An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 113

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Odyssey Social Care**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**23rd, 24th and 29th of April 2025**
Registration Status:	**Registered from 11th January 2025 to 11th January 2028**
Inspection Team:	**Mark McGuire** **Eileen Woods**
Date Report Issued:	**17th July 2025**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.

The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined. During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 11th of January 2016. At the time of this inspection the centre was in its fourth registration and was in year one of the cycle. The centre was registered without attached conditions from 11th January 2025 to 11th January 2028.

The centre was registered as a dual occupancy service to accommodate young people aged thirteen to seventeen on admission. At the time of inspection, the organisation was in the process of transitioning to a recognised model of care. The delivery of care in the centre was informed by this model, alongside a positive behaviour support framework and a recognised approach to behaviour management. There was one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

The pre-inspection notification identified that standards 2.3, 3.2, and 5.2 would be examined during this process. However, due to the centre's staffing numbers not being in compliance with ACIMS Regulatory Notice on Minimal Staffing Level & Qualifications for Registration in Children's Residential Centres (August 2024), the remit of the inspection was expanded to include an examination of standard 6.1, which was explained to centre and senior management during the inspection process.

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the

centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young person, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 26th of May 2025. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 16th of June 2025. This was deemed unsatisfactory as it did not include the required schedule of works to address the deficits identified during the inspection. In May 2025, the Alternative Care Inspection and Monitoring Service (ACIMS) also wrote to the named registered proprietor seeking clarification regarding staffing deficits. The Chief Executive Officer responded, confirming that the matters identified during the inspection would be fully addressed by June 2025. Following further clarification with centre and senior management, an updated CAPA was received on the 27th of June 2025. This version was deemed to be satisfactory, and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 113, without attached conditions from the 11th of January 2025 to the 11th of January 2028 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 2: Effective Care and Support

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

The centre was a spacious two-storey house situated on an acre of land, featuring an outdoor summer house that could be utilised for recreational purposes. There were two bedrooms designated for young people, ensuring they had their own private space. One of these bedrooms included an en-suite bathroom and a walk-in wardrobe. The young person residing in the centre at the time of the inspection had recently moved into this room. The upstairs office space was equipped with sleep facilities for staff, and there was an additional separate bedroom available for staff use on the first floor along with a bathroom for use by young people.

The ground floor comprised two sitting rooms, a kitchen/dining room with an adjacent small utility room, laundry facilities, and a bathroom. In total, the centre had four bathrooms, including one large bathroom located on the ground floor. Additionally, there was an office downstairs, utilised by centre staff and management.

Inspectors noted that the young person had the opportunity to move to a new bedroom that better met their needs in terms of space, en-suite facilities, and additional storage. However, repairs to the room were not found to have been addressed promptly. Issues such as a damaged door, an unpleasant smell in the en-suite, and moss from recent maintenance work on the floor were observed. Additionally, the removal of door alarms while fire doors were being replaced was not tracked or identified in relevant risk assessments. Window restrictors, noted as a safety measure following an incident, were also not in place on both of the bedroom windows. These matters required better tracking and action by the centre staff and management team.

Inspectors found that the communal spaces were not overly stimulating or enticing for the young person to spend time in. The sitting rooms lacked a variety of recreational items, with minimal games and no televisions or channels for communal viewing. This led to them not meeting their stated purpose and function, which outlined that "both sitting rooms have televisions and are warm and inviting." Although one television was provided during the inspection, it was evident that there was a prolonged period when both rooms were without televisions. The team needed to ensure such matters were promptly identified and addressed. Centre management and the care team noted to inspectors that there had been property damage to the televisions several months ago, and they had not been replaced at the time as they felt they would have been broken again. However, there was a notable reduction in these behaviours in the centre, yet the televisions had still not been promptly replaced. The living room spaces needed to be addressed to make them more homely and inviting for young people.

Both the internal and external areas of the centre required repair and upkeep in terms of painting and decorating. This need was acknowledged by centre and senior management and identified two months prior to the inspection in the service's own audit system. While significant work had been done on fire doors and some windows to comply with fire safety regulations, general upkeep such as cleanliness of the grounds, broken drain covers, cobwebs, damaged furniture and kitchen units, flooring, the front door, and painting needed attention. These issues had persisted for some time, as evidenced by maintenance logs and interviews with staff and management during the inspection. The service's audit from February 2025 also noted their impact on the homely feel of the centre. Despite the recent purchase of the centre property, these matters should have been addressed more promptly, even while renting the premises. A schedule of works needed to be developed to address all remaining issues and improve the homely feel of the centre, as noted by inspectors and the service's own auditor.

Inspectors met informally with the young person in the centre, who mentioned having the opportunity to discuss decorations, though they chose not to engage in these conversations. Inspectors observed some progress in displaying pictures in the centre to help make it feel more homely; however, more could be done in this regard. The young person’s room was observed as bare as not all of their personal items had been moved from their old room to their new room. Inspectors observed that the old room had become dusty from works by maintenance, affecting their personal items. This needed to be addressed without delay by the centre manager to ensure the young

person's remaining items were transferred to their new room and properly looked after.

Inspectors observed that fire extinguishers, emergency lighting, the fire panel, and alarms were all in place and that extinguishers had been recently serviced as part of their annual inspection. However, the register had gaps in terms of relevant checks not being tracked, fire training details not being recorded, and some details of fire drills, such as follow-up for non-participation. Nighttime drills were occurring annually. While there were entries indicating quarterly servicing of the fire system, the accompanying dockets from the company responsible for this were missing and had not been followed up on, despite being noted as a gap in the service audit back in February 2025. Centre management acknowledged this and rectified the issue while inspectors were present, ensuring the relevant certificates of works were now on file.

The centre's fire policy and care team indicated that drills were to be completed monthly, which was not found to be occurring, with gaps noted in the register over a six-month period in 2024. Monthly inspection checks of fire safety equipment had not been recorded by the team since July 2024. Inspectors also observed a fire exit obstructed with a clothes horse and the kitchen fire blanket covered with tea towels, making it difficult to locate. The centre manager addressed these matters while inspectors were present; however, it is important that emergency exits are kept free of obstructions and that the fire blanket is not covered. Overall, inspectors found the care team were unclear on the fire safety policy and required refreshing to ensure they had a thorough understanding of this and to ensure all relevant checks were being carried out routinely in the centre.

There was a personal emergency evacuation plan (PEEP) in place for the young person residing in the centre and inspectors also reviewed the centre-specific safety statement in place which outlined safety measures and some key contact points. However, it was noted by inspectors that the safety statement failed to name the designated fire officer in the centre, and it was also found that staff were unclear on those assigned with additional responsibilities such as the health and safety officer role in the centre. The safety statement should be updated to record those with additional safety responsibilities and then clearly communicated to the team for clarity.

Centre management advised inspectors that half of the team did not have first aid responder (FAR) training in line with their own policy. While a risk assessment for this gap was in the health and safety risk register, it failed to identify control

measures to ensure that there was always a staff member on shift with FAR training to respond to incidents and accidents. Given the nature of behaviours that presented in the centre, this matter needed to be addressed without delay to ensure there was always someone available on shift to respond with first aid in an emergency. This issue had been identified in service audits from the end of 2024 and the beginning of 2025 yet had still not been addressed. Inspectors noted that the monthly governance reports failed to record this risk consistently. Centre management must address the training deficits relating to first aid, ensure there is always a team member on shift with first aid training, and ensure that the monthly governance reports accurately capture and escalate such deficits to senior management for actioning.

Inspectors observed the centre vehicle and noted significant bodywork damage to the front wings, wheel arches, and front bumper. The front bumper was protruding in a hazardous manner, and several other panels on the vehicle's body were also damaged. Additionally, the driver's side wing mirror cover had been broken off and had not been repaired for several months. Both inspectors and staff felt it was inappropriate for a young person to be driven around in a vehicle with such significant damage. The repairs to the vehicle needed to be carried out without further delay and included in the required schedule of works. Staff and management noted that the bodywork damage had been priced some time ago and forwarded to senior management, but no response had been received. The regional manager informed inspectors that there was a plan to switch to fleet cars and assured inspectors there were no funding issues, suggesting the repair quote had "fallen through the cracks" and committed to following up on the matter without further delay.

Inspectors observed that the centre vehicle's tax, insurance, and NCT discs were in place and up to date. However, the main tax and insurance documents in the health and safety folder were outdated and needed to be updated with the current certificates. It was positive to see a RECI (Register of Electrical Contractors of Ireland) certificate on file for electrical testing in the centre and the previously mentioned work on fire doors and windows as a means of escape. Inspectors acknowledged that the centre manager had only been in post for three months and had plans for large-scale upgrades for the centre, such as a tarmacadam driveway, which required time to be fully implemented given her short tenure thus far. However, general repairs and upkeep needed to be addressed more promptly in the centre.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 13** **Regulation 14** **Regulation 15**
Regulation not met	**Regulation 8**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 2.3**

Actions required

- Centre management must ensure communal spaces are equipped and maintained to make them warm and inviting, replacing televisions in the sitting rooms and ensure they are maintained in line with their stated purpose and function.
- Centre management must address the training deficits relating to first aid, ensuring there is always a team member on shift with first aid training. They must update the health and safety risk register to include control measures for first aid coverage.
- Centre management must ensure repairs and maintenance are addressed promptly. They must ensure window restrictors, as part of safety plans, are in place on both bedroom windows and develop a schedule of works to address general upkeep issues.
- The registered provider must ensure the centre vehicle is maintained to a higher standard by carrying out repairs to the vehicle's bodywork. They must include vehicle repairs in the required schedule of works.
- Centre management must ensure the young person's personal items are transferred to their new room and properly looked after.
- Centre management must ensure staff are recording monthly fire drills and inspection checks of fire safety equipment, keeping emergency exits free of obstructions, and ensuring the fire blanket is not covered.
- Centre management must refresh the care team on the fire safety policy to ensure thorough understanding and routine checks. They must update the safety statement to include the designated fire officer and other staff with additional safety responsibilities and clearly communicate this to the team.

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

Inspectors observed that several policies were in place to support behaviour management, including the risk management policy, management of substance abuse, safety and social media, child protection, promoting positive behaviour management, and managing absences. However, during interviews, staff did not demonstrate a clear understanding of these policies. It was recommended that these policies be reviewed and refreshed. Inspectors found that staff could not always recall the policies and guidance when working and responding to young people's behaviours that challenge with staff indicating to inspectors that they "just know what to do," rather than following relevant policies and intervention plans. It is important that interventions are planned, agreed upon, and monitored and guided by management and the multidisciplinary team (MDT).

The team spoke of how the recognised model of care was being used to support their understanding of the young person through a trauma lens and assist in their development in several areas, such as placement planning. However, it was acknowledged that the implementation of this model was in its infancy and would take some time to be fully embedded within the team. Support sessions and training with a consultant from the recognised model of care programme were occurring, and the model's development would be better assessed at a future time. At the time of inspection, staff noted to inspectors that they did not fully understand the model. It will be important for management to support the implementation of this model in their care systems and its development within the staff team. The team were also trained in a recognised behaviour management model, which supported the overall approach to positive behaviour management in the centre.

Inspectors reviewed the training log and noted that, aside from gaps in mandatory training already mentioned in this report, a wide variety of additional training was offered to the care team to support them with the knowledge and skills appropriate to their role and to understand underlying issues for young people in the centre. The team members who took part in interviews with inspectors spoke positively of the training opportunities afforded to them. It was evident that additional training on

suicide awareness, positive behaviour support, online safety, and childhood sexual exploitation had been carried out with most of the team, assisting them in supporting the young person and responding to their specific needs.

Inspectors observed that there were several supports in place for the young person in the centre, including input from an occupational therapist (OT), the service's own positive behaviour support (PBS) team, the Tusla Assessment Consultation Therapy Service (ACTS), and an MDT of social work and Guardian ad Litem (GAL). The care team could also access and communicate with these services for additional support and advice, with training having been provided in the past by ACTS to the team. However, the young person's social worker noted to inspectors that with recent changes in staff and management, they felt there was a need to refresh some of this training with the care team as a majority would not have received the initial training when delivered.

It was clear to inspectors that significant efforts were being made to help the young person improve in various aspects of their life, and the recent reduction in significant event notifications (SENs) and property damage was a positive development. Inspectors also saw records that showed how the PBS team had determined that the young person had made significant progress. The young person was beginning to build relationships in the community with peers and through supervised attendance at the gym. However, inspectors saw occasions in the care records where staff were not supervising the young person in the gym in line with safety plans agreed with social work. Centre management must ensure that supervision occurs as planned to maintain the young person's safety. The young person spoke positively about this recreational time and the benefits it brought to them when speaking with inspectors.

An Individual Crisis Support Plan (ICSP), Absence Management Plan (AMP), and individual therapy plan were on file to guide staff when working with the young person. Inspectors noted that the AMP required updating to reflect the arrangements for their personal free time, where supervision responsibility was shared with a peer's parent, yet had not been formally agreed upon. The ICSP was found to have a large focus on restraints as safety concerns and could benefit from a more balanced approach, by better including matters such as self-injury/self-harm, and the risks identified regarding free time. The young person had a peer with whom they spent regular time, and despite a significant age gap between these two young people, inspectors did not see relevant risks appropriately assessed and responded to. Given the already identified risks for the young person and the naturally occurring risks associated with teenage development, inspectors advised that this be thoroughly

reviewed with their MDT and appropriate adjustments made to relevant support plans.

Staff were found to be unclear on the AMP and when they should report the young person as Missing Child from Care (MCFC). Additionally, the document failed to capture their arrangements with the previously mentioned peer and the relevant contact/address details, which are essential for providing to An Garda Síochána during MCFC incidents. Centre management agreed to follow up on this to ensure the AMP appropriately captured the young person's absence protocols and points of contact more accurately, as well as ensuring the care team were clear on when to report the young person as MCFC. The centre manager advised inspectors that this had been addressed post-inspection and distributed to the MDT for approval and sign-off.

Evidence was seen of Life Space Interviews (LSIs) and key working being carried out to help the young person identify underlying causes of behaviour and develop coping strategies following incidents. Inspectors noted that the SENs on file had been reported to relevant parties within the accepted timeframe; however, several incidents where SENs were not submitted when required were brought to centre management's attention for follow-up. Good commentary was seen in the SENs available from centre management, and cross-referencing to LSIs and key working was being identified as a follow-up to incidents. The SEN log needed more robust oversight to capture better details. For example, all physical interventions from a recent SEN were not captured, and centre management must ensure the accuracy of such records.

Auditing was taking place in various areas, and behaviour management was captured in a wider themed audit in February 2025 by the service's own auditor and in a separate quality assurance audit in late 2024. Inspectors advised against stating that all actions were completed in audits when issues such as outstanding FAR training remained an issue requiring a response.

Significant Event Review Groups (SERGs) were taking place with good attendance from senior management, members of the PBS team, and the service's trainer of the recognised behaviour management model. However, inspectors noted that the accuracy of events was not always captured in SERGs, with a notable physical intervention being omitted from the associated SERG for one SEN. Centre management needed to ensure that an accurate account of SENs and physical interventions was brought to SERGs for review and learning.

Several restrictive practices were observed in place, such as door alarms, window restrictors, and the removal of cutlery and breakable kitchen items like plates, bowls, and cups. Inspectors observed that, given the noted reduction in SENs and property damage over several months, the latter restrictive practice required review to ensure its continued necessity. The recording template for restrictive practices did not capture the full detail of review conversations and was more appropriate for capturing Individual Risk Assessments (IRAs). For example, the ongoing review details of the breakable items in the kitchen were not visible in the templates. The restrictive practice for the door alarm was not updated to inform staff that it was not on the young person's bedroom door at the time of inspection. One restrictive practice required the addition of window restrictors as a safety measure following an incident, and inspectors found that this had not been installed on both windows. Centre management and staff were unaware of this oversight, leading to a notable safety concern. Centre management addressed the issue with the window restrictor immediately on the day of inspection.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- Centre management must ensure that all staff have a clear understanding of the policies supporting behaviour management to ensure staff are able to recall and apply them when responding to young people's behaviours that challenge.
- Centre management must ensure that supervision of the young person occurs as planned. The Individual Crisis Support Plan (ICSP), Absence Management Plan (AMP), and individual therapy plan must be updated and accurately reflect all of the young person's needs and arrangements.

- Centre management must review and ensure the accuracy of Significant Event Notifications (SENs) and the SEN register. All physical interventions and incidents must be captured accurately, and robust oversight must be maintained.
- Centre management must review the necessity of restrictive practices being used in the centre and the recording template for restrictive practices needs to be updated to capture review details accurately.

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

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The centre manager had taken up post in January 2025 and was supported by a newly appointed deputy centre manager, with both working a nine-to-five, Monday to Friday routine in the centre. Everyone inspectors spoke with expressed positive views about the newly appointed centre manager and their supportive working style. Care team members also noted the positive impact of the regional manager when they stepped in to support as centre manager during a gap late in 2024. Staff mentioned that the regional manager's leadership appeared to have a positive effect in terms of establishing boundaries and beginning to address previous deficits such as handover processes and young person engagement.

The team were found to be clear on the management structure and noted that they felt the senior management team was accessible to them. While the care team stated they had received job descriptions outlining their roles and responsibilities, some deficits were observed in their understanding of these, particularly those with additional health and safety responsibilities previously mentioned and the importance of following and responding to young people in line with agreed behaviour management plans such as their ICSPs and AMPs. It was important to ensure that interventions and key working with young people were guided by relevant persons and overseen by management, especially when sensitive topics relating to past trauma were being discussed. This matter was brought to the attention of centre management and the social worker for the young person, with the latter

acknowledging this point and agreeing to bring recent key work to the MDT for review and guidance.

Inspectors were advised that a service level agreement (SLA) was in place with key performance indicators (KPIs) provided to the Tusla National Placement Team (NPT) to demonstrate compliance with relevant legislation and standards, which included service audits, progress reports, and inspection reports. As previously mentioned, the service also had its own auditor, and a full themed audit had taken place in February 2025 along with regional manager audits on specific areas such as child protection. While staff voiced to inspectors that they were aware audits took place, they were unclear on the findings from these. It would be beneficial to ensure that staff and management were clear on the audit schedule and methodology and that findings were routinely brought back to the team for learning.

Service audits were found to capture good detail and follow up on previous actions to ensure their completion. However, as noted earlier in this report, some items from the recent service audit in February 2025 were still outstanding regarding maintenance. The health and safety audits, while capturing a lot in terms of health and safety matters, did not always capture details such as those gaps in FAR training and failed to capture the condition of the centre vehicle. A similar issue was noted for governance reports – while capturing young person details and incidents relatively well, they did not always emphasise the centre's needs regarding staffing and FAR training, with one report stating all mandatory training was completed. Centre management must ensure monthly governance reports capture all deficits accurately so that they are escalated for action to senior management.

Centre policies were developed and reviewed by the senior management team bi-annually or when legislative changes occurred. Despite gaps in staff knowledge regarding policies, inspectors noted that policy discussions were taking place in team meetings.

Inspectors found the risk management framework required clarification, with two risk matrices in operation. The team lacked clarity on the risk management policy, necessitating a refresh. SENs and IRAs had differing risk ratings, making it difficult to categorise 'low, medium, and high' ratings. Some risks were rated as 'low' despite evidence to the contrary, with high response control measures such as window restrictors in place. Inspectors advised a review of the risk assessments, as some contained outdated details of previous staff, management, and interventions due to the reactivation of historical risk assessments for current risks. This led to confusing

guidance on staff intervention, such as the mistaken interpretation that night checks should be in operation when they are not. Centre management acknowledged this oversight and committed to rectifying the matter post inspection.

The health and safety risk assessment register noted that all staff had first aid training in the first aid/accident management risk assessment. However, there was a separate and conflicting risk assessment noting that this was not the case with associated contingency plans. Lone working standalone risk assessments and how this was captured in the risk register did not mitigate the issue of staff deficits leading to one staff member on shift. These risk assessments were for temporary lone working and protocols in the normal routine of work, such as contacting another staff member every thirty minutes for check ins. The risk assessment for assault and allegations noted both 2:1 staffing and the importance of other staff on shift for support, and it was a regulatory expectation that two staff were to be on shift at minimum. This point will be expanded further under standard 6.1 in this report.

A delegation list was in place, and the team was clear on who would step in when centre management was absent, with it being a notable positive that a deputy social care manager was now in place and establishing in the role. Overall, it was clear that the new centre manager was identifying areas for improvement and required further time and support to implement all the changes and improvements needed following a difficult end to 2024. It was important that oversight of all systems, such as IRAs, key work, staffing, training and property matters, remained a key focus moving forward.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- Centre management must ensure that all staff understand their roles and responsibilities, particularly those with additional health and safety responsibilities. Interventions and key working with young people must be guided by relevant persons and overseen by management, especially when discussing sensitive topics related to past trauma.
- Centre management must ensure that staff and management are clear on the audit process, and that findings are routinely brought back to the team for learning. Monthly governance reports must capture all deficits accurately so that they are escalated for action to senior management.
- Centre management must review and refresh the risk management framework to ensure clarity and consistency. Risk assessments must be updated to reflect current staff, management, and interventions, and must accurately categorise risk ratings.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

At the time of inspection, the centre was registered as dual occupancy and required eight staff in accordance with the ACIMS Regulatory Notice on Minimal Staffing Level & Qualifications for Registration in Children's Residential Centres (August 2024). However, only six staff members were available to centre management, leading to significant rostering difficulties. Due to the impact on the young person and the effective running of the centre, inspectors expanded the initial inspection scope to cover standard 6.1 of the National Standards for Children's Residential Centres (HIQA, 2018).

Inspectors reviewed a sample of rotas for the previous two months, which showed staffing deficits requiring the use of agency personnel on multiple occasions. Despite attempts by the service to use consistent agency personnel, the use of agency staff led to notable difficulties in maintaining a consistent approach, which was also observed and flagged by the young person's social worker. For example, rules such as handing up phones at night were not always adhered to when agency personnel were on shift.

Inspectors noted that on thirteen occasions over the past two months, staff had completed double shifts (48-hour cover), with one relief member routinely doing this on Sundays and Mondays. On other occasions, full-time team members carried out double shifts and a third shift in the week, without risk assessments in place despite previous advice from ACIMS management regarding this in January 2025. While there was a specific risk assessment for the relief member's routine back-to-back shifts and one for the issue of double shifts as a whole, it was intended for emergency cover, yet the relief member's shifts were planned weekly rather than for emergencies. It was unclear why alternative options were not sought, and the implementation of planned and scheduled back-to-back shifts must cease.

On two occasions, staff members were alone on shift with the young person in the centre without a supporting staff member. This was unacceptable, and lone working risk assessments did not negate the centre's obligation to have a minimum of two staff on shift. The duration and circumstances exceeded the argument of an emergency timeframe, with one instance lasting nine hours and the other four hours when the centre and deputy centre manager left at 4 pm, leaving the staff member alone until 8 pm. The centre's on-call policy outlined that on-call management should go into the house if there was inadequate staffing, yet this did not happen.

Inspectors informed centre and senior management that the practice of double shifts needed to cease unless in an emergency situation where all other options had been exhausted, and if so, up-to-date risk assessments must be in place.

Inspectors also saw that supervision of staff had not been occurring frequently in line with the centres supervision policy, although the new centre manager had an initial session with all staff and was working to address this. More time would be needed for the manager to implement the planned schedule to ensure regular and consistent supervision.

Despite these deficits, it must be acknowledged that there was evidence of extensive workforce planning and the organisation's efforts regarding recruitment, with innovative plans implemented internationally. Inspectors were also provided with details of several new staff members awaiting vetting clearance before taking up posts in the centre. The registered proprietor must inform the ACIMS when they have a full staff complement in place and outline how they will address the deficits in staff in the interim.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 6.1**

Actions required

- Centre management must ensure staffing levels meet the requirements set by the ACIMS Regulatory Notice addressing rostering difficulties and maintaining a minimum of eight staff members.
- Centre management must cease planned and scheduled back-to-back shifts and ensure a minimum of two staff members are on shift at all times. A review of the on-call procedure is needed also to ensure appropriate management response in the absence of adequate staffing.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	Centre management must ensure communal spaces are equipped and maintained to make them warm and inviting, replacing televisions in the sitting rooms and ensure they are maintained in line with their stated purpose and function.	Centre management has ensured communal spaces are equipped and maintained to make them warm and inviting by replacing televisions in the sitting rooms and including additional fixtures such as soft furnishings, this was completed on 06.06.25.	Centre management will monitor and report on going/required maintenance and repairs as part of monthly service governance reports and further in the monthly health and safety audit. Regional management will complete the service governance log as part of their monthly unit visit which will provide further oversight on reporting maintenance pieces. During regional manager house visits, both centre management and regional management will complete a walk around of the house to review the condition and functionality of all communal spaces inclusive of furniture, TVs, décor and general atmosphere. Further to this, the internal quality auditor will include environmental elements/maintenance pieces as part of their service audits.

			Any tasks connected to maintenance work needed will be reported to the maintenance manager weekly or sooner if needed.
	Centre management must address the training deficits relating to first aid, ensuring there is always a team member on shift with first aid training. They must update the health and safety risk register to include control measures for first aid coverage.	Centre management has ensured that all staff with outstanding first aid training have been added to the training dates for June 18th and 19th 2025. Once completed all staff working in the centre will have completed first aid training. The daily health and safety risk register has been updated by centre management on 25th of April 2025 to include control measures for first aid coverage; this includes ensuring a member of staff with first aid training is always on shift within the centre.	The organisation is in the process of rolling out basic first aid training to all staff members with the first session on 12th of June 2025. This will ensure that all staff including new starters will be trained in basic first aid until they complete first aid responder training. Regional management and centre management will have further oversight within the monthly training reviews, service governance and health and safety reports as to what first aid training is needed for individual staff and escalate any areas of need. The internal quality auditor will complete service audits and staff training needs will be included to ensure another layer of oversight.

	Centre management must ensure repairs and maintenance are addressed promptly. They must ensure window restrictors, as part of safety plans, are in place on both bedroom windows and develop a schedule of works to address general upkeep issues.	The window restrictor was added on day of inspection 23.04.25. Centre management have completed a full audit of current repairs and maintenance needs both internal and external to the property on 12.05.25 and ordered a full schedule of works from the maintenance department, received on 12.06.25 with all outstanding issues to be resolved by the end of July 2025. Further to this, the organisation has also hired additional maintenance personnel to support the prompt and efficient response to maintenance/repair requests.	The centre manager will complete a monthly premises walk through with the regional manager in order to identify maintenance needs early. Any urgent or outstanding maintenance needs will be discussed within the weekly centre manager/regional manager meeting. The centre manager will continue to monitor and report ongoing/required maintenance and repairs as part of monthly service governance reports and further in monthly health and safety audits. The centre manager will ensure that the maintenance log is kept up to date in real time and reviewed on a weekly basis to track outstanding/completed works and circulate to regional manager for review. The regional manager will bring any deficits in maintenance work to the monthly quality meetings including any health and safety concerns identified.

	The registered provider must ensure the centre vehicle is maintained to a higher standard by carrying out repairs to the vehicle's bodywork. They must include vehicle repairs in the required schedule of works.	The centre manager booked the centre car for full vehicle check and repairs on 10.06.25, and the second centre car will be used as the main vehicle. Further to this, a new centre vehicle has been approved for purchase. To allow the maintenance manager to source this the aim will be to have this car in place from the end of June 2025.	The centre manager will ensure that vehicle maintenance needs will continue to be included in the service governance reports. Any car damage will be recorded in the weekly car check; this is reviewed weekly by centre management to ensure any car maintenance needs are promptly identified and addressed. The centre manager will complete a daily walk around of the house/grounds and these checks will be inclusive of centre cars. Centre vehicles are also to be included in the quality auditors service audits for another layer of oversight. Any car needs will be escalated by regional management within monthly quality meetings and senior leadership team meetings, and any issues rectified in a timely manner.
	Centre management must ensure the young person's personal items are transferred to their new room and	Centre manager has ensured that remaining items from the young person's previous bedroom have been moved to	Regional management oversight will be provided through service governance support logs as part of their monthly unit

	properly looked after.	new room as of 08.05.25. Any potential/future moves will be carried out with an accompanying time framed plan. A key working session will be completed with young people should they refuse to allow the team to move remaining items from their previous bedroom and protective coverings/ storage options will be implemented in the interim. Centre management also discussed this at the team meeting on 20.06.2025.	visits. This will ensure that in any instances of young people moving bedroom that prompt planning is put in place and completed.
	Centre management must ensure staff are recording monthly fire drills and inspection checks of fire safety equipment, keeping emergency exits free of obstructions, and ensuring the fire blanket is not covered.	The centre manager completed full review of current fire safety practices, policies and procedures with the staff team as part of the team meeting on 23.05.25 to ensure that importance and understanding of same by all team members has been reemphasised. They have ensured all emergency exits and fire blankets are free of obstructions.	In line with policy on fire safety and prevention - fire drills take place every quarter however, when there is a fire risk in the house a risk assessment will be completed, and frequency of drills will be determined by the risk assessment. A refresher training session on fire safety procedures will be delivered to all staff on the 30.06.25 by the organisational training manager The regional manager will also ensure

			accurate recording as part of their quarterly health and safety audit for additional oversight regarding fire safety related pieces and ensure all emergency exits are free of obstructions. Additionally, the quality auditor will also review health and safety procedures as part of their service audits.
	Centre management must refresh the care team on the fire safety policy to ensure thorough understanding and routine checks. They must update the safety statement to include the designated fire officer and other staff with additional safety responsibilities and clearly communicate this to the team.	Centre management have booked a refresher training for the full team which will be delivered on 26.06.25. The session will cover emergency responses and procedures, evacuation protocols, and the importance of routine checks and documentation of same. The safety statement has been updated by centre management to ensure all designated staff with additional safety related responsibilities are clearly documented. This has been communicated to the staff team as part of the team meeting on 23.04.25.	The regional manager and the quality auditor will review the safety statement as part of their own audits to ensure robust oversight is maintained and that the document is always kept up to date, this will also capture the teams understanding of designated roles within the centre.
3	Centre management must ensure that all staff have a clear understanding of	Centre management will complete a refresher of all behaviour management	The regional manager will ensure the behavioural management policy and

	the policies supporting behaviour management to ensure staff are able to recall and apply them when responding to young people's behaviours that challenge.	related policies with the team as part of the team meeting on 20.06.25 to ensure they are responding to behaviours in line with policy guidance. The senior leadership team have also completed a full review of all training on 28.05.25 inclusive of risks management, report writing and behaviour support in conjunction with the integrated care services department. Dates are scheduled for July 2nd, 14th and 21st 2025 for the full staff team to attend these trainings.	procedures, along with behaviour support plans are being adhered to as part of their service governance support visits and reviewing relevant registers. Further to this, the quality auditor will also capture the adherence to behaviour management policies and use of language as part of their themed centre audits.
	Centre management must ensure that supervision of the young person occurs as planned. The Individual Crisis Support Plan (ICSP), Absence Management Plan (AMP), and individual therapy plan must be updated and accurately reflect all of the young person's needs and arrangements.	The centre manager has completed a full review and update of all relevant documentation, which has been circulated to the social work department following inspection for their review and approval on 30.04.25. All staff have been updated on the revised documents and plans during a dedicated handover piece on 01.05.25 held by centre management.	Centre management will review working documents at least once a month or as needed- these reports will be sent to the social work department monthly, as part of the monthly packs for further review and input. As part of the service audit the quality auditor will review young person's plans and communicate any changes needed to the centre and regional manager.

	Centre management must review and ensure the accuracy of Significant Event Notifications (SENs) and the SEN register. All physical interventions and incidents must be captured accurately, and robust oversight must be maintained.	The centre manager has conducted a full review of the SEN register and all recent SENs on 30.04.25, ensuring all physical interventions and incidents are clearly and accurately documented in line with regulatory requirements. Any inaccuracies have been rectified.	The internal SEN process will be maintained where all SENs are reviewed by centre management and regional manager within 24 hours of occurrence, (or nearest day following the weekend where an SEN has occurred). This includes ensuring consistency between documents, reports, physical interventions and the SEN register. The regional manager and quality auditor will also review house registers during visits to the centre, which will ensure that that they accurately capture any and all instances of physical interventions and SEN details.
	Centre management must review the necessity of restrictive practices being used in the centre and the recording template for restrictive practices needs to be updated to capture review details accurately.	The centre manager has completed a full review of necessity of restrictive practices in place on 01.05.25 and updated the recording template for this to ensure review details are captured accurately.	Restrictive practice will continue to be documented within the monthly service governance report and reviewed by centre and regional management. The regional manager will also review any and all current restrictive practices in place for the young person through observations as part of monthly visits and reviewing this as part of service governance support logs.

			They will also ensure review details are accurately captured.
5	Centre management must ensure that all staff understand their roles and responsibilities, particularly those with additional health and safety responsibilities. Interventions and key working with young people must be guided by relevant persons and overseen by management, especially when discussing sensitive topics related to past trauma.	Centre management carried out a full discussion and clarification of additional roles and responsibilities at the team meeting on 23.05.25. The integrated care services department have developed a full training programme on child development, attachment styles and trauma – centre management has booked the team in to attend this on the 2nd, 14th and 21st of July 2025 and will also review centre practice to ensure guidance by relevant persons, especially when discussing sensitive topics relating to past traumas.	The centre manager will review key-working sessions weekly to ensure topics discussed with the young person are accurately delivered in line with guidance by relevant persons. The regional manager will ensure thorough oversight of integrated care services department involvement by reviewing samples of key working and discussions as part of their monthly service governance support visits. The regional manager will communicate any additional needs to the services integrative care team regarding guidance for the team/keyworkers as needed.
	Centre management must ensure that staff and management are clear on the audit process, and that findings are routinely brought back to the team for learning. Monthly governance reports must capture all deficits accurately so	A full refresher session was completed on the centres internal auditing processes with the full team by centre management as part of the team meeting on 23.05.25, including the purpose and function of internal and external auditing, how	Centre manager will ensure that monthly team meetings will now include a standing agenda item for discussing any recent audit findings with the wider team. The centre manager will ensure that service governance reports continue to be

	that they are escalated for action to senior management.	findings should be used as learning tools, how to record and communicate audit findings and how to action any findings from same.	regularly updated throughout the month to ensure clear capturing of any noted deficits and assigned actions to same. The regional manager will have oversight in this area and note any deficits within the centre within the action section of the service governance log and in service governance reports. The quality auditor will review service governance reports as part of their service audit and action any improvements needed in recording of deficits in the centre.
	Centre management must review and refresh the risk management framework to ensure clarity and consistency. Risk assessments must be updated to reflect current staff, management, and interventions, and must accurately categorise risk ratings.	Centre management has completed a full review of the current risk management framework on 07.05.25, ensuring all individual and environmental risk assessments are up to date, confirming that risk ratings are consistent with the organisations risk matrix and ensuring that assessments reflect the current staffing arrangements, management structure and all relevant interventions in place.	The current practice in place of monthly risk reviews will be maintained and overseen by centre management, risk assessments will continue to be included as part of monthly governance reports for regional manager review. A further review of risks within the centre will be completed by the regional manager within monthly centre visits. Centre risks are also reviewed monthly within the quality, practice and safety

		Any discrepancies or outdated elements have been amended; updated risk assessments were then shared with the wider staff team to ensure familiarity and consistency in understanding of same.	committee meetings. Any learnings from this will be communicated to the centre manager by the regional manager who will be in attendance.
6	Centre management must ensure staffing levels meet the requirements set by the ACIMS Regulatory Notice addressing rostering difficulties and maintaining a minimum of eight staff members.	Centre manager has completed a comprehensive roster review for the upcoming three-month period to support proactive planning and address any potential shortfalls. The daily staffing requirement is two team members per shift to meet the needs of the young person. The revised roster ensures that at least one permanent staff member is present on each shift along with another permanent, relief or agency staff member to maintain consistency of care.	The organisation continues to recruit for the centre. The aim will be to have additional staff on the team to mitigate any gaps where staff may leave. There at three permanent contracts currently pending for the centre, with all three staff members scheduled to commence on 20 June 2025 following completion of training. These additions will bring the centre into full staffing compliance which was communicated to ACIMS management by the organisation. As a temporary support measure, the deputy manager will provide on-floor coverage where necessary. Recruitment efforts will remain ongoing to ensure consistent and secure staffing levels and to proactively address any future shortfalls as outlined by senior

			management in their letter to ACIMS management on 29.05.25.
	Centre management must cease planned and scheduled back-to-back shifts and ensure a minimum of two staff members are on shift at all times. A review of the on-call procedure is needed also to ensure appropriate management response in the absence of adequate staffing.	Effective immediately, all planned or scheduled back-to-back shifts have been ceased as outlined to ACIMS management on 29.05.25. Rosters are shared with the regional manager on a weekly basis to support with rostering needs while awaiting new starters going through the recruitment process. In the event of unplanned absences such as sick leave, agency and relief staff will be deployed immediately to prevent any recurrence of single cover or double shifts. The on-call policy has been revised by the head of residential care to ensure that the designated on-call personnel are available to attend the centre in person, rather than providing phone support only, should agency or relief staff be unavailable.	Senior management have written to ACIMS management on 29.05.25 outlining that back-to-back shifts have ceased. A weekly review process has been put in place to monitor and address any emerging gaps in the rota to ensure there are two staff members on shift at all times. Weekly reports are provided to regional management to ensure there is no further use of back-to-back shifts. Where gaps are identified in the rota relief or agency staff will be used to cover absences. A live staffing tracker will be maintained by recruitment in conjunction with senior and centre management to monitor current coverage in real time and allow early intervention should cover drop below the required level.