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: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Peter McVerry Trust**
Registered Capacity:	**Three young people**
Type of Inspection:	**Announced**
Date of inspection:	**21st & 22nd of June 2022**
Registration Status:	**Registered from the 03rd of October 2022 to the 03rd of October 2025**
Inspection Team:	**Eileen Woods** **Sharon McLoughlin**
Date Report Issued:	**28th September 2022**

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 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 in March 2014. At the time of this inspection the centre was in its third registration and was in year three of the cycle. The centre was registered without attached conditions from 03rd of October 2019 to the 03rd of October 2022.

The centre was registered as a multi-occupancy centre for up to three young people but with the option to be a dual or single occupancy service depending on referral needs. It aimed to provide a trauma and attachment informed care setting. The approach included an assessment of outcomes, promotion of the young person's wellbeing and the implementation of a strength-based approach through a model called the Well Tree programme. This was delivered in a well-resourced environment with a high level of staffing. There was one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2

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 person, 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 28th of July 2022 and to the relevant social work departments on the 28th of July 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 15th of August 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: 069 without attached conditions from the 3rd of October 2022 to the 3rd of October 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

Inspectors conducted a walkthrough of the property and found it to be well presented with the painting updated and furnishings in good order. The property was of a size and layout that provided opportunities for different designated areas, for example a quiet room, a gym and crafts/music room. There was a finance structure in place for the centre that ensured it was well resourced to respond to young people's interests and needs. A young person greeted inspectors and spoke about their pets and how they cared for them at the centre. There was evidence of a young person's room being personalised in the manner they wanted.

The centre had internal audits and a dedicated accommodation audit had been completed in April 2022. In the year since the 2021 ACIMS inspection the centre had to be temporarily relocated due to a safety issue for a young person in the first instance and in the second was not suitable for use following extensive property damage. The repairs were completed to a good standard and inspectors recommend that a plan of a range of actions, aside from repairs, be put in place to reduce the levels of damage that can be done. The staff interventions for property damage were the use of numbers of staff present and de-escalation skills and inspectors recommend that these be reviewed to ensure the property and accommodation remain usable.

Inspectors found that there had been a fire safety audit conducted in January 2022 and no actions were noted as required as an outcome on this. Fire warden training was last completed in February 2021 but the audit did not note renewal timeframes for fire training or the numbers who may require it or not. Inspectors found that an external management audit completed over March and April also reviewed fire safety compliance, oversight and service checks at the centre as well as fire safety training being required. The response to this and actions from other internal audits were not

consistently recorded on them and the management team must ensure that they do so. A management meeting and the training matrix reviewed by inspectors confirmed that in fact fire safety training was being booked in 2022 appropriately.

The records at the centre showed that fire safety was discussed with the young people and any known previous risks addressed regarding fire setting. Inspectors found that the fire safety policy and procedure was reviewed in quarter one 2022 and discussed at the regular management meetings. The fire safety risk assessment had been updated as had the policy and circulated to all staff. The staff knew the updates which incorporated a change to the scheduling of fire drills. The management discussed with inspectors their intention to do a night time drill as well during 2022. There was evidence of service contracts for the maintenance of fire alarm and fire safety equipment along with the signage and sensors. There was fire fighting equipment in place and escape routes clearly identified.

The centre had a health and safety folder in place and a health and safety statement on file signed as reviewed in May 2022. Inspectors found that the site-specific risk assessments had been reviewed in February 2022. There were dedicated health and safety reports completed monthly and these were circulated to the centre manager and the senior management team. There were persons assigned to roles within the centre including to health and safety officer post. Inspectors have requested that the management verify if it should be the person in charge who should hold this role with tasks delegated thereafter by them in order to align with health and safety guidelines. Inspectors found that the team completed a combined one day first aid and ligature cutter training and request that the management verify if this is suitable for the type of centre and the service it provides.

The centre maintained accident and injury logs for young people and for staff and there were no significant accidents or injuries recorded. The centre had a vehicle with the requisite documents and oversight in place for its servicing and upkeep. A second vehicle can be available to the centre should they require it. There were maintenance records available which in the main were recorded on a digital system and were processed through that. The centre records should reflect when jobs were completed and this was not currently the case or move fully to a paperless system that can be digitally audited in the future. The centre manager confirmed that the online system and the centre records will align in future and register dates of work completed.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **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 2.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must confirm what persons should hold the role of health and safety officer for the centre.
- The centre management must confirm what level of first aid training is required for the centre taking account of its purpose and its location.

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.

Inspectors found that the staff team had completed renewal of their Children First E learning modules in 2022. The staff team had also trained in the organisation's policy on child protection in 2021 with more planned for 2022 for newer staff or any who wished to avail of it. Inspectors found that the staff team understood their roles as mandated persons, and the manager held the role of designated liaison person (DLP). There was discussion at the senior management meetings and at the team meetings of child protection concerns and reporting and the management consulted with the allocated social worker on matters arising. One such occasion was related to

an incident that took place outside the centre but was not reported by them. The centre manager confirmed with the social worker that another statutory service, the Gardai, had already opened a case. The centre noted this on their register as a concern and recorded the known details regarding where and how it had been reported.

There was evidence from staff interviews and on records that approaches to child protection in policy and in practice were a live aspect of team discussion and awareness. The team were knowledgeable about the child safeguarding statement and the statement was circulated to staff, displayed at the centre and had been updated in 2022. There was a child protection reporting register in place and this was up to date with evidence of oversight and discussion with social workers of the items contained within it.

There was robust evidence of co-operation between the centre, the social work department, the guardian ad litem, the previous placement and the clinical and therapeutic teams for a move into the centre. The young people and their close family were involved and their comments and wishes reflected in the planning. This multi disciplinary style approach was also reflected in another young person's move into the centre whose file inspectors also reviewed. Comprehensive histories and assessment reports were received pre-admission and information gained from the from professionals was found by inspectors to have been incorporated into the planning. Some aspects of the pre-admission risk assessment process had been weighted differently to what later occurred and behaviour management plans reflected the changing situation.

The purpose of this centre was to work with young people in need of significant support through their flexible occupancy approach, the large qualified team, the model in place and through planning to support young people away from behaviours hampering their progress and their personal safety. There were plans in place for young people which inspectors found were geared to their identified and known areas of vulnerability. Serious and concerning incidents were occurring and there were weekly multi-disciplinary meetings between Tusla and the centre. A social worker confirmed that all parties were alert to the level of concern about the distress experienced and the need for ongoing evidence of an improvement in personal safety.

The centre had an escalation policy in place and this had been triggered when risks to young people's safety passed a threshold of concern. The centre manager was clear about the balance of high risk being held with young people and the open discussions that take place with the young people themselves. The goal remained providing them with guidance and support to opportunities to grow positively, be educated and build safer independence. The centre manager's line management were in daily

communication and worked through the significant review process and collaborative working to track all events. A social worker outlined the manner in which the centre had responded to the issues at hand and planned accordingly. A social worker also confirmed that shared practices in response to risk areas had been agreed with clinical professionals and the social work department.

Through a review of the significant events and other records inspectors could see the evidence recorded of the ongoing episodes of harm and safety concerns that had occurred and also saw evidence of the focused approach to building a level of trust and relationship to further enhance safety. The centre was and remains an open residential setting and all parties, including clinical specialists, were holding the awareness around this.

There was evidence on file of direct work and key working with young people including follow up post incident, personal safety work related to social media, being in the community and social skills. Where risk related to significant self harm, plans had been developed and reviewed related to this. Additional staff training had been identified to take place in response to suicidal ideation and actions. Inspectors found that the risk management plans were detailed and practical but relied on broad statements at times related to providing emotional support. This must be broken down in more detail in order to demonstrate how this will provide more safety. A young person in placement presented as comfortable with staff and in the centre however did not specifically speak with inspectors about safety in or out of the centre.

In the area of absence management, the inspectors found that the use of absence at risk as well as missing child from care was being utilised on occasion, the category of absent at risk was removed from the Tusla and An Gardai Siochana joint. Although the centre was not using that categorisation to report a young person to the Gardaí its use should be reviewed so that it generates the set of actions that the situation merit. There is no official mechanism for absent at risk within the protocol. There was evidence that the staff utilised on call for absences and followed the guidance given.

There was a policy on protected disclosures and the staff interviewed had a good insight into the policy, its purpose and its procedures to follow.

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

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

Actions required

None identified

Regulation 5: Care Practices and Operational Policies

Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

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-centred, safe and effective care and support.

There was leadership evident throughout the structures at the centre and at each level of the organisation. The centre manager and their team displayed commitment to the service through their day to day practices in planning and direct work with the young person. The model of care was supported by an expert consultant and was evidenced as implemented through the placement planning process and into the direct work.

The centre manager was positively focused on service delivery and team development in order to best meet the needs of the young people referred to the centre. Outcomes had been mixed for the young people in the past year with some unplanned discharges including periods where the centre did not operate in the designated premises. Inspectors found that there was a focus on reflection and learning regarding service development at the senior management team meetings. There was also evidence of review at team meetings and the reasons for placements ending were discussed. Inspectors found that there was room for more review as the demands of the day to day running of the centre and the ongoing impact of the pandemic had left limited space for this in the first half of 2022. The senior management team must facilitate a review of any patterns from placements and share the learning in order to better support future placements.

The staff team provided positive feedback on the quality of management, leadership and support provided within the centre. The staff interviewed gave clear descriptions of approaches to care guided by taking an informed, individualised approach to young people and there was clear evidence of a current young person's involvement in what they needed and wanted from the team. The team utilised handovers, team meetings and significant event review to provide consistency and review approaches also. There was evidence that practice adapted where the situation demanded it, for example during escalating periods of risk taking.

Inspectors found that throughout the external and internal management meeting records that policies and standards were evidenced as discussed regularly, with actions taken where identified. There was internal auditing completed by the centre manager and delegated members of the senior staff. The action plan element of the templates was rarely used so it was not fully possible to track where the items identified were followed up. For example, in May 2021 a personnel file and training audit list of actions did not fully relate to the body of the findings and it was unclear if the actions as listed were fully completed, these related to if certain additional trainings had been booked and for when. The centre manager explained that some of this may relate to the gradual movement onto a digital system and that these dates were being booked or being sourced at senior management level. Inspectors found that given the structure was in place and the templates were linked to the national standards that the action plans should be utilised and the connecting systems whether they relate to booking training or otherwise should reflect the actions identified, or the reasons why not for the interim period.

There was a structure in place for external management audits to be completed on a quarterly basis, there had been one completed in quarter four 2021 and over the end of quarter one into quarter two 2022. The template for the external management audit whilst found to be thorough required some ongoing adaptations to it structure, for example to allow more detailed audit of specific areas on occasion, and again the action plan template was not always utilised to its intended purpose. In discussion inspectors found that the items identified were known and had actions in place around them from the centre management to the senior external management levels. Overall governance was evident throughout on the areas of quality and impact of the care provided, the leadership and the staff role - from care practices to new admissions inclusive of risk management.

There was a risk management policy and set of clear procedures including a matrix in place. The staff had either trained already in this or were booked to do so in the summer months. There were registers in place for service risks and for direct care risks, these were separate registers and overseen by the centre manager. Inspectors

found that for example in missing child from care that risks had been measured and then reduced by the listed mitigating actions in place but that the evidence surrounding it did not support such a reduction as yet. The centre management must ensure that ratings are congruent and consistent with the known information and with their current absence management plans. The staff team were knowledgeable about the risk management policy and expected practices and there was routine discussion and review of risk assessments and planning geared to reducing risk and supporting the young person to a safer decision making. The service risk register was reviewed and updated appropriately, this was also on the agenda at senior management meetings.

The centre manager had a deputy social care manager who had been supporting the running of another centre for a number of months. Therefore, the centre manager had arrangements in place with another named and experienced senior social care leader who acted up in their absence. The centre manager maintained clear delegation logs and there were roles assigned across a number of staff.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 6**
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 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The senior management team must ensure that they have a mechanism to facilitate a review of patterns from previous placements and share the learning from this with the team.
- The senior management team must ensure that the audit action plans and responses are recorded clearly.
- The centre management must ensure that specific risk ratings are congruent and consistent with the known information and plans on file.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre management must confirm what persons should hold the role of health and safety officer for the centre. The centre management must confirm what level of first aid training is required for the centre taking account of its purpose and its location.	Centre manager will hold the role of Health and safety officer of the centre. This will be recorded in service delegation log with support of designated staff member for day to day follow up. PHECC First aid will be rolled out for staff starting with those requiring refresher and will continue to be available to all staff on an on-going basis from October 2022 in line with trainer's availability.	Role will continue to be allocated to the centre manager. All staff members will be offered refresher training every 2 years. This will be overseen, by the training officer, as part of the manager's audit and by Head of Services quarterly audit.
3	None identified		
5	The senior management team must ensure that they have a mechanism to facilitate a review of patterns from previous placements and share the learning from this with the team.	Senior management will enhance the use the CRA form to identify patterns of behaviour and identify strategies to support in relation to these presentations, utilising support from any involved professionals, previous placements, ICSPs	This will be reviewed by Director of Services and Head of Services following next referral to identify if any further improvement is required.

		etc. This will be completed by 30th September 2022.	
	The senior management team must ensure that the audit action plans and responses are recorded clearly.	Director of Services and Head of Services will review audit template in particular action plan section to ensure relevant actions plans and outcomes are captured appropriately. This will be completed by 30th September. Head of Services will carry out training with centre managers and social care leaders in relation to completing the audits and correct use of the actions plans by 30th September 2022.	Head of Services will ensure audits are being completed and action plans are acted upon for quarterly service audits.
	The centre management must ensure that specific risk ratings are congruent and consistent with the known information and plans on file.	Head of Services will carry out further training on risk management policy specifically risk ratings with the team by 30th September 2022. In weekly team meetings particular focus	Head of Services will review congruence of risk ratings as part of audit process.

		will be placed on accurately measuring the risk rating on the service risk registers. In situations where interventions may not reduce the risks sufficiently the rating will remain the same.	