An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 070

Year: 2022

Inspection Report

Year:	**2022**
Name of Organisation:	**Peter Mc Verry Trust**
Registered Capacity:	**Five young people**
Type of Inspection:	**Announced**
Date of inspection:	**11th, 12th & 20th January 2022**
Registration Status:	**Registered from 4th March 2021 to 4th March 2024**
Inspection Team:	**Lisa Tobin** **Eileen Woods**
Date Report Issued:	**15th March 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 Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 04th March 2003. At the time of this inspection the centre was in its ninth registration and was in year one of the cycle. The centre was registered without attached conditions from 04th March 2021 to 04th March 2024.

The centre was registered to provide multi occupancy for medium to long term care for up to a five young people aged between 12 to 17 upon admission, the centre by agreement accommodates a maximum of four young people at any one time. The provision of aftercare support forms part of the purpose and function also. The centre operated a strengths-based therapeutic model of care which is trauma informed within which individualised planning for young people was guided by a therapeutic placement planning model called the Well Tree model. There were three young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
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 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. This inspection was undertaken remotely due to a risk assessment carried out where a positive case of Covid 19 was identified in the centre. A visit to the centre was arranged for a later date.

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 15th February 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 2nd March 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: 070 without attached conditions from the 4th March 2021 to the 04th March 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.

Inspectors reviewed documentation that outlined ways in which the young people were listened to and how their views were considered. Daily log entries captured young people's voices throughout their daily interactions and consultation books were used weekly as a way of gauging the young people's wants/voice prior to being discussed at the team meetings. Complaint forms were reviewed by inspectors which showed how the young people were able to voice any issues they had with the daily living arrangements. Inspectors were informed during interviews that feedback to the young people was part of how the centre worked, which was noted by the inspectors when the young people received feedback after the team meeting regarding the issues they had outlined in their consultation books. The staff informed inspectors that there was a process in place for the young people to receive feedback in a way that ensured they understood the feedback based on their individual needs and abilities.

There was a policy on complaints in place which currently identified them as formal or informal complaints. The complaints policy did not outline the types of complaints in the policy and only discussed the types when addressing the procedures.

Informal complaints were recorded in a register and were identified as complaints that were being dealt with in the centre. Inspectors found that all complaints made by the young people were identified as informal since the last inspection. Inspectors noted there was a gap in entries in the informal register between March and August 2021. There was no evidence to suggest that complaints had been made during this timeframe. Inspectors saw that the informal complaints were addressed with the young people promptly by staff and management in line with their policy, however further detail was required on the complaints form regarding actions taken/decisions made/meetings arranged and if the young person was satisfied with the outcome.

A formal complaint was identified as a complaint that couldn't be resolved by the centre and required social work/Tusla notification. An external option for assistance for the young people from other agencies such as Empowering Young People in Care (EPIC) or the Ombudsman for Children was available if the young people did not wish to make their complaint through the centre staff. There were no formal complaints on file since the last inspection.

Inspectors reviewed informal complaints that were logged such as bedroom door alarms and managing peer relationships which were appropriately dealt with through the informal process and individual work reports. Other complaints such as bullying and a young person wanting to leave care were also entered into the informal complaints log. Social workers were informed by phone/email of bullying issues as they arose. The current system for logging the latter complaints as informal were not deemed as sufficient due to the lack of follow up of a significant event, lack of informing family members and the relevant social worker which was not noted on the informal complaint. Clear processes were required for identification of complaint types, the need for appropriate follow up by the team, management, senior management and external agencies and feedback documenting how the young person found the complaints process and if they were satisfied with the outcome.

Inspectors reviewed individual work completed with the young people during their admission which informed them of their rights, the complaints process and of other external agencies that they can speak with regarding their care. Young person's booklets and family booklets were available which stated there was a complaints process however, it didn't differentiate between formal and informal complaints. There was no organisational process identified for family to appeal a complaint within the service as they were directed to external agencies. Information on the model of care and scoring mechanism with involvement from the young people to help create the plan or add to the plan was identified in a previous inspection in this centre which hadn't been included in the young people's booklet to date.

Inspectors reviewed a complaints audit form that was completed by the manager and inspectors identified areas of improvement required regarding how it was filled in, identifying whether the complaint was formal/informal and identifying how many young people were in the centre. This would benefit from being more specific with direct input from the staff and the young people.

Two young people completed questionnaires and identified different staff members they could speak with if they had any concerns. Inspectors saw that complaints were

discussed at team meetings and at senior management meetings on a regular occurrence.

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 manager and senior management must have clear complaints structures in place in addressing formal and informal complaints. They must ensure that follow up includes the young persons response to the outcome of the complaint.
- The centre manager and senior management must include relevant information in the booklets for the young people and their family. The organisation must look at developing internal processes for appeals of complaints for families.
- The centre manager must ensure that the audit for complaints shows the relevant information to ensure appropriate oversight.

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.

There were several policies in place to ensure the young people were safeguarded from abuse which included bullying prevention and intervention, social media policy, child protection and safeguarding policy and a number of policies relating to the procedures regarding disclosures of abuse and allegations. There was a child safeguarding statement in place which was reviewed every two years or as required. Inspectors saw that the anti-bully policy and the child safeguarding policy was discussed at the team meetings.

When reviewing the training log, it was noted that all staff had completed Tusla E-Learning module: Introduction to Children's First. Two staff required child protection training within the organisation. Inspectors were informed that dates were being arranged for this training. During interviews, staff were aware of their responsibilities as a mandated person and the processes for making a child protection welfare report form (CPWRF) notification through the Tusla portal. The staff were aware of making individual CPWRF or completing it jointly with the designated liaison officer. The centre manager was the designated liaison person (DLP) and staff were aware that they were to contact on call if the manager was not onsite and notify them of a concern.

Inspectors reviewed an excel sheet which recorded CPWRF's. There were eight reports noted since November 2021. Some of these were related to an ex-resident and the manager had requested closure letters from relevant social workers. There were closure letters attached to one young person from their social worker. Inspectors did not see any significant events relating to informing a social worker that a CPWRF's had been submitted through the Tusla portal system.

Inspectors spoke with allocated social workers and family members, and all reported good links and communication with the centre. They were informed of incidents and were aware of the young people's vulnerabilities and how the staff were addressing these. Families reported the support the young people received was relevant to their current needs and the family members were happy with the updates they received

from the team and the level of input they had into the care of the young people. All social workers and family members stated they felt the young people were safe in the centre, but some did have concerns about the outside environment and potential risk exposure based on the location of the centre relating to the individual young person's risks. Staff and others go to and from there every day without much risk identified and stated the young people know the community well and were familiar with it. However, social workers and family members also stated that they felt that these potential risks were identified, addressed and managed with the young people through the use of pre-admission risk assessments, individual risk assessments and absent management plans.

Individual work reports were reviewed by inspectors which showed work completed with the young people around self-care, bullying and managing appropriate peer relationships. Staff spoke of different specialist supports undertaken with the young people at their level which included the use of supports from speech and language therapy interventions. The team used the Well Tree model of care guidelines throughout the placement plan meetings, life skills work had been undertaken with the young people to address self-esteem, self-worth and keeping safe in daily living events.

Team meeting minutes showed that discussions about the young people's risks, vulnerabilities, ICMPs, AMPs, child protection concerns and CPWRF's were all discussed at team meetings. Inspectors reviewed individual crisis management plans (ICMPs), risk management plans, safety plans, absent management plans (AMPs) and risk escalations that were completed for the young people as part of the safeguarding processes that were put in place for the young people. For one young person, the ICMP had some conflicting information regarding responses from the team, for all young people, the ICMP did not identify whether staff were or were not to undertake physical interventions or if there were any contra indicators. The centre manager and key worker must ensure that the ICMP's included the current risks/vulnerabilities for each young person and how staff address those risks/vulnerabilities.

There was an escalation process in place for the CPWRF policy process of responses although it was not called this, it was identified as "special considerations in under 18's residential service". This process was clear and well detailed and inspectors recommend that it should be replicated in the care planning section when care plans have not been received in an appropriate timeframe for the young people.

Staff were aware of the whistleblowing policy when questioned during interview and knew who they can contact or speak with if they had any concerns/disclosures about a colleague or a work performance issue. The staff said they felt confident in using this policy if they needed to. Inspectors noted that the whistleblowing policy was reviewed at the team meeting.

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 manager must ensure significant events are sent to the relevant people when a CPWRF is reported through the Tusla portal.
- The centre manager must review the individual crisis management plans to ensure they record all relevant information in addressing the young people's risks/vulnerabilities.

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.

Inspectors found that only one young person out of three had an up-to-date care plan on file. One young person was due to have had their child in care review in December 2021 and the other young person was new to the care system and was awaiting a date for their first child in care review. Inspectors saw evidence of the centre manager requesting dates for the relevant child in care reviews. Of the one care plan available for inspectors to review, the health section was very detailed and gave guidance for

the centre to follow up on certain health related issues for the young person. The issues identified in the care plan related to health were noted in the Well Tree placement meeting and subsequently pieces of key working, and individual work reports were completed which addressed those health issues.

For the two young people without up-to-date care plans, family members, social workers, general practitioners, and community workers provided relevant medical information to the centre to help guide their health aspect of their placement planning. Some medical information couldn't be sourced such as vaccination records or there was little medical information available to the social worker or the centre. The two new young people were awaiting an appointment to complete their medical into care and dental appointment which had been cancelled due to a positive covid outbreak.

Specialised services being utilised currently with the young people and staff included child adolescent mental health services (CAMHS), community gardai, speech and language therapist, neighbourhood youth project (NYP) and counselling. Staff also had access to a Tusla psychologist to help with addressing presenting behaviours. Staff supported the young people in attending medical appointments and attending any specialist services.

Each young person had access to a general practitioner and inspectors saw reports of the young people attending their GP and of the staff arranging appointments for the young people.

There was a policy on medical attention and administration of medication in place. The training log specified that 5 staff had completed safe administration of medication management (SAMMs) however, the policy states that all staff must have completed SAMMs training. Inspectors were informed this was due to occur in January 2022 but had not by the time of inspection. The policy also outlined that any controlled medicine for ADHD must be given by 2 staff and signed off by 2 staff. This practice was not occurring in the centre based on a review of the young people's Kardex. Inspectors noted that a Kardex was not completed accurately by staff when identifying if a young person was given or refused a daily medication. Inspectors were informed that first aid training was in date for 6 staff and that the other members of the team were assigned new dates as part of the monthly training list.

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 manager must ensure that the administration of medication policy is followed by the team.
- The centre manager and senior management must ensure that all relevant training is completed by the staff team.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The centre manager and senior management must have clear complaints structures in place in addressing formal and informal complaints. They must ensure that follow up includes the young persons response to the outcome of the complaint.	The Complaints structures are currently being reviewed by Director of services, Head of Services and centre management, this will be completed by 30th of April 2022, young person's response and outcomes of the complaint will be included as they are currently on formal and informal complaints form. Informal complaints were recorded where young people did not wish to make a complaint but had voiced feedback in relation to some aspect of the service or their experience which support was put in place to resolve. Such informal complaints were reviewed for patterns and trends. This will also be reviewed to consider how best to track such patterns.	Complaints will be reviewed in line with amended policy and procedure as part of SCM and Head of Services Audit to ensure they are in line with requirements.
	The centre manager and senior management must include relevant	Information on appeals process to PMVT Head of Services will be included in Family	The booklet will be updated with relevant information for family members.

	information in the booklets for the young people and their family. The organisation must look at developing internal processes for appeals of complaints for families. The centre manager must ensure that the audit for complaints shows the relevant information to ensure appropriate oversight.	booklet. Further information on Welltree Model of Care will be incorporated. This will be completed by the 31st of March. The Complaints audit will be reviewed Director of services, Head of Services and centre management to ensure all relevant information is included. This will be completed by 31st of March.	Complaints will be reviewed in line with amended policy and procedure as part of SCM and Head of Services Audit to ensure they are in line with requirements.
3	The centre manager must ensure significant events are sent to the relevant people when a CPWRF is reported through the Tusla portal. The centre manager must review the individual crisis management plans to ensure they record all relevant information in addressing the young people's risks/vulnerabilities.	SEN's will be completed for a CPWRF and sent to relevant parties. This has already been implemented. All ICMP's have been reviewed and relevant information incorporated as outlined.	This will be reviewed as part of SCM and Head of Services Audit to ensure they are in line with requirements. The monthly review of ICMPs will be overseen by the SCM, any information no longer necessary will be removed. Audit by SCM and Head of Services will monitor content.
4	The centre manager must ensure that the administration of medication policy is followed by the team.	All staff have reviewed the policy and ensured their practice is in line with requirements.	SCM will show oversight of signatures following administering medication on weekly review.

	The centre manager and senior management must ensure that all relevant training is completed by the staff team.	5 staff members completed SAMs training on the 28/02/2022 (date re-scheduled due to Covid)	SCM and Training Officer will continue to review training requirements and schedule. Audit by SCM and Head of Services will monitor this.