St. Mary's Children's Home
Established
July 1857
Treasure The Children

St Mary's Children's Home

MODEL OF CARE

2023

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Foreword

FROM
THE HONOURABLE AYANNA WEBSTER-ROY,
MINISTER WITH RESPONSIBILITY FOR GENDER AND CHILD AFFAIRS

PUBLICATION | MODEL OF CARE | ST. MARY'S CHILDREN'S HOME

JANUARY 2023

The Government of Trinidad and Tobago values a robust child protection system as a major pillar in building our nation. Positive reinforcement and nurturing serves as an effective promoter of changes and improvements to our societal structure. This mirrors the crucial role of our caregivers and child care institutions in the upbringing of children in need of support systems for their care and protection.

As Minister with responsibility for the Gender and Child Affairs portfolio, I am mindful of the need for better understanding and support of children's homes so that those in their care can be appropriately served and provided with ample opportunities to be productive and respected members of society. In the absence of ideal family settings, alternative care becomes essential to the upbringing and supervised care of a child in need of stability and mentorship. I want for all children residing in our nation to be exposed to opportunity, have their rights respected and needs fulfilled.

The St. Mary's Children's Home launch of the Model of Care in Trinidad and Tobago will aid in the empowerment of our most vulnerable, as it sets the tone for a future of strengthened institutional support systems which offer positive reinforcement and minimization of practices that may inhibit and negatively affect children in care. It will set the tone for the way we promote the wellbeing of residents. I look forward to our nation's adaptation of best practices so that our younger generations can flourish holistically and realize their fullest and true potential.

The Honourable Ayanna Webster-Roy

Minister with Responsibility for Gender and Child Affairs

Foreword

MESSAGE FROM FATHER ANDERSON MAXWELL
DIRECTOR | ST. MARY'S CHILDREN'S HOME
IN HIS CAPACITY AS CHAIRMAN OF THE WELFARE SUB-COMMITTEE OF THE BOARD OF MANAGEMENT

I am pleased, as current chair of the Welfare Committee of the Board of Management of the St. Mary's Children's Home, to be associated with this document, "The St. Mary's Children's Home Model of Care 2023". This document had its origins in the deep caring and commitment of the Management and the Caring and Welfare Team with whom lies the responsibility for the welfare and nurturing of the children of the St. Mary's Children's Home.

I applaud the desire of the leadership supported by the entire caring team to bring to bear contemporary knowledge and practice and their own experience in an intentional and deliberate manner to a structured approach to the job of healing and unlocking the full potential of each child at the SMCH and to do the hard work of producing this initial Model of Care document. By its very nature it will be a continually evolving document as it responds to the needs of the children under care and to developments in knowledge and practice in the field. It goes without saying the much effort will be needed to ensure that all staff are thoroughly familiarised the overall purpose and objectives of the Model of Care document and their role in its application.

It is my hope and prayer that with the full cooperation of every category of staff at SMCH, all the hard work invested into producing this document and will be required to keep it relevant and current will indeed bear bountiful fruit.

May God bless the efforts of all involved!

Message

MS. GWENYTH BLEASDELL
CHILDREN'S HOME MANAGER

The St Mary's Children's Home Model of Care 2023 is indeed a milestone that we can all be proud of. It is the first of its kind formally launched for Trinidad and Tobago Resident Care and the Second known of its kind for the Caribbean following that of the Village Academy in Jamaica.

I am proud of all of the hard work and dedication that went into developing this document by various levels of staff including the Board of Management and members of the Care Giving Team and the Welfare Team. I am particularly grateful to the Management Team for their support in carrying out this strategic initiative and particularly of Mr. Dominic Martin who worked tirelessly in assisting with the development of the document. Special thanks is given to Dr. Marlon Anatol, our consultant on the document who volunteered his time, knowledge and capacity to working with us to develop the document.

It goes without saying however, that while we are formalizing systems within SMCH, the ethos, processes and procedures outlined in this document are long standing in our Institution. We have a cadre of hardworking staff that have managed to build an effective foundation that we can only build on to create a better, stronger more purposeful St. Mary's Children's Home. I look forward to our continued efforts as we work as a team to continue to improve our Home as we continue to Treasure our Children.

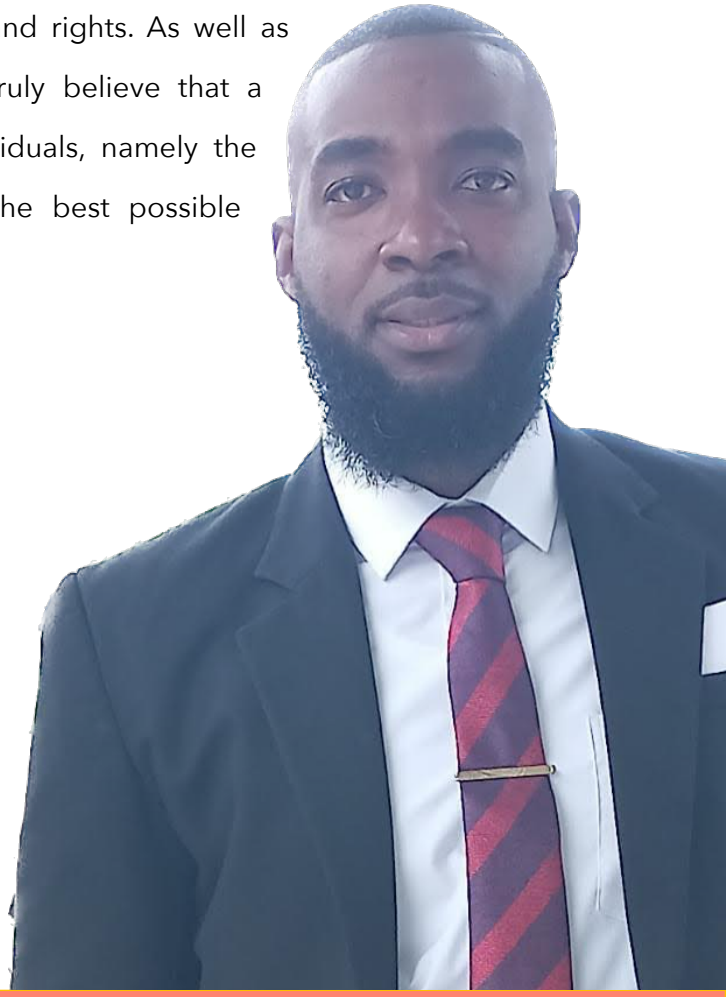
Message

MR. DOMINIC MARTIN
DEPUTY CHILDREN'S HOME MANAGER

As we embark on this monuments phase of child care at the St Mary's Children's Home, it must be underscored that our continued thrust to better enhance the quality of care for the nation's youth propels us to be proactive in seeking and implementing new methods of intervention, and compliant to best practices of international standards.

The fruition of this document solidifies St Mary's commitment to best practice and genuine care for children. A model of care defines the way service is delivered to our population. It outlines best practice care and service given as the various cohorts matriculate through their stages of development.

As persons who are placed in a position of trust and care for these children, it is our responsibility to be advocates for their various needs and rights. As well as being genuinely committed to their development. I truly believe that a genuine recognition of the dignity and worth of individuals, namely the children in our care, will constrain us to providing the best possible evidence based care.



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History of St. Mary's Children's Home

The History of the St. Mary`s Children`s Home dates back to the year 1857. Then known as the "Coolie Orphan Asylum", it was established in response to a grave human need resulting from the awakening of the social consciences of three men who had connections with the Orange Grove Estates in the district of Tacarigua.

The first residents, nine orphaned children, took up residence there on 2nd July, 1857, when the institution was formally inaugurated with a function attended by His Excellency, the Colonial Governor, Robert W. Keate, as well as members of His Majesty`s Council and other dignitaries. Evolving through several socio-economic phases which characterized the course of history, the institution has moved from Asylum through Orphanage and Orphanage to Home to its present status of Children's Home.

Nestling at the foot of the Northern Range, the Home is located on 25 acres of flat arable lands bisected in part by the Tacarigua River, and bounded on the south by the Eastern Main Road. A number of imposing buildings which house the nursery, dormitories, a primary school, library, Wellness Centre, kitchen, laundry, homework centre, trade and music shops, a cultural hall, administrative block, (and up to 1980,the manager`s residence) constitutes the physical infrastructure of the Home. In, 2008, two new buildings were constructed by the United States Army.

The Home is an Anglican Institution and one of its main purposes has always been to provide and maintain, for its residents, the best possible child-care services, so as to ensure that:

a. Children in residence are given every opportunity for personal growth and development through the acquisition of proper attitudes, values, skills and knowledge; and
b. Upon leaving the Home, children are adequately equipped with basic societal and vocational skills which will enable them to adjust appropriately to "life" in any community in which they find themselves.

The previous managers of the Home included Ms. Ingrid, Ms. Patricia Rousseau and Mrs. Patricia Martin-Ward. Managing the affairs of the Home devolves upon the present Children Home Manager – Ms. Gwenyth Bleasdell, who is supported by the Deputy Children Home Manager – Mr. Dominic Martin and an entourage of senior and junior staff to assist in the day to day running.

Model of Care and the Strategic Linkages

The St. Mary's Children's Home Strategic Plan 2021 – 2023 outlines the following as two (2) of its five (5) Strategic Goal:

- "to create effective and relevant systems of operation"
- "to create targeted programmes that focus on preparing residence for effective transition into society"

With these goals in mind the Strategic Plan further outlines the following Major Projects and Programmes under the three Strategic Areas of Focus – Childcare and Development; Managing Performance Outcomes; Niche opportunities for increased developmental skills of the residents; Legislation and Infrastructural Development:

- "Implementation monitoring and evaluation of child care plans"
- "Develop policy, procedure and documentation that addresses the relationship between the welfare department and caregivers with relation to the individual child care plans"
- "Operationalize an orientation unit for new admissions"
- "Review Policy, Procedure and Documentation for appropriate orientation programme for new admissions"
- "Identify and Allocate a building/space for the orientation programme"
- "Develop appropriate orientation programme for new residents"
- "Utilization of Volunteers"
- "Re-establish and operationalize a volunteer programme that in keeping with the demands of the pandemic"
- "Adapt a transition programme to meet the needs of the current residents entry to exit in preparation for independent living"
- "Develop documentation that provides direction for the operation of the dormitory system with relation to staff and resources"
- "Conduct ongoing evaluation of the dormitory system with relation to staffing, resources and systems"
- "Utilization of in house resources to facilitate the development of social, vocation, psychomotor and life skills"

- "Utilization of in house resources to facilitate the development of affective aspects of child development including problem solving emotional intelligence altruism, soft skills and the like"
- "Utilization of in house and external resources to facilitate the development of cognitive aspects of child development"
- "Leadership, Entrepreneurship, financial management, networking and self-reliance, sustainability, personal and professional development"
- "[Development of] Arts and culture"
- "Design a system for vocational education"
- "[Development of] Spiritual [programmes]"
- "To review, update and develop policy as relates to the legislation and to ensure that it is accessible to all stakeholders"
- "Re-evaluate our model of care in collaboration with all stakeholders"
- "Develop a design for SMCH in keeping with its identified Model of Care"
- "Evaluate, Renovate and Maintain currently existing structures to align with the identified care model"
- "The development and renovation of facilities based on the selected model of care"

All of these action items outlined in the Strategic Plan 2021- 2024 are achieved or impacted by the operationalization of this Model of Care 2023.

It is important to note however that the Model of Care is a working document that is meant to be reviewed and updated/adapted to the current needs of St. Mary's Children's Home as impacted by the Convention on the Rights of the Child, The Laws of the Republic of Trinidad and Tobago, International Best Practices and the Impact of the needs expressed by the Home and the Residents in our care. As such as SMCH continues to develop and build capacity, this document must evolve to match with its changes.

The operationalization of this document also encompasses a rigorous monitoring and evaluation system that will be discussed further in the document and is necessary to ensure that all improvements

to this Model of Care are not only strategically directed by are measurable and therefore evidence based.

Introduction

The impact of investing in early childhood development is paramount for the development of any country. As such, homes like St. Mary's Children's Home (SMCH) have a responsibility to develop and maintain standards of care that are of the highest quality, not only by Trinidadian standards, but by international standards. Our Vision therefore, is *"To be the ideal Home to nurture, care and develop residents to reach their full potential, so that they can contribute positively to society."* The young people that are under our care constitute a portion of the high-risk and vulnerable individuals in our society, and as such, we have an added responsibility to ensure their care and development. Thus the Mission of SMCH maintains that *"through a dedicated team we will all contribute by utilizing our resources to systematically develop the residents in a supportive environment"*

It is therefore imperative to develop a care plan for the institution as well as the children. While in some cases children in our care may have a living parent, they are nevertheless part of the child protection system, and this situation needs to feed into our transition and development plans. Thus there is a "need for professionals in child protection to acknowledge the diverse ways in which children contribute to their lives and the requirement for supportive relationships between adults and children."[1] Part of our strategy should incorporate at least, or include at best, the reunification of the family unit as a long-term goal, ceteris paribus; even with the knowledge that they came to us due to familial, environmental and other circumstances.

The care of the child requires significant investments in resources; financial, emotional, psychological, educational, physical, technological, spiritual and otherwise.

A system of monitoring and evaluation needs to be established from the beginning to be better able to track the progress (and in some cases, the limitations and failures) of specific interactions; this

[1] Williams, K. (2021). Child Protection, Paternalism and Participation: Re-Framing Children's Participation in Care- A Case Study from Trinidad and Tobago. Caribbean Journal of Social Work Vol. 14 pg. 58

allowing for the maximization of use of available resources, and providing evidence for the increasing of resources in targeted areas.

Simply placing a child in our care does not ensure quality nor protection of the child. We recognize that positive experiences in institutional care[2] can improve and facilitate children's positive integration into families and the society[3]; while negative experiences can have lifelong detrimental effects.[4] As noted by Dr. Khadijah Williams (2021) "significant to the process is the realisation that increasing staff training and qualifications alone will not solve the problems associated with child care (Choy & Haukka, 2010; Sinclair & Gibbs, 1998). Other issues to consider include the culture of homes, understanding how staff members make sense of change, how they see the need for change and come to terms with change situations, which create feelings of loss and despair (Marris, 1974). At the same time staff members need to maintain their self-worth and understand they are needed by the children and management. They should therefore be included in the change process as much as possible at every level." (pg 73.)[5]

While there is evidence that many of the children who come into our care lack finances at home to support their basic needs of food, shelter, clothing, water and sanitation, education, and healthcare, they are also particularly vulnerable to higher risks of emotional, psychological and child abuse. (Social Development Division and the Statistics and Economic Projections Division of the Economic Commission for Latin America and the Caribbean, 2012).

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2 Bruskas, D. (2008). Developmental health of infants and children subsequent to foster care. Journal of Child and Adolescent Psychiatric Nursing, 23(4), 231-241.

3 Jones Harden, B. (2004). Safety and stability for foster children: A developmental perspective. The Future of Children, 14 (1), 31-47.

4 Cassidy, J., & Berlin, L. J. (1994). The insecure/ambivalent pattern of attachment: Theory and research. Child Development, 65(4), 971–991.

5 Williams, K. (2021). Child Protection, Paternalism and Participation: Re-Framing Children's Participation in Care- A Case Study from Trinidad and Tobago. Caribbean Journal of Social Work Vol. 14 pg. 73

To ensure that we are able to care for these children and provide the foundations for their future, there is a need to strengthen not only in the internal institutional support systems[6] but also to reinforce the responsibility of St. Mary's Children's Home to ensure healthy socio-emotional development and reduce (and eliminate) practices that create more psychological distress on the children.[7]

We have to ensure that as an institution, we are well-prepared to receive children, and develop the fundamental infrastructure support systems required for the level of care needed[8], for the development of the vulnerable children to ensure a minimisation of developmental delays as we provide appropriate care and attention.[9] More importantly, there is a strong body of international evidence that shows the positive effects of quality care and attention.[10] [11]

One also needs to be cognizant of the fact that poor caregiving is detrimental to the lives of the children under care[12], and can have long-lasting effects that carry into adulthood and retard the psycho-social development of the children;[13] and these poor outcomes have high-cost implications

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[6] Rosas, J., & McCall, R. B. (2009). Characteristics of institutions, interventions, and resident children's development. (Unpublished manuscript). University of Pittsburgh Office of Child Development, Pittsburgh, PA.

[7] Duncan, G. J., & Brooks-Gunn, J. (2000). Family poverty: Welfare reform and child development. Child Development, 71, 188-196.

[8] Johnson, D. E. (2000). Medical and developmental sequelae of early childhood institutionalization in Eastern European adoptees. In C. A. Nelson (Ed.), The effects of early adversity on neurobehavioral development: The Minnesota symposium on child psychology series (pp. 113-162). Mahwah, NJ: Lawrence Erlbaum

[9] Smyke, A.T., Koga, S.F., Johnson, D.E., Fox, N.A., Marshall, P.J., Nelson, C.A., Zeanah, C.H., & the BEIP Core Group (2007). The caregiving context in institution-reared and family-reared infants and toddlers in Romania. Journal of Child Psychology and Psychiatry, 48(2), 210-218.

[10] Baker-Henningham, H., & Lopez Boo, F. (2010). Early childhood stimulation interventions in developing countries: A comprehensive literature review series. Washington, DC: Inter-American Development Bank.

[11] Center on the Developing Child at Harvard University. (2007). A Science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behavior, and health for vulnerable children.

[12] Caspi, A., Henry, B., McGee, R., Moffitt, T., & Silva, P. (1995). Temperamental origins of child and adolescent behavior problems from age three to age fifteen. Child Development, 66, 55-68

[13] Felitti, V. J., Anda , R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. American Journal of Preventive Medicine, 14(4), 245-258.

for any community or society and ultimately contribute to intergenerational transmission of poverty, poor mental health and overall development.[14]

Early childhood development can be assisted by targeted programmes, especially for vulnerable children, and the benefits of investments in these children is well-founded, while failing to invest is costly to families, communities, businesses and nations.[15]

In this region generally, and in Trinidad and Tobago in particular, there is a dearth of literature on the return of investment for orphanages, though the costs associated with adults who have received poor institutional care are well documented in the literature.[16] For developing countries, the promise of return on investment in early childhood is more than a moral imperative, it is a path out of poverty.[17]

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[14] Whitaker, R. C., Orzol, S. M., & Kahn, R. S. (2006). Maternal mental health, substance use, and domestic violence in the year after delivery and subsequent behavior problems in children at age 3 years. Archives of General Psychiatry, 63(5), 551-560.

[15] Cobb, K. (2003). The ABCs of early childhood development: A discussion on the economics of early childhood development. The Region, 17(4), 1-5.

[16] Tobis, D. (2000). Moving from residential institutions to community based social services in Central and Eastern Europe and the former Soviet Union. Washington, DC: World Bank

[17] Penglase, J. (2005). Orphans of the Living: Growing up in care in twentieth century Australia. Perth: Curtin University Books.

The Role of the Convention on the Rights of the Child

The Basics

The Convention on the Rights of the Child of 1989 stipulates that "States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children conform to the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision".

St Mary's Children's Home understands that Trinidad and Tobago has signed the agreement to uphold the Geneva Convention on the Rights of the Child. As such our Model of Care is guided by the principles that are espoused by this Convention which include but is not limited to the following:

1. Article 6
   - 1.1. States Parties recognize that every child hasthe inherent right to life.
   - 1.2. States Parties shall ensure to the maximum extent possible the survival and development ofthe child
2. Article 8
   - 2.1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.
   - 2.2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.
3. Article 12
   - 3.1. States Parties shall assure to the child who is capable of forming his or her own views the rightto express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age andmaturity of the child.
   - 3.2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affectingthe child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.
4. Article 14
   - 4.1. States Parties shall respect the right of thechild to freedom of thought, conscience and religion.
   - 4.2. States Parties shall respect the rights and duties of the parents and, when applicable, legalguardians, to provide direction to the child in theexercise of his or her right in a manner consistent with the evolving capacities of the child.
5. **<Missing Article>**

5.1. Freedom to manifest one's religion or beliefsmay be subject only to such imitations as are prescribed by law and are necessary to protectpublic safety, order, health or morals, or the fundamental rights and freedoms of others.

6. Article 19
   6.1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury orabuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
   6.2. Such protective measures should, as appropriate, include effective procedures for theestablishment of social programmes to providenecessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification,reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.
7. Article 23
   7.1. States Parties recognize that a mentally or physically disabled child should enjoy a full anddecent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
   7.2. Recognizing the special needs of a disabledchild, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individualdevelopment, including his or her cultural and spiritual development
8. Article 25
   8.1. States Parties recognize the right of a child whohas been placed by the competent authorities for the purposes of care, protection or treatmentof his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to hisor her placement
9. Article 28
   9.1. States Parties recognize the right of the childto education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:
      9.1.1. Make primary education compulsory and available free to all;
      9.1.2. Encourage the development of different forms of secondary education, including generaland vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

9.1.3. Make higher education accessible to all on the basis of capacity by every appropriate means;

9.1.4. Make educational and vocational informationand guidance available and accessible to all children;

10. Article 29

10.1. States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegrationof a child victim of: any form of neglect, exploitation, or abuse; torture or any other formof cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recoveryand reintegration shall take place in an environment which fosters the health, self- respect and dignity of the child." (United Nations 1990)[18]

Thus we surmise that these rights of the child supports the following views that are upheld by the systems embedded in this model of care:

- The Right to equal access to services and protections without prejudice or discrimination. (Article 2)
- The attention paid to ensuring that the Best Interest of the Child is the foundation of all decisions made on behalf of the child. In so doing we align ourselves with the approach of the Children's Authority of Trinidad and Tobago and ensure that our policies, administrative decisions, requests for resources and other measures are formulated based on the impact they will have on children. (Article 3)
- The Right to life, survival and development ensuring that .all children in our care continues to be protected and to receive all the resources necessary for their continued survival (Article 6)
- The Right of the child to have an input in the decisions made concerning them and to have their views respected (Article 12)
- The Rights to protection outlined throughout the CRC
- The Rights of provision outlined throughout the CRC
- The Rights of participation outlined throughout the CRC

[18] United Nations (1990) Convention on the Rights of the Child; https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

Intervention Overview

The premise of the St. Mary's Children's Home intervention plan is centered on the minimum set of conditions needed to ensure that every child's basic psychological (psycho-social) needs are met by focusing on four fundamental areas of evidence based best practices. These four practice areas are:

- Supporting an organizational structure that will sustain a primary relationship between caregiver and child;
- Improving the quality of interaction between caregiver and child;
- Ensuring that the physical space supports child development;
- Ensuring that each child's own sense of being an individual is honored.

St. Mary's Children's Home's intervention is designed to provide for children's socio-emotional and psycho-social wellbeing through a series of tailored interventions.

The four practice areas are addressed through four intervention components:

1. training and collaboration;
2. organizational training and change;
3. academic training and development;
4. monitoring and evaluation.

Methodology

Methodology used for Creating the Model of Care

This first iteration of the Model of Care is a compilation of the ethics, values and principles governing the Model; the Procedure engaged in the operationalization of the Model and the forms utilized in both the operationalization and evaluation of the Model. The ethos outlined in this document is influenced by the following:

- The ethical, moral and spiritual views of the Anglican Diocese that oversees the day to day running of this institution and therefore the Biblical Principles including the belief in the Father, the Son and the Holy Spirit; and the spiritual development of the child
- The Geneva Convention on the Rights of the Child and the 2015 Package of Children's Legislation and Associated Regulations. Additionally the Children's Authority Act; the Children's Act 2012; the Adoption of Children (Amendment) Act 2015; and the Children's Community Residences, Foster Care and Nurseries Act
- The SMCH Strategic Plan 2021-2024 and the Goals and Areas of Focus outlined in it.
- International and Regional best practices influenced by the local demographic and culture of the Republic of Trinidad and Tobago.

Not all of SMCH Procedures are currently included in this document as we are still developing and building capacity as an organization. In order to select procedures for this document they were first developed from an in-depth. Review of the current system. This review was used to determine what methods currently used were effective and the potential for new methods to enhance the system. Once this was completed policy and procedure was drafted and submitted first to the relevant Board of Management (BOM) sub-committee where it was reviewed and then to the BOM for final approval. Only then was it included as a procedure in this current instalment of the Model of Care.

Forms that were effective in the system were maintained as part of the Model of Care; and new forms were also created for two main purposes:

- To enhance our system of data collection to ensure accuracy and relevance to the body of knowledge needed to support the effective management of the Home

- To create a system where, through the use of accurate, valid and reliable data collection and the application of methods of triangulation, data captured can be used measure the success of all aspects of intervention and to ensure the quality of our care is maintained.

Methodology used for Operationalization and Evaluation of the Model of Care

TRAINING

St. Mary's Children's Home believes that in order to operationalize this Model of Care we must first begin to train all Stakeholders involved. SMCH is therefore dedicated to training all levels of caregivers and staff (e.g., administrative staff, cleaning staff, laundry staff, cooking staff, security guards, etc.) through its signature caregiver training program.

Aside from training staff in the processes and procedures outlined in this document, this program combines interactive classroom trainings on topics such as positive communication, routine care and interactions, environment and materials, observation, freedom of movement, value of play, cognitive and emotional development, and professional care and boundaries, with on-site one-on-one technical assistance provided by trainers and senior staff.

Perhaps the largest and most critical approach is to highlight the importance of intervention and development of the relationship between the caregiver and the child.

ASSESSMENT AND EVALUATION

SMCH is focused on ensuring that we remain relevant to the current needs of resident care and therefore that we maintain standards of best practice in research and development to enhance our systems. These systems are affected by five major areas of concern:

- Funding - Diocese/Government collaboration
- Technical assistance and training
- Sustainability
- Staff buy-in and commitment
- Institutional structures

Thus to safely operationalize the procedures outlined in this document we must ensure that we engage in supporting activities that positively impact these five areas. Our assessment and evaluation systems must therefore include the ongoing evaluation of our support systems and programmes but we must also ensure that the procedures outlined in this document are also being continuously reviewed.

To this end assessment and evaluation is multifaceted at SMCH and includes but is not limited to the utilization of the following methods of research:

- Review of data collected on internal forms and log books with in the system
- Staff appraisal
- Systematic review of operations
- Financial audits both internally and externally
- Stakeholder satisfaction surveys
- Reviews done by external stakeholders including but not limited to Ministry of Health, Fire Services and the Children's Authority of Trinidad and Tobago

By engaging in these activities we ensure that our methods are eclectic and numerous and maintain principles of triangulation throughout our systems. Furthermore as we engage in standardized monthly, quarterly, and annual reviews we ensure that our methods remain reliable. Additionally validity is maintained and bias is minimized as we continue to utilize multiple methods of data collection and verification within our system.

SAFETY AND INSTITUTIONAL ISSUES

Transparent procedures should be in place in relation to admission and length of stay. St. Mary's Children's Home has a clear policy for procedures in relation to admission, care, development, intervention planning, transition programmes and monitoring and evaluation, as part of its mandate to provide the best possible care for its and ensuring appropriate aftercare and/or follow-up.

Of high priority also, is the need to respect the privacy of all the children under our care, and as such all records, histories, intervention plans, evaluations and the like will be held in the strictest confidence and secured in a safe place.

Further, policies have established to ensure that children are not discriminated against on the basis of social group, class, gender, religion or ethnicity in the home.

As many of our wards have living parents, we strive to ensure that we create an environment that helps to maintain links with their families and communities, and provide safe places for children with security provided at all times through effective implementation of safety measures, rules and regulations.

As part of our general policy, training is provided for staff to ensure that they are aware of the latest methodologies and approaches to childcare, and child protection.

At St. Mary's Children's Home, we recognize the importance of establishing methods of controlling and redirecting children when their behaviour is challenging, while ensuring that we maintain through all our actions and words that care and respect for the law and children's rights and maintenance of the child's dignity are paramount. Further, the issues of health and hygiene practices

PSYCHOSOCIAL SUPPORT

Psychosocial support relates to all actions that enable the children to live meaningful and positive lives. It is an ongoing process of meeting the physical, social, emotional, mental and spiritual needs of children, all of which are essential elements for meaningful and positive human development.

THE ISSUES OF PSYCHOSOCIAL SUPPORT

The primary actors in our children's psychosocial support are the children themselves, us as caregivers in St. Mary's Children's Home, their families and communities, including their schools. Since psychosocial effects are both psychological and social, interventions must address the relationship between the individual child and his/her social environment.

While the psychosocial needs of our children and their caregivers have often been ignored, superficially handled or seen as a specialized, low-priority type of intervention, at this facility we see a critical need for the fulfilment of these inherent human needs as they have long-term impacts on the development of the child. Psychosocial issues are crosscutting and are a critical component of all aspects of prevention, care and support and should therefore be addressed in all areas of our work.

To be sure, our approach is that non-material needs of children separate into the following categories: guidance and counselling, behaviour formation, psychosocial support, health and hygiene education, life survival skills and protection.

As iterated earlier in this paper, at St. Mary's Children's Home, we promote close contacts between children and caretakers in the aim of enabling the creation of secure and safe environment which will encourage healthy and growing relationships. With this approach, we are confident that we are meeting the physical, emotional, social, cultural, intellectual and spiritual needs of the children in our care.

SUSTAINABILITY OF THE CHILDREN'S HOME

Sustainability involves taking action to provide a future where the environment and living conditions are protected and enhanced.

We are operating in a diverse, challenging and changing world, and this means that we have to embrace change in order to survive. As such, there is now a greater need, more than ever before, to make sound decisions presently in order to avoid limiting the choices of generations to come.

COLLABORATION STRATEGY

Strategies that utilize collaboration usually have a greater influence on the overall performance of orphanages like ours, and help us to strategize in revenue generation strategies that have a positive effect on our performance, increase the inputs of our strategic leadership, and the performance of orphanages generally.

These collaborative approaches and arrangements in the implementation of our programmes and projects are driven by the need to succeed within the limitations of scarce resources and therefore we dedicate extra efforts to ensure the success of our operations. The aspects of managerial skills that influence management at St. Mary's Children's Home to a great extent, include the manager's innovativeness as well as the motivation and dedication of our caregivers.

Our stainability relies to a large extent on individual staff capacities, skills and aptitude, and our collective synergies and the organizational capacities to attract and retain highly trained and motivated staff of the calibre to execute programmes effectively. This approach necessarily prioritizes the overall effectiveness of the home, and for sustainability to be achieved, at St. Mary's Children's Home we must have a clear direction and scope over the long-term, which will help us achieve an advantage in this changing environment through our configuration of resources and competences with the aim of fulfilling stakeholder expectations. This will involve developing strategies that take into account both efficiency and effectiveness, in order to remain relevant in the future.

We have to focus and continuously evaluate our performance.

Performance refers to a process which contributes to the effective management of individuals and teams in order to achieve high levels of organizational performance.

Performance[19] traces its origin to three approaches to management, namely merit rating, management by objectives and performance appraisals.[20] This will necessarily include, in order to yield the best results, appropriate training and development, and performance-related pay.

The staff's performance focuses on the jobs, tasks, structures and procedures that are a part of the workload, and if the performance management system is relevant and comprehendible, it should enable all staff members to develop their abilities increase their job satisfaction and achieve to their own benefit and that of the organization as a whole.[21] This process is useful as it provides a roadmap which all staff members and management can follow to reach their desired common, mutually-

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[19] Owolabi, S. A., & Makinde, O. G. (2012). The Effects of Strategic Planning on Corporate Performance in University Education: A Study of Babcock University. Kuwait Chapter of the Arabian Journal of Business and Management Review, 2(4), 27.

[20] Gathoni, N. L. (2012). Perceived effect of performance management practices on employee satisfaction at Swedish Cooperative Centre (Doctoral dissertation).

[21] Cole, G. A. (2004). Management theory and practice. Cengage Learning EMEA.

decided-upon destination;[22] and this is achieved through effective communication and feedback mechanisms.

SCREENING AND ASSESSMENT

As part of our approach to care SMCH ensures that we engage in appropriate Screening and Assessment from Intake to Transition/Termination. Screening and assessment provides valuable information about each child's interests, strengths, and needs. Screening gives a snapshot of whether the child's development is on track. Assessment is an ongoing process that includes observation and provides information about development over time. Systematic, ongoing child assessment provides information on children's development and learning.

- Know what you want to observe without direct engagement or as part of an exercise
- Decide what to catalogue
- Know what time of day you are going to observe
- Always have a journal handy

Plan to look for the same behavior in many contexts to determine if knowledge, skills, and behaviors generalize across contexts. For example…

- Indoors versus outdoors
- What people are around?
- What materials do the children have available?
- Is the teacher guiding the activity or are the children playing freely?

Be on the lookout for surprising behavior.

How we document is important

In order to understand what is important in the screening and assessment processes we must target a different developmental area . In so doing we engage in the following activities:

- Provide adequate opportunities to see a range of development.
- Plan which children to observe each day.

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[22] Bevan, S., & Thompson, M. (1991). Performance management at the crossroads. Journal of Personnel Management, 23(11), 36-9.

- Plan the easiest way to document what you want to know.

Strategies for Interpretation

When the work of determining the criteria for assessment is complete it then becomes necessary to formulate ways of interpreting the data that can be collected from the various observations of the life of the children. To achieve this, one can engage in the following activities:

- Look for patterns.
- Identify areas where more information is needed.
- Look for critical incidents (surprises).
- Analyze errors.

Combined Assessment

The concept of triangulation of data is necessary in the SMCH environment to ensure accuracy of information. Children engage with varied stimuli and indicators on a daily basis; that when combined with their traumatic experiences (both prior to intake and at the institution) would create varied results in behaviour, temperament etc. It becomes necessary then to use more than one method of collecting relevant data and compare findings to ensure that reliability and validity is maintained and to reduce bias/error in the assessment. Use information from all of your assessments to better understand children's growth and needs then becomes necessary. For example:

- Work/reading sampling
- Direct assessments
- Ongoing, daily observations

Consider Culture

Children of SMCH come from varied family types, communities and backgrounds; their socialization and cultural foundations also vary. Our Model of Care must therefore consider the following:

- A child's individual circumstances may play out in what you see.
- Consider children's background when observing and interpreting. For example:
- Cultural background may lead different children to respond to the same activity in different ways.

- The religious beliefs of the child is also part of what shapes their world view and should be taken into consideration when interacting with the child.

Documenting Observations – Guiding Principles

SMCH therefore trains its staff in the appropriate considerations when documenting the observations they make that are necessary for any assessment. These are as follows:

- Observe without interpreting.
- Record facts rather than opinions.
- Use words that describe but do not judge.
- Record only what you see and hear.
  - Don't assume the child's feelings.
  - Don't assume the child's motivation.

N.B.

- Plan other ways to help a child to learn a skill if the child is having difficulty.
- Plan other ways to help a child adjust his/her behavior.
- Plan other ways to help a child identify inappropriate and unacceptable behavior.
- Help a child find alternative ways of interpreting events'
- Help a child develop skills to modify inappropriate and unacceptable behaviors.
- Use the information you collected in collaboration with colleagues to help a child.
- Plan additional opportunities to practice skills and provide praise or positive comments.
- Plan ways to help children take the next steps.

For the best results: – Let children see their own progress when you have saved work samples; make positive comments on what they are learning.

"The result of a painful event, physical or mental, causing immediate damage to the body or shock to the mind. Psychological traumas include emotional shocks that have an enduring effect on the personality, such as rejection, divorce, combat experiences, civilian catastrophes, and racial or religious discrimination." (Corsini 2002)

"Continuing result of such an event to the body or mind or both. Plural is traumata, traumas." (Corsini 2002)

Trauma is a part of the environment of SMCH as all of our residents would have experienced trauma in some form prior to being placed in the Institution. The daily life of SMCH for the residents would also have instances of trauma that would be faced. Thus the environment at SMCH can easily be described as a "Trauma Informed Environment". This type of screening is designed to be able to be administered to every child within a given system (such as St. Mary's Children's' Home) to determine whether the child has experienced trauma, displays symptoms related to trauma exposure, and/or should be referred for a comprehensive trauma-informed mental health assessment.

Trauma screening can include a particular tool or a more formalized process. Trauma screening should evaluate the presence of two critical elements:

1. Exposure to potentially traumatic events/experiences, including traumatic loss
2. Traumatic stress symptoms/reactions

Not all children who experience negative events suffer post-traumatic or trauma-specific reactions as a result. As such, trauma screening should measure a wide range of experiences and identify common reactions and symptoms of trauma (e.g., PTSD, dissociation), as well as other commonly reported difficulties (e.g., anger, behavior problems, depression, anxiety).

Screening typically covers the following types of traumatic stress reactions:

- Avoidance of trauma-related thoughts or feelings
- Intrusive memories of the event or nightmares about the event
- Hyper-arousal or exaggerated startle response
- Irritable or aggressive behavior
- Behavioral problems
- Interpersonal problems
- Other problems based on the developmental needs and age of the child

Emotional Screening

Social-emotional screening is an applied method for detecting and monitoring signals that indicate whether a young child may be delayed in aspects of social-emotional development, such as communication, autonomy, affect, and interaction with people.

One must be cognizant of the fact that the process of screening is not intended to serve as a diagnosis for a child, but rather, to carefully and accurately inform meaningful next steps, such as more in-depth social-emotional assessment, further monitoring, etc. Typically, in many cases, the act of screening rules out the need for deeper assessment.

Screening tools usually take the form of a series of questions or checklists used to track the child's development relative to milestones achieved by a larger group of children of the same age. A home-grown checklist won't accurately evaluate this development. Effective screening tools need to be carefully and systematically validated by research.

Social Work Psychosocial Assessment

The Law Insider dictionary definition of psychosocial needs is: "Any combination of mental health, emotional, spiritual or behavioral needs, concerns or aspects" of the individual's life which are identified as important to the individual

A psychosocial assessment takes a detailed look at the child from a holistic perspective. If you look at an example psychosocial assessment report, you'll find a key element included that you may not see in other types of assessment, which is **physical health**.

A psychosocial assessment in social work is a complete comprehensive evaluation of the **emotional, mental, and physical health** of the child. It also includes the child's perception of him/her self and his/her ability to function in the community.

Not everyone being interviewed by a social worker or medical professional will require a social work psychosocial assessment. It is generally performed on those that require more intensive interventions, such as children in palliative care, patients of substance abuse, those that have experienced physically and mentally traumatic situations, and mental health patients.

Psychosocial examples of this type of evaluation will include a series of questions, which can change, depending upon the client's reason for needing social services.

The types of questions included in an example psychosocial assessment report would include those asking about **a person's family history, general health and wellbeing questions, and those asking about any past traumatic experiences.**

Questioning the client to learn first-hand information and interviewing any pertinent family members or care professionals makes up the first part of the psychosocial assessment social work process. The other part is the assessment report written by the social worker that details the gathered information and provides **a recommendation for a treatment and care plan**.

Here is a social work psychosocial assessment example of the main three sections of a psychosocial assessment report and what to include:

Basic Client Information: Name, address, presenting problem, referral, etc.

Background & Current Functioning: Family and educational background, employment and skills, physical functioning capabilities, psychological and psychiatric functioning, basic life necessities, client strengths, opportunities, influences, etc.

Summary, Assessment & Recommendations: Clinical summary, social worker impressions and assessment, goals, and recommended care/treatment plan

The goal of social work psychosocial assessment examples is to help address the psychosocial needs of clients/patients.

Examples of psychosocial needs include:

- Social companionship
- Therapy or counseling
- Substance abuse rehabilitation
- Improved living conditions
- Financial assistance
- Medical care
- And more

Case Management

The Case Management system at SMCH starts from the intake process and ends at the transition into independent living when the child turns eighteen (18) years old. As such it begins with the initial assessment of the child and the creation of a Care Plan and Intervention Plan for the child. Upon integration of the child into the dorm system the child is then placed in a transition stream. Care Plan, Intervention Plan and Transition streams areas are coordinated to create the Case Management System within this model of care. The development of the plans include the input of three key players:

1. The Welfare Officer responsible for the finalization of the Care Plan and for its approval internally and externally.
2. The Intervention Social Worker who is responsible for the finalization of the Intervention Plan and for its approval internally and externally.
3. The Transition Social Worker who is responsible for placing the child into and following up on Transition Streams.

All three positions are required to work with the requisite staff in the assessment and evaluation aspects of Case Management, and also in the execution of their various responsibilities as itemized above. Each plan will also be reviewed by the Welfare Team[23], inclusive of the three Officers, before they are submitted for approval. Case Management in SMCH must always be verified by the team. The Case Management Protocols are designed to ensure the following:

1. Child's and family's strengths, challenges, needs, and desires as determined from the child and family assessments
2. Plans for support and interventions to be implemented
3. Measurable goals, time frames to achieve them, and resources to be used.

[23] The Welfare team Consist of Two Welfare Officers, Two Social Workers, A Psychologist and A Nurse

Principles of Transitioning

The Care Plan: is a formal document used in SMCH to outline the biological, psychological, social and spiritual needs of the resident, and to make recommendations for a plan of action to address these issues. This document must be included in the resident's personal file; while this document is required to be updated to reflect new concerns/realities it will remain the only Care Plan for the child in the care of SMCH.

The Intervention Plan: is a formal document used in SMCH to outline specific interventions for individual resident and provides justifications for actions to be taken. It must therefore include details of the engagement and assessment processes used to determine the recommended courses of action to be taken as intervention strategies. Further it will outline the methods through which the interventions will be performed, the methods of evaluating the outcomes of the interventions, and an outline of the expected termination of the intervention. This document must be included in the resident's personal file. It is expect that during the residency of the child at SMCH, the Institution would have created several Intervention Plans to ensure that issues are appropriately treated.

The Transitions Streams: refer to a form of intervention that is specific to the process of transitioning the resident from Intake to Termination. Its purpose is to ensure that the child is ready for each level of transition and for life beyond SMCH. There are currently five Transition Streams which include; Sports and Academics; Arts and Theatre; Culinary Arts; Entrepreneurship and Innovation; and Agriculture and Industry. At the beginning of the child's residency at St Mary's, it is expected that he/she would be encouraged to participate in as many streams as possible. However, it is expected, as they move from stage to stage another that they would eventually gravitate to one primary stream.

A Transition program involves young people, their caregivers, and health care workers working through a collection of units to prepare and support young people throughout the transition (Starship, 2019). SMCH believes that the main aim of this program is to equip residents with the necessary skills and tools needed to be contributing members of society and to develop residents to be emotionally, psychologically, socially, physically, and spiritually equipped to function effectively in the wider society. It is therefore a continuous program utilizing five streams:

1. Agriculture,
2. Entrepreneur,
3. Academic and sports,
4. Arts and Theatre.
5. Culinary arts

These streams will be used to enhance sustainable development for resident career choice and transitioning to independence. Residents are placed in streams based on affinity and interest.

SMCH understands that a young person who lives in a residential home is more vulnerable than the average person who lives in a "family setting." It is therefore essential that residents in Care receive considerable preparation before they transition into independence. Guenzi 2015, stated that the process of exiting the Care system and entering into independence and adulthood has been identified by contemporary local and internal researchers as exposing care leavers to further vulnerability. The lack of adequate preparation has tended to mean loneliness, isolation, unemployment, poverty, homelessness, and 'abuse' are likely to feature significantly in many of their lives (Guenzi, 2015). Petra Robert a Social worker from Trinidad and Tobago conducted a study in 2016 on Institutional care in Trinidad and Tobago: 'Toward a New Model of Care for Developing Countries.' Based on the findings of the study, Dr. Roberts recommended that an aftercare plan with planning at the beginning of admission might ease the transition process. The transition program at St. Mary's Children's Home will be designed with different components and utilized developmental theories that will guide the development and transition process for all residents.

SMCH has therefore consistently worked toward the successful Transitioning of its residents and continues to further develop past efforts. In 2001 there was the implementation of a "Living 18 and Beyond pilot project" where senior residents were taught life skills in preparation for transitioning and in 2018 a further expansion of an "Independent Living and Transition program (InLiveTP) was also implemented. The InLiveTp program adds another component that we believe will assist in the holistic development of our residents. The institution has identified a gap in the above programs and believes that the transition process was too abrupt. It is the responsibility of the institution to prepare our

residents adequately for life independent living. It is our hope not only to restart such initiatives but to expand on them by including a Five-Stream System mentioned above in the project scope, beginning at admission. In this way, our residents will be adequately prepared for the wider society.

Theoretical approach to transitioning

Theories help social workers to "understand and contest ideas, offer explanation and understanding, offers a practice framework and to be accountable, self-disciplined professionals." (Payne, 2015).

Erik Erikson's psychosocial theory will be used as the overarching theory in the transition planning for our residents. Psychosocial development consists of eight stages of human development. However, the focus of this project will be on stage 4: Industry vs inferiority (6-11 yrs.) and stage 5: Identity vs Role confusion (12-18yrs). The theory speaks to how the family or human experience impacts a child's growth and development and why some children experience identity crisis.

According to Erik Erikson's theory at stage 4: Industry Vs Inferiority, children develop a sense of pride in their accomplishments and abilities through social interactions. Children who are encouraged and commended by parents and teachers, develop a feeling of competence and belief in their skills. Those who receive little or no encouragement from parents, teachers, or peers will doubt their abilities to be successful. Successfully finding a balance at this stage leads to the strength known as competence, in which children develop a belief in their abilities to handle the tasks set before them.

The fifth psychosocial stage takes place during the often turbulent teenage years. This stage plays an essential role in developing a sense of personal identity which will continue to influence behavior and development for the rest of a person's life. Teens need to develop a sense of self and personal identity. Success leads to an ability to stay true to yourself, while failure leads to role confusion and a weak sense of self.

During adolescence, children explore their independence and develop a sense of self. Those who receive proper encouragement and reinforcement through personal exploration will emerge from this stage with a strong sense of self and feelings of independence and control. Those who remain unsure of their beliefs and desires will feel insecure and confused about themselves and the future. (Cherry, 2022). Cherry (2022) further explained that our identity gives each of us an integrated and cohesive sense of self that endures throughout our lives. Our sense of personal identity is shaped by our experiences and interactions with others, and it is this identity that helps to guide our actions, beliefs, and behavior as we age. Psychosocial theory explains why a child behaves as he or she does.

To meet the needs of a child and assist in their development, as well as channel the child in the correct career path, other theories will be used that will complement the overarching theory.

For effective learning to be achieved, there are essential needs that caregivers have to take into consideration such as their safety and wellbeing. Abraham Maslow's Hierarchy of needs postulates that people are motivated by five basic needs. From the bottom of the hierarchy upwards, the needs are: physiological (food and clothing), safety (job security), love and belonging needs (friendship), esteem, and self-actualization. Needs lower down in the hierarchy, must be satisfied before individuals can attend to needs higher up (Saul McLeod, 2007).

Humans are sociable beings, who love to interact and form an attachment. Children have an innate drive to form attachments. Children in residential care are much more likely to form attachments with their caregivers and a sense of feeling secure. Attachment is an emotional bond with another person. Bowlby believed that the earliest bonds formed by children with their caregivers have a tremendous impact that continues throughout life (Cherry, 2022). Bowlby explained four types of attachment styles, secure, avoidant (aka dismissive, or anxious-avoidant in children), anxious (aka preoccupied, or anxious-ambivalent in children), and disorganized (aka fearful-avoidant in children). According to Robert, 2015, the

behaviour of the primary caregiver, regardless of whether it is the mother or father, has the most influence on the infant's attachment. Social learning theory- Social behavior is learned by observing and (modeling) imitating the behavior of others. (Payne, 2014)

Operant conditioning – using either reinforcement or punishment to increase or decrease a behavior. (Payne, 2014)

System Theories are based on the idea that behavior is influenced by a variety of factors that work together as a system. These factors include family, friends, social settings, economic class, and the environment at home. The theory postulate that these and other factors influence how individuals think and act -"The whole is greater than the sum of its parts." (Payne, 2014) The three main systems of intervention: Micro-system- Residents, SMCH (individual) Meso-system-School, Clubs (group) Macro-system – Children's Authority, Social Welfare, and the children's Court.

Goals and objectives of the internal transition program at SMCH

1. For residents to develop a strong sense of self through encouragement, practical demonstration, social interactions, and relationship building.
2. To develop a well-rounded self-sufficient individual who can function effectively after transitioning from the St. Mary's Children's Home
3. To assist the resident in developing the necessary Health & Wellness, Social & Interactive skills set needed for Independent living and relationship building.
4. Residents to develop skills in money management
5. Identify skills that will guide career choice

Principles of Case Management

SMCH seeks to follow the following principles in the conducting of its case management system:

- Do No Harm
- Prioritize the Best Interests of the Child
- Ensure Accountability – take responsibility for your actions

- Based on Sound Knowledge of Child Development and Child Rights
- Child's Right to be Heard, Participate, and their Views taken Seriously – involve children and seek out their opinions
- Provide Culturally Appropriate Processes and Services
- Seek Informed Consent
- Respect Confidentiality
- Work in Non-discriminatory Way
- Maintain Professional Boundaries
- Competency
- Advocacy

Procedures in the Model of Care and Accompanying Forms

This section of the Model of Care focuses on the procedures involved in the Model of Care. More specifically the procedures will be outlined along with the accompanying forms and explanations of how these forms are to be utilized. It will also include the formats for the reports to be submitted for the children's files with explanations of each component of the report. The procedures outlined are as follows:

- The Intake Procedure
  - The Procedure for Developing the Care Plan
  - The Procedure for Developing intervention plans
  - The Procedure for placing children in transition streams
  - The Procedure for Transitioning the child into Independent Living
- The Handover Procedure
  - Administrative Handover
  - Clinical Handover
- The Medical Procedure
  - Guidelines for Medicine administration
  - storage of medication
  - ordering of medication
  - urgent prescriptions
  - procedure for medication administration
  - procedure for medical independence program
  - Addressing illness that may require hospitalization
- Transition Procedure
  - Transitioning between dorms
  - Assignment to the Five Streams
  - Independent living
- Dorm related documentation procedures
  - Utilization of the Log Book
  - Utilization of the maintenance book
  - Ordering goods (household items and small and large appliances)

- Special request for individual care plans.
- Disposing of items.

- Procedures under child supervision
  - Daily in-dorm timetable.
  - Daily out-dorm timetable.
  - Disciplinary action within the dorm
- Procedures for lockdown
  - lockdown of the compound
  - lockdown of individual residents
- Aftercare Procedure
  - Financial Support
  - Career/Educational Support
  - Independent Living/Housing
- Volunteer Screening Procedure
  - Recruitment of Volunteers
  - Registration Process
  - Documentation
  - Probation period
  - Training
  - Supervision of Volunteers
  - Termination

The Intake Procedure

The Intake Procedure is taken from the approved Intake Procedure Manual for St. Mary's Children's Home (SMCH).

1. Receive child from the Children's Authority
   1.1. Receive all relevant documents as outlined in
      1.1.1. Child is physically assessed for marks, cuts and any noted body abnormalities by the JHS3 or one of the Officers in the Intake Unit in the presence of the CATT Officer handing over.
      1.1.2. All Officers must sign off assessment documents upon completion of the physical assessment, including the CATT Officer

1.2. Ensure all relevant supporting documents are handed over and verified
    1.2.1. Receiving officer ensures that the child is presented with a court order, medical and negative PCR test.
    1.2.2. Where applicable other supporting documents such as birth paper, medical reports and psychological reports can be forwarded after.
1.3. Verbal handover from Children's Authority to receiving officer
    1.3.1. Children's authorities will debrief the receiving officer about the child's history and any other relevant information that can aid in the care of the child such as allergies and visiting restrictions.
1.4. Introduction of child to the St Mary's Home, ensure child feels a state of comfort
    1.4.1. Staff will welcome the child and begin building relationships
    1.4.2. Staff will outline the Home's rules and regulations to the child.
    1.4.3. Staff will allow the child to ask follow up questions and seek clarity on information given
    1.4.4. Staff will familiarize the child with the compound and give various safety and 'out of bounds' updates.
    1.4.5. Staff will inform the child of the procedure to make requests and launch complaints.
1.5. Receipt of the child, along with a verbal handover.
    1.5.1. JHS 111 or another Senior officer will then hand the child over to the officer assigned to the intake unit.
    1.5.2. A verbal handover will be given with all relevant information. Example, allergies, medication needed.
    1.5.3. Other documentation can be given at a later date
1.6. Assessments conducted by the Welfare team
    1.6.1. Welfare Officer will interview the child
    1.6.2. Welfare Officer will interview other relevant persons and institutions relevant to the child including but not limited to the for school the child attended, the community and parents/guardians/family of the child
    1.6.3. The Intervention Social Worker will interview the child for the purpose of creating the initial intervention plan
    1.6.4. Psychologist will assess the child
    1.6.5. Resident nurse will examine the child
    1.6.6. Care team will hold a multidisciplinary meeting to amalgamate findings into one document.
    1.6.7. The Transition Social Worker will conduct an assessment of the child for the purpose of placing the child in a transition stream
1.7. Care-plan and Initial Intervention Plan created and Child is placed in Transition Stream
    1.7.1. Welfare Officer assigned to the child will compile all the elements of the assessment into a working document that is used to record progress of the child as it relates to a plan of action for care
    1.7.2. 1.7.2 The Intervention Social worker assigned to the child will compile all elements of the assessment into a working document that is to guide ongoing intervention and evaluation of the child
    1.7.3. The Transition Social worker assigned to the child will compile all elements of

the assessment into a working document that outlines the various streams in which the child is placed and captures data as it relates to the child's progress in the streams

1.7.4. The compiled documents will be reviewed and approved by the Home Management Team

1.8. Care-plan approved by external stakeholders (Children's Authority/Court)

1.8.1. For children brought by the CATT the care plan will be submitted to the CATT for review and approval through signature

Forms and Reports Attached to the Intake Procedure

The forms and reports relating to the Intake Procedure attached to this document are as follows:

- The Intake Checklist[24]
- Intervention Assessment Form[25]
- Intake Assessment Form[26]
- Resident Independent Verification Form[27]
- Psychological Assessment Form [28]
- Medical Assessment Form [29]
- Transition Stream Assessment Form[30]
- Care Plan[31]
- Intervention Plan [32]
- Transition Stream Recommendation Report

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[24] Appendix 1

[25] Appendix 2

[26] Appendix 3

[27] Appendix 4

[28] Appendix 5

[29] Appendix 6

[30] Appendix 7

[31] Appendix 8

[32] Appendix 9

The Handover Procedure

The Handover Procedure is taken from the approved procedure manual for St. Mary's Children's Home. Please note that the Handover procedure relates to handovers that happen external to the Intake Procedure. In this context Handover refers to the handover that takes place between dorm shifts. The Procedure for Intake outlined above addresses all intake related handovers. In this regard therefore there are two types of handover, administrative and clinical. The procedure for Handover is as follows:

ADMINISTRATIVE HANDOVER

2.

- 2.1. Verbal and written handover from outgoing staff to incoming staff.
  - 2.1.1. Conduct a physical inspection of the department, this means all areas of the internal and external structure
  - 2.1.2. Conduct a roll call and ensure accountability of all resident's whereabouts.
  - 2.1.3. Handover information to the incoming officer about the medication that was prescribed to a resident and the instruction on how it should be administered.
  - 2.1.4. Ensure that all sharp objects and chemicals are accounted for and secured.
  - 2.1.5. Handover of care plan responsibilities as outlined in correspondence from the welfare department or the management team.
  - 2.1.6. Communicate all clinical observations/challenges of any residents that may have occurred during the shift to the incoming/receiving officer thereby ensuring continuity of care.
- 2.2. Handover of all relevant documents and physical criteria
  - 2.2.1. Review of the inventory checklist by both the incoming and outgoing caregivers to ensure that all relevant documents and keys are handed over based on the shifts that are ending and commencing
  - 2.2.2. Items to be handed over may include the following:
    - 2.2.2.1. supplies,
    - 2.2.2.2. furniture
    - 2.2.2.3. equipment
    - 2.2.2.4. inventory log
    - 2.2.2.5. Disciplinary matters and their consequences via the daily log
  - 2.2.3. All assigned duties must be fully completed by the outgoing officer before handing over to the incoming officer.
  - 2.2.4. Relevant documents include the following:
    - 2.2.4.1. Clinic appointments and any other appointments
    - 2.2.4.2. Instructions/documents from the Manager, Deputy Manager, JHS3, JHS2, and Welfare.
    - 2.2.4.3. Medication that was prescribed to a resident and the instruction on how it is to be administered.

2.2.4.4. Tolerance for medication and any clinical observation.
2.2.4.5. Movement of residents between the dormitories.
2.2.4.6. Documentation of incidents that occurred on all shifts

2.3. Handover verification and acceptance

2.3.1. When handover is completed the incoming caregiver accepts all responsibilities of managing the dorm from the outgoing caregiver including, overseeing of children, devices, and disciplinary matters/consequences

CLINICAL HANDOVER

2.4. The Incoming Officer is required to complete the Peer Assessment form for the Outgoing Officer which is designed to evaluate wellness of the Caregiver/JHS after the shift.

Forms Attached to the Handover Procedure

The following forms relating to the Handover Procedure are attached to this document:

- Dorm Review Checklist
- Inventory Checklist
- Peer Assessment Form

The Medical Procedure

The Medical Procedure is developed to provide a guideline for the administration of medication at St. Mary's Children's Home. It is applicable in all circumstances in which children are placed to be residents at St. Mary's Children's Home. This procedure will incorporate transition elements in line with the ethos of St Mary's Children's Home that transition begins from engagement to post termination. All systems and guidelines are in harmony with medical best practices and laws governing the rights of a child.

The following sections outline the procedures of each aspect of medical care for SMCH:

GUIDELINES FOR MEDICAL ADMINISTRATION :

3.

3.1. What are the guidelines for administering medication?

3.1.1. Give medication administration your complete attention.
3.1.2. Give medications in a quiet area, free from distractions.
3.1.3. Never leave medications unattended, even for a moment. Medication must not be left unattended and must be secured when not being administered.

3.1.4. Wash your hands. You must wash your hands before giving medications and then again after you have given medication to each individual

3.1.5. Encourage a standing or sitting position when administering medication. Medication should be taken with at least a half glass of water to ensure adherence and tolerance.

STORAGE OF MEDICATION:

3.2.

3.2.1. Only assigned dorm staff should have medication keys in their possession. This member of staff is responsible for ensuring the safe securing of medications while holding the keys

3.2.2. Medication cupboards should be sited away from direct sources of heat, moisture and sunlight

3.2.3. Medication cupboards should be fixed to a wall, and should be kept clean, tidy and in good condition. No medication should be left unattended and secured safely in lockable medication cupboard

ORDERING OF MEDICATION:

3.3.

3.3.1. The Nursing Officer is responsible for checking the current stock levels of medication prior to ordering medication to avoid any unnecessary waste. Any excess stock should be carried forward onto the next ordering cycle with clear documentation.

3.3.2. Medication should be ordered at a 28 day interval to allow sufficient time for sourcing prescribed medication from public or private providers as well as allow the required checks on prescriptions issued, dispensation, and delivery to the dorm.

URGENT PRESCRIPTIONS:

3.4. Exceptions to the ordering process may include orders for acute medication such as:

3.4.1. If a resident is acutely unwell

3.4.2. Recently admitted to St. Mary's children's home

3.4.3. Requires urgent supply of medication

PROCEDURE FOR MEDICATION ADMINISTRATION:

3.5. Retrieve the resident's medication from the designated medication cupboard

3.5.1. Call resident to receive their prescribed medication ensuring the SIX R's

3.5.2. The Right Resident

3.5.3. The Right Medication. This will be labelled and previously dispensed in his/her designated weekly medication box by the Nursing Officer.

3.5.4. The Right Dose of medication

3.5.5. The Right Route of administration eg. Oral administration

3.5.6. The Right Time for administration of said medication

3.5.7. The Right to Refuse medication. Consent must always be given by the resident

before administration of any medication and the resident has the right to refuse the same. This must be clearly documented and highlighted to the line manager and Nursing Officer.

3.5.8. Ensure administration of medication is undertaken in the presence of staff

3.5.9. The resident should be encouraged to tolerate medication at time of administration. This is particularly important for residents with previous history of non-compliance, those on psychotropic medication and those who are now commencing their respective pharmacological regime. Staff must check for potential concealment of medication in mouth: cheek, and under tongue, palming of medication, dropping of medication on floor or cup/glass. This ensures maximum desired benefit of prescribed medication for the resident and deters any potential hoarding or medication for future negative outcomes. Document administration of prescribed medication on designated medication reports form noting the time. Secure the resident's weekly medication box back in a lockable cupboard. Observe the resident for any potential side effects, abnormal behaviors or self-reporting of changes to their physical wellbeing.

3.5.10. Report any changes observed or concerns to senior staff and the nursing officer immediately.

3.5.11. Communicate any concerns to supervisor and colleague at handover to ensure consistency of observation and monitoring.

PROCEDURE FOR MEDICAL INDEPENDENCE PROGRAMME:

3.6. This program commences when the resident turns 16 years old and concludes 3-6 months post turning 18 years old. Each step is for a year's duration and promotes greater medical responsibility with each progressive step.

3.6.1. At age 16 , residents are given a SMCH clinic card. This will be used to book in visits to the nurse, SMCH's doctor, dressings etc. This card mirrors public health services documents and will be used in a similar manner.

3.6.2. Here the resident will be counselled individually on its use and begin being weaned off open/liberal access to the clinic and medical services provided by the Home.

3.6.3. The resident is responsible for ownership of their clinic card and the same is to be used to attend scheduled appointments.

3.7. At age 17, residents should already be familiar with the use of the SMCH clinic card.

3.7.1. Medication management (Phase one): If on prescribed medication he/she will be given their respective weekly medication tray (already in use at the dorm level). This tray will be pre-loaded as prescribed with their respective medication. They will be counselled and advised accordingly with regards to tolerance, compliance, medication side effects etc. He/she will be expected to comply and tolerate the same independently on a weekly basis. Here they will have a weekly appointment for review at the clinic (using the clinic card) and ongoing education on reloading medication etc.

3.7.2. It is noteworthy that concerns for safe storage of medication needs to be further examined due to risk issues to the communal population.

3.8. At age 18 , resident should already be familiar with steps 1 and 2

3.8.1. He/she will be given a flyer 'So I'm turning 18…now what?' Please see attached.

3.8.2. Medication management(Phase two): allows for greater autonomy where he/she is now given one month's supply of medication. Clinic review (by use of the clinic card) is now on a monthly basis, with review, and education accordingly.

3.8.3. During this time, he/she will be assisted to register in the local health facility, any related external clinics and FPA . There will be ongoing education regarding access to services and a promotion of eventual autonomy in the same.

3.8.4. It is the hope that post months three after turning 18 he/she will no longer be dependent on the Home and able to access the relevant health services needed independently.

3.8.5. This program will be implemented on an individualised basis, but once successful the young adult at age 18 years and 3 months will no longer rely on SMCH for their medical needs.

ADDRESSING ILLNESS THAT MAY LEAD TO HOSPITALIZATION

3.9.

3.9.1. When a child shows signs of or complains of illness they must be taken to see the onsite nurse

3.9.2. In the absence of the onsite nurse or if the onsite nurse believes it is required an ambulance will be called

3.9.3. When they ambulance arrives the child must be examined by the paramedic. Once the paramedic believes it is necessary the child must be taken to the hospital.

3.9.4. In the event that any child has to be taken to the hospital each dorm must have in its possession two already packed hospital bags and an emergency cell phone

3.9.5. A card with the child's basic medical information must also be confidentially stored with the JHS II to ensure that when the child is taken to hospital all the necessary medical information can be provided to the examining doctors.

3.9.6. The child must be accompanied by a staff member who is provided with the hospital bag and the emergency cell phone as well as the child's information card

There will be a follow up appointment scheduled in six months post discharge to review any concerns /issues that may arise. This will be the last time the clinic card will be used and it is thus expected that after this appointment he/she will be independent medically from the Home.

FORMS ATTACHED TO THE MEDICAL PROCEDURE

The following form is attached to the Medical Procedures section:

- The Medical Assessment form[33]

The Transition Procedure

The following procedure outlines the elements of the three aspects of transitioning that are prioritized by the SMCH. These outlines are necessary to ensure residents experience consistent care and quality care that can be monitored and evaluated.

4.

4.1. Transitioning between dorms: it must be noted that the criteria for movement from one dorm to another is the age of the child as dorms are housed based on childhood growth from early childhood (birth to 5 years old), to small (5 to 11) to intermediate (12 to 15) to senior (16 to 18). Movement from one dorm to another is also the responsibility of the welfare department and not the caregiving staff.

4.1.1. Upon the age of transition the welfare team meets to review the child's care plan and determine whether mobility into a more senior dorm is advised at this time

4.1.2. During this care plan meeting a decision is made by the welfare team concerning the date of transition.

4.1.3. A memorandum is then sent to the JHS3 and the JHS2 and both the receiving and the removing dorm are copied on the letter.

4.1.4. The JHS3 then oversees the removal of the resident from the previous dorm to the new dorm

Please note that movement into the senior dorm and the independent living program has its own rules outlined in the section of this document labeled Independent living.

4.2. Independent living: This section outlines transitioning specifically for children over the age of 16 years old who are being transitioned out of residential care

4.2.1. The resident is transitioned into the senior girls/boys dorm at the age of 16 at the discretion of the welfare care plan review team.

4.2.2. The resident will be oriented to the new dormitory and its rules by the social worker and JHS 1

4.2.3. The resident is placed in their own room/cubicle that they are responsible for in terms of upkeep and chores.

4.2.4. The resident is responsible for preparing his/her own meals (as outlined by the independent living programme) and washing and ironing his/her own clothes

4.3. Assignment to the Five Streams

4.3.1. An assessment will be conducted on each resident, which along with their interest will determine the stream/s they are placed in.

4.3.2. New intakes will be placed in a stream/s based on the information gathered from their biopsychosocial.

[33] Appendix 6

4.3.3. Several modes of assessment should be conducted before placing a child in a stream such as but not limited to: biopsychosocial, observational, semi and structured interviews.

4.3.4. Triangulation should be used to evaluate the efficacy of the program and its impact on the child. This can be done through monthly, quarterly and random measures.

Forms Attached to the Transition Policy

- Transition Checklist
- Child Development Tracking Form

Dorm related documentation procedures

The outlining of procedures for dorm related documents are necessary for the standardization of operations at SMCH. This will aid in the monitoring and evaluation to ensure that best practices are maintained and optimal care continues to be provided.

5.

5.1. Utilization of the Log Book.

5.1.1. Log books should be read at handover to address or clarify matters as necessary.

5.1.2. All sections in the log book must be filled out on each shift.

5.1.3. Manager, Deputy Children's Home Manage, JHS 111, Social Worker, Welfare Officer can read and sign as reading the log book.

5.1.4. The Children's Authority can read and request information from the log book.

5.1.5. The Court can request information from the log book.

5.1.6. Log books should not be read or filled out by residents.

5.1.7. At the end of each month, log books should be handed over to JHS 111 to be stored in a secure location.

5.2. Utilization of the maintenance book.

5.2.1. When a maintenance issue is discovered by any member of staff assigned to the dorm, they are required to input the same into the maintenance book.

5.2.2. Maintenance officers are required to daily check maintenance books and report issues to JHS111.

5.2.3. JHS111 is required to delegate work based on order of priority.

5.3. Ordering goods (household items and small and large appliances). It should be noted that the ordering of household items and small appliances is done using the purchase order books which are verified by the JHS3 before going to stores. For the large appliances orders are made utilizing the requisition book. This is authorized by the JHS3 but approved by the Deputy Children's Home Manager (DCHM) and in his/her absence

the Children's Home Manager (CHM).

5.3.1. Order is made by the JHS2 in the required book and then sent to the JHS3 for approval/authorization

5.3.2. Once approved/authorized the book is sent to the DCHM/Stores keeper for further action to be taken.

5.3.3. At this point accounting, stores and procurement policy and procedure takes over.

5.3.4. Once the order/requisition goes through the relevant channels the items will be provided by stores to the JHS2 for utilization in the dorm

5.4. Special request for individual care plans: It must be noted that the welfare team can make special requests for the dorm staff to fill out documentation as part of a resident's individual care plan, intervention plan or transition plan.

5.4.1. Welfare team submits request for special consideration for the individual care/ intervention/transition plan via internal memorandum to the DCHM and in his/ her absence the CHM. The JHS3 and the JHS2 of the dorm in which the resident resides must be copied on the letter.

5.4.2. Once approved by the DCHM/CHM a further correspondence is written to the JHS3 sanctioning the considerations outlined via internal memorandum.

5.4.3. Where necessary the welfare team must provide training to the JHS2 and JHS1s responsible for the dorm on how to fill out the required documentation

5.4.4. Documentation must be filled out as required and resubmitted to the welfare team via the welfare officer/transition social work/intervention social worker.

5.5. Disposing of items.

5.5.1. The supervisor duplicate book (SDB) is used for the disposal of non subvention items.

5.5.2. JHS 11 should present the disposal item and with the SDB for signature before disposal.

5.5.3. Subvention items should only be disposed of when relevant legal documents are completed and approval is given from Home Manager/Deputy Home Manager.

Procedures Under Child Supervision

The following procedure outlines the daily requirements for dorm life, relating to dorm life or impacting dorm life in some way. It focuses on the day to day interactions with the child and caregiving staff.

6.

6.1. Daily in-dorm timetable. This represents the established daily dorm timetable outlined for all children in the dorm from when they are to wake up to when they are to go back to bed.

6.1.1. The JHS2 for the dorm is to initiate a review of the existing dorm timetable along with the JHS1s/Caregivers belonging to the dorm

6.1.2. When the time table is established all staff of the dorm are to work together to

ensure that the dorm has a structure

6.1.3. The time table includes the following:
- 6.1.3.1. lights on and lights out
- 6.1.3.2. chores
- 6.1.3.3. homework and study times
- 6.1.3.4. extra curricular activities as outlined by the Programme Coordinator
- 6.1.3.5. devotions
- 6.1.3.6. in dorm meetings
- 6.1.3.7. in dorm activities
- 6.1.3.8. handover

6.2. 6.2 Daily out-dorm timetable: This time table outlines the procedure for rostering children's out of dorm activities

6.2.1. This section covers extra curricular activities, volunteer activities, excursions/ field trips and the like

6.2.2. The individual/organization whether internal or external must make the request for resident participation through the Programme Coordinator who is responsible for the children's roster

6.2.3. The Programme Coordinator is to include the activity in the master roster and liaise with the JHS2 to include it in the dorm roster

6.2.4. The Programme Coordinator is to inform the CHM, DHM and JHS3 of the activity and the child/children involved via internal memorandum so that any necessities are put in place

6.3. Disciplinary action within the dorm

6.3.1. Rules and consequences should be displayed in the dormitory.

6.3.2. The residents should be clearly acclimatized to the rules and consequences for breach of same.

6.3.3. Consequences should be given when the infraction is done based on the list of consequences.

6.3.4. All consequences should be clearly recorded and reported to colleagues and supervisors.

6.3.5. All staff are required to follow through and uphold consequences given.

6.3.6. Adjustments of consequences must be done in consultation with relevant parties.

Procedures for lockdown

The following are guidelines for restrictions implemented on the compound or individuals for the safety of residents.

7.

7.1. Lockdown of the compound

7.1.1. When it is assessed to be a crisis such as: natural disaster, external physical threat, pandemic, health outbreak or extreme disciplinary challenges.

7.1.2. Authorization is needed from the Children's Home Manager or Deputy Children's Home Manager for a lockdown of the compound to be approved.

7.1.3. During that period residents will be restricted to their dorms unless permission is given otherwise.
7.1.4. Any additional guidelines or special contingencies will be written to dorms.

7.2. 7.2 lockdown of individual residents
7.2.1. Residents who are assessed to be a serious harm or flight risk to themselves and others.
7.2.2. Residents are restricted to an assigned area.
7.2.3. Residents should not be outside of the assigned area without supervision
7.2.4. Residents have a right to phone calls (as directed) and visits from external personnel (Family, Children's Authority, Court, Child advocate) during this period.

Other Related Forms and Reports

There are several forms and reports that are also expected to be utilised in the system but a copy of its format is not provided in this document. They include, but are not limited to the following:

- Attachment Test
- Personality Test
- Psychosocial Assessment Tool
- Child-Caregiver Assessment Tool
- Guardian to Resident Assessment Tool
- Resident Behavioral Checklist
- Child Anxiety Assessment
- Depression Assessment
- Emotional Development Assessment
- Transition Stream Recommendation Report
- Dorm Review Checklist
- Inventory Checklist
- Peer Assessment Form
- Transition Checklist
- Child Development Tracking Form
- Intervention Assessment Form

1	Receiving The Child From the Children's Authority of Trinidad and Tobago			
A	Name of Receiving Officer:	Date and time:	Collection Location:	Signature of Receiving Officer:
No.	**Step**	**Details /Findings**	**Description**	**Explanation**
1.a	Receive Court Order			
1.b	Receive Negative PCR Test			

Appendix 1: SMCH Intake Checklist

1.c	Receive other related documents. (Birth paper, immunization card, treatment plan, medical report, any assessment reports. This also includes receipt of personal items)	What documents were received?:	Description of the condition of the documents:	Indication of any circumstances that must be noted:

ST. MARY'S CHILDREN'S HOME
INTAKE CHECKLIST

This checklist is to be filled out by a Social Worker, Welfare Officer or Caregiver receiving the child from the gate and acclimatizing them to the Intake Unit at St. Mary's Children's Home (SMCH). Please note that all the steps on the form must be accounted for and in the case where it is not an explanation must be provided. An outline of how to utilize this form can be found on page 11 of this document. This form is in compliance with the SMCH Policy and Procedure for Intake.

Name of Child: _____

Date of Birth: _____

Gender of Child: ☐ Male ☐ Female

Age of Child: _____

Child's Ethnicity: _____

Does the Child have any disabilities: ☐ Yes ☐ No

If yes, what?:

1.d	**Assess Child for marks cuts or any notable abnormalities**			**Please indicate if assessing officer is different from receiving officer:**

2	Ensure all relevant supporting documents are handed over and verified			
B	Name of Officer Handing Over:	Date and time:	Collection Location:	Signature of Officer:
C	Name of Receiving Officer:	Date and time:	Collection Location:	Signature of Receiving Officer:
No.	**Step**	**Details /Findings**	**Description**	**Explanation**
2.a	Handover of court Order			

2.b	**Handover of Negative PCR Test**			
2.c	**Handover of Medical**			

2.d	**Hand Over of Related documents (birth paper, immunization card, treatment plan, medical report, any assessment reports. This also includes receipt of personal items)**	**What documents were received/handed over?:**	**Description of the Condition of the Documents:**	**Where necessary the details and signatures of any officer receiving a document other than the receiving officer:**

3	Verbal handover from CATT to Receiving Officer			
D	Name of CATT Officer Handing Over:	Date and time:	Collection Location:	Signature of CATT Officer:
E	Name of Receiving Officer:	Date and time:	Collection Location:	Signature of Receiving Officer:

3.a	Description of Details verbalised by CATT Officer	Details coming from description:	Recommendations based on details:	Any other points to note:

4	Introduction of the child to the SMCH, ensure the child feels a state of comfort			
F	Name of Officer:	Date and time:	Collection Location:	Signature of Officer:
No	**Step**	**Details /Findings**	**Description**	**Explanation**
4.a	Staff will welcome the child and begin building relationships			

4.b	**Staff will outline the Home's rules and regulations to the child**			
4.c	**Staff will allow the child to ask follow up questions and seek clarity on information given**			

4.d	Staff will familiarize the child with the compound and give various safety and out of bounds updates			
4.e	Staff will inform the child of the procedure to make request and launch complaints			

5	Receipt of the child, along with verbal handover			
G	Name of CATT Officer Handing Over:	Date and time:	Collection Location:	Signature of CATT Officer:
H	Name of Receiving Officer:	Date and time:	Collection Location:	Signature of Receiving Officer:

No.	Step	Details /Findings	Description	Explanation
5.a	Handover to officer assigned to the intake unit			
5.b	Details of verbal handover to be filled out by receiving officer			

6	Assessments conducted by the Welfare team			
I	Name of Welfare Officer:	Date and time:	Assessment Location:	Signature of Welfare Officer:
J	Name of Transition Social Worker:	Date and time:	Assessment Location:	Signature of Social Worker:

K	Name of Intervention Social Worker:	Date and time:	Assessment Location:	Signature of Social Worker:
L	Name of Psychologist:	Date and time:	Assessment Location:	Signature of Psychologist:
M	Name of Nurse:	Date and time:	Assessment Location:	Signature of Nurse:

No.	Action	Yes/No	Explanation/Brief	Date and Signature
6.a	Welfare Officer to Interview Child Using Necessary forms			
6.b	Welfare Officer to Interview other relevant persons and institutions relevant to the child including but not limited to the for school the child attended, the community and parents, guardians, family of the child using necessary forms			

6.c	The Intervention Social Worker will interview the child for the purpose of creating the initial intervention plan			
6.d	Psychologist to assess child using necessary forms			

6.e	Resident Nurse to examine child using necessary forms			
6.f	Care team to Hold Multidisciplinary meeting to amalgamate findings into one document			
6.g	The Transition Social Worker will conduct an assessment of the child for the purpose of placing the child in a transition stream			

7	Care-plan and Initial Intervention Plan created and Child is placed in Transition Stream			
N	Name of Welfare Officer:	Date and time:	Assessment Location:	Signature of Welfare Officer:
O	Name of Transition Social Worker:	Date and time:	Assessment Location:	Signature of Social Worker:
P	Name of Intervention Social Worker:	Date and time:	Assessment Location:	Signature of Social Worker:

No.	Action	Yes/No	Explanation/Brief	Date and Signature
7.a	Welfare Officer to compile all elements of the assessment into a working document to guide intervention			
7b	Children's Home Manager and/or Deputy Children's Home Manager to review and approve			

7c	**Social Worker to formulate intervention plan out of care plan**			
7d	**Children's Home Manager and/or Deputy Children's Home Manager to review and approve**			

7e	The Transition Social worker assigned to the child will compile all elements of the assessment into a working document that outlines the various streams in which the child is placed and captures data as it relates to the child's progress in the streams			
7f	Children's Home Manager and/or Deputy Children's Home Manager to review and approve			

8	Where necessary Care Plan to be approved by external stakeholders			
Q	Name of Welfare Officer:	Date and time:	Handover Location:	Signature of Welfare Officer:
No.	**Action**	**Yes/No**	**Explanation/Brief**	**Date and Signature**
8.1	Care Plan to be forwarded to external stakeholder (CATT or Family Court) when necessary for supporting signatures			

Instructions for the use of the Intake Checklist

This section of the Checklist is designed to provide guidance on its utilization. Please read the form and ensure that you have an understanding of how it is to be utilized and populated/filled out. This form is meant to be used by various officers as it follows the intake process of the child. Upon completion this form will be placed/located in the resident's personal file stored in the Welfare Department.

Section 1: Receiving the child from the Children's Authority of Trinidad and Tobago

This section has 5 components which are as follows:

- A: In this component the JHS I II or III, Social Worker, or Welfare Officer that is receiving the child from CATT must place their name in block letters, the date and time in which the received the child. The Location in which the child was received and the signature of the Officer receiving the child.
- 1.a, 1.b are specifically related to the receiving of the court order and the negative PCR test. In this section the receiving officer must note any details that they deem necessary as it relates to the handing over of these documents, a description of the condition of the documents when handed over and an explanation for any anomalies in the exchange (eg. Photocopy of the document was provided and the original will be sent subsequently)
- 1.c concerns the receipt of any other document upon handover of the child from CATT. In the Details/Findings section it is expected that the receiving officer will outline what documents were received. They will also provide a brief of the condition of the documents upon receipt and provide an indication of any circumstance that must be noted
- 1.d: An initial assessment of the child for marks, cuts or any other abnormality must be conducted by the receiving officer who would then provide any details of said anomalies, a description of the anomalies and will provide an explanation should the assessing officer be different from the receiving officer (eg. We received a little girl, but the receiving officer was male, so he brought her to the nurse's office to be assessed). In the case where the assessing officer is different from the receiving officer they must also sign and date and place the time of the assessment in the explanation section of this question.

Section 2: Ensure all relevant supporting documents are handed over and verified

This section has 6 components which are as follows:

- B: In this component the Officer handing over from CATT will place their name in block letters, will also provide the date, time and location of the handover and will sign to confirm handover of the child to a St. Mary's officer.
- C: In this component the Receiving officer from St. Mary's as outlined in A will also place their name in block letters , the date and time in which the received the child. The Location in which the child was received and the signature of the Officer receiving the child.
- 2a,2b,2c requires the Receiving officer to note any details that they deem necessary as it relates to the handing over of the court order, the negative PCR test and the medical , a description of the condition of the documents when handed over and an explanation for any anomalies in the exchange
- 2d concerns the receipt of any other document upon handover of the child from CATT. In the Details/Findings component it is expected that the receiving officer will outline what documents were received. They will also provide a brief of the condition of the documents upon receipt and provide an indication of any circumstance that must be noted. Where necessary the details and signatures of any other officer receiving a document other than the receiving officer including the name of the document and the date and time of the handover of the document.

Section 3: Verbal handover from CATT to Receiving Officer

This section has 3 components which are as follows:

- D: In this component the Officer handing over from CATT will place their name in block letters, will also provide the date, time and location of the handover and will sign to confirm handover of the child to a St. Mary's officer.
- E: In this component the Receiving officer from St. Mary's as outlined in A will also place their name in block letters , the date and time in which the received the child. The Location in which the child was received and the signature of the Officer receiving the child.

- 3a: In this component the receiving officer is expected to note the details of any descriptions provided verbally by the CATT officer handing over and to make recommendations based on these details. They are also expected to outline any other points that must be noted including allergies of the child, medication the child may be on, any experiences of a physical nature that the home should be aware of, whether there is psychometric issues and so on.

Section 4: Introduction of the child to the SMCH, ensure the child feels a state of comfort

This section has 6 components which are as follows:

- F: the name of the officer in block letters who is acclimatizing the child to the Home, the date and time of the exercise, the location in which the child is collected by the officer and the officer's signature.
- 4a, 4b, 4c, 4d, 4e all relate to activities that must be carried out as the staff acclimatizes the child to the Home environment. The staff is to not any observations, a description of the observations and any further explanations as it relates to each outlined duty.

Section 5: Receipt of the child, along with verbal handover

This section contains 4 components and they are as follows:

- G: In this component the Officer handing over from acclimatizing the child to the Home and taking the child to the Intake Unit, will place their name in block letters, will also provide the date, time and location of the handover and will sign to confirm handover of the child to the intake unit staff.
- E: In this component the Receiving officer from the intake unit will also place their name in block letters , the date and time in which the received the child. The Location in which the child was received and the signature of the Officer receiving the child.
- 5a, 5b relates to the process of handing over the child to the intake unit. The handing over officer must submit all the child's belongings along with this checklist and must relay verbally any necessary information provided by CATT or observed during the acclimatization process.

No.	**Areas of Concern**	**Category**	**Proposed Interventions**
1.	Child's expectation from care and protection (Child's thoughts, wishes, desires)	Caring adult Safety Needs Family Contact Home Reintegration Other _____	Meet personal needs Maintaining contact/ visitation with families Work towards return to family Work towards other care options Other _____
2.	Health and Nutrition Needs	Prescription medication Allergies Immunizations Malnutrition Physical impairment Visual impairment Hearing impairment Speech impairment Dental care Hygiene issues Disease	Regular medical attention Special diet Medications Support for impairments Other _____

3.	Emotional and Psychological Support needs	Anger management Adjustment issues Abuse/Neglect Aggression/violence Anxiety Bullying Disobedience Depression Stealing Traumatic experience Hyperactivity Self-harm/suicidal ideations Lying Sexualized behavior Alcohol/drug abuse Lack of trust in adults Other_____	Additional support and attention from staff/ community members/role models Individual counseling Group counseling Life-skills education Other _____

Section 6: Assessment conducted by the welfare team

4	Educational and Training needs	Delayed learning (for late starters) Concentration issues Behavior issues at school Study Skills/Management Computer Training Career counseling Other _____	LD Testing ADHD Testing Additional educational support Career Counselling Life Skills Education Other _____
5	Leisure, Creativity, and Play	Lack of interest in leisure activities Lack of participation in leisure activities Lack of time for leisure activities Other _____	Encourage finding time for leisure Help identify interest Enroll in lessons/joint team Other _____
6	Attachment and interpersonal relationships	Bonding with adult figure Interactions with staff Interactions with peers/ friendships Other _____	Guidance from staff Individual counselling Group counselling Life skills education/ interpersonal skills Other _____

7	Religious Beliefs	Lacks knowledge of personal beliefs and practices Child does not display moral character Other _____	Religion of choice identified and supported Participate in daily prayer Opportunity to visit religious establishment Religious/spiritual teaching for moral/character development Participates in religious holidays Other _____
8	Self-care and life-skills training for all kinds of abuse, neglect and maltreatment	Communication skills Selfconfidence/self awareness Problem solving/decision making Conflict resolution/ mediation Expressing emotions Other _____	Lifeskills - selfawareness Goal setting Effective communication Lifeskills education- problem solving/decision making Lifeskills education - sexual abuse prevention Individual Guidance Other _____

This section has 12 components which are as follows:

9.	Independent living skills	Vocationtraining Financial training Nutrition/cooking Health/hygine Household chores Scocial and community network Using public transportation Other _____	Life skils education – Financial Training Enroll in vocational course Group activities/field trops Support to develop and sustain relationships Individual guidance Other _____
10.	Traumatic Experiences	Socialized with guardians with mental health issues Buylling Neglect/Abandoment Physical Abuse Sexual Abuse Trafficking	Aditional support and attention from staff Individual conseling Group counseling Other _____

- I, J, K, L, M,: In these components the Welfare Officer, Transition Social Worker, Intervention Social Worker, Psychologist, and Nurse all have to conduct various assessments with the child. They must therefore place their names in block letters in the sections provided, provide the

date and time they conducted the assessment, the location where they conducted the assessment and their signatures

- 6a, 6b, 6c, 6d, 6e, 6g: In these sections the respective Officers are to submit the instruments with their assessment data to the BOA II for the Deputy Children's Home Manager of the SMCH. They are to state whether they completed the relevant forms, provide explanations or briefings of any difficulties encountered and date and sign upon submission
- 6f: In this section the care team must hold a meeting to consolidate their varied submissions to inform the development of a Care Plan for the child. A biopsychosocial spiritual assessment must therefore be conducted by the team. The BOAII for the DCHM must therefore state whether they completed the tasks, provide explanations or briefings of any difficulties encountered and date and sign upon submission

Section 7: Care-plan and Initial Intervention Plan created and Child is placed in Transition Stream

This section has 9 components which are as follows:

- N, O, P: In these components the Welfare Officer, Transition Social Worker, and Intervention Social Worker, must submit assessment reports to the CHM and DCHM they must therefore include their name in block letters, the date and time of the submission of the reports, the location when the assessment took place and their signatures
- 7a, 7c, 7e: In these components the respective Officers are to submit the reports the Deputy Children's Home Manager and the Children's Home Manager of the SMCH for review. They are to state whether they completed the reports, provide explanations or briefings of any difficulties encountered and date and sign upon submission
- 7b, 7d, 7f: In this component the DCHM and the CHM are to state whether they received the appropriate reports for review, any details of issues to address upon receipt of the documents and the date time and signature for when they received the documents.

Section 8 Where necessary Care Plan to be approved by external stakeholders

This section has 2 components which are as follows:

- Q: In this component the Welfare Officer relating to the external stakeholder will place their name in block letters, the date and time of the submission of the document to the external stakeholder, the Handover location of the document and their signature.
- 8a: In this component the representative of the external agency will state whether they received the care plan, any explanation for any issues or difficulties with the plan and will sign, date and time stamp the checklist for when the document was handed over for approval.

Appendix 2

1.	Child's expectation from care and protection (Child's thoughts, wishes, desires)
2.	Health and nutrition
3.	Emotional and psychological
4.	Educational and training
5.	Leisure, creativity and play
6.	Attachments and inter-personal relationships
7.	Religious beliefs

INTAKE ASSESSMENT FORM

Name of Welfare Officer: _____

Current Date: DD MM YY _____

Date for Preparing the Individual Care Plan: ☐ Male ☐ Female

If Applicable, Police Station: _____

Date of Admission: DD MM YY _____

Stay of the child (circle as applicable)

1. Short term (up to a year)
2. Medium Term (one year to three years)
3. Long Term (more than three years)

8.	Self-care and life skills training for protection from all kinds of abuse, neglect and maltreatment
9.	Independent living skills
10.	Traumatic experiences
11.	Any other

A. PERSONAL DETAILS

1. Name of Child _____

ST MARY'S CHILDREN'S HOME
RESIDENT INDEPENDENT VERIFICATION FORM

This form is to be utilized as a guide to independent investigations of residents home, community and school.

Details of the Resident Case:

1. Biographical information for each child and parents or caregiver

Details of Child

Name of Child: _____

Age: _____

Date of Birth DD MM YY _____

Birth Certificate Number _____

School attended while living with family: _____

Grade they were in when taken from their residence: _____

Address of the location they were taken from: _____

_____

_____

2. Age/ Date of Birth _____

3. Sex: Male/Female (circle)
4. Father's Name _____
5. Mother's Name _____
6. Guardian's Name _____
7. Nationality _____
8. Religion _____
9. Last Address/Community

_____

_____

10. Level of Education _____
11. Details of child's belongings, if any

_____

_____

_____

12. Details of awards/rewards received by the child, if any, based on case history, social investigation report and interaction

_____

_____

_____

13. Based on the results of Case History, Social Investigation report and interaction with the child, give details on the following areas of concern and interventions required, if any

_____

_____

_____

B. PROGRESS REPORT OF THE CHILD

This progress report is to be done based on the period of entry into the intake unit to when they are due to leave the intake unit.

General conduct and progress of the child during the period of the report:

For Official Use Only

Social Worker's Signature _____

Date of Birth DD MM YY _____

No.	Category	Proposed Interventions	Progress of the Child Please rate and give rationale for ratings. 4 = No further intervention needed 3 = Good progress 2 = Some progress
1.	Child's expectation from care and protection (Child's thoughts, wishes, desires)		
2.	Health and nutrition needs		
3.	Emotional and psychological support needed		
4.	Educational and training needs		
5.	Leisure, creativity and play		
6.	Attachments and interpersonal relationships		
7.	Religious beliefs		
8.	Self-care and life skill training for protection from all kinds of abuse, neglect and maltreatment		
9.	Independent living skills		
10.	Traumatic Experiences		

11. Any proceeding before the children's court

    (i) Variation of conditions of bond

(ii) Change of residence of this child

(iii) Other matters, if any

C. PRE-RELEASE REPORT

Appendix 3

2. Primary Parent/Guardian

Name: _____

Address: _____

Telephone: _____

3. Other household members: (including ages)

Name: _____

Address: _____

Telephone: _____

4. Tasks completed:

- ☐ CPU/TTPS/Other: state date, if it was a visit or a telephone call
- ☐ School visit: state name and address of school and date visited and name of persons interviewed
- ☐ Home visit: state date and names of person interviewed.
- ☐ Community visit: state date and names of person interviewed
- ☐ Interview with CATT: state date and names of person interviewed
- ☐ Other: state date and names of person interviewed

5. Sources of information

Outline the names, position, address and contact information of the person interviewed. If anonymous please state location and date of interview.

_____

_____

_____

_____

6. Detailed findings from investigation (all interviews with persons residing in the home or who assist with the care of the child/children.

Name, Date and Time of Interview

_____

_____

SECTION 5 – HOME ENVIRONMENT

A. **Type of accommodation** *(building material, ownership, levels, rooms)*

Structure Type

- ☐ Wooden
- ☐ Concrete
- ☐ Galvanised
- ☐ Grass/Mud
- ☐ Flat
- ☐ Two-Story
- ☐ More than Two Stories
- ☐ Other (please specify)

_____

Ownership Status

- [ ] Squatting
- [ ] Rented Apartment/House
- [ ] Mortgage
- [ ] Owned
- [ ] Other (please specify)

_____

Details of accommodation

- [ ] Bedroom(s) _____
- [ ] Kitchen _____
- [ ] Living Room _____
- [ ] Dining Room _____
- [ ] Indoor Toilet & Bath _____
- [ ] Outdoor Toilet & Bath _____
- [ ] Porch _____
- [ ] Other (please specify)

_____

Amenities (water supply, electricity, communication)

- [ ] Pipe-borne water
- [ ] Truck-borne water
- [ ] Rain water
- [ ] Stand-pipe water
- [ ] Natural water source
- [ ] Electricity
- [ ] Alternative Powersource

_____

- [ ] Landline telephone
- [ ] Mobile telephones
- [ ] Internet
- [ ] Cable/DirectTV/Satellite
- [ ] Airconditioning
- [ ] Other (please specify

_____

A. Safety

Health and Safety Standards

B. Neighbourhood

Surroundings, condition, people, facilities, activities, community inquiries

C. Nature of Relationships

Communication and Interaction with family, visitors, neighbours, conflict, etc.

7. Community Inquires

Please list details of interviews conducted with members of the community and the community/local TTPS.

Name, Date and Time of Interview

_____

_____

8. Situational Risk Assessment and Analysis

Report of the situational Risk Assessment of the child and environment and the potential implications to residential care

_____

_____

9. Recommendations

_____

_____

10. Additional Information

_____

_____

Appendix 4

ST MARY'S CHILDREN'S HOME
PSYCHOLOGICAL ASSESSMENT FORM

Name of Child: _____

Date of Birth: DD MM YY _____

Religion: _____

First time in Residential Care: ☐ Yes ☐ No

Details:

_____

_____

_____

_____

_____

1. Child Protection History

☐ Has interacted with the Children's Authority

☐ Has interacted with the Child Guidance Clinic

☐ Has interacted with the Court

2. Birth and Development

- Pregnancy

  ☐ Normal Birth

  ☐ Cesarian Section

_____

_____

_____

MEDICAL	NORMAL	ABNORMAL FINDINGS	MEDICAL	NORMAL	ABNORMAL FINDINGS
Hair			Heart		
Mouth			Lungs		
Teeth			Musculoskeletal		
Head			Nervous system		
Eyes			Feet		
General appearance			Skin		
Chest			Nails		
Abdomen					

_____

- Developmental milestones

  ☐ Babbling

- [ ] Crawling
- [ ] Toilet Training
- [ ] Talking

_____

_____

_____

_____

3. Medical History

☐ Medical disturbances during childhood

_____

_____

- Psychological Diagnosis

Has the child been diagnosed or presents any of the following

☐ Conduct Disorder

☐ Oppositional Defiant Disorder

☐ Attention Deficit Hyperactivity Disorder

☐ Obsessive Compulsive Disorder

☐ Sexual Abuse

☐ Verbal Abuse

☐ Emotional Abuse

☐ Molestation

☐ Rape

☐ Post Traumatic Stress Disorder

For Official Use Only

Social Worker's Signature _____

Medical Officer (PRINT) _____

Date DD MM YY _____

☐ Depression

☐ Addiction

☐ Physical Abuse

☐ Out of control behaviour

- [ ] Pretesting for Learning Disorders _____
- [ ] Sexual Confusion Issues
- [ ] Bullying
- [ ] Stealing
- [ ] Lack of trust in adults
- [ ] Suicidal Ideation
- [ ] Other (please specify _____

Details of Child

Name of Child: _____

Age: _____

Date of Birth DD MM YY

Date for Preparing the Individual Care Plan: ☐ Male ☐ Female

Favourite Colour: _____

Favourite Food: _____

4. Family History

- Name, Date and Time of Interview

- Raised by

- How was growing up?

- Was there any trauma in the home?

- Major Life Events

5 Best Events

5 Worst Events

CHOICE	1st	2nd
Academics & Sports	☐	☐
Entrepreneur	☐	☐
Agriculture	☐	☐
Arts & Theatre	☐	☐
Culinary Arts	☐	☐

STREAM	1st
Academics & Sports	☐
Entrepreneur	☐
Agriculture	☐
Arts & Theatre	☐
Culinary Arts	☐

- What are your strengths and weaknesses?

ST MARY'S CHILDREN'S HOME
TRANSITION STREAM ASSESSMENT FORM

Details of Child

Key Worker: _____

Date of Care Plan DD MM YY _____

Resident Name: _____

Age: _____

Gender: ☐ Male ☐ Female

Date of Entry: DD MM YY

Date of Birth: DD MM YY

Address _____

_____

Disability _____

☐ Remand Control ☐ Transition

☐ Beyond Control ☐ Other

Risk Level

☐ High ☐ Medium ☐ Low

Strengths

_____

_____

_____

	PLANNING GOAL	IMPLEMENTATION	EVALUATION	GOAL MET	
Pertinent data based on history and current state	*The resident will…*	*Staff will…*	*What happened after _1_month*	**YES**	**NO**
1. **PHYSICAL**– **Health checks as required:** **Extracurricular Activities:**					
2. **SPIRITUAL**					
3. **ENVIRONMENTAL**- To ensure the environment is safe. *i.e. Mary's Children's Home. accommodation etc.*					

4. **FINANCIAL**– i.e. grants, income, debt					
5. **EDUCATIONAL** –i.e. knowledge, skills					
6. **EMOTIONAL** – i.e. psychological, mental health **Emotional Functioning**					
7. **OCCUPATIONAL**– i.e. job, trade, prospects etc.	S.M.A.R.T.				

Weaknesses

- What are your life's goals and aspirations?

CURRENT ISSUE	PRESENTING BEHAVIOUR

- No. of Children, their ages and sex

INTERVENTION METHOD	THEORITICAL FRAMEWORK	EVALUATION METHOD

- How is your current family life in your own words?

School & Post School History & Ages at each

- Primary School

_____

_____

- Secondary School

_____

_____

- Vocational School

_____

_____

- How would understanding yourself help you in making life decisions?

_____

_____

_____

_____

- Is there anything that I didn't ask you that you believe needs to be noted?

_____

_____

_____

_____

ADDITIONAL NOTES

Appendix 5

ST MARY'S CHILDREN'S HOME
MEDICAL EXAMINATION FORM

Details of Child

Name of Child: _____

Age: _____

Date of Birth DD MM YY _____

Gender ☐ Male ☐ Female

Telephone Number: _____

HEIGHT:	WEIGHT:	B/P:	PULSE:	URINE:	TEMP:

2. FAMILY HEALTH HISTORY (Tick where appropriate)

- ☐ Typhoid
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Mental Health Concerns
- ☐ Cardiac Problems
- ☐ Diabetes
- ☐ Other (please specify _____

3. Medical History

A. Any allergies?

- ☐ Yes
- ☐ No

B. Asthmatic?

- ☐ Yes
- ☐ No

C. Any Seizures?

- ☐ Yes
- ☐ No

Nature & Degree

_____

_____

D. Diagnosis of Illness and /or Disability

_____

_____

_____

_____

_____

_____

E. Current Treatment/Medication

_____

_____

_____

_____

_____

4. Examination

5. Immunization:

☐ Attached ☐ Not Attached ☐ Missing

Missing:

_____

_____

_____

6. Hospitalization

☐ Yes ☐ No

If Yes, Explain:

_____

_____

_____

_____

_____

_____

Date: _____

Venue: _____

Reason: _____

Followup:_____

7. Medical Officer Comments/Recommendations:

Appendix 6

St. Mary's Children's Home
EASTERN MAIN ROAD, TACARIGUA, REPUBLIC OF TRINIDAD AND TOBAGO
Tel: 1-868-640-2806 / 6132. Manager: 640-6767. Fax: 1-868-640-6767. E-Mail: smch@tstt.net.tt

TRANSITION FIVE (5) STREAMS PLACEMENT QUESTIONNAIRE

The purpose of this questionnaire is to implement a Five Stream Transition Programme at the St. Mary Children's Home. Know that your participation is crucial for placement. Please be as honest as possible in answering these questions. Thank you for your cooperation.

QUESTIONS

1. What are two (2) goals you have for your life?

A. _____

_____

_____

B. _____

_____

_____

2. Have you identified a career of interest?

☐ Yes ☐ No

If so, what skills/strengths do you currently possess that will help you in that career?

_____

_____

_____

3. List two (2) weaknesses that you would like to develop.

A. _____

_____

B. _____

_____

4. SMCH 5 Streams

5. Which of the aforementioned five streams did you participate in before relocating to St. Mary's Children's Home?

6. Are you interested in any other stream/ area not listed?

☐ Yes ☐ No

Appendix 7

CASE SUMMARY

Preliminary Psychological Diagnosis:

With reference to Safety Plan, briefly indicate the nature and level of the most critical risk factor?

☐ High (Health/ Disease) ☐ Medium (Violent) ☐ Low (Violent)

Appendix 8

ST MARY'S CHILDREN'S HOME
INTERVENTION PLAN

History

Please fill out the history outlined in the handover process by the handing over agency (eg. CATT) in point form.

_____

_____

_____

Assessment Outline

Based on the information given in the assessment of the child's history please outline the current issues that may be affecting the child and the behaviours used to identify these issues.

Intervention Plan

Please outline the method of intervention taken based on the child's presenting issues; the theoretical framework for the approach taken and the intended method of evaluation.

Findings and Advocacy

Please outline any new findings based on the interview and any steps that must be taken to advocate on behalf of the child

Reviewers Comments

The St. Mary's Children's Home is to be applauded for taking the initiative to develop a Model of Care in accordance with the International Convention on the Rights of a Child and best practices in child care and protection. Indeed, the level of detail given to the formulation of the plan showcases the desire of the Board, Administration and staff to provide quality care and a stable foundation for the holistic development of children who are placed at the Home. The research which informed the plan was quite impressive and infers a wealth of knowledge of the theoretic approaches to establish an efficient Model of Care. The reference to previous documents that guided the Home's past operations also augurs well for continuity of programmes and the effective delivery of the Home's services. Altogether, the Model of Care encompassed and addressed several of the wide-ranging issues that impact upon governance of Children's Homes in general, and more specifically, the wellbeing of the children placed under the care of the St. Mary's Children's Home.

Warm regards

Renee Joseph

Attorney at Law