An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 132

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Daffodil Care Service**
Registered Capacity:	**Four Young People**
Type of Inspection:	**CAPA Review**
Date of inspection:	**27th January 2025**
Registration Status:	**Registered from the 20th November 2023 to the 20th November 2026**
Inspection Team:	**Joanne Cogley**
Date Report Issued:	**11th March 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 a corrective actions and preventative actions (CAPA) review 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 20th of November 2017. At the time of this CAPA review the centre was in its third registration and was in year two of the cycle. The centre was registered without attached conditions from 20th November 2023 to the 20th November 2026.

The centre was registered as a multi-occupancy centre to provide medium to long term care for four young people aged thirteen to seventeen years on admission. The centre's model of care was based on a systemic therapeutic engagement model (STEM) and provided a framework for positive interventions. STEM draws on a number of complementary philosophies and approaches including circle of courage, response ability pathways, therapeutic crisis intervention and daily life events. There were two young people in residence at the time of the CAPA review a referral for a third young person was in process.

1.2 Methodology

The inspector examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated 4th & 5th September 2023. The inspector reviewed documentation sent by the provider via email and conducted a visit to the centre on the 27th January 2025 specifically to review compliance with standard 2.3. During the visit, the inspector provided opportunities for young people to meet with the inspector. Interviews were conducted via MS Teams on the 28th January 2025 with the centre manager and two social care staff.

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 17th February 2025. The findings of the CAPA review were used to inform the registration decision.

The findings of this CAPA review have determined the centre to have substantially implemented the required actions and therefore 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 132: without attached conditions from the 20th November 2023 to the 20th November 2026 pursuant to Part VIII, and 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care practices and operations 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.

Issue Requiring Action:

- The registered provider must ensure that a plan is provided regarding the ongoing effective maintenance of the centre by suitably qualified persons.
- The regional manager must ensure that monthly health and safety audits are fit for purpose and adequately identify all issues.
- The centre manager must ensure that fire doors are checked and maintained in working order at all times.
- The registered provider must ensure that the scorched couch is replaced.
- The centre manager must ensure full details of fire drills are recorded and a drill under the cover of darkness take place.
- The centre manager must ensure that mandatory training is completed by all team members as soon as is reasonably possible and certificate kept up to date.

Corrective Actions:

- A blended maintenance response is being finalised comprising of 2 full-time maintenance staff plus an external property management company who will provide a dedicated regional response to maintenance requirements. This will be implemented from December 2023.
- Monthly health and safety audits will be reviewed by centre manager monthly, and a walk around completed by the manager before sign-off to ensure all health and safety issues have been adequately identified. Feedback and direction will be provided to staff responsible for completing audits. The regional manager will complete a health and safety senior management themed audit in October 2023. The regional manager will complete walk-

around of the centre and document any findings in monthly governance reports and communicate them to the centre manager.

- The two fire doors which required attention have been repaired and are in full working order as of 15.09.23. New checklist in place specifically for fire doors to ensure that they are reviewed correctly. This will be communicated with team in team meeting 19.10.23.
- The couch has been removed and a new couch ordered – due to be delivered on 20.10.2023. Feedback and direction will be provided to staff responsible for completing audits.
- Fire drill in darkness took place on 12.10.2023 at 21.00 and recorded as such in the fire register. Fire drills under cover of darkness are planned and in diary for future dates. The team will be reminded that all details including times to be recorded at the team meeting on 19.10.2023. A review of the fire drill form is being completed by the quality assurance manager to ensure more transparent information is recorded. This will be completed and circulated by 25.10.2023.
- A full review of training was completed by the centre manager on 28.09.23. All staff have been booked onto required training.

Review Findings:

The inspector visited the house to review compliance with the findings and actions from the previous inspection. On the day, the house was clean, well presented, warm and homely. The Inspector saw two bedrooms that were prepared for any new young people moving to the centre and one staff bedroom. The sitting room and kitchen were well maintained and the suite of furniture in the sitting room had been replaced since the previous inspection. The garage area had also been converted since the last inspection and was now an additional space for the young people with boxing bag, gym equipment, pool table, sofas and television.

The centre now had its own dedicated regional maintenance team. The centre manager reported that maintenance was being dealt with in a timely manner with maintenance being available to the centre almost weekly. There were some outstanding issues that were reliant on external contractors. The inspector reviewed maintenance records and found on the whole issues were being rectified in a timely manner. However, on the 24th November 2024 there was an issue identified in the maintenance record that noted a leak in the sitting room ceiling and coming from the light fitting. Maintenance response to this was that they checked the roof, and it needed to be replaced but it only leaks in extreme weather. No further action was

noted on this. Whilst the centre manager continued to highlight this in their monthly health and safety audit, the regional manager listed it as an outstanding issue in their own monthly audit report in November but there was no evidence of them following up with assigned responsibilities or timeframes. On the day of the visit the inspector requested an electrician be contacted as a matter of priority to assess the electrics to ensure there were no immediate health & safety or fire safety concerns. The inspector received email correspondence on the 14th February 2025 showing adequate action had been taken.

The inspector reviewed the fire register and found that there was clear guidance on file to show staff the correct procedures for checking all fire doors were in proper working order. All fire door checks had been completed appropriately and all fire doors in house on the day of the visit were operating properly. Fire drills were also occurring, and the records had been updated to include the time the drill occurred. Eight drills had occurred in 2024 with two under darkness and there was evidence to show drills occurred in line with policy i.e., where new staff started, or new young people moved in.

As outlined in the CAPA response an audit had been completed by the regional manager in October 2023 however none had occurred since that date. In addition to this, both the health & safety records and fire safety records had a cover sheet that was to be signed by senior management when files were reviewed. There was no evidence to show the written fire records had been reviewed since 23rd March 2023 (22 months) and no evidence to show the written health & safety records had been reviewed since 27th August 2024 (5 months). In continuing to strengthen compliance with governance the regional manager must ensure they demonstrate adequate oversight by utilising the systems in place.

The inspector reviewed mandatory training records. Eight staff members had started in 2024 and on average it took three months for training to be provided in a recognised model of behaviour management with some staff falling on the higher than average at five and six months. All staff had completed fire safety and manual handling training. Four staff were yet to receive any first aid training and were booked onto a course on the 11th March 2025. One staff who started in December 2024 was yet to complete any training, including child protection.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **Regulation 17**
Regulation not met	**None Identified**

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

Regulation 5: Care practices and operational policies

Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Issue Requiring Action:

- The regional manager must ensure that those responsible for risk management understand and apply appropriate risk ratings to areas of concern.
- The regional manager must ensure that a clear plan to support the knowledge of the team and accurate implementation of the complaint policy and procedure is developed.
- The centre manager must ensure that all documents are signed and dated in a timely manner and without undue delay.
- The registered provider must ensure that the arrangements in place to assess the safety and quality of care provided against the National Standards are robust alongside effective mechanisms for sharing learning across the organisation.

Corrective Actions:

- The risk matrix was discussed at the team meeting on 05.10.23 and 21.09.23. Risk will be discussed in supervisions with all staff members.
- The quality assurance manager will attend the team meeting on 02.11.23 and review the complaint policy and procedure with the team and answer any questions. A complaint audit will be completed by regional manager in November 2023, which will include staff interviews on the complaint policy and procedure. Feedback will be provided to the centre management team and action plan developed. Staff members will be reminded of the complaints learning resource available.
- A review of all files was completed by the centre manager on 05.10.23 and all outstanding documents signed and dated.
- Safety and quality of care will be assessed in senior management audits completed quarterly along with their monthly governance report. Feedback to the organisation, which require a change in policy, procedures or practice is discussed at senior management meetings, formulated, completed and communicated to all centres.

Review Findings:

The inspector reviewed the risk management policy and found it outlined a clear and concise framework that consisted of a matrix for assessing and scoring risk. Two staff members were interviewed, both were clear in their understanding of the risk management framework and provided examples of how it applied in practice. The regional manager had conducted two risk management audits, one in March 2024 and one in August 2024. These audits included interviews with staff members to assess their knowledge of the risk management framework. Areas of partial compliance were identified during these audits and actions implemented to correct any deficits identified. Three team meetings occurred between September 2023 and June 2024, in which the risk management framework was discussed with the staff team. These discussions included the risk matrix, how to score assessments, how to identify risk and the importance of reviewing risk with newer staff members.

The complaints policy had been updated in November 2024 and rolled out throughout the organisation. This new policy removed the ambiguity around 'formal' and 'informal' complaints. It identified a complaint as a complaint and then outlined the different stages of response that could be utilised to reach an outcome. One complaint had occurred in the centre since the new system was rolled out. The inspector reviewed this complaint and found it had been recorded and reported in

line with the new policy. Two staff members were interviewed, both were clear on the new complaint procedure and how to respond to any complaints raised by young people. There was some confusion around who the complaints officer was for the organisation and this should be revisited with the team. A complaint audit was carried out by the regional manager in October 2024 and whilst this pre-dated the new policy it did include staff interviews to assess knowledge of the procedure in place at the time. A second complaint audit was carried out in January 2025 and assessed staff knowledge against the new procedure. Areas of partial compliance were identified during these audits and actions implemented to correct any deficits identified.

A new system had been implemented whereby all printed documents were not permitted to be filed until they had been signed by staff members. The inspector saw this in practice in the house and whilst there were still some signatures outstanding, significant progress was made since the last inspection.

There had been a change in regional management since the previous inspection. The incoming regional manager had completed audits in child protection, complaints, behaviour management & risk management, supervision and personnel files. An external audit had been completed on behaviour management in November 2023 from an outside company. Audits included a review of documentation whilst also interviewing one staff member on their knowledge of the area under review. In addition to the senior management audits, the regional manager now completed a monthly monitoring visit governance report. This identified areas of themes they reviewed during their weekly visits in that month. Areas for further action were identified in these reports and timeframes were outlined. The inspector did note through review of senior management meetings that where policy changes occurred and inspection feedback was provided, this was discussed throughout the organisation to ensure learnings were shared with all.

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

Compliance with standards	
Practices met the required standard	**Standard 5.4**
Practices met the required	**Not all standards under this theme**

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

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

Issue Requiring Action:

- The registered provider and the regional manager must ensure that a plan is developed to identify and address the factors that may be contributing to low morale amongst the team.

Corrective Actions:

- A check in was completed by regional manager in supplementary supervisions on 21.09.23 with staff members and will be completed with further staff members on 19.10.23. Morale and self-care will be discussed in team meeting 19.10.23 and will be a focus of monthly supervision. Attendance of the Burnout Resilience Workshop scheduled for all employees on 10.10.23. Team building day is being planned at present. Group supervision planned for November 2023.

Review Findings:

Since the last inspection the centre had experienced high turnover with ten staff leaving. The manager, deputy manager and one other staff member continued to be part of the team. Exit interviews were completed by the organisation's compliance officer. Of the ten staff who left, six completed an exit interview with the inspector seeing evidence that attempts had been made to contact the other four. From a review of the six exit interviews there were consistent themes through all six. All spoke highly of the support received from the centre manager and deputy manager. All left for better working hours and all commented that they felt the pay could have been improved upon. Two noted the changes in the staff team made work difficult

with one noting the team was “fractured and fragile”. Inspectors saw no evidence to show that a formal senior management review had been completed in relation to staffing and turnover. There was no evidence to show exit interviews had been analysed or used to inform changes. The regional manager in situ during the previous inspection had also changed. As such due to the level of turnover it was difficult to assess compliance with the action plan set out in the previous inspection report.

As highlighted in response to the CAPA review, a burnout resilience workshop occurred for employees in October 2023 and a number of group supervisions occurred. The centre manager informed the inspector that despite turnover these meetings went ahead with the new staff team to ensure expectations were set from the offset and to allow the team to strengthen relationships with each other. The inspector visited the house and met with a number of staff and one of the young people. It was evident during the visit there was a warm and friendly atmosphere, and all staff appeared happy and relaxed in their work on the day and spoke openly with the inspector. The young person spoke positively about living in the centre and their relationship with the staff team.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 6.3**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**