An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 052

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Care Ireland**
Registered Capacity:	**Six young people**
Type of Inspection:	**CAPA Review**
Date of inspection:	**28th & 29th January 2025**
Registration Status:	**Registered from 6th December 2024 to 6th December 2027**
Inspection Team:	**Lisa Tobin** **Eileen Woods**
Date Report Issued:	**22nd April 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 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 6th of December 2009. At the time of this CAPA review the centre was in its sixth registration and was in year one of the cycle. The centre was registered without attached conditions from 6th of December 2023 to 6th December 2027.

The centre was registered to provide medium to long term care for six young people from age thirteen to seventeen years on admission. The centre supports young people who come under the care status of separated children seeking international protection (SCSIP). The centre worked from the Welltree model of care, whose goal was that each young person is protected, respected, and fulfilled. The model was trauma informed and encompassed attachment theories with a focus on challenge and support. There were six young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated 20th and 21st May 2024. Inspectors gathered the relevant documentation and reviewed these both in the centre and remotely. The centre manager was interviewed in the centre and five of the young people completed questionnaires to gather all the relevant information.

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 March 2024. 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 not fully implemented the required actions and that further work is required. A compliance meeting occurred with the management team of the service on the 11th of April 2025. An updated service improvement plan is required to be provided to ACIMS by the end of July 2025. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 052 without attached conditions from the 6th of December 2024 to the 6th of December 2027 pursuant to Part VIII, and 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 11: Religion
Regulation 12: Provision of Food and Cooking Facilities
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.1 Each child experiences care and support which respects their diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child.

Standard 1.4 Each child has access to information, provided in an accessible format that takes account of their communication needs.

Issue Requiring Action:

- The centre manager must ensure the young people receive feedback on any issues that they raise at young people's meetings, that there are records kept about the feedback and their response.
- The centre manager must ensure that curfews and interventions undertaken are equal, realistic, and reasonable for all young people.
- The centre manager must ensure that any disclosures made by young people remain confidential and are only shared with relevant people with the young person's knowledge.
- The centre manager must ensure that when disclosures are made by the young people that they are identified and reported as required on a CPWRF.

Corrective Actions:

- The Centre Manager (CM) has developed and will oversee a forum where the CM, or alternatively the team leader in-situ, will meet with the young people to provide feedback on the issues they have raised. In place now.
- The CM has met with each young person to discuss their curfew times. The curfew for each young person is developed in collaboration with the social work department here it is agreed and signed off by the allocated social worker.
- The CM has, in several team meetings, emphasised to staff the confidentiality of disclosures by young persons and how this information is only shared with

the relevant people and professionals with the young person's knowledge (July 2024).

- The CM ensures that each member of staff follows the protocol in meeting their obligation of CPWRF disclosures through submissions via the Tusla portal to the relevant social work department. Completed in August 2024.

Review Findings:

This CAPA relates to an inspection that took place in May 2024. Inspectors interviewed the new centre manager who commenced employment in September 2024. During interview with the centre manager, inspectors were informed that they had been using the CAPA document to focus their work and implement the actions identified since their appointment.

Inspectors reviewed the new format of the young people's meetings and found that they were being held weekly and that a new feedback form had been introduced to be completed after each young person's meeting. This new feedback form was not being used on a consistent basis and read like a request form rather than a feedback form. The feedback form required revision to ensure it is being used appropriately where the issues raised by young people are identified and responded to in order to show the consistency throughout the process. In the sample of governance meeting minutes reviewed, inspectors found discussion about certain areas of the young people's lives discussed but not necessarily the young people's meetings or the feedback form aspect which was committed to in the CAPA that this would be discussed at governance meetings.

Individual absent management plans (IAMP's) were on file for each young person. For the majority, they had been updated monthly although some were not. Inspectors saw that social workers had signed off on the IAMP's. During interview with the centre manager, inspectors were informed that the curfews were now determined by age, any known risks and in agreement with the social worker. Inspectors found that there weren't any risks identified but there were different curfew times for each young person despite four of them being the same age at the time of inspection. This had been an outstanding issue during the inspection in May 2024 in which the young people were vocal about the differences in their curfew times. The centre manager forwarded updated IAMPs post inspection which showed those four young people now had the same curfew.

The centre had introduced a new induction form for staff for signing off on policies that are in place. The staff team had been provided with further external specialist

training around child safeguarding and managing disclosures in November 2024 on the backfoot of the inspection findings around gaps in child protection reporting procedures. All current staff had completed mandated persons training online and inspectors were satisfied that any disclosures and concerns had been appropriately reported. Inspectors reviewed a sample of team meeting minutes and found that identifying disclosures and the procedures in reporting child protection concerns were discussed regularly since the new centre manager commenced in the centre.

Since the last inspection in May 2024, it was evident to see that changes were continuing to occur in the areas of ensuring the young person's rights were being protected and that their voices were being heard however there was still areas requiring refinement and further focus which have been mentioned above. The young people's questionnaires identified areas where further responses were required from the centre staff which included the types of food in the centre, understanding what was expected of them in the centre, storage availability, and the changes/numbers of staff.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 11** **Regulation 12** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 1.4**
Practices met the required standard in some respects only	**Standard 1.1**
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 5.2 The registered provider ensures that the residential centre has effective leadership, governance, and management arrangements in place with clear lines of accountability to deliver child-centred, safe, and effective care and support.

Issue Requiring Action:

- The registered provider must ensure that the governance systems in place identify and respond appropriately to the day to day running of the centre.
- The registered provider must ensure that there is oversight from the governance team to address the actions that had been identified from the audit undertaken in February 2024.
- The centre manager must ensure the staff are aware of who the Designated Liaison Person is.
- The registered provider must ensure that the policies and procedures reflect and are relevant to the new purpose and function of the centre.
- The centre manager with the governance team must ensure there is a robust risk management framework in place and that it is reviewed to ensure its effectiveness.
- The registered provider must ensure there is sufficient alternative arrangements in place when the person in charge is absent.

Corrective Actions:

- The registered provider will expand the membership of the Proprietor's Governance Meeting (PGM) to include a professional social worker (PSW) to enhance the governance and day to day running of the centre. 1 September 2024.
- The PGM is overseeing the implementation of actions arising from the February 24 Internal Audit. Ongoing, for completion by 30 August 2024.
- The PGM has appointed the CM as the DLP; team leaders have been informed, and staff have been briefed.
- The PGM adopted (18th June) a revised purpose and function that reflects the care of SCSIP. Policies and Procedures will be reviewed in line with the new purpose and function. For completion by 31 October 2024

- The CM reviewed and the PGM adopted a high-level policy towards embedding risk management in the service. The CM will implement a new risk management framework in line with applicable HIQA national standards for completion and review by 1 October 2024.
- Vacancies in the management team (CM and two team leaders) have been filled and the team strengthened. The centre is now operating with the CM and three team leaders. (July 2024). The CM has an on-call system in place. The centre is represented six days a week with a management structure of the CM and / or an on-duty team leader.

Review Findings:

The governance structure of the organisation had changed since last year with a number of additions. There was a second registered provider, an area manager, and a principal social worker (PSW) linked to the organisation that also sat in on the governance meetings and each had a role within the running of the organisation. The area manager and the PSW were both supporting the new centre manager in their role in a mentoring capacity and also with oversight of the day to day running of the centre. The area manager was providing supervision to the centre manager and had commenced undertaking audits recently since taking up their post in September 2024. There were no audits noted prior to this from any other person on the governance group until the quality improvement plan in October 2024. Governance meetings were due to be held bi-monthly although gaps were noted by inspectors in July 2024 and in January 2025. In reviewing the minutes of the governance meetings, inspectors found it difficult to ascertain what actions or follow up was required. Inspectors found that there were improvements noted from the governance discussions but that they would benefit further from being more specific, showing accountability and further discussions that were relevant to the delivery of service.

An external audit was completed in November 2024 on aspects of theme three and six of the National Standards. Fourteen actions were identified from this audit and although inspectors were informed these were completed, the responses would require further detail to show the evidence of the completion of tasks as some were shown as ongoing. There was little discussion noted in the governance meetings about the overall findings of the external audit or how the actions were being responded to. This external audit was contradictory to the annual quality improvement plan (QIP) undertaken in October 2024, which showed the centre was in compliance with all areas bar one around probations. This would require review

from the governance team in their learnings around the results from both reports and establishing how best to deliver outcomes from the actions identified.

The centre manager had undertaken audits since in post covering a range of areas related to service delivery and governance however, inspectors found these audits were not directly identifying gaps, needs, risks, responses, or team capacity in detail. For example, theses audits did not notice the gaps with delays receiving care plans for the young people. There were not any outcomes attached to this audit and there was no response noted from the area manager about how this audit benefits and supports the centre manager with governance oversight in their new role. The area manager had commenced quarterly audits in January 2025. There were aspects of theme one reviewed from the National Standards for Children's Residential Centres HIQA (2018). There were seven actions identified for follow up by the centre manager.

The PSW was meeting regularly with the centre manager via MS Teams and in person. The PSW was supporting the centre manager with advice and problem solving, helped with creating sample forms and looked at the overall wellbeing of the young people. Where the centre manager identified that these sessions with the PSW were beneficial, there were no minutes of their meetings which may benefit the centre manager to have for reference later. The PSW also attended the fortnightly governance management meetings.

Inspectors reviewed a sample of the team meeting minutes which showed discussion about who the designated liaison person (DLP) was and what their role entailed. There was reference to this in the new induction sign off sheets for staff where details of the DLP were made known.

The purpose and function of the centre had been updated in June 2024 however, when inspectors reviewed this, there were references to foster placement, HSE protocols and outdated National Standards. There were similar findings when reviewing the updated policies and procedures where the age profile was incorrect, there was no reference to the young people being cared for under the status of SCSIP and the policies continued to read as mainstream residential care rather than the new purpose and function. Both require review to ensure they are relevant to the current purpose and function.

In the inspection in May 2024, there were deficits in the risk management framework where appropriate oversight and reviewing of risks was not occurring. During interview with the centre manager, inspectors were informed of a new risk register

that was in place since December 2024, training on risk management and risk registers was undertaken and that this was reviewed with the area manager. The centre manager informed inspectors that there was further work required around risk management, and it was to be brought to the governance team to review the current risk management structure and be completed by February 2025.
Inspectors found that there were individual risk assessment books in place for each young person. There were gaps in the risk assessment books during the change in management which makes it difficult to determine if there were any or if this was not being completed. Some risks identified were not risks and required review with the team as to what constitutes a risk to a young person. Oversight from centre management of the risk assessment books was noted from 2025 onwards but not in the 2024 records. The general pattern from the risk assessment books showed that there was a reduction in the use of the risk assessments since the new centre manager commenced and that they were now being signed off by centre management showing oversight.

The risk register was described to inspectors as a live document and therefore changed as risk changed. However, inspectors were informed of a risk that had reduced for a young person but was still described as a high risk and the change was not reflected in the risk register. Centre management and staff must ensure that the risk register is reviewed and updated to reflect the current risks and concerns for the young people. There were references in the governance meetings where risks and concerns had been identified and discussed for some young people, however this was not consistent and would be beneficial to ensure senior management continue to have awareness of the risks the centre holds to respond appropriately and effectively.

Overall, the risk management framework has improved since the last inspection as some areas were being used better. There was still evidence as noted above that there continues to be areas that require further development to ensure all aspects of the risks are being reviewed and monitored appropriately.

Since the last inspection, the management structure has been added to with a second team leader in place. There is now a centre manager and/or a team leader in the centre six days a week. When the centre manager is absent, the team leaders act up in their place.

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

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