relating to child protection are discussed at team and management meetings.	The director has ensured that the previous team meeting template which included child protection and complaints as standard agenda items is back in use.	This will be monitored as part of audit process and further support provided as required.

	The director must ensure that there is an audit and analysis of behaviour management and ensure that there is evidence of exploration of strategies to support change and manage risk.	The director and centre manger have explored behaviour management and risk management strategies to best support the current group of young people. This will be monitored as part of the centre manager and compliance and regulation manager monthly audit and will be shared in Under 18s manager's meetings.	This will be monitored as part of audit process and further support provided as required.
	The director must ensure that there is a review of the significant event group to ensure that all incidents are analysed for antecedents, interventions and outcomes and that any learning is communicated to the staff team.	The significant event group is reviewing and updating the template in November 2020 and mechanism for feeding back to the team has been agreed.	Once implemented in December 2020 this will be monitored as part of the audit process.
	The director must ensure that there are mechanisms in place to receive feedback from significant people in young people's lives to identify areas for service improvement.	The director and centre managers are developing a survey for significant people in young people's lives to support service improvement. This will be rolled out and reviewed in first quarter 2021.	Once implemented this will be monitored as part of the audit process. Trends and patterns will be considered for service development purposes and will be included in the annual review of the service.

5	The director must ensure that the records of management meetings are improved to evidence all aspects of governance highlighted in centre audits. The director must ensure that the complaints policy is updated and that all complaints are recorded, monitored and analysed for learning purposes and service development.	Minutes of management meetings are being recorded comprehensively, as per original structure. The director will ensure minutes reflect evidence of all aspects of governance in centre audits. Implemented November 2020. The complaints policy has been included in overall PMVT Under 18s policy review in November 2020. All complaints are reviewed and monitored at monthly management and centre team meetings to identify learning outcomes and for service development purposes.	This will be monitored by the compliance and regulation manager and the director of services. This will be monitored by the compliance and regulation manager and the director of services.