An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 037

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Daffodil Care Services ULC**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**4th & 5th March 2026**
Registration Status:	**Registered from 16th September 2025 to 16th September 2028**
Inspection Team:	**Janice Ryan** **Niamh Lennon**
Date Report Issued:	**04th of June 2026**

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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 its first registration on the 16th September 2010. At the time of this inspection the centre was in its sixth registration and was in year one of the cycle. The centre was registered without attached conditions from 16th September 2025 to the 16th September 2028.

The centre was registered as a multi-occupancy centre that could accommodate four young people from age thirteen to seventeen years on admission, providing medium to long term care. The centre's model of care was based on a systemic therapeutic engagement model (STEM) and provided a framework for positive interventions. There was one young person living in the centre at the time of the inspection however, two weeks prior to this inspection another young person had been discharged.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.3
6: Responsive Workforce	6.1

This inspection was conducted as a result of ACIMS receiving two escalations from the NPT in a short period time. Additionally, unsolicited information was received by the ACIMS in relation to concerns raised following the discharge of one young person from the centre. The inspectors reviewed a sample of centre and young people's records relevant to these concerns between September 2025 and March 2026.

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 to the relevant social work departments on the 7th April 2026. 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 21st April 2026. Following a review of same the inspectors deemed the CAPA not satisfactory and the centre manager was required to submit evidence and updated actions. The inspectors received a second CAPA on the 29th April 2026 with supporting evidence to address the issues. The inspectors deemed the CAPA satisfactory and the inspection service received evidence of the issues addressed. As regulation 7: staffing was deemed not to be met on inspection, a compliance meeting was held with the registered provider, regional manager and centre manager on the 11th May 2026. The registered provider agreed that no further admissions would take place to the centre while new staff were onboarding and until a further compliance review meeting takes place on the 1st September 2026 to review the implementation of the current CAPA and staffing requirements in line with regulation 7.

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: 037 without attached conditions from the 16th September 2025 to 16th September 2028 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 3: Safe Care and Support

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

While the new centre manager was attempting to promote an open culture among the team the inspectors found from interviews, observations and from a review of documentation this was proving difficult as there had been significant changes within the staff team over the previous months. Inspectors found that young people's meetings were held regularly and the young people were supported and encouraged by centre staff and managers to raise concerns, express their views and have their voice heard.

The inspectors reviewed a sample of complaints for both young people and found that while the majority of them had been reported in line with the organisations complaints policy others were not. The inspectors found that complaints that warranted notification to professionals were not identified, recorded or reported correctly especially when they related to day-to-day care issues. A Guardian Ad Litem (GAL) for one young person raised issues in relation to aspects of the young person's care provision including pocket money and the young person's discharge from the centre. In interview, with the centre manager they confirmed that they had not considered these issues in relation to aspects of care provision until this was raised by the GAL. The centre manager confirmed that they had resolved some aspects of the issues raised in regard to pocket money. However, the young person and GAL remained unhappy with how their discharge was managed. The young person who spoke to inspectors felt that where issues had been raised by them in relation to care provision that the staff team had not responded appropriately to these nor had management. In interview with the centre and regional manager they both confirmed that this discharge did not happen in line with the organisation's policy or in a child centred manner and that a review will be undertaken to identify any learning from this.

Complaints had also been raised by one young person in relation to unfamiliar staff working in the centre and although measures had been put in place to address this

issue these could not be effectively implemented. While young people knew how to raise complaints the inspectors found that how complaints were identified and managed was inconsistent across the team and management and was not in line with the organisation's policy. Furthermore, none of these issues had been identified by external management. The centre manager must ensure that all complaints are reported in line with policy and that all staff have a clear understanding of how to identify and report complaints.

The organisation had a policy for the recording and reporting of significant events. The inspectors reviewed the significant event register and found that at times significant events were not always reported or notified in line with policy. Inspectors found that dates for some significant events were entered on the register retrospectively and there were duplicated entries recorded for the same significant event. In interview with the centre manager, they confirmed that following discussions with the GAL they had been made aware of one incident that had not been reported. The centre manager confirmed that on review of the associated daily log for one young person an incident was referenced within and dated back to October 2025 however, they found that no follow up or reporting of this concern had taken place. At the time of inspection, the inspectors found that this incident had yet to be notified.

Prior to the centre manager taking up post there was a large number of child protection concerns that had been reported and remained open for a long period of time. The inspectors found that while some follow up had been completed to address this issue by centre and external management it was inconsistent and sporadic. The inspectors found that in recent months the current centre manager had continued to follow up on these concerns. Inspectors were informed by one social worker that they were satisfied that incidents were reported in a timely manner.

Significant events were reviewed on a monthly basis at the significant event review group (SERG) meetings to evaluate and identify learning outcomes. The inspectors reviewed minutes from these meetings and found that for one young person their behaviours of concern were mainly around technology use, night time routines and unfamiliar staff. Interventions were identified to manage these behaviours and included the team being emotionally present and to create a place of safety and belonging for the young person. However, the inspectors found that the large turnover of staff and use of agency and external staff made it difficult for these interventions to be effectively implemented. SERG meetings did not identify strategies on how this could be achieved in the absence of a stable team.

Team meetings took place on a fortnightly basis. Within team meetings the inspectors found that these at times were brief and there was limited feedback and discussions in relation to significant events and improvements to practice. The inspectors noted that agency staff and staff from sister's centres did not attend team meetings and it was difficult for inspectors to determine how these staff were supported to understand the day to day running of the centre and plans for the young people. Within interviews staff cited the importance of handover to communicate plans and up dates for each young person and the general day to day running of the centre. However, on review of the daily handover records the inspectors found that the information documented within was not sufficient to guide a team in planning for the young people on a daily basis and ensure consistency across an unstable team.

The inspectors found that records were of poor quality, were not up to date, sequential and were disorganised. The inspectors spoke with the staff team and management, and they advised that the majority of the time they were unable to print off up to date information for the young people as the printer was not working due to issues with the internet connection. In discussions, with the regional manager they also confirmed that this was the case and that they were attempting to fix this issue. Inspectors found that given this was ongoing for a period of four months and it was not acceptable that this issue had yet to be resolved. Outside of this the inspectors found that there was limited oversight of centre or young people's records and the deficits discussed above had not been identified within regional management audits. The regional manager advised that they had commenced post in November 2025 and were still working through the gaps however, on review of the majority of records over the previous six to nine month period the inspectors found limited review of files by external management or the quality assurance officer for the organisation. The inspectors reviewed the annual compliance report for the centre and found that actions identified during the months October 2025 to February 2026 in relation to records had not been completed and there was no commentary or follow up to the reason why this was outstanding.

The centre had no formal mechanisms in place for significant people in children's lives to provide feedback and identify areas for improvement. Within professional meeting minutes reviewed the inspectors found that where issues were raised by the social worker or guardian ad litem for one young person the inspectors could not see how these were resolved or addressed as the recording of information within the minutes was brief. One social worker interviewed stated that the centre manager regularly liaised with them however, communication was challenging at times due to the circumstances surrounding one young person who was residing elsewhere.

Overall, the inspectors found that due to the inconsistent staffing team incidents had not being effectively identified, managed or reported in line with the organisations policies and procedures.

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 3.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that all significant events are identified, reported and notified in line with the organisation's policy.
- The registered provider must ensure that the staff team are trained in the organisations complaints policy.
- The registered provider must ensure that the oversight mechanisms in place to review the quality of records that guide staff practice is effective.
- The centre manager must ensure that where learning is identified from incidents that this is effectively communicated to the staff team and documented within team meeting minutes. Additionally, consideration needs to be given of how this learning is going to be communicated to external team members to ensure consistency in practice.
- The registered provider must ensure that a review of one young person's placement who was recently discharged in completed to identify any learnings, and this is used to support the development of practice and improve the care provided in the centre.

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.

Workforce planning was discussed at weekly recruitment meetings. In interview with the regional manager, they confirmed that they attended same with a staff member from the recruitment department. The inspector reviewed a sample of meeting minutes and found that these meetings took account of staff who were available to the centre and also staff who were in the process of onboarding. Senior management meetings took place on a monthly basis which were attended by centre manager, regional management and the registered provider. Meeting minutes reviewed by inspectors evidenced that staffing deficits were discussed briefly and the inspectors noted that the staffing deficits had been placed on the organisational risk register. This was also confirmed in interview with the regional manager. However, within both of these meetings the inspectors found that there was no documented discussions of what measures would be taken should deficits in staffing continue across the centre and organisation. Furthermore, inspectors found that within senior management meetings the documented discussion in relation to staffing deficits remained unchanged for all minutes reviewed.

A staffing information sheet was submitted as part of this inspection and on review of same the inspectors found that the centre was operating with a centre manager, a deputy manager, one social care leader and four social care workers. In interview with the centre manager, they confirmed that they would be leaving the centre in the coming weeks and had only agreed to a six month post. The current deputy manager had been identified to take up the post of centre manager. The centre manager also advised that the social care leader was also on extended leave for the previous two months and a return date to the centre had not been identified. There was one relief staff member identified however, the centre manager confirmed that this staff member had not covered shifts in the centre and was not available.

Since the previous inspection in July 2025 four staff members had left the centre. Staffing deficits had been identified in the previous inspection and the inspectors found that since that inspection the registered provider had not provided a full and stable staff team to the young people.

The regional manager stated in interview that two new care staff had been identified but no start dates were confirmed. This also had been noted within the weekly recruitment meetings. The centre manager confirmed that two interviews had taken place over the past week however, these candidates had not been successful.

The centre was operating with double cover on a daily basis. The inspectors reviewed a sample of rosters from the period November 2025 to March 2026 and found that the roster was being supplemented by staff from sister centres and agency staff member and at times centre management. The centre was also experiencing high levels of sick leave among the team. During the period under review one young person who was residing in the centre for a period of two years had refused to return and live in the centre and was staying in an alternative arrangement from December to their discharge on the 18th February 2026. During this time period the centre were providing outreach support to this young person every second day which had been agreed by all professionals. This resulted in one staff member being available to the young person who was living there. The centre had implemented a risk assessment in relation to the use of agency staff following this young person voicing their dissatisfaction with the level of different staff members being in the centre. The inspectors found that measures identified as part of this assessment included that one staff member known to the young person was to be rostered on shift daily. However, the inspectors found from a review of rosters that this was not always in place as there was not sufficient core team members available. This assessment since implementation in early January had not been updated or reviewed to ensure that measures in place were effective.

The inspectors found that there were not sufficient numbers of staff with the necessary experience and competencies to meet the needs of the young people living in the centre. There was one staff member who was employed as a social care worker since July 2024 and had commenced a development programme to become a social care leader. On review of the on-call roster in place, this staff member was providing on call support to five centres in the area. The inspectors reviewed supervision meeting minutes and in interview with the relevant staff member found that they did not have the necessary experience to complete this function and had not been provided with sufficient support or guidance to develop in this role or partake in this function. The social care leader who was in post since November 2025 was unable to provide mentorship or guidance to them as they went on extended leave since January 2026 and the new manager was only in post since November 2025. The decision to give this staff member on call responsibilities lacked good oversight and governance.

Personnel files reviewed by inspectors found that all staff members had up to date garda vetting on file. Inspectors found that not all files were up to date with the required documentation including job specifications, roles and responsibilities and qualification parchments. Where references were received the information requested within was not always ticked or filled out and this had been verified and signed off by a relevant staff member in human resources department. The last recorded date of oversight and governance of these records was recorded for July 2024 by external management and inspectors found that these deficits not been identified.

The inspector reviewed the centre's training audit and staff personnel files and found that staff had engaged in a good level of training to date however, not all staff were up to date with mandatory training identified within the organisations training policy. Within the training audit reviewed, inspectors found that dates had been allocated to complete outstanding training over the coming weeks. The inspectors also found that staff members had commenced in the centre without having training in the organisation's behaviour management model for a period of four months and this had not been risk assessed or identified by external management. On review of the centre's risk register the inspectors found that a risk assessment had been put in place in relation to core staff not having the required training however, this was dated June 2025 and had not been reviewed or updated to reflect the current cohort of staff in the centre. Additionally, not all staff members had completed training in Tusla's child sexual exploitation, and this must be completed.

Supervision records reviewed evidenced that supervision was not always up to date or in line with policy however, the inspectors found that the new centre manager had attempted to complete supervision in line with policy over the previous months since commencement in post. Inspectors found that supervision was mainly focused as a supportive function. Within minutes reviewed the staff team were experiencing low morale due to the impact of low staffing numbers, lack of experience among team members and inconsistency in practice which had led to sick leave. Additionally, the inspectors found that when an issue presented with one staff member, there was limited documented evidence on file to say how this staff member was being supported in relation to this issue. A team reflection meeting was held in January 2026 and facilitated by an internal clinician which had identified issues among the team. The centre manager confirmed that this meeting was to support the staff team and develop staff practice in the centre.

The inspector met with one young person and observed their interactions with staff on shift. The young person confirmed that there was a lot of staff working in the

centre and that they were unhappy about this which was also confirmed in interview with one staff member. The inspectors observed the interactions of one staff member with this young person, and it was clear that the young person did not engage with the staff member nor did the staff member make any efforts to engage with them and remained using their personal phone while the inspectors were present for over a thirty minute period.

The inspectors found that with the change in management over the past few months combined with the staffing deficits and increase in agency staffing across the centre that there was not sufficient experience or stability among the team to provide safe and effective care.

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

- The registered provider must ensure that there is sufficient staffing numbers in place to provide consistent care to the young people and meet their needs.
- The registered provider must ensure that all staff members have up to date training in line with the organisations policy.
- The registered provider must ensure that all documentation is held on all staff members personnel files in line with safe recruitment practices.
- The registered provider must ensure that where a staff member is allocated significant responsibilities for e.g. on call that they have sufficient experience to complete this role and function.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure that all significant events are identified, reported and notified in line with the organisation's policy.	The significant event notification (SEN) policy was reviewed in the management meeting on 18.02.2026. The centre management team are aware that all significant events should be reported to professionals within a 48-hour period (72 hours in the case of a weekend) in line with the organisation's policy. The centre manager will cross reference the system and the register each morning to ensure SENs are sent out to the relevant professionals within the expected timeframes.	The centre manager is responsible for the oversight of all sens. The relevant parties will receive written notification, utilising the sen form, within 48 hours of the significant event (72 hours in the case of a weekend). The details of each sen will be recorded in the centre's register of significant events. The sen policy will be reviewed quarterly in both centre management and team meetings commencing 28.04.2026. The regional manager will provide oversight monthly in their auditing and governance reports.
	The registered provider must ensure that the staff team are trained in the organisations complaints policy.	The complaints policy was reviewed in team meeting on 01.04.26. A workshop on complaints is scheduled with the staff team on 28.04.2026.	The complaints policy will be reviewed quarterly at team meeting commencing on 28.04.2026, 04.08.26 and the 08.12.26. The centre management team will review daily logs, sens and young person's meetings to identify any missed complaints

			and ensure that they are responded to. Regional manager to complete a themed audit on complaints in June 2026.
	The registered provider must ensure that the oversight mechanisms in place to review the quality of records that guide staff practice is effective.	All practice documents including individual crisis support plans, individual absence management plans and practice guidelines were reviewed on 09.04.2026 by the regional manager with feedback provided to the centre team. There was a full review completed 09/04/26 with feedback given to the team. Management team will review practice documents on the 30th of each month prior to sending to the social work department for review.	The regional manager will record their findings following the review of all practice documents in the April senior management auditing and governance report. Practice documents will be reviewed as part of the monthly significant event review group commencing May 2026, and feedback will be provided to the team. Document review will form part of the monthly SMT monitoring commencing April 2026 and monthly thereafter. Review will be completed by SERG 12/05/26.
	The centre manager must ensure that where learning is identified from incidents that this is effectively communicated to the staff team and documented within team meeting minutes. Additionally, consideration needs to be given of how this learning is going to be communicated to external	Learning identified following incidents will be addressed though structured debrief processes including supplementary supervision sessions, scheduled supervision and in team meetings which take place every two weeks and will support reflective practice. In addition, learning identified through monthly SERG	The centre management team will ensure that learning is implemented into daily practice and recorded in practice documents. In addition, the centre management team will ensure that any actions identified are completed within the agreed timeframe. The regional manager will attend team and management

	team members to ensure consistency in practice.	meetings will be shared with the staff team. Relevant information will be communicated with all staff including non-core staff through handovers, internal house diary and practice documents for young people including ICSPs, IAMPs and practice guidelines. The centre management team will ensure that these are reviewed at the start of each shift by external staff.	meetings on a regular basis and ensure that any learning is identified and discussed, recording this in their monthly reports. The centre management team to be present for handovers to ensure that all practice documents are being reviewed by non-core staff and updates by core staff.
	The registered provider must ensure that a review of one young person's placement who was recently discharged in completed to identify any learnings, and this used to support the development of practice and improve the care provided in the centre.	The discharge policy was reviewed in the team meeting on 01.04.26 and discussion took place around the recently discharged young person, this was delivered by centre manager. Centre management identified the discharge did not occur in line with organisational discharge policy or best practice. The end of placement report was reviewed and evaluated by the team with centre management and regional manager identifying areas of growth for practice.	Discharge policy and process to be reviewed quarterly throughout the year. The regional manager to have oversight of all discharges and discuss these in the senior management auditing and governance report. Centre and senior management will continue to attend child in care review's and professional meetings with the young person's social work department to discuss the young person's and highlight concerns should they arise. The centre will continue to work with the young person and raise issues the young people voice through complaint forms and

			encourage the young people to link in with additional advocacy services such as EPIC and use of the Tusla Tell Us Portal.
6	The registered provider must ensure that there is sufficient staffing numbers in place to provide consistent care to the young people and meet their needs.	The registered provider will provide an update when appropriate staffing levels are in place, including current staff onboarding. The centre roster is supported where required with staff from sister centres and agency staff. Double overnight cover is always upheld in the centre. The centre management team have developed a good working relationship with an agency and try to ensure that staff covering shifts are familiar to the young person thus providing some consistency. Staffing deficits are recorded on the organisational risk register.	Weekly recruitment meetings to continue to occur between the regional manager and recruitment department, where updates on international onboarding staff will be provided. Additional advertising resources have been utilised, coupled with an organisational focus on staff retention with a staff survey and management training being rolled out.
	The registered provider must ensure that all staff members have up to date training in line with the organisations policy.	The centre manager completed a training audit and action plan in February 2026 and April 2026. All required training has been identified and scheduled. Training dates are incorporated into staff shifts on the roster. Staff members completed CSE	Bi- monthly training audits and action plans will be completed by the centre management team. Where training is not available, this will be escalated to the regional manager who will request additional training dates.

		training by 09.04.26. The centre management team and the regional manager reviewed and updated the training risk assessment on the 01.04.26.	
	The registered provider must ensure that all documentation is held on all staff members personnel files in line with safe recruitment practices.	The regional manager completed a review of personnel files in February 2026, recording their findings in their monthly governance report. All identified action were recorded in the report which has been completed and verified.	Personnel file audits are scheduled to take place twice yearly in May and September by the centre management team. This will be overseen by the regional manager.
	The registered provider must ensure that where a staff member is allocated significant responsibilities for e.g. on call that they have sufficient experience to complete this role and function.	The On-call policy was reviewed in the team meeting on 01.04.26 and will be reviewed with the identified staff member during their supervision 15.04.2026 where scenario-based questions will be provided to ensure that they are sufficiently trained in their response. During this period a more senior member of staff to be a backup on call support until the staff member is deemed experienced.	The On-call policy will be reviewed on an ongoing basis during this staff members supervision sessions to ensure the staff member fully understands and fulfils their roles and responsibilities. The centre management team to ensure that adequate mentoring and guidance is provided to staff members who are completing on call duties. Any new staff member who is new to on call such as social care leaders or undertaking the leadership progression programme. Social care leader will have the support of the centre manager as back

			up. They may contact the centre manager at any time for guidance and assistance in managing on call situations.