An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 101

Year: 2025

Inspection Report

Year:	2025
Name of Organisation:	Huruma CLG t/a Wellsprings
Registered Capacity:	Six young people
Type of Inspection:	Unannounced
Date of inspection:	14th & 15th January 2025
Registration Status:	Registered from the 03rd November 2025 to the 03rd November 2028
Inspection Team:	Paschal McMahon Joanne Cogley
Date Report Issued:	8th April 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 03rd November 2007. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle. The centre was registered without attached conditions from the 03rd November 2022 to the 03rd November 2025.

The centre was registered to provide residential and aftercare services for young women who cannot live at home and who do not have enough ongoing support to enable them to live independently. It provides short to medium term placements for up to six residents between the ages of 16 and 23 years in a structured living environment that includes a "home feeling". The centre worked in partnership with Tusla and the aim of the service was to equip each young person with skills for independent living and adulthood, to identify their needs and help plan for the future. Central to the centre was an outreach service where the young people were welcome to visit for additional support both during their time in the centre and after they leave. 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
3: Safe Care and Support	3.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.3

Inspectors look closely at the experiences and progress of young people. 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. All young people in the centre were aged over 18 years at the time of inspection and two young people consented to the review of their care records by inspectors. They conducted interviews with the relevant persons including senior management and staff, the allocated aftercare 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

At the time of this inspection the centre was registered from the 03rd November 2022 to the 03rd November 2025. A draft report was sent to the registered provider and relevant social work department on the 3rd of March 2025. On the 11th March, the registered provider in their capacity as the chair of the board of management notified ACIMS that particular records presented to the inspectors had been altered and were not in fact a true representation of the record. As a result of this notification, the inspection was paused to allow for formal steps to be undertaken by both ACIMS and the centre's board of management. This included an escalation to the National Registration and Enforcement Panel.

A second draft inspection report was issued to the registered provider, senior management, centre manager and relevant social work departments on the 4th February 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 10th March 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: 101 without attached conditions from the 03rd November 2025 to the 03rd November 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 3.2 Each child experiences care and support that promotes positive behaviour.

The inspectors found that there was a positive approach to managing behaviour which was supported by a number of policies. Staff in the centre did not have formal training in a specific model of care. In interviews staff referred to the centre operating a trauma informed model of care. However, inspectors were informed by the service manager that the centre operated a relationship model of care and this should be revisited with the staff team. In practice it was evident that the centre drew from a number of approaches in their work with the young people which acknowledged that when young people live independently in the community they needed to rely on their inner resources to respond effectively to the different situations they will meet. The centre advocated positive forms of discipline, which emphasised the individual to assume a sense of responsibility for personal actions and develop an inner sense of self-discipline. Each young person signed a contract regarding their behaviour on their admission.

Training records provided to inspectors showed that all of the team with the exception of two relief staff had received training in the centres approved behaviour management model. The centre had two certified trainers who provided the training to the team. All those interviewed during the course of the inspection knew the young people well and were attuned to their emotional well-being. The centre had an anti-bullying policy in place which emphasised the centres culture of respect, fairness where the opinions of the young people and staff were taken seriously. Staff members gave clear consistent messages that bullying was unacceptable and there was no evidence of bullying occurring in the centre at the time of the inspection.

Inspectors were satisfied that the care team had a good understanding of the young people's needs and the underlying causes of behaviour. It was evident from staff interviews and confirmed by a young person who met with inspectors that individual work was being carried out with the young people to support them in managing their behaviour. However, this was not reflected in the individual work records on the two

young people's files viewed by the inspectors. These records in the majority of cases only included a brief description of the issues that were discussed with the young people and did not document any supports, strategies, decisions or outcomes of these discussions. Issues that arose in relation to impact of the young people's behaviour on each other were also discussed on a communal basis through young person's community meetings. Questionnaires completed by the young people all commented positively on the staff team and the care being provided to them and this was confirmed by a young person who met with the inspectors during the inspection. The allocated aftercare workers stated that the staff team provided a safe and caring environment for young people where they could learn better coping skills to prepare them for independent living.

The person in charge was satisfied that they were provided with the relevant background information on each young person prior to admission. Inspectors viewed evidence on the sample of care records reviewed that there was sufficient background information on file. Aftercare workers reported there was a lot of preparatory work and planning undertaken prior to the young people's admission to support them in managing any issues that may arise including strategies for managing any behaviour that challenges. Aftercare workers also stated that when behaviours of concerns arose strategy meetings took place with them, the young people and other professionals to address these concerns. Safety plans and individual crisis management plans had been developed when required.

The centre had a significant events policy to provide guidance to staff on the notification and recording of significant events for young people. It was evident from a review of the centres significant event register that there had not been a high number of significant events in the period under review. All significant event notification records on file were signed by the person in charge. In interviews staff stated that all serious incidents were reviewed at team meetings. One of the social care leaders, who was also a behaviour management trainer reviewed significant events in some cases for learning purposes and gave feedback to the team. Inspectors did not find discussions or learning in relation to significant events recorded in the sample of team meeting minutes reviewed and recommends that this information is recorded going forward. Inspectors found that there were no mechanisms or audits systems in place that evidenced the oversight and monitoring of the centre's approach managing behaviour that challenges.

The centre had a policy on the use of restrictive practices. Inspectors reviewed the current restrictive practices in place and was satisfied that the restrictive practices in

place were necessary and subject to regular review. During the inspection, inspectors identified one of the restrictive practices on file that did not have a corresponding risk assessment and recommended that an appropriate risk assessment is developed.

Compliance with regulations	
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 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that there are systems in place for the auditing and monitoring of the centre's approach to managing behaviour that challenges.

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.

Inspectors found that there was a management structure in place which provided accountability and authority within the centre. The centre was managed by a person in charge who had overall responsibility for the delivery of care and the day-to-day operation of the centre. The person in charge reported to a service manager who had oversight of the centre along with the organisations outreach service. It was evident that they were working collaboratively and providing good leadership to the team. This was supported through interview with staff members who stated that both the person in charge and the service manager were approachable and supportive. At the

time of the inspection the service manager was due to go on planned leave and there was a process in place to recruit an acting service manager. All aftercare workers allocated to the young people in placement commended the management in the centre. They confirmed that communication was excellent and they were strong relationships between all relevant parties.

There were clearly defined governance structures within the organisation. The service manager reported to a board of management which met eight times a year and they maintained regular contact with the chairperson of the board. Staff members stated they had met members of the board of management and there were plans for the chairperson to consult with the team in relation to the appointment of the new acting service manager.

The service manager confirmed there were appropriate service level agreements in place with Tusla and the HSE and there was evidence of regular meetings occurring to review these service level agreements with the relevant representatives. The centre received funding from a number of sources including Tusla who provided the funding for staffing. The centre management reported that the level of staffing in the centre was an ongoing concern. While additional staffing resources were made available to care for young people who were admitted under the age of eighteen, at times the centres staffing allowed for only two staff members on shift caring for up to a maximum of six young people, some of whom have high needs. Inspectors found that there had been a high level of sick leave in the year prior to the inspection which had also placed additional stress on the centres staffing resources. In addition, centre managers informed inspectors that the centre did not have an allocated training budget. This resulted in difficulties at times in providing staff with core training such as behaviour management training as the centre did not have the funding to provide relief cover to release staff from the roster.

The centre had an auditing system in place. The person in charge completed monthly audits and the service manager completed quarterly audits. The inspectors reviewed a sample of these audits conducted in the year prior to the inspection and found that all of the quarterly audits undertaken reviewed all eight themes of the national standards. While these audits recorded strengths, opportunities and actions under each theme they contained limited detail and commentary. The process lacked a sufficient analysis of each of the standards and did not assess the centre levels of compliance in key areas such as, child protection, behaviour management and risk management. Post inspection, the inspectors were informed that concerns had arisen internally regarding the accuracy of records presented at the time of the

inspection. This further highlights the need for a robust auditing system. Inspectors recommend that the service manager should review the audit process to ensure a more in depth analysis of the standards to assess the centres level of compliance. All of the audits reviewed outlined a number of follow-up actions to be undertaken by the team. Staff in interview told inspectors that they were made aware of the audit findings in team meetings and by email and were responsible for completing action plans.

The inspectors reviewed the centres policies and procedures and were satisfied that they were regularly reviewed and subject to approval by the board of management. Staff members interviewed confirmed that they had a role in this process and were delegated a number of policies and procedures to review and to provide feedback to the care team. There was also some evidence of policies and procedures being reviewed in team meeting minutes.

The centre had a risk management framework in place. The service manager maintained an organisational risk register and there was evidence that risks were discussed at board of management meetings. Individual risk assessments were developed for the young people when required. Two young people provided inspectors with consent to review their care files in the context of risk management. From review it was evident the centre had conducted pre-admission impact risk assessments. This accounted for the potential impact the referred young person may have but also the impact of current residents on the referred young person. Inspectors found that from reviewing these risk assessments that there were some risks identified in the referral information which did not result in the creation of risk assessments and inspectors recommend that the risk assessment process is more robust. The inspectors found there were effective on-call arrangements at evenings and weekends to support the team in responding to high risks or emergencies.

There was an appropriate internal management structure in place to support the person in charge. Three social care leaders were in post all of whom were very experienced in social care and had worked in the centre for long periods. The person in charge and the social care leaders held regular internal management meetings to review the operation of the centre, however, a number of deficits highlighted in this report were not identified by the management team.

There were alternative management arrangements in place when the person in charge was on leave. The service manager assumed responsibility for the centre in

their absence. There was also a clear delegation log in place whereby all staff were assigned a number of tasks and responsibilities within the centre.

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**

Actions required

- The registered proprietor must ensure there is a more robust auditing system in place to assess the centre's compliance with the national standards.

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 the centre had a very experienced, dedicated and committed staff team. All staff interviewed were clear on their respective roles and responsibilities and the management structure within the organisation. The inspectors found good care practices in the centre in accordance with policies and procedures. There was strong evidence that all those working in the centre were encouraged and supported to share their opinions, to hold one another accountable and to use their professional judgement.

Inspectors were satisfied that there were procedures in place to protect staff and minimise the risk to their safety. Staff in interview cited a number of protective measures including a lone working policy, protective disclosures policy and a zero

tolerance policy on violence which was made clear to the young people at the admission stage.

The centre had a culture of learning and development and an emphasis on shared learning. A number of the team had worked in the centre for many years and had built up a high level of expertise which they shared with the staff team. As previously stated, the centre did not have a training budget. Despite this there were several staff members who had undertaken training opportunities in their own time and other staff were enrolled in a number of upcoming training courses.

Team meetings were held on a fortnightly basis. Inspectors reviewed the team meeting records in the period prior to the inspection and found that attendance at times was sporadic. Staff in interview reported that agenda items discussed at team meetings in addition to the progress of the young people included centre policies and procedures, risk assessments and training. Inspectors found that this was not evidenced in the recorded minutes of the meetings on file which primarily recorded the staff being provided with updates. Furthermore , the sample of meeting records viewed by inspectors did not include a review of previous meetings' actions or a record of the discussions that took place.
The centre had a supervision policy which stated that all full time staff would receive supervision six times a year and relief staff would be supervised every three months. Inspectors reviewed the supervision records and found that the frequency of supervision was not in line with the supervision policy. The provision of supervision had been impacted by the number of staff on sick leave and other forms of leave which resulted in a number of changes of supervisors and delays in supervision taking place. The centres supervision model was focused on three pillars of accountability, learning and support. Inspectors found that this was not reflected in the supervision records viewed by inspectors. The quality of supervision records also varied and in some cases, there was limited recording of supervision sessions. Post inspection, the inspectors were informed that concerns had arisen internally regarding the accuracy of supervision records presented to the inspectors. However, the inspectors found that this did not alter their findings in relation to supervision. Although some records were identified as having been altered, the original inspection findings remained unchanged: supervision was not taking place in line with policy, practice did not reflect the supervision model, and the recording of supervision sessions was limited.

There was a system in place to formally appraise staff members’ performance on an annual basis. A written record was kept of this appraisal and signed by the staff

member and the person in charge. Inspectors found that a number of staff had not had their annual appraisals. The person in charge informed the inspectors that these were in the process of being scheduled.

The inspectors found there were policies and procedures in place to support staff to manage the impact of working in the centre including a Compassion/Fatigue/ Vicarious Trauma policy and access to an occupational health programme. The team had participated in a wellness day prior to the inspection. All staff reported that there were good support systems in place and a culture of self-care and respect amongst the team.

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 service manager must ensure that the minutes of team meetings include a record of issues discussed and decisions made along with a review of follow-up actions agreed at previous meetings.
- The service manager must ensure that all staff receive regular supervision in accordance with the model of supervision and supervision sessions are recorded appropriately.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must ensure that there are systems in place for the auditing and monitoring of the centre's approach to managing behaviour that challenges.	• The centre has an established restrictive practice log which is reviewed regularly. • All incidents are reviewed by the centre's behaviour management instructor for learning and practice development. • PIC commentary is recorded on all incident reports. • Incidents and associated learning are discussed at team meetings and documented in meeting minutes. • Where required, issues arising from incidents are addressed through individual supervision and additional training. On return to post part time (Jan 2026), the Service Manager has reviewed documentation processes to ensure that this oversight is clearly and consistently	· Monthly review of restrictive practice log by PIC and Service Manager. · Standing agenda item at team meetings for review of incidents and learning. · Quarterly summary of behaviour incidents and trends to Board of Management. · Supervision records to reference any incident-related learning or development needs.

		evidenced. Recording expectations have been clarified with the management team to ensure that review, learning and follow-up actions are explicitly documented.	
5	The registered proprietor must ensure there is a more robust auditing system in place to assess the centre's compliance with the national standards.	The centre operates a multi-layered audit framework including: • Monthly PIC operational audits • Quarterly governance and compliance reports • Monthly keyworking audits • Medication management audits • Organisational risk register and biannual formal risk reviews with Board oversight Following a period of leadership transition during which formal quarterly audit reporting paused (May 2025 – February 2026), the audit framework was formally reviewed in February 2026. The framework has been strengthened to: • Explicitly align audit findings to	· Quarterly audit presented at Board meetings with documented oversight and challenge. · Random file sampling included in each quarterly audit · Cross-verification of supervision, behaviour management and team meeting documentation · Annual governance review of audit effectiveness by the board to be established.

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		each relevant National Standards • Include a formal compliance judgement per standard • Introduce structured action tracking with completion monitoring at all meetings! • Incorporate measurable trend analysis across incidents, complaints, supervision, training and risk The revised audit format will be implemented for the next quarterly review (April 2026).	
6	The service manager must ensure that the minutes of team meetings include a record of issues discussed and decisions made along with a review of follow-up actions agreed at previous meetings.	·Team meeting minute template reviewed and revised. New template now includes: Agenda items • Summary of discussions • Decisions made • Named person responsible • Timeframes • Review of previous action points	

		· Chairperson of meeting assigned responsibility for minute quality. · Service Manager to review minutes monthly for governance assurance.	
	The service manager must ensure that all staff receive regular supervision in accordance with the model of supervision and supervision sessions are recorded appropriately.	· Supervision schedule for 2026 issued March 2026. · All outstanding supervisions scheduled for completion by 31st March 2026. · Supervision to explicitly reflect three pillars: • Accountability • Learning • Support · Supervisors briefed on recording standards at management planning day 5th March 2025. · Supervision compliance tracker introduced.	· Monthly supervision compliance monitoring by PIC. · Quarterly supervision compliance report to Board – discussed 9th March 2026. · Random supervision file sampling included in quarterly audit moving forward. · Annual review of supervision effectiveness incorporated into governance review (Q4 2026).

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