



An Ghníomhaireacht um
Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 009

Year: 2025

Inspection Report

Year:	2025
Name of Organisation:	Galtee Clinic
Registered Capacity:	Four Young People
Type of Inspection:	Unannounced Inspection
Date of inspection:	1st & 2nd September 2025
Registration Status:	Registered from the 19th October 2024 to the 19th October 2027
Inspection Team:	Paschal Mc Mahon Lorna Wogan
Date Report Issued:	24/11/2025

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality 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 their first registration in 2015. At the time of this inspection the centre was in their fourth registration and in year one of the cycle. The centre was registered without attached conditions from the 19th October 2024 to the 19th October 2027.

The centre was registered to provide multi-occupancy medium term care for up to four young people from age ten to seventeen years on admission. The model of care was informed by the principles of social pedagogy. Relationships between the adults and young people were central to the work of the service. There were three young people living in the centre at the time of this inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.1

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and relevant social work departments on the 3rd October 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 14th October 2025. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 009 without attached conditions from the 19th October 2024 to 19th October 2027 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies

Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their wellbeing and personal development.

There were three young people living in the centre at the time of the inspection, one of whom was a recent admission. Two other young people were discharged in the period prior to the inspection in a planned manner. The inspectors found that updated care plans were on file for two of the young people in placement. A date for a child in care review to update the care plan for the young person recently admitted was due to be scheduled. There was evidence that a number of planning meetings had taken place and a transition plan was developed prior to the young person's admission. The care plans reviewed by the inspectors were comprehensive and detailed the aims and objectives of the placements. While there were delays in receiving the updated care plan for one young person the inspectors found that the minutes recorded by care staff at the child in care review meeting were sufficient to enable the care team to update the young person's placement plan and facilitate the progress of identified goals.

There were placement plans on file for two of the young people. Records viewed by inspectors showed that the key workers met with centre managers every two months to assess the progress being made around each identified goal. Inspectors were informed that a placement plan for the new young person admitted would be developed following their statutory care plan review meeting. Inspectors recommend that a draft placement plan is developed in the interim, based on the comprehensive referral information and assessments provided to the centre along with the care teams knowledge of the young person to date. Inspectors found that the placement plans on file were in line with the care plans and their identified needs and there was evidence that individual work was undertaken with the young people to meet the placement plan goals. The most recent placement plans on file evidenced that both young people were consulted in relation to their placement plan goals and they had an opportunity to discuss how best the team could support them.

There was evidence that the quality of placement plans was reviewed, and improvements were identified. The quality improvement coordinator had recommended in a recent audit that placement plans needed to clearly evidence the participation of the young people in their development and review. Improvements were also identified in the requirement to record all individual work and to ensure bi-monthly progress reports were completed to evidence the progress made in meeting the placement plan goals. Inspectors were satisfied that appropriate actions had been taken to address these deficits. The progress reports that were on file were comprehensive in outlining the young person's progress in a number of areas including health, education, independent living skills and any other positive developments. These progress reports were sent to the young people's social workers along with placement plans and other relevant documentation.

The inspectors met with one of the young people during the inspection and they confirmed that they were consulted in relation to their care and placement plan. The inspectors found evidence that the young people's views were represented at child in care reviews either through written consultation forms or by staff representation of their views.

Care plans evidenced that the views of parents were taken into account where possible and there was evidence on the care records that the care team made every effort to consider the wishes of the parents of the young people. The parent of one young person spoke to inspectors and praised the work and commitment of both the centre manager and care team highlighting the excellent communication and the high standard of care their child was receiving to date.

The young people had access to appropriate external supports and specialist services. At the time of inspection, the care team were caring for one young person with complex needs who required a number of support services. The management and care team demonstrated a high level of commitment to caring for this young person and there was evidence of regular strategy meetings with relevant professionals outside of the statutory review process to progress the young person's care. In addition, the care team had access to their own in-service clinical psychologist who met with the care team regularly and provided training, resources and guidance to them to support each of the young people. In interview staff stated that these meetings were beneficial and informed their interventions and understanding of the young people's presentation.

Inspectors reviewed care records and found that there was regular communication with social workers. In interviews, the allocated social workers and a Guardian ad Litem for one young person were satisfied that the centre management and the care team worked collaboratively with them to implement the care plans. They reported that communication with the centre manager was excellent and spoke highly of the service provision to the young people and the strong relationships the young people had established with key staff members.

Compliance with Regulation	
Regulation met	Regulation 5 Regulation 17
Regulation not met	None Identified

Compliance with standards	
Practices met the required standard	Standard 2.2
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

Actions required

- None identified

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.

Inspectors found there were a number of systems in place whereby managers reviewed the quality, safety and continuity of care provided. This included managers monthly service governance reports, centre manager meetings and senior management meetings. All staff interviewed highlighted the strong consistent leadership provided by the centre manager and how they felt the organisation supported them in their work. Team meetings took place monthly. Inspectors reviewed a sample of team meeting minutes and found that there were no recurring

standing agenda items and no recorded review at the start of each meeting of the previous meeting minutes and of any agreed follow up actions. Inspectors recommend that the centre manager ensures that staff meetings are more structured going forward to include standing agenda items such as complaints, child protection and policy discussions along with a review of any follow up actions identified at previous meetings.

The centre manager reported to a service manager who provided oversight to the organisations three centres and monitored the quality of care through receipt of monthly governance reports, oversight of records and visits to the centre. The current service manager was recently appointed to this role in April 2025. Inspectors found limited evidence of the service managers oversight of care records or care practices in the centre. This was acknowledged by the service manager in interview who told inspectors that their oversight of the centre had been limited as they had to focus on other priorities in the service since they took up their role. The registered provider must ensure that other competing demands across the wider service do not impact on a continued and sustained basis on the governance and oversight function of the service manager.

The service had a dedicated quality improvement coordinator who conducted audits to assess the centres level of compliance with the National Standards for Children's Residential Centres, 2018 (HIQA). They also had responsibility for the review of the organisations policies and procedures. The centre auditing policy stated that audits would be conducted every seven weeks. There was an annual auditing schedule in place which was agreed in advance with the organisations operations manager. The audit schedule covered a number of themes of the National Standards but was also subject to change based on more relevant themes arising from issues or concerns that arose within the centre.

The inspectors reviewed the audits conducted in 2025 and found that there were three audits carried out in the eight-month period from January to August 2025. These audits assessed the centres level of compliance with two standards under theme 1 and one standard under themes 3 and 4 of the national standards. Two of these audits examined centre records from September to December 2024. While there had been delays in some audits taking place due to unforeseen circumstances and priorities in some of the other organisation's services, the inspectors found that the auditing process was not occurring in line with their policy and was not effective in its current structure to assess compliance across the range of standards set out in the national standards. The registered provider must ensure that the auditing process

is reviewed to ensure that there is a more robust process in place to assess the safety and quality of care provided in the centre against the National Standards for Children's Residential Centres.

Inspectors were satisfied that information in relation to complaints, concerns and incidents were recorded and monitored. There was evidence that young people were facilitated to make complaints should they wish to raise a concern and team members were aware of the requirement to document complaints in line with their complaints policy. Young people were made aware of their right to make a complaint through the provision of a welcome booklet. This booklet included details on house rules, the rights of young people, how to make a complaint, the role of the Ombudsman for Children and information on the Tusla 'Tell Us' complaints procedure. All complaints were acknowledged by the centre manager, who ensured that the young people involved were spoken to regarding the resolution of their complaint and individual work was undertaken when required. Complaints were also reported on the centre managers monthly self-report to external managers. Inspectors found that while there were systems in place to track complaints and the follow up through the governance reports and audits there was no evidence of oversight on the centres complaint register. Additionally, the register did not document the outcome of complaints, noting whether they were upheld, not upheld, or inconclusive as part of the complaint tracking and analysis process. There had been a focus on complaints in the centres auditing process and the service improvement plan in the period prior to the inspection. This resulted in several actions being taken to ensure that staff had an awareness of complaints, information was provided to parents and a new template for complaints had also been developed.

The inspectors were provided with an annual review of compliance of the service's objectives completed in May 2024 by the operations manager. This outlined improvements in the service in the previous year and along with a service development plan developed for the upcoming year. Inspectors reviewed the service improvement plan and found evidence that some of the identified actions were addressed while other issues were ongoing. The inspectors found that the annual review of compliance for the period May 2024 to May 2025 was outstanding. The registered provider must ensure that the annual compliance report is completed annually in line with the requirements of the National Standards.

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 5.4
Practices did not meet the required standard	Not all standards under this theme were assessed

Actions required

- The registered provider must ensure that the auditing process is reviewed to ensure that there is a more robust process in place to assess the safety and quality of care provided in the centre against the National Standards for Children’s Residential Centres.
- The registered provider must ensure that the outcome of all complaints is recorded on the complaint register for tracking and analysis purposes.
- The registered provider ensure that the annual compliance report is completed annually in line with the requirements of the National Standards.

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.

Inspectors were satisfied that workforce planning occurred to ensure the centre was adequately resourced with appropriate staffing levels. Staffing levels were reviewed on an on-going basis at the organisation’s management meetings. Inspectors reviewed staff rosters and noted that there were appropriate numbers of staff on shift to meet the needs of the three young people in residence and the centre’s statement of purpose.

Inspectors found that there was a relatively consistent experienced staff team in place with a good gender balance and a suitable mix of qualifications. The centre had

adequate relief staff to cover annual leave, sick leave and other forms of leave. At the time of inspection members of the team were covering shifts in another of the organisation's centres occasionally. Inspectors recommend that every effort is made to limit this practice as it is unsettling for staff to be asked to undertake shifts in other centres on an ongoing basis and impacts on consistency of care for the young people.

There was evidence that the organisation had placed a strong emphasis on staff retention in an effort to maintain a continuity of care and stability for the young people. There was a benefits & retention package in place for staff which had been updated prior to the inspection and included a range of benefits including salary increases and bonuses, incremental annual leave and access to insurance and pension schemes.

The centre had a formalised procedure for on-call arrangements at evenings and weekends which staff found responsive and supportive.

Compliance with Regulation	
Regulation met	Regulation 6 Regulation 7
Regulation not met	None identified

Compliance with standards	
Practices met the required standard	Standard 6.1
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

Actions required

- None identified.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	<p>The registered provider must ensure that the auditing process is reviewed to ensure that there is a more robust process in place to assess the safety and quality of care provided in the centre against the National Standards for Children’s Residential Centres.</p> <p>The registered provider must ensure that the outcome of all complaints is recorded on the complaint register for tracking and analysis purposes.</p>	<p>Audit tools are being revised to incorporate multiple standards where applicable.</p> <p>A review of the existing audit framework has been initiated to identify gaps in scope, frequency, and depth of audit tools currently used. This will be undertaken by the Quality Improvement Manager & Operations Manager and completed by the 31st Oct 2025.</p> <p>There has been a review all complaints that have been recorded since January 2025 to ensure outcomes have been recorded in the complaints register. Update register to include the outcome and detail when the resolution occurred and any actions that need to be completed.</p>	<p>An annual audit schedule has been implemented to ensure a broad and representative range of standards are reviewed throughout the year, supported by clear timelines. All audits will assess against multiple standards where applicable.</p> <p>Centre Manager’s Self-report should reflect any complaints each month and detail outcomes of complaints. Centre Manager to ensure register is up to date at time of Self-Report. Service Manager to provide oversight on register on a monthly basis to ensure that complaints are recorded and outcomes are noted for tracking and analysis purposes.</p>

	<p>The registered provider must ensure that the annual compliance report is completed annually in line with the requirements of the National Standards.</p>	<p>Centre manager to ensure complaints register is up to date once a complaint has been logged. Complaints register to be a 'live document'. This will be completed by the 10th November 2025.</p> <p>Annual Review of Compliance (ARC) /Service Improvement Plan (SIP) Meeting scheduled for 21st October 2025, where the ARC will be reviewed and SIP completed. Persons Responsible: Service Manager, Operations Manager, Quality Improvement Manager and Registered proprietor. Timeframe: To be completed by 30th November 2025.</p>	<p>Complaints will be reviewed as part of our internal auditing system that will be completed by our Quality Improvement Manager and any recommendations will be implemented.</p> <p>ARC to be completed annually by Operations Manager and Registered Proprietor, to be reviewed by Service Manager and Quality Improvement Manager. SIP to be implemented following review of ARC and to be reviewed by the Service Manager, Operations Manager, Registered Proprietor and Quality Improvement Manager.</p>
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