An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 187

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Peter McVerry Trust**
Registered Capacity:	**Six young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**17th & 18th May 2022**
Registration Status:	**Registered from 05th February 2021 to 05th February 2024**
Inspection Team:	**Lorraine Egan** **Catherine Hanly**
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 first opened in 2014 and repurposed in 2021. It was granted its first registration on the 05th February 2021. At the time of this inspection the centre was in its first registration and was in year two of the cycle. The centre was registered without attached conditions from the 05th February 2021 to the 05th February 2024.

The centre was registered to provide short term emergency care for six young people between 12-18 years of age for a period of three weeks. The referrals were submitted from Tusla, National Out of Hours Service and the Crisis Intervention Service. This placement was offered on a short-term basis, however in exceptional circumstances, applications could be made for a further week at the centre to allow for an appropriate and safe transition for young people. All the referrals were for young people requiring an immediate residential placement. The centre offered a strength based, trauma and attachment informed care which is guided by the Welltree model of care. Five young people were living in the centre at the time of the inspection and one had been admitted the night before inspectors went onsite.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
4: Health, Wellbeing and Development	4.2
5: Leadership, Governance and Management	5.3
6: Responsive Workforce	6.1

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 and to the relevant social work departments on the 10th June 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 4th August 2022, and a reviewed CAPA was submitted on the request of the inspectors on the 24th August 2022. This was deemed to be satisfactory, and the inspectors were assured that the issues identified in the report were being addressed on an ongoing basis with Tusla, the Child and Family Agency, as the funding body.

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: 187 without attached conditions from the 5th February 2021 to 5th February 2024 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.

The centre had a complaints policy in place which contained a five-stage process for managing dissatisfactions from complainants. The procedures outlined within required updating, specifically regarding informal complaints which did not include how issues of concern would be responded to and resolved in consultation with young people. Overall, the various stages within the policy were not clear. The language and terms used should be more child centred and reflective of good practice for dealing with complaints made by or on behalf of young people and their families. The policy was due for review in 2022 and had commenced at the time of inspection.

Inspectors found that the staff team made every effort to listen to young people's views and preferences and a culture existed in the centre of providing them with opportunities to participate in decision making about their care and daily living. This included involvement in planning meetings about their future and individual weekly consultations between staff and each young person so that they could raise issues of importance to them that would in turn be discussed at the team meetings by staff. While the latter forum afforded young people an option to make their views known about day-to-day routines and other matters, it was not clear how this impacted on positive outcomes and resolutions for issues raised as these were not regularly recorded. Inspectors recommend that the purpose of these consultations are reviewed and to consider introducing young people's meetings as an alternative.

The team were strong in their respect of young people's rights to be heard and were open and transparent in their practice in this regard. However, improvements were required in the timeline for informing young people of how to make a complaint as from a review of the young people's files, inspectors observed that in some instances this was not completed close to their date of admission. Staff at interview described

an induction session with young people which included access to an information booklet, however, the section on complaints within the booklet should be reviewed so that the language used to outline the process is clearly explained for the user.

Inspectors found that a number of complaints raised by young people and their parents were responded to and recorded and inspectors found evidence that these had been brought to a full conclusion with oversight by centre management and escalation to senior management. However, a number of concerns were either not managed appropriately through the complaints system or not at all so that the process in use was inconsistent. Consequently, this hindered effective monitoring of complaints and, if not reported, could not be tracked for emerging themes or patterns by senior management. In addition, inspectors did not see evidence that learning from investigations was implemented to improve practices in the centre and this must be addressed. Further, there were deficits for the staff team in distinguishing which complaints were informal and which ones should have been responded to as part of a formal process including escalation to an external body. Examples of these included young people's personal items and belongings being stolen from their bedrooms, incidents of persistent bullying, threats and violence by young people to peers living in the centre and dissatisfaction by a parent regarding the unsuitability of the placement for their child after admission. In addition, a number of complaints that had been recorded on the centre's dedicated forms were not thoroughly completed to reflect the response and outcome of the concerns made. There were some gaps in the documentation of who was informed from once the issues were raised by the young person through to the conclusion of the complaint. The centre manager must ensure that the procedures in place to identify, record, investigate and resolve complaints should be consistent and robust in practice and all dissatisfactions and concerns must be considered as part of the complaints system including escalation to external bodies such as the Ombudsman for Children. Records should identify who has been informed of the complaint and of the outcome.

A register was maintained by the centre of complaints that they had determined were either formal or informal and this was discussed at senior management and team meetings with guidance from the centre manager on how to ensure that young people's voices were heard so that their issues could be addressed. Inspectors were informed that one young person had access to an EPIC worker from their previous placement, and there was evidence on records of the staff team advocating on their behalf and making representations regarding accommodation and homelessness. Social workers interviewed stated that they were satisfied with the way the staff team collaborated with them on issues and complaints. Young people's questionnaires

along with one young person who spoke to inspectors described how they felt listened to and said they could talk to any of the staff team if they ever had difficulties.

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 director of services and centre manager must ensure that the centre's complaint's policy is reviewed and updated and in line with best practice guidelines.
- The centre manager must ensure that young people are made aware of how to raise complaints in a timely way.
- The director of services and the centre manager must update the complaint's section in the young people's information booklet so that the language used to outline the process is clearly explained for the user.
- The registered provider must ensure that there is an effective system in place to review complaints. Learning from investigations should be implemented to improve practice.
- The centre manager must ensure that the procedures in place to identify, record, investigate and resolve complaints should be consistent and robust in practice and all dissatisfactions and concerns must be considered as part of the complaints system including escalation to external bodies such as the Ombudsman for Children. Records should identify who has been informed of the complaint and of the outcome.

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.

As the centre provided short term emergency care for young people, overall, there was an absence of care plans on centre files. This hindered the identification of goals to support meeting young people's health and development needs. Because a number of young people remained in the centre beyond the maximum stay of three weeks, this impacted the provision of appropriate and necessary health needs for these young people. It was not clear to inspectors if care plans were requested by the staff team for young people whose move-on became more protracted.

However, placement reviews and planning meetings were frequently held for most young people and these contained short overviews and updates of a number of their needs including health and wellbeing. In addition, young people had a health, physical and mental wellbeing plan on file guided by the Welltree model of care which captured some of their immediate goals. Despite this, inspectors found that it was difficult to track young people's specific health and development needs across the various records and consequently found that this contributed to deficits in access to more immediate supports and interventions required by them. In addition, it was not always clear to inspectors which appointments and programmes had been attended by young people and which required rescheduling and completion. This was the case despite individualised synopses of current health needs for two young people submitted to inspectors during the inspection process. However, these were not linked to the young people's stated immediate goals and therefore difficult to assess if these needs were being met. Further, because of the nature of the service being provided, the centre did not co-ordinate referrals to specific external support agencies as this was typically the responsibility of placing social work departments. On occasion this led to gaps in access to appointments, for example, optical and physiotherapy that were overdue at the time of the inspection for some young people that should have already been prioritised. While generally, the centre did facilitate transport to specific appointments, in one instance a young person could not be accompanied by centre staff to a hospital appointment where typically this would be the responsibility of social care staff where the young person lived. This specific matter was highlighted to inspectors by the young person's allocated social worker and team leader who said it was a direct result of staffing issues in the centre,

however the centre stated that this function remains the role of the social work department given the purpose of the placement for young people. They said that they will endeavour to provide this support where possible.

As some of the current cohort of young people had various medical and complex health conditions, they required imminent care and coordinated medical planning to ensure they had prompt access to all of their prescribed medication and appropriate medical services. While the staff team were working collaboratively with young people, social work departments, families and community agencies including hospitals, to make links and ensure young people engaged with the necessary supports and schedules, a more comprehensive identification of their individual health needs and goals was required along with a plan to be regularly reviewed and updated for each young person. As the aim and objectives of placements in the centre was to provide care for young people who required a short-term period of residential support, case management for young people's health needs in this regard may go beyond the centre's remit as a service. The centre must have a clear understanding of the scope of the centre's service provision and respond to young people's health and medical needs in a way that is appropriate to their own purpose.

While there were some records on the young people's files of medical diagnosis, previous medications, referrals to hospitals and dental services, there were deficits in how concise and complete the records were in relation to individual health information. The centre's medical policy outlines that they request a young person's medical history prior to or on admission and inspectors saw evidence of the centre requesting medical histories from social work departments. However, staff stated that this was a slow process and the required health information was not always submitted in a timely way. This issue should be escalated to senior management.

Not all young people had access to a dedicated GP nor did they all have medical cards on file. The staff team made efforts to connect young people with Caredoc shortly after admission and also maintain links where possible to their own local GP service where they had lived previously. Inspectors found that from a review of the team meeting minutes there were robust discussions taking place regarding young people's health and wellbeing which included sleeping patterns, health routines, nutrition, support with prenatal care as well as consideration for introducing achievable and realistic goals for young people in this area on admission. However, as discussed above, inspectors did not observe this plan being implemented in a consistent way in practice.

Although individual work sessions were conducted with young people on emotional wellbeing and substance misuse, inspectors observed that over a prolonged period of time young people's exposure to significant incidents of bullying, threats, assaults and property damage was impacting on their mental health. While risk assessments were in place and updated regularly, it did not reduce the effect of these episodes on young people living there during this time. This will be discussed further in the report in relation to purpose and function for the service. The staff team were aware of referrals to specialist services for young people and worked with social workers in this regard including agencies such as CAMHS.

Policies were in place on medical attention and administration of medication. First aid training was outstanding for some staff but these were scheduled to take place. The majority of the team had completed Safe Administration of Medication training (SAM) and going forward it was planned to access the HSEland module. Inspectors found that the records for the administration of medication required attention as they were difficult to follow at times. From a review of these files, some of the young people's individual prescribed medicine sheets were incomplete and some were not stored on their file, and it was difficult to establish which medication doses were finalised and which were no longer being administered or being refused by the young people. Over the counter medications were documented, however young people's names or initials were not recorded. Written consent from parents/guardians were not on file. Weekly medication audits were conducted, however, there were gaps in completion for some weeks. There was a health and wellbeing tacker conducted by a staff team member, there was no concrete evidence recorded for each action. The registered proprietor must ensure that SAMs training is provided to all staff. The centres medication documents should be reviewed so that a clear and complete record of each young person's prescribed and non-prescribed medication is maintained as part of their file. Written consent from parents/guardians should be sought and stored on the young person's file.

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 centre must have a clear understanding of the scope of the centre's service provision and respond to young people's health and medical needs in a way that is appropriate to their own purpose.
- The centre manager must ensure that where social work departments do not forward details of young people's health and medical details as required that this is escalated to senior management for attention.
- The registered proprietor must ensure that SAMs training is provided to all staff. The centres medication documents should be reviewed so that a clear and complete record of each young person's prescribed and non-prescribed medication is maintained as part of their file. Written consent from parents/guardians should be sought and stored on the young person's file.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

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 written statement of purpose which also incorporated the model of care, aims and objectives, core elements of service provision and any supports in place for the operation of the service. Inspectors found that the centre was not in general operating in line with its purpose and this must be addressed by the registered provider without delay. The centre was described as accommodating up to six young people between the ages of 12 and 18 years with referrals being considered from Tusla National Out of Hours Service or the Crisis Intervention Service (NHOS Day Service). Placements were stated as being offered on a short-term basis for a period of up to three weeks. Despite this, inspectors found evidence that young people were typically remaining in the centre for a duration that exceeded this period and in some cases for up to two months after admission. For the current cohort of young people who were living there at the time of the onsite inspection, four out of six had been in placement beyond the stated accepted period and in addition the centre's

annual service review compiled by Peter McVerry Trust found that out of the total number of placements between February 2021 and December 2021, approximately 46% of young people were remaining in the centre past the three-week time period for transition. Some of the reasons given by the centre manager and the director of services was because there were no available alternative placements available for the young people to transition to. Allocated social workers interviewed told inspectors that they were finding it problematic to identify options for some young people, however they understood that the purpose of the centre was emergency accommodation only and that applications could be made by them for extensions for up to one week only to allow for safe transition of the young person onwards. This issue was highlighted in the previous inspection of 2021 and at that time the registered provider gave a commitment to review the length of placement as per the centre's purpose by September 2021. This was to be completed in conjunction with Tusla, however, it had not been addressed and this action remains outstanding. In addition, inspectors found that the delayed stay was contributing to a substantial number of significant high-risk incidents that had taken place in the centre and that had negatively impacted a number of young people placed there at certain periods. These have been identified above but included behaviours relating to threats, sustained bullying, violence, property damage, fire setting and substance misuse. The registered provider must ensure that the centre is operating within its statement of purpose. Young people must be supported to transition out of the centre within these stated timeframes.

Staff were aware of the statement of purpose and could describe the model of care in practice with young people.

Compliance with regulations	
Regulation met	**Regulation 6** **Regulation 5**
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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 5.3**

Actions required

- The registered provider must ensure that the centre is operating within its statement of purpose. Young people must be supported to transition out of the centre within these stated timeframes.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

The centre's staff team had skills and competencies to respond to the needs of the young people living there and inspectors found that in general, the workforce was planned and configured to provide child-centred and safe care. Where staff did not have previous experience of working with under eighteens, the roster was organised to take account of this deficit. Staff were committed and engaging with young people and at interview they demonstrated that their focus was meeting the individual needs of the young people within the context of trusting relationships. There was strong evidence across centre files that young people were supported and advocated for and staff made efforts to spend time getting to know them from once the admission process began. Young people at interview and on their questionnaires were consistently positive about staff in the centre and described how they got on well with the team and that they 'take me out to shop and meet my family' and that staff 'are so kind and welcoming'. One parent described how the team went 'above and beyond' what they would expect them to do and staff 'did everything they could to facilitate the young person' when they were living there including keeping in touch with them regularly when they went missing from the centre to ensure they were safe. Social workers told inspectors that the team worked collaboratively with them and had young people at the centre of what they provided as a service.

The full complement of staff consisted of a centre manager, deputy manager, six social care leaders, seven social care workers and one activities social care worker. In addition, the centre had a panel of relief staff to provide cover for various periods of leave when needed. One of the panel members was working a full line currently in the centre but had not yet obtained their qualification in Social Care until June 2022. From a review of personnel records, inspectors were satisfied that the centre had the required number of social care qualified staff.

The rota in the centre consisted of three-day shifts from 8 a.m. to 9 p.m. and three live nights from 8 p.m. to 9 a.m. These shifts had been devised in such a way to suit the emergency aspect of the service being provided. Inspectors found that although at times, there were four staff on duty for both shifts, this was not consistently the case for periods of crisis in the centre and this must be addressed. Staff interviewed described how increased staffing was necessary on an ongoing basis considering the number of young people admitted to the centre at any one time and given their complex needs and the significant number of risks and presenting behaviours. This was also highlighted as an action at the previous inspection in 2021 but was not actioned at that time. The director of services stated that they could not resource an increased rota on a regular basis because of the deficit in funding from Tusla, the Child and Family Agency. In addition, as identified in the previous inspection's findings, an activity worker who was employed as such was not working a full roster in this capacity and as a consequence there was a gap in service provision for young people in this regard. This must also be addressed by the centre as soon as possible. Inspectors recommend that more attention is given to the balance of male and female staff on the centre's rota. This was an issue raised by one young person as a complaint.

Despite a number of changes to the staff team since the last inspection, the centre had measures in place to promote stability in the workforce including an employee assistance programme, study support, training and supervision when required. Senior management were in the process of reviewing pension options for staff also. Staff told inspectors that they were well supported by the centre manager and the team as a whole. On call arrangements were in place and was utilised by the team when necessary for support and direction.

Compliance with regulations	
Regulation met	**Regulation 6** **Regulation 7**
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 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that all staff working in the centre have achieved their qualification in social care.
- The registered provider must ensure that there is enough staff available to fulfil the activity programme for the young people and that a review of the staffing requirements is undertaken for the centre when at full capacity.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The director of services and centre manager must ensure that the centre's complaint's policy is reviewed and updated and in line with best practice guidelines.	The complaint's policy review by centre manager and director of services and update was completed in May 2022. A further review will be completed in 2023 to ensure that the policy remains in line with best practice guidelines.	The policies and procedures are reviewed on an annual basis to ensure they are up to date with current requirements. The complaint's policy will be reviewed again in 2023 as part of this process.
	The centre manager must ensure that young people are made aware of how to raise complaints in a timely way.	All young people are informed of the complaints process by the social care worker and social care leader who are completing the admission. This is reflected in the admission paperwork and induction checklist. The manager will continue to have oversight of the admission process and the recorded details. This will ensure that all young people are made aware of how to make a complaint.	This will be monitored by the manager as part of the weekly review of paperwork. The quarterly audits by head of services will further monitor the complaint's process.
	The director of services and the centre manager must update the complaint's section in the young people's	In June 2022 the complaint's section in the young people's booklet was reviewed by director of services, head of services,	The induction booklet will be reviewed after policy and procedure annual reviews to check if any further changes are

	information booklet so that the language used to outline the process is clearly explained for the user.	manager, deputy manager and further reviewed by the u18 management team to ensure the complaint's process is more clearly explained for the user. The HIQA guidance for communicating in plain English was used to support this.	required to support the young person's understanding and update accordingly. The centre manager will continue to monitor the young people's induction booklet to ensure its effectiveness.
	The registered provider must ensure that there is an effective system in place to review complaints. Learning from investigations should be implemented to improve practice.	The centre manager will continue to review complaints, all formal complaint forms will be forwarded to the under 18s manager's meetings and to team meetings for further discussion, review and learning. Identified learnings will be recorded.	The manager will ensure weekly oversight of complaints and resolution process. Review of complaints to be monitored during quarterly head of services audits.
	The centre manager must ensure that the procedures in place to identify, record, investigate and resolve complaints should be consistent and robust in practice and all dissatisfactions and concerns must be considered as part of the complaints system including escalation to external bodies such as the Ombudsman for Children. Records should identify who	Feedback and complaints will be monitored through young person's voice in daily report books, consultation and feedback forms and complaint's forms will identify complaints and ensure they are responded to appropriately. Escalation to other channels within Tusla and the Ombudsman for Children will be kept under review to support young people to access services as required. Records of	The manager will ensure weekly oversight of complaints and feedback. Review of complaints to be monitored during quarterly head of services audits.

	has been informed of the complaint and of the outcome.	those informed will be kept together to ensure that it is clear who has been informed of complaints.	
4	Senior and centre management must have a clear understanding of the scope of the centre's service provision and respond to young people's health and medical needs in a way that is appropriate to their own purpose.	As the service provides immediate accommodation to young people on an emergency basis for a short-term period, immediate health needs identified during admission or during the young person's stay will be followed up on, in conjunction with the young person's social work department and the National Out of Hours Service. Due to the nature of the service, it is the role of the social work department to ensure there is support for the young person to attend medical appointments. Where other supports are not available the service will attempt to provide support to appointments, wherever possible and dependant on an assessment of the service at the given time. Prolonged periods of support at hospital will not be routinely possible due to the nature of the service and cover in place. Where this occurs, discussion with the social work department and National Out of Hours	This will be reviewed as part of the quarterly audit. Social Work teams will be reminded of the difference between this service and a medium to long term placement. Routine discussion will also take place at team meetings and under 18s manager's meetings to ensure the team and the on-call team are aware of this level of support and reminded of the purpose of the placement.

		Service will take place to ensure that the young person is appropriately supported.	
	The centre manager must ensure that where social work departments do not forward details of young people's health and medical details as required that this is escalated to senior management for attention.	Where health and medical details are not received from the social worker in a timely manner the centre manager will escalate this on to the social work team leader or the National Out of Hours social work team leader for resolution. Where this is not successful the centre manager will escalate this to the head of services.	This will be reviewed as part of the manager's weekly audit and the quarterly audit by the head of services.
	The registered proprietor must ensure that SAMs training is provided to all staff. The centres medication documents should be reviewed so that a clear and complete record of each young person's prescribed and non-prescribed medication is maintained as part of their file. Written consent from parents/guardians should be sought and stored on the young person's file.	SAMS Training has been completed by the majority of the team. An online training on HSEland on children's residential services medication management is available, any remaining team members have completed this and going forward this is available to all staff. Consent to administer OTC medication is sought and recorded as part of pre-admission process from placing social worker. A written consent form from parents/guardians will be drafted for the	The training records will be reviewed as part of the manager's weekly audit and the quarterly audit by the head of services. This will be reviewed as part of the manager's weekly audit and the quarterly audit by the head of services.

		administration of prescribed and non-prescribed medication and stored on the young person's file, dependent on care status. This will be given to the social work team to sign where appropriate or to provide to parents / guardians to sign at the earliest opportunity.	
5	The registered provider must ensure that the centre is operating within its statement of purpose. Young people must be supported to transition out of the centre within these stated timeframes.	A weekly report is now compiled by the centre manager on the status of current residents for the Tusla regional manager of CIS services, this is reviewed at the weekly regional manager's meeting to support each young person's placement progression and highlight any aspects of concern. Progression from the centre, in line with stated purpose and function, has at times been hindered by availability of appropriate assessment and or onward placements. A meeting has been requested with Tusla and is now scheduled for August 2022 to consider strategies for responding to issues related to the length of placement. The centre will continue to advocate on	The length of placement will continue to be monitored and escalated to the regional manager and an annual report generated. Any further steps required after the scheduled meeting with Tusla in August 2022 will be completed to minimise the risks of extended placements, wherever possible.

		behalf of the young people and their observed needs, particularly in relation to their move on plans and the importance of achieving these in a timely manner.	
6	The registered provider must ensure that all full-time staff working in the centre have achieved their qualification in social care. The registered provider must ensure that there is enough staff available to fulfil the activity programme for the young people and that a review of the staffing requirements is undertaken for the centre when at full capacity.	One staff member was transitioning onto a core social care worker contract at the time of this inspection. This role had been fulfilled by a full-time relief social care worker up until this time. Centre manager and HR will ensure that all full time Social Care staff have achieved their degree in Social Care or equivalent. The centre continues to have triple cover at all times with activities supported on a daily basis. This is an addition to supports such as YAP and Extern which are made available to the young people through social work and National Out of Hours Social Work Departments in line with each young person's needs. Extra staffing has at weekends and when at full capacity has been discussed with Tusla and will be reviewed in meeting in August 2022.	This will be reviewed by HR, centre manager and the quarterly audit by the head of services to ensure all staff are appropriately qualified.