



An Ghníomhaireacht um  
Leanaí agus an Teaghlach  
Child and Family Agency

## Alternative Care - Inspection and Monitoring Service

### Children's Residential Centre

**Centre ID number: 070**

**Year: 2025**

## Inspection Report

|                              |   |
|------------------------------|---|
| <b>Year:</b>                 | <b>2025</b>   |
| <b>Name of Organisation:</b> | <b>Peter McVerry Trust</b>  |
| <b>Registered Capacity:</b>  | <b>Five young people</b>  |
| <b>Type of Inspection:</b>   | <b>Unannounced</b>  |
| <b>Date of inspection:</b>   | <b>26<sup>th</sup> &amp; 28<sup>th</sup> of August 2025</b>                     |
| <b>Registration Status:</b>  | <b>Registered from 04<sup>th</sup> March 2024 to 04<sup>th</sup> March 2027</b> |
| <b>Inspection Team:</b>      | <b>Mark McGuire<br/>Lisa Tobin</b>  |
| <b>Date Report Issued:</b>   | <b>30<sup>th</sup> October 2025</b>   |

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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 4<sup>th</sup> of March 2003. At the time of this inspection the centre was in its eighth registration and was in year two of the cycle. The centre was registered without attached conditions from 4<sup>th</sup> of March 2024 to the 4<sup>th</sup> of March 2027.

The centre was registered to provide medium to long term care for up to five young people aged between 12 to 17 upon admission. However, the centre chose to accommodate a maximum of four young people at any one time. The centre operated a strengths-based therapeutic model of care which was trauma informed within which individualised planning for young people was guided by a recognised therapeutic placement planning model. There were four young people living in the centre at the time of the inspection.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme                                | Standard |
|--------------------------------------|----------|
| 1: Child-centred Care and Support    | 1.6      |
| 3: Safe Care and Support             | 3.1      |
| 4: Health, Wellbeing and Development | 4.2      |

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 22<sup>nd</sup> of September 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 10<sup>th</sup> of 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: 070 without attached conditions from the 4<sup>th</sup> of March 2024 to the 4<sup>th</sup> of March 2027 pursuant to Part VIII, 1991 Child Care Act.

### 3. Inspection Findings

**Regulation 5: Care Practices and Operational Policies**

**Regulation 16: Notification of Significant Events**

**Regulation 17: Records**

**Theme 1: Child-centred Care and Support**

**Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.**

Inspectors found strong evidence that young people's views and preferences were listened to and taken into account within the centre. The tracking of feedback from young people was generally of a high standard, with printed records of comments linked to a broader feedback register. Inspectors reviewed documentation that demonstrated how team discussions around young people's feedback were captured and reflected back to the young people, alongside recording their response to these outcomes. This demonstrated a strong culture of young people's consultation.

However, inspectors found that the process was not always used to its full effect. There were instances where young people were described in logs as having made a complaint, but these were not logged as such in the feedback and complaints register, despite being low-level in nature. Inspectors also found that the team needed to ensure that young people were fully informed about the Tusla Tell Us feedback and complaints procedure, and that this information was refreshed periodically, particularly when patterns of concern emerge, as was the case for one young person who spoke with inspectors as part of the interview process. This young person expressed frustration with the social work department when they met with inspectors, and it was recommended that this be followed up with them to ensure they knew how to raise such concerns through the Tell Us procedure. Centre management responded proactively to this recommendation ensuring individual work was refreshed with the young person with this regard. Inspectors spoke with this young person's allocated social worker who advised the matter had been addressed with them also and that the care team had supported the young person by advocating on their behalf too. A meeting with the social work team was scheduled to allow this young person to voice their views further.

While some issues require improvement, inspectors observed that low-level difficulties raised by young people were taken seriously, discussed by the team, and outcomes were fed back to the young people demonstrating a child-centred ethos.

Inspectors also noted that while the complaints register included an “outcome” column, it would be strengthened by linking directly to relevant supporting documents, such as any significant event notifications (SENs) that were completed in response.

There was clear evidence of a culture of openness and transparency within the centre. Young people told inspectors they could approach staff at any time and expressed that they felt listened to and liked living in the centre. The voice of young people was also captured through changes made to the centre’s environment, such as updates to the garden area, which were discussed in team meetings and implemented as a result of young people’s input. All of the social workers interviewed as part of the inspection complimented the care team for their engagement with young people and on how they listened to and valued their input.

However, one of the young people reported feeling misunderstood at times, particularly with regards to their expressed preferences when staff were responding to them in moments of distress. The young person named that while they felt staff responded quickly to them from a place of care, that they would prefer space to vent and express themselves, as opposed to having an immediate ‘fix’ presented to them. This should be revisited to ensure the team captured and responds to their preferences appropriately in daily practice.

The centre’s complaints policy and process required review and update. Inspectors noted references to complaints being referred to the HSE using HSE templates as part of the service’s wider operations. Centre management acknowledged this and committed to addressing the issue as part of a service wide policy review that was currently taking place. Once updated, the revised policy should be revisited with the team to ensure consistent understanding and application. While staff demonstrated a good understanding of the current process and the stages involved, inspectors found that the young person’s induction booklet could better capture the complaints process. This could include a sample complaint form and expanded information on the UN Convention on the Rights of the Child and contact details for EPIC (Empowering People in Care) and the Ombudsman for Children’s Office. Despite this, inspectors found that young people were well linked with advocacy services,

including EPIC, and one young person spoke positively about attending training and information sessions at the Ombudsman for Children’s Office.

| <b>Compliance with Regulations</b> |   |
|------------------------------------|---|
| <b>Regulation met</b>              | <b>Regulation 5<br/>Regulation 16<br/>Regulation 17</b> |
| <b>Regulation not met</b>          | <b>None Identified</b>                                  |

| <b>Compliance with standards</b>                                 |   |
|--|---|
| <b>Practices met the required standard</b>                       | <b>Not all standards under this theme were assessed</b> |
| <b>Practices met the required standard in some respects only</b> | <b>Standard 1.6</b>                                     |
| <b>Practices did not meet the required standard</b>              | <b>Not all standards under this theme were assessed</b> |

#### **Actions required**

- Centre management must ensure that all complaints are consistently recorded and categorised within the complaints register, and that the register links to any associated supporting documentation, such as SENs, where applicable.
- The registered proprietor must review and update the complaints policy and revisit this with the team on completion.

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

#### **Theme 3: Safe Care and Support**

**Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.**

Inspectors found that the centre had a comprehensive suite of policies in place relating to child protection and safeguarding, whistleblowing, social media use, bullying prevention, and procedures for managing allegations of abuse. A clear one-page guideline was also displayed in the staff office outlining the process for making child protection and welfare referrals via the Tusla portal, including details of external notifications required and the accompanying SEN and internal reporting procedures.

All staff were trained in Children First (three online modules) and the online Tusla Mandated Persons training. In addition, staff were expected to complete internal child protection training tailored to residential care, which explored centre-specific safeguarding scenarios and appropriate responses, as well as the centre's own child protection policies. These policies were found to be well understood by the staff team during interviews with inspectors.

Inspectors found that a bullying prevention policy was in place. While there were no current incidents of bullying, the team demonstrated familiarity with the policy and a clear understanding of the centre's zero-tolerance approach. Staff remained vigilant in supervising even minor disagreements between young people to mitigate risks.

A procedure was in place for managing risks associated with visitors to the centre. Risks relating to digital media use and child sexual exploitation (CSE) were addressed through a recently updated child safeguarding statement (CSS). Inspectors found that the CSS was well understood by the team.

However, inspectors noted that an outdated CSS remained on display in the staff office and required immediate replacement. The Director of Services explained the delay was due to the service awaiting professional printing of the recently updated CSS for distribution service wide. Additionally, the CSS did not identify mandatory training in CSE as a mitigating measure for the identified risk, and inspectors found that not all staff had completed this training at the time of inspection despite it being a current risk for young people. Centre management must ensure this training is completed by the full team. The head of service committed to addressing this without delay post inspection.

Inspectors reviewed an incident where a CSE related risk was managed effectively. As a response to safety concerns with this regard for one young person, inspectors saw how when they were missing child from care (MCFC), specific check in calls were to be implemented at night as part of their risk management plan (RMP). However, inspectors found that recording of night-time check in calls required greater consistency to demonstrate alignment of practice with the agreed RMP. Furthermore, there was no accompanying risk assessment to address potential staff safety concerns related to sleep disruption and broken rest. While an informal support plan for staff was in place — including time off in lieu and managerial support — a formalised approach would strengthen practice.

Staff demonstrated a good understanding of the RMPs in place and were proactive in supporting young people during times of crisis or MCFC episodes. Inspectors observed caring and responsive approaches from the care team, along with prompt notification and dialogue with relevant professionals including liaison with An Garda Síochána and social work. There was also evidence of regular and ongoing strategy meetings to review the safety of young people where required. Social workers interviewed by inspectors all noted that there was positive and prompt communication from the team when risk presented and of how they felt well informed of such matters.

Inspectors found that while all staff were able to access the Tusla portal and had individual accounts to submit Child Protection and Welfare Report Forms (CPWRFs), there were gaps in child protection reporting. One disclosure of child sexual abuse (CSA) had been missed by the care team and had not been submitted as a CPWRF, and a collective safeguarding concern involving serious criminality and potential criminal exploitation risks was also not reported. These reports were subsequently submitted retrospectively following inspectors' feedback, which demonstrated a proactive response from centre management. Inspectors also noted gaps in the child protection register, including a missing entry to correspond with a submitted CPWRF and another with a mismatched reference number.

Despite these shortfalls, inspectors found that, in general, child protection concerns were responded to promptly, with notifications sent without delay and timely discussions taking place with social workers. Accompanying SENs were submitted as required, and inspectors reviewed several high-quality individual work records which demonstrated an empathic and supportive approach to working with young people around safeguarding concerns. Social workers interviewed also praised the care team for their response to young people while in crisis, noting how supportive and committed they were to the best interests of the young people living in the centre.

Inspectors found that parents were appropriately notified of incidents in most cases, but on some occasions, incorrect options were selected on CPWRFs to reflect this communication.

Inspectors found that individual vulnerabilities were captured within Positive Behaviour Support Plans, Individual Crisis Support Plans and Absence Management Plans (AMPs). However, some gaps were identified, including insufficient detail regarding the therapeutic response to a mental health concern for one young person and incomplete recording of communication preferences for another. While the

medical response to the mental health concern was documented thoroughly, the therapeutic elements could have been strengthened with input from the relevant specialist services that were guiding the young person’s care.

Inconsistencies were noted between practice documents and AMPs regarding when a young person should be classified as missing from care, and inspectors found outdated terminology such as “AAR” (Absent at Risk) still in use. The An Garda Síochána/Tusla Joint Working Protocol makes clear that young people are either missing from care or not missing from care, and terminology must be aligned to reflect this – particularly given the significant risks associated with the two young people with significant missing episodes.

Inspectors found that the centre’s protected disclosures (whistleblowing) policy was well understood by the staff team.

| <b>Compliance with Regulation</b> |                                       |
|-----------------------------------|---------------------------------------|
| <b>Regulation met</b>             | <b>Regulation 5<br/>Regulation 16</b> |
| <b>Regulation not met</b>         | <b>None Identified</b>                |

| <b>Compliance with standards</b>                                 |   |
|--|---|
| <b>Practices met the required standard</b>                       | <b>Not all standards under this theme were assessed</b> |
| <b>Practices met the required standard in some respects only</b> | <b>Standard 3.1</b>                                     |
| <b>Practices did not meet the required standard</b>              | <b>Not all standards under this theme were assessed</b> |

### **Actions required**

- Centre management must ensure that all staff complete mandatory CSE training.
- Centre management must ensure that CPWRFs are submitted in line with centre policy and Children First.
- Centre management must ensure that that child protection register is accurate, complete, consistently aligned with submitted CPWRFs.

## Regulation 10: Health Care

### Theme 4: Health, Wellbeing and Development

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

Inspectors found that, while there was no formal health and development assessment on file for the young people, their medical needs were generally well attended to. All young people were registered with a General Practitioner (GP) and had access to appropriate medical assessments and treatment as required. One young person refused all offers of medical intervention despite staff making persistent and creative efforts to encourage engagement.

Inspectors found that specialised assessments were on file for two young people. Staff were actively working on the recommendations arising from one of these assessments and demonstrated efforts to liaise with the social work department regarding psychiatric support recommendations. Inspectors noted that consideration of privately funded psychiatric input could be explored further to ensure timely access to supports, given the limited timeframe remaining for one young person in placement.

However, recommendations from the mental health assessment for another young person were not consistently documented in intervention plans. This created some confusion among staff as to whether there were ongoing child sexual exploitation (CSE) concerns for this young person, which was later confirmed by centre management as not being a current concern.

A record of medical interventions was maintained, including dental and GP appointments and hospital visits. However, immunisation records were missing from the young people's files, and there was no evidence of escalations or follow-up requests to secure these records.

Inspectors reviewed an incident involving a medication error. While the relevant social worker had been informed and a "need-to-know" notification submitted, an accompanying SEN had not been completed. Staff responded appropriately in the immediate aftermath by contacting the Poison Information Centre and carrying out required observations. The centre manager acknowledged their oversight regarding

submission of the SEN notification and submitted one retrospectively during the inspection process.

From review of the medication folders, inspectors identified that staff had not been following the centre's own medication management policy. Issues identified included:

- Controlled medications were not always administered by two staff members as required.
- Medication administration signatures were missing on some occasions.
- Routine audits of medication practices were not being completed.
- A loose tablet was found within the medication cabinet.
- Controlled medications were not consistently double-locked as required by policy.

While supervision sessions were conducted with the two staff members involved in the medication error, inspectors found that the failure to follow policy was not fully identified or addressed during supervision. Inspectors emphasise the importance of management being fully aware of, and consistently enforcing, centre policies and procedures, and best practice in medication management.

Inspectors also noted that the supervision records referred to were not consistently double-signed by both supervisor and supervisee. However, it was clear to see the staff members in question responded appropriately and transparently to this incident and had ensured they learned and developed from this event. This incident was also brought to the attention of the full team by centre management and used as a learning opportunity.

Inspectors acknowledged the prompt and constructive response of senior management following the inspection feedback. A medication audit tool was introduced, and all staff were scheduled to undergo retraining in medication management, including the head of service. These actions demonstrated a proactive approach to addressing inspection findings and ensuring practice was realigned to policy and best practice in medication management.

| <b>Compliance with Regulation</b> |                        |
|-----------------------------------|------------------------|
| <b>Regulation met</b>             | <b>Regulation 10</b>   |
| <b>Regulation not met</b>         | <b>None Identified</b> |

| <b>Compliance with standards</b>                                 |   |
|--|---|
| <b>Practices met the required standard</b>                       | <b>Not all standards under this theme were assessed</b> |
| <b>Practices met the required standard in some respects only</b> | <b>Standard 4.2</b>                                     |
| <b>Practices did not meet the required standard</b>              | <b>Not all standards under this theme were assessed</b> |

### **Actions required**

- Centre management must ensure that SENs are completed for all medication errors.
- Centre management must ensure full compliance with the centre's medication management policy.

## 4. CAPA

| Theme | Issue Requiring Action   | Corrective Action with Time Scales  | Preventive Strategies To Ensure Issues Do Not Arise Again  |
|-------|--|---|--|
| 1     | <p>Centre management must ensure that all complaints are consistently recorded and categorised within the complaints and register, and that the register links to any associated supporting documentation, such as SENs, where applicable.</p> <p>The registered proprietor must review and update the complaints policy and revisit this with the team on completion.</p> | <p>Centre management will review complaint and feedback categorisation and completion of the relevant register with all required documentation with the staff team during team meeting on 08.10.25.</p> <p>Complaints register was amended to include 'related documentation completed/ reference number' to support clarity.</p> <p>The organisation is currently completing a scheduled review of the complaint's policy; the director of child and family services will ensure this review incorporates children's residential specific procedure.</p> <p>Once the organisational review has been completed, the policy and children's</p> | <p>Centre management will oversee all complaints made and oversee accurate recording of same.</p> <p>Head of service and professional support manager will review complaints and feedback registers as part of monthly audits schedule and on other visits to the service.</p> <p>Centre management will review children's residential complaints policy annually with the staff team to ensure full understanding of process. This will be reviewed by head of services and professional support manager during scheduled audits.</p> |

|          |   |   |  |
|----------|---|---|--|
|          |   | residential service’s procedure will be reviewed with the team.   |  |
| <b>3</b> | <p>Centre management must ensure that all staff complete mandatory CSE training.</p> <p>Centre management must ensure that CPWRFs are submitted in line with centre policy and Children First.</p> <p>Centre management must ensure that that child protection register is accurate, complete, consistently aligned</p> | <p>Outstanding CSE training has been completed by relevant staff members. A further in-person CSE training was requested and is scheduled also on the 12.11.2025.</p> <p>Centre management have reviewed CPWRF submissions with staff on the 10<sup>th</sup> of September.</p> <p>As part of the roll out of the updated organisational child protection policy. An in-house workshop is scheduled to begin on 5<sup>th</sup> of November 2025 to further support the learning, development and adherence to policy and Children First principles.</p> <p>Centre management have reviewed the child protection register to ensure it is accurate and aligned with submitted</p> | <p>Centre management will ensure that the staff team complete CSE training every 2 years or when required.</p> <p>Centre manager will continue to oversee submission of all CPWRF’s. Head of services and professional support manager will review as part of audit schedule. Head of services scheduled to complete mandated person train the trainer training in October/November 2025 – once completed will support delivery to the staff team and as an ongoing support.</p> <p>Centre management will ensure all CPWRF’s are recorded on child protection register. Head of services and professional</p> |

|   |   |  |   |
|---|---|--|---|
|   | with submitted CPWRFs.  | CPWRF's. Centre management are reviewing the child protection register and have moved to weekly monitoring of all CPWRFs recorded.   | support manager will review as part of scheduled audits.<br><br>Monthly child protection specific meetings have been scheduled with all children's residential services managers to support oversight.  |
| 4 | Centre management must ensure that SENs are completed for all medication errors.<br><br>Centre management must ensure full compliance with the centre's medication management policy. | The medication management policy was reviewed with the staff team on 10.09.25, this review included ensuring that a medication error is notified as an SEN.<br><br>To support compliance all staff refreshed medication management in CRS training by September 30 <sup>th</sup> , 2025.<br><br>Administration of medication audit template is being completed by centre management monthly from September 2025. | Centre management will ensure staff team complete medication management training every 2 years.<br><br>Head of services and professional support manager will review administration of medication audit as part of scheduled audits.<br><br>Medication management policy currently under review by the senior management team, expected to be completed by end of November 2025. Once completed will be reviewed with the staff team. |