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: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Peter McVerry Trust**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Date of inspection:	**28th & 29th of September 2022**
Registration Status:	**Registered from 31st of December 2020 to the 31st of December 2023**
Inspection Team:	**Eileen Woods** **Lisa Tobin**
Date Report Issued:	**12th December 2022**

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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 and Regulation 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 under the current organisation in 2005. At the time of this inspection the centre was in its sixth registration and was in year two of the cycle. The centre was registered without attached conditions from the 31st of December 2020 to the 31st of December 2023.

The centre was registered for as a multi occupancy medium to long term centre for a maximum of five young people, both male and female, aged between twelve to seventeen years old. There was also a single occupancy semi-independent apartment for over eighteens attached to the premises, this was not occupied at the time of the inspection. 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. There were four young people living in the centre at the time of this inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.1
4: Health, Wellbeing and Development	4.2

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 8th of November 2022 and to the relevant social work departments on the 8th of November 2022. 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 22nd of November 2022. 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 of December 2020 to the 31st of December 2023 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

There was a young person's booklet in place and this had been reviewed. There was individual work and key work taking place that displayed evidence of time spent with the young people and of building relationships. The two young people who met with inspectors were happy at the centre and said there were staff they could talk to and that they felt safe there. Inspectors found that there was an experienced, skilled and warm team who engage freely and well with the young people. They sought out the young people and opportunities for them to talk. All staff were actively engaging and demonstrating skills in communication with young people.

The current structures for consultation were found by inspectors to be comprehensive on an individualised basis but somewhat fragmented regarding the group setting. The current measures were individualised and mainly completed through key working, by consultation books and via informal contact and discussions. The consultation books were limited to requests and dependant on the team meeting schedule and were about needs and wants as opposed to consultation in a wider sense. Items such as food and activity choices for example were discussed separately but not typically recorded, inspectors heard about it from staff and young people and observed these in place to a good standard day to day. There was evidence that each young person was listened to but the group living aspects regarding upholding of expectations around things like a social media and phone policy, a drug free and drink free environment were less evident.

The staff stated that as a team they communicate well and positively challenge each other's practice to reach agreements that benefit practice. The centre and organisational culture supported connection to the external management team as well as the internal management.

There was strong evidence of liaison and communication with families, significant others and guardians of the young people found across the records and interviews.

Where there were challenges, plans were devised to hold communication and connection appropriately, these were agreed on an interdisciplinary basis. A parent said that they were very happy with the centre, the team and the assistance their child was receiving. A significant person involved with a young person described the teams use of positive incentives and having a good experience of communication with the team there. One social worker highlighted the professional skills demonstrated and the guidance provided by the centre manager and the team in developing strategies for intervention. Other social workers found that the participation in meetings and recording and reporting of significant events was to a good standard.

There was a complaints policy and procedure that had been reviewed and records adapted to the new system of feedback and complaints. This new policy was in its first six months of operation. The goal of the revised system aimed to record feedback from young people and others and that all other matters raised would be captured as a complaint to be addressed as such. Inspectors did not as yet see an increase in recorded complaints as might be expected but in due course the outcome should be more recorded complaints on file. An informal complaints system had been maintained up until July of this year and records of local complaints that had been addressed and resolved or escalated to a Tusla complaint or to a child protection report were on file. Under the revised system several of these could have been and should be categorised as formal.

The centre recorded evidence of the processes engaged in these informal complaints, including though to team meetings, meetings with other professionals and reaching solutions. Inspectors recommend that the team ensure that they increase the practice of going back to young people after they have received the conclusion to ensure they understood and were happy with the outcomes. As the centre continues to roll out the new system the centre staff must reflect on what constitutes a complaint. The head of services and the director of services have planned to review the impact of the new system for effectiveness after the six month initial phase, that being at the end of 2022.

Inspectors could see where some day to day matters had been followed up and acted on for and with the young people. The approaches, previously recorded on informal complaints forms, evidenced a non-judgemental approach where the centre team showed initiative and flexibility in response, with good emotional support offered. There was evidence of the social care manager speaking with young people and supporting resolutions.

A parent complaint was raised and addressed, then withdrawn as was satisfactorily answered by staff and management. There were records maintained of the full process and learning taken from it around information sharing with parents in the event of an emergency or urgent admission. This complaint had been entered onto the centre register.

Staff were confident in outlining that one of their roles in a complaints process was about supporting young people to access a resolution. They recorded their conversations and the solutions reached with the young people. There was some follow up post complaints, but the team overall should continue to focus on routinely recording that as part of the process. Social workers, and family members also in the main, were told about day to day issues as they arose. The centre team were also able to support young people in negotiating solutions for matters outside the centre. There were audits completed by external management, the learning from which had contributed to the policy review and procedural changes.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 1.6**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management and staff must review the centre consultation processes to include how the group feedback is gathered and how the community living aspects are upheld.

Regulation 5: Care practices and operational policies
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.

With regard to policy, procedure, training and review inspectors found that the structures for child protection and safeguarding were clearly established. The centre team had been supplied with internal training/briefings in the child protection policy when it was updated. There was a child protection reporting register in place and this was a digital document also so that external management could track reporting taking place. There was oversight on child protection from the centre to Board level. Inspectors requested that the head of services verify if there was an agreed policy for the protection of information, related to child protection reporting, gathered to inform the Board reports. Inspectors were made aware that the information is anonymised for the Board. The staff team had renewed their Tusla online national eLearning modules and had access to the three available - Introduction to Children First, Children First in Action and Implementing Children First. A number of staff had also completed a Tusla national eLearning module on child sexual exploitation. The social care manager holds the role of designated liaison person and they should consider whether they may wish to have the social care leaders, who act up in their absence, complete the designated liaison person/DLP training also in the event that it is they and not the external management who are delegated that task at that time.

Inspectors found that staff had a role as a mandated person and performed in accordance with the requirements of that role. The social care manager was the DLP and was trained and experienced in that role. There was a register in place for child protection reporting and for concerns that did not meet the threshold inclusive of actions related to each category.

When risks and child protection reports were escalated the head of services and the director of services became involved. There was evidence that the centre engaged in multidisciplinary planning regarding interventions to improve young people's safety, records of strategy and professional's meetings at increasing levels of frequency were on file. The centre team had regular liaison with the local area child protection specialist Gardai which was a very relevant professional working relationship given the presentations of the young people. The management also completed a Tusla local area reporting form alongside these processes to ensure that high risks were escalated.

As stated there was a child protection register in place and details were entered regarding reports made. There were several open child protection and welfare reports from 2021 and 2022 on the register and the management must continue to look at how they structure and record the follow up to confirm closure of the items by Tusla. There was some evidence of communication with social work departments seeking follow up but this could be developed further.

Staff had a rounded understanding of the policies underpinning safeguarding like safe recruitment, lone working, the child safeguarding statement, anti-bullying, and missing child in care procedures. The team meeting evidenced good follow up on child protection and on risks. There were a number of live risks amongst the group some related to social media and phones and ongoing issues of the core rules of the centre not being followed by young people. There was smoking and substance misuse occurring onsite and rules around the use of phones not being adhered to. There had also been issues related to the property, people and items entering or exiting on occasion without staff knowledge. These had been looked at on a case and case basis and reported but not looked at as a whole combining the incidences.

Social media risks were named and there was evidence of work and sharing information on the team related to specific apps and the settings on these. Inspectors found that there could be more evidence of addressing social media in an integrated way as part of the work as opposed to on a case by case basis. It was possible to see in the complaints and records that a young person did seek support from staff around their online experiences and pressure from peers. The team displayed good understanding of the roots of the behaviours from both sides and the likely experience of it, but inspectors found that there was room to build on this regarding strong follow up on social media management.

The young people's individual areas of vulnerability were identified and the plans on file had been regularly updated. The individual crisis management plans, the absence management plans and risk management plans were utilised to support interventions and to measure impact in the case of the risk management framework. Despite this there were risks and issues that remained a serious concern with risk escalations issued a number of times. Inspectors were informed that warnings were in place regarding the viability of a placement. Higher levels of supervision were noted as a response in the centre but no additional staff were requested to complete this. A complement of eight social care workers was working with four young people.

As stated there had been a number of issues related to entering and leaving the property undetected or getting drugs or alcohol into the centre. There were some actions related to review of alarms and window security. Inspectors did not find that there had been a co-ordinated set of responses as each event occurred in order for the centre to assure themselves that they had addressed as many of the root causes as was possible to control. There was no comprehensive review done of the events to look at this from an external perspective to advise the team, therefore it was unclear if there were supervision issues, building configuration issues or other factors at play.

There were mechanisms in place to monitor, improve and evaluate the safety and care of the young people. Inspectors found that it would benefit from acknowledging more the level of complexity of the presenting behaviours and needs. The management team have worked hard to review and strengthen the collective pre admission risk assessments and engaged further with the therapeutic supports now more available from Tusla social work areas. The team had previously set centre culture goals for themselves in March of 2022 and it would be positive, with external management support, to look at what has worked and not since then.

Inspectors spoke with some of the young people and one noted that they had taken on board some of the advice given by the team on how to be safer when out. The family and significant others for young people were positive about the centre and the opportunity it might present the young person to mature over time. Another raised that it was impossible for the team to stop young people leaving and engaging in risky behaviours but that reinforcing of rules and incentives might support this work if enhanced. The records on file at the centre evidenced direct work on supporting the young people to have greater insight into the things making them less safe and how that might look differently if they made alternate choices.

There was evidence of parents and guardians being informed regarding all incidents including of a child protection or concerning nature or through social workers if required. There were strategy meetings convened, collective decision making completed and advice taken from the Tusla therapeutic personnel involved. The senior management team became involved at clearly defined junctures.

Inspectors found that staff were fully aware of the protected disclosures policy and the principle of whistle blowing and procedures for same. The evidence suggested that staff would approach levels of management with the confidence that they would be heard.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management and external management team must review the current status of compliance with the centres safe rules for living at the centre and how these can be supported to better and more effective implementation.
- The centre management and the external management must review the planned culture reset identified in March 2022 to identify what had been effective and not to date and take appropriate action to further support the centre in it work.
- The external management must complete a review of the instances of movement within and on and off the property to ensure that the centre team and the young people have as safe a location as possible.

Regulation 10: Health Care

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

The centre team utilised a model of placement planning called the Well Tree model which supported a strong focus on health and wellbeing both in planning and response. There were care plans for the young people with the health needs identified. Inspectors could see clear evidence of a holistic and practical approach to health and wellbeing in the placement plans agreed with the young people, in direct work and in the work of the staff to be active and engaged with the young people.

There was some gym equipment available at the centre and ample space in which to use those.

Young people are brought to their GP upon admission and could remain with their family GP if they wished to do so. Inspectors found that appointments were made for GP and medical care of all types. There was follow up on hospital appointments and referrals for presenting illnesses, in emergencies all efforts were made to assist the young people to get treatment. Where a young person may have suffered an injury, illness or accident and refused care there was good evidence of all staff repeatedly following up until appropriate care had been received or attended. There was evidence of actions on dental and optical care as well and of repeated efforts by the team to return to these needs where young people refused to go or missed appointments. The records on file verified that histories of immunisations were sought for the young people and that there was follow up on any additional vaccines.

The centre team worked in co-operation with the social work teams to continue attendance at any specialist services such as a child and adolescent mental health services or through a Tusla therapeutic hub service. There were records maintained on file and advice and direction from the clinical specialists was reflected in the ICSP's in particular. The experienced team displayed professional experience in and awareness of low mood and the potential for self harm. Some staff had attended training in this area and the social care manager was committed to ensuring that training of this nature was provided for all staff or renewed as required as a standard part of the staff tool kit. For example, the team had noted on a team meeting record that positive mental health training had been completed.

The organisation provided access and links to their addiction specialist who had worked with the team on their knowledge base around current substances prevalent in the community and their affects as well as how to take a harm reduction approach in their direct work with young people. The team had also worked with community substance intervention organisations and had good working relationships with them. Inspectors could see that young people were fully supported to attend their appointments. Misuse of drugs were a current and ongoing issue within the centre and instances and incidents related to this were recorded and reported as noted on the register of significant events and on the child protection register. The concerns and responses to substance misuse were discussed as part of the care planning meetings, in key working and in the strategy and professionals meetings held.

The centre had undertaken renewed training in the management of medication provided online by Tusla. There was a new medicines management protocol which had been implemented in quarter three 2022 and the medication files had been adapted to reflect the new recording system. Inspectors found that the process was still not fully implemented with the internal centre audit and use of the recording system not fully completed. The monthly audit tool must be completed as per the protocol requirements in order to track the correct implementation of the new system of medication management.

Inspectors found that the team had completed first aid training and ligature cutting was part of this with the required or advised first aid supplies and cutters strategically placed in readily accessible locations for the staff. There was a safe system of storage for all medications including refrigeration if required. There were no controlled drugs in use or in storage at the centre at the time of the inspection.

Compliance with regulations	
Regulation met	**Regulation 10**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The social care manager must complete the medication audit tool as per the protocol requirements in order to track the correct implementation of the new system of medication management.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre management and staff must review the centre consultation processes to include how the group feedback is gathered and how the community living is upheld.	The centre consultation processes has been reviewed by the management team and the consultation form has been amended to also capture feedback on community living in order to uphold community living in the centre.	On-going review of the consultation processes and use of consultation books will be reviewed as an item of agenda at weekly team meetings. The Centre manager and external management will monitor the consultation processes are effective and appropriate to the needs of the young people in placement as part of the centre auditing process. Where there may be a change within the group the possibility of a group meeting can be reviewed and assessed. The Head of Services will ensure audits are being completed and action plans are acted upon for quarterly service audits.
3	The centre management and external management team must review the current status of compliance with the	The safe rules for the service were discussed within the staff team meeting and response strategies in relation to a	The rules will be reinforced with the young people on an ongoing basis. Centre manager and external management to

	centres safe rules for living at the centre and how these can be supported to better and more effective implementation.	breach of these rules has taken place in November 2022. This has also been reviewed in the Under 18s Management meeting.	monitor compliance with safe rules for living in the centre. This will be reviewed as part of the manager's weekly audit and the quarterly audit by the Head of Services.
	The centre management and the external management must review the planned culture reset identified in March 2022 to identify what had been effective and not to date and take appropriate action to further support the centre in it work.	The staff team have reviewed the culture reset established in March 2022, as part of a Welltree training session as a group with the support of the relevant consultant. Culture was defined as a collection of values, expectations and practices that guide the actions of the staff team with a trauma informed approach. Completed in November 2022. This has been reviewed with the external management team also.	In order to monitor and track the culture of the centre effectively, this should be an item on the staff team agenda once a month. This will be reviewed as part of the manager's weekly audit and the quarterly audit by the Head of Services.
	The external management must complete a review of the instances of movement within and on and off the property to ensure that the centre team and the young people have as safe a location as possible.	A review of the instances of movement within and on and off the premises has been completed to ensure the safety of the young people and staff. There is a plan to add additional CCTV. A visit by the Garda Crime Prevention Unit to assess the security of the building to further identify	Regular review of centre security by centre manager and external management. Head of Service will ensure audits are being completed and action plans are acted upon for quarterly service audits.

		if any additional security measures are required, this visit to be completed by December 2022.	
4	The social care manager must complete the medication audit tool as per the protocol requirements in order to track the correct implementation of the new system of medication management.	The medication audit has been completed by centre manager, as per regulation requirements. Completed in November 2022.	The centre manager will ensure the audit tool is used as per protocol requirements and in line with medication management policy and completed once a month This will be reviewed as part of the manager's weekly audit and the quarterly audit by the Head of Services.