An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 049

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Daffodil Care**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**16th & 17th April 2025**
Registration Status:	**Registered from 5th March 2025 to 5th March 2028**
Inspection Team:	**Lisa Tobin** **Mark Mc Guire**
Date Report Issued:	**15th July 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 its first registration on the 5th of March 2012. At the time of this inspection the centre was in its fifth registration and was in year one of the cycle. The centre was registered without attached conditions from 5th of March 2025 to the 5th of March 2028.

The centre was registered as a multi occupancy short to medium term centre catering for up to four young people of mixed gender between the ages of sixteen and eighteen years of age on admission. The young people can remain in the centre until they are nineteen years old. Its specific purpose was to prepare young people for leaving care, independent living, and adulthood. The model of care was based on the systemic therapeutic engagement model (STEM) which was described as providing a framework for positive interventions with young people. It supported the development of relationships which focused on achieving strength-based outcomes through daily life interactions and targeted programmes. It draws on a number of complementary philosophies and approaches including Circle of Courage, Response Abilities Pathways, Therapeutic Crisis Intervention and Daily Life Events. There were two young people living in the centre at the time of the inspection, one who was over eighteen.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
4: Health, Wellbeing and Development	4.2
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.3

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, the aftercare manager, 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 4th of June 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 19th of June 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: 049 without attached conditions from the 5th of March 2025 to the 5th of March 2028 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 10: Health Care
Regulation 12: Provision of Food and Cooking Facilities

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

There were a number of policies within the organisation linked to the health, wellbeing and development of the young people. Some of these were drugs and alcohol policies, administration of medication policy, health and wellbeing policy self-injury policy and ligature policy. This was an unannounced inspection to this centre which cares for young people aged sixteen to nineteen, supporting them with their independent living and preparing them for adulthood. Each young person had their own apartment with a kitchen and bathroom. Inspectors found that there were areas that required improvement regarding the young people's health and development needs, ensuring they were being identified, documented and responded to.

The child in care review (CICR) was delayed for one young person due to the young person's availability to attend and took place thirteen weeks post admission. The Tusla social care leader for this young person stated that due to the delay, they planned another CICR for June 2025. The other young person had an aftercare plan in place since March 2023 and there had been no updates noted to the plan since then.

During interviews the aftercare manager and the social care leader both spoke positively of the centre, the care provided to the young people and the support they received from the staff. Inspectors met with one young person who stated their experience of the centre was positive to date regarding their apartment and staff support. However, the young person also reported that the pace they were expected to complete tasks at was not one they could meet due to their own anxieties and diagnosis. They stated they were being compared to their peers regarding their abilities to complete tasks of their independent living programme. Inspectors gave this feedback to the centre and senior management which needs to be followed up with by management to ensure the young people feel supported and that they are met with understanding of what the young person's abilities are.

The care plan and aftercare plan outlined the health and emotional needs for both young people. The placement plans for the young people did not capture these goals appropriately and staff must ensure that the relevant actions are put into the young people's placement plans and include when the goals have been completed. There were specialist reports on file from August 2024 and September 2024 that had been provided to the team recently and must be incorporated into the relevant placement plans. Inspectors found there were health and emotional needs of the young people relating to areas such as eating disorders/dietician support required, low moods, suicidal ideation and anxiety, staff did not have any specific training undertaken to be able to support the young people in the absence of the young people engaging in specialist services. It was difficult for inspectors to see where recommendations for the young people had been followed up. Inspectors found that there were gaps in the individual work reports and that there were low numbers of individual work noted for the health and well-being of the young people, despite care documents outlining these areas were of concern for both young people. The centre and regional manager both said they had undertaken individual work with the young people and had not written up the evidence of this. The centre management must ensure the placement plans have clear goals, that staff source supports required for the young people and that there is evidence of the work undertaken on the young people's care records.

When reviewing the care records, inspectors found that there was clear correspondence between the centre and the young people's social care leader and aftercare worker. There was placement meetings arranged, and relevant people attending these to discuss the ongoing work and supports for the young people. Progress reports were sent monthly to the Tusla workers giving updates on the young people's care. Any previous specialist services used were detailed in the young people's documents. Inspectors found that there were some key working and individual works completed around the young people's diet and healthy eating which was relevant to parts of the care plan. However, staff continued to have concerns about the ongoing diet and eating habits of one of the young people.

The young people had access to a general practitioner (GP) and were facilitated with appointments as needed and staff supported the young people with these appointments. The young people had access to a dentist, ophthalmologist, and orthodontist where ongoing treatment was in place. For one young person, regular appointments with the GP were recommended to monitor their health issues, the young person was refusing to attend. Staff were looking at alternatives and seeking social work support around this.

Specialist supports were recommended for both young people to address different areas of their emotional, health and well-being needs. There was evidence of one young person recently attempting to source counselling services to support their ongoing issues. Again, it was difficult for inspectors to see evidence of other occasions where specialist services were sourced or implemented for the young people. As staff were able to name different supports made available to the young people, this may be a recording issue where the work was not evidenced.

There was a policy in place for the administration of medication. Staff were aware of its content. The training audit provided to inspectors showed that one staff member required safe administration of medication management training. Young people were self-administering medication which was risk assessed when they were out of the centre on holidays or staying with others.

Compliance with Regulation	
Regulation met	**Regulation 10** **Regulation 12**
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 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must ensure that the placement plans include actions identified in the care plans, that supports are in place to achieve the goals and that there is evidence of the work undertaken in the young people's care records.
- The centre manager and regional manager must ensure that staff have access to training that will respond to the needs of the young people to be able to support them effectively.

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.

The quality, safety and continuity of care was reviewed through the ongoing audits undertaken by the regional manager, centre management, compliance officer and centre staff. Significant event review group's (SERGs) centre reports were undertaken by a social care leader to look at the presenting behaviours of young people and to focus on any trends or learning from those incidents. Inspectors found the SERG reports were not fully completed, and some reports omitted the learning aspect on the sample reviewed. The SERG's purpose was for gathering team learnings from incidents and this aspect was not noted as it was completed by one person only. Despite the numerous audits and monthly SERG centre reports, it was difficult for inspectors to see how improvements in the care of the young people were tracked and established.

There was an auditing schedule for the year in place for governance oversight. Each month there were areas identified for the regional manager and centre manager to complete. The regional manager linked their audits to the standards they related to. Throughout the majority of audits undertaken, it was evident that there were deficits in the oversight of paperwork, of current filing systems not working and other practice deficits. This was also what inspectors found during the care file review, that the majority of the paperwork was not signed by management. Despite this being a recurring issue, there was no evidence of how or if these actions were being implemented or followed up by centre management or senior management.

During interviews, staff discussed the use of reflective practice as an on-going practice with the team during team meetings, at handovers and in general when on shift. In reviewing the sample of team meeting minutes, it was not evident where staff were being reflective in their practices. There was a further gap within the minutes as there was no discussion evident about the presenting needs of the young people and how the team could best meet them.

In January 2025, the regional manager undertook an audit on complaints and found that the team was under-reporting. A review of the complaints policy and what meets the threshold was discussed with the team as a result. Inspectors reviewed the complaints register and found them to be reported as required. Inspectors found the centre required a number of works regarding fire safety aspects and the general upkeep of the centre for decoration. Senior management monthly audit reports were undertaken and included the general décor of the centre. The need for an office space for management was identified and an apartment to be decorated, however there was no mention of fire doors that needed to be replaced/repaired, fire equipment repaired, flooring needing replacement and the general upkeep and painting of the centre was not identified. Due to a period of instability in the centre and property damage occurring, other areas of the centre had been overlooked and required attention. Inspectors asked for a schedule of works to be undertaken due to the level of works required which was provided by the regional manager during the inspection process.

An annual review of compliance was undertaken in October 2024 for the centre. Actions and recommendations were identified for any deficits that were found. There was evidence of certain aspects being completed such as updates made to the complaints policy and documentation, however there were other actions named where staff required training, and the date attached to the timeframe was February 2025.

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 centre manager must ensure that there are appropriate processes in place for the team to review incidents and identify learning outcomes and trends.

- The regional manager and centre manager must ensure that all aspects of the centre upkeep are reflected in the audits and that relevant works that are required are undertaken.

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.

Inspectors found that staff were aware of their roles and responsibilities, were able to state the reporting lines, and were able to outline the centre policies that were discussed at team meetings. Induction checklists were part of the staff files, however, were not evident on all staffs' files to show they had been completed in full. Contracts and job descriptions were not on some of the sample staff files reviewed, however staff did confirm they received the job specification at time of acceptance of the role.

During interviews, staff spoke of being supported in their decision making and taking accountability for their professional judgements. There were new staff to the team, and they outlined the opportunities to take on tasks and that support was provided to them in their ongoing learning development. There had been challenging times for staff since the last inspection in July 2024 and they were able to identify the impacts on the team and the internal and external supports available to them should they wish to utilise them. While reviewing team meeting minutes inspectors found there was reference to the impact on the team of one ex-residents' behaviours, however there was no further discussion noted on this topic. Throughout each staff interview, they all spoke about the ex-resident in some way, and it was clear to inspectors the impact that was still present to the team members. A debrief had not occurred with the team since the discharge and would be recommended to support the staff. This would also be an opportunity to use the learning outcomes from that placement to improve service delivery for the centre moving forward. Currently, staff identified that risks to their safety was minimal but named the support from colleagues and management through daily interactions and supervision as beneficial.

As mentioned earlier there were new staff to the team and when asked about the culture of learning and development, they described the training received as part of

their role and how every opportunity was a learning opportunity with the different things that happened throughout the day. Team meetings were held every two weeks, staff named these as beneficial. A sample of team meeting minutes reviewed showed poor attendance at some due to different types of leave, some absences were not identified. Centre policy outlines that staff are required to attend the team meetings every two weeks and must be held accountable for ensuring the smooth operation of the service delivery. Inspectors recommend that the minutes outline clear direction/guidelines for staff, as the minutes held a lot of information rather than guidance.

There was a supervision policy in place. Inspectors reviewed a sample of the records and found some were not very detailed or were incomplete. The centre manager was due to complete a supervision audit in April 2025 which was planned after the inspection. Based on the training audit provided, all staff had completed supervision training. There had been a number of gaps identified on the training audit; this was updated by the centre management with an accurate account during the inspection. Centre management must also identify any training needs that would be beneficial for the team in supporting the young people in the centre. Staff had identified the need for training in autism and further knowledge about coercive control which would be relevant. Those interviewed found their supervision to be beneficial and supportive. Yearly appraisals were in place.

Staff outlined the supports in place that were part of the employee handbook. The employee assistance programme (EAP) was in place for staff. The availability of counselling, training, support from management, access to the hospital Saturday fund and team days were some of the support systems available to staff. Inspectors were made aware of the counselling service or EAP not being available to staff who were on probation. Given that retention of staff is a significant challenge cross the social care sector, this would need to be reviewed by senior management to ensure staff are being provided with the supports they need even when on probation.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
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 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must ensure that supervisions are completed with staff as outlined in centre policy and that the supervisor completes the records.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
4	The centre management must ensure that the placement plans include actions identified in the care plans, that supports are in place to achieve the goals and that there is evidence of the work undertaken in the young people's care records.	Centre Management have reviewed all placement plans in accordance with the young people's care plans on file, to ensure there is strong correlation between the goals identified via Care Plan and Placement Plan Goals. The staff team will receive training in relation to placement planning & evidencing positive outcomes on 23.06.2025 & 07.07.2025 All specialist supports and services are referenced within the placement plans and practice documents.	Regional Manager will continue to oversee and review monthly placement plans as part of their monthly reviews. This will be commented upon within the monthly Senior Monthly Governance and Auditing Report. Centre Manager has implemented the practice (Team meeting 09-06-25) for key workers to include all recommendations/needs from external reports into practice guidelines document for each young person. All goals/ needs identified within young person's care plan and aftercare plan will also be included in this document. This will then feed into monthly placement plans. SCM/ DSCM will complete monthly checks to ensure this practice remains in place. Senior Management will complete an Audit on Placement Planning by the 15.07.25, to

	The centre manager and regional manager must ensure that staff have access to training that will respond to the needs of the young people to be able to support them effectively.	The Regional and Centre Management team have completed a training needs analysis, based on the presenting needs of the young people on the 13.06.25 and has sourced appropriate training, to meet the current needs. The following training is due to take place; - Coercive control – date TBC - Autism Awareness – date TBC - Bodywhys 08-07-2025 - Self Harm webinar 15/07/2025 - Suicide Prevention- HSE self-directed course- will be completed by 30/06/2025	ensure learning has been embedded within the team. Training Audits which are overseen by The Regional Manager and Quality Assurance Department every two months, to ensure all identified training has been scheduled.
5	The centre manager must ensure that there are appropriate processes in place for the team to review incidents and identify learning outcomes and trends.	The Centre Manager will ensure that discussions surrounding incident reviews and identified learning, is recorded within the team meeting minutes. Team Meetings occur on a fortnightly basis; whereby incident review is a standing item on the agenda. Centre Management team attend monthly	The Regional Manager will provide oversight and governance of team meeting minutes, to ensure such review and feedback is occurring, minute and feedback is available to staff team. The Regional Manager will attend team meetings monthly, to ensure this practice is embedded within the centre.

		Significant Event Review Groups and will ensure such feedback is provided and recorded to the team within team meetings.	
	The regional manager and centre manager must ensure that all aspects of the centre upkeep are reflected in the audits and that relevant works that are required are undertaken.	All fire safety adjustments/schedules of work have been completed 08.05.2025 Centre Manager will conduct a review of maintenance requests within the health & safety file, and ensure prompt follow up and escalation for completion of tasks to regional manager by 20.06.25. Centre Management will continue to oversee and action Monthly Health and Safety Audits. Centre management will lead on a number of improvements in respect of centre decor.	Centre Manager will conduct weekly review of maintenance requests, along with enhanced daily site checks to identify areas for attention and upkeep. To be recorded and request submitted promptly, Regional Manager alerted to each request for follow up with maintenance department. In addition to the above, as part of the Regional Managers centre visits, they will review the overall up-keep of the centre, this will be commented and actioned within the monthly Senior Management Governance and Auditing Report.
6	The centre management must ensure that supervisions are completed with staff as outlined in centre policy and that the supervisor completes the records.	Centre Management and Regional Manager will complete a review of all supervision records, to ensure all are up to date and in-line with policy. Supervision Policy will be reviewed within	The Regional Manager and Compliance Officer will provide oversight and monitor the Supervision Schedule, to ensure supervision is occurring in-line with the Supervision Policy.

		a Centre management meeting on the 23.06.25. Centre Management has developed a supervision schedule, which is overseen by The Regional Manager and Quality Assurance Department.	Senior Management will conduct a review of Supervisions by the 30.07.25 & 30.09.25 to ensure a change in practice has occurred.