An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 163

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Tus Nua Childcare**
Registered Capacity:	**Four young people**
Type of Inspection:	**CAPA Review**
Date of inspection:	**16th and 17th June 2025**
Registration Status:	**24th October 2025 to 24th October 2028**
Inspection Team:	**Ciara Nangle** **Janice Ryan**
Date Report Issued:	**22nd October 2025**

Contents

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 in 24th October 2019. At the time of this CAPA review the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from 24th October 2022 to 24th October 2025.

The centre was registered to provide multiple occupancy care for up to four young people age thirteen to seventeen on admission. The model of care was described as the secure base model which was informed by attachment theory and resilience. There were four young people living in the centre at the time of the inspection.

1.2 Methodology

The inspectors examined the progress made by the centre with the implementation of the CAPA's from two separate inspections that occurred in March and October 2024. The latter inspection was completed by the risk response team (RRT) in line with a term of reference and the report was shared with the registered provider and supervising social work departments. However, due to potential identifying information reported on within, it was not published. There were actions generated following on from the RRT inspection, however most of the actions were similar in nature to the actions generated from the March 2024 inspection and as such their implementation can and has been considered in the centres progress in implementing the March 2024 CAPA. Where there was a variance in the action from the March 2024 inspection, the progress on the implementation of the RRT inspection actions will be referred to in the body of this report under the relevant theme.

Inspectors completed an announced blended inspection, both within the centre and remotely. Two young people were met with during the inspection and all four young people completed questionnaires. The acting centre manager and members of the staff team were interviewed. Centre documentation and young people's care records relevant to the actions within the CAPA were also reviewed.

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, centre manager and to the relevant social work departments on the 15th August 2025. The findings from this CAPA review were used to inform the registration decision.

These findings determined that the centre had not fully implemented the required actions to address the deficits identified. A regulatory compliance meeting was held with the registered proprietor and centre manager on the 22nd September 2025. Assurances were provided from the registered provider in relation to the centre maintaining regulatory compliance.

The findings of this report and consideration to the assurances provided by the registered provider 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: 065 without attached conditions from the 24th October 2025 to the 24th October 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 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

Issue Requiring Action:

- The registered provider must ensure that all staff are familiar with and competent in their application of the centre's policies and procedures.
- The registered provider must ensure that the training database is kept up to date and that all certificates of completed training are maintained on personnel files.
- The registered provider must ensure that all staff maintain up to date training in the centre's mandatory trainings, as set out in their policy and procedures.
- The registered provider must ensure that placement plans contain specific and achievable goals for the month and key working plans are in place to support the young people addressing identified areas of need and vulnerability.
- The registered provider must ensure that the young people's risk register clearly indicates outcomes of reviews and rationale for closure of risk assessments and there is a clear mechanism in place to share this information with the team.
- The registered provider must ensure staff are familiar with the purpose of the protected disclosure policy and outline in the policy the external agencies to whom staff can report a concern.

Corrective Actions:

- The registered provider has engaged the services of an external consultant, and they are currently developing a practical day to day guide that will be delivered as a training piece for all new staff that join the service. This guide will be linked to the centre's policies and procedures and will aim to provide staff guidance on how our policies and procedures are being implemented in practical terms. This will be part of all new staff's induction and is in addition to our current induction that all staff read the centre's policies and procedures

and sign to confirm they understand them. This training will be provided to all staff by 12.07.24

- The registered provider has employed the services of a part time administer with responsibility for ensuring our training database is kept up to date. All training certificates will be held within a new HR system. This process has already commenced with existing training certificates already uploaded.
- The registered provider has changed the training service engaged that provides staff training. This service allows for individual staff to be trained and no longer relies on block bookings.
- The registered provider has completed work with the staff team in relation to placement planning for the young people. Key workers completing the young person's placements plans will ensure identified goals are realistic and achievable. Key working plans have been implemented and are used in consultation with the young people.
- Risk register will be discussed at team meetings to update the staff team on any changes to risk ratings and this will also include risks that have been closed. The reason for closure will also be documented on the initial risk assessment.
- The registered provider has discussed the protected disclosure policy will all staff at our team meeting on the 24.05.24. All staff are aware of the reporting protocol and to whom staff report a concern to.

Review Findings:

The registered provider had facilitated trainings days with the team where the policies and procedures were reviewed. These occurred in July 2024, September 2024, March 2025 and there was another scheduled for June 2025. These training days were provided to new members of the team after their induction to embed the practical implementation of the policies into practice. This training has been provided to all existing staff also. Staff in interview reported that they found the training days beneficial as they were practical and they were a good reminder of the policies they operated under. These training days also included discussions regarding the protected disclosures policy.

Following on from the March 2024 inspection, the registered provider had implemented a new online human resources (HR) system which held the personnel records and staff training certificates. This system was managed by an administrator as referenced in the CAPA. However, during the RRT inspection completed in October 2024, inspectors found that a dual system was in operation with some records being maintained online and some in paper files. The findings at the time of

that inspection were that neither system was fully operational or effective as there was documentation absent from personnel files and no clarity in relation to where these were being maintained. As part of the actions identified from that inspection, the registered provider opted to return to the paper filing system to ensure that they had one system effectively being used. As an online system was no longer in operation, the support from the administrator was no longer required and as such the actions within the CAPA relating to their role were no longer relevant and the responsibilities assigned to the administrator returned to the registered provider.

In light of the change in system, personnel files were reviewed as part of this CAPA review. On review of these inspectors found that training certificates were being maintained on the file. All staff had up to date children's first online training, mandated persons training and other relevant mandatory trainings had been completed or were arranged for newer staff members. A small number of staff required training in the framework for managing behaviour and the model of care, however planning for these was in progress. The centre maintained a training tracker with dates of completed trainings recorded within. Inspectors noted some minor errors on the training tracker with incorrect dates recorded. These were rectified during the course of this inspection. In interview with the acting centre manager, they had identified some of these errors and were aware of same and the training needs required. The centre continued to utilise an external agency to provide training to staff, however the ability to send staff individually rather than awaiting a block booking appeared to be more effective in ensuring the timely provision of mandatory training. The registered provider advised that they were now responsible for the tracking of training and ensuring that refreshers occurred on time. In order to achieve this the registered provided must ensure that the training tracker is kept up to date with accurate information to ensure effective governance and oversight.

While reviewing the personnel files, inspectors found that there continued to be documentation missing from files. Garda vetting was on file for all staff bar one. The absence of this vetting had already been identified during the RRT inspection and action to source it had been agreed. However, the vetting, which was from their country of origin, was still not available. A risk assessment had been put in place in relation to this and the risk was assessed to be low, however evidence of the efforts made since the October inspection to source the document, as set out in the risk assessment, were not available. The registered provider advised that the staff member had made some enquires to source this however advised that follow up in relation to sourcing this and recording the efforts made in relation to it will be completed as a priority. Additionally, on some files, some documents relating to safe

recruitment practices, namely reference checks and verification of qualifications in line with the organisations policy was not occurring. These policies must be adhered to ensure the safeguarding of all young people in the centre.

The placement planning document in place had been updated and now focused on specific and achievable goals for each month. The sample of placement plans reviewed were of good quality and were aligned to the young person's care plans. They were updated monthly and identified clear goals to be worked on with the young people. They identified the key working to be completed to achieve the goal, and contained resources staff could referred to, to support them in their work. There was some variance in the level of detail recorded within the plan, dependent on who was responsible for composing it. Further work around the writing and recording within the placement plan would be beneficial to ensure continuity across young people's records. There was evidence of the young person's voice being sought to be included within their plans.

There was a significant amount of key working being completed with the young people. Each day, within the shift planning document the area of key working to be completed with each young person was identified. At the end of the month a record of the completed key working was recorded on the young person's care record alongside the progress reports. The acting centre manager identified in interview that they planned to complete further work with the team to ensure they were differentiating between key working and significant conversations to ensure that they were accurately recorded. From the sample of key work reviewed, they were of good quality, and there was good engagement from the young people with various members of the team around the areas identified within the placement plans.

The young people who spoke with inspectors reported positively on the care they received. They could identify who their key workers were, however noted that they were not only reliant on their key worker if they wanted to speak about an issue or topic and noted good relationships with all members of the team. The young people spoke about their overall plans for summer and what they wanted regarding education, aftercare etc and these were in line with the goals within their placement plans. This suggests that the young people's voices are reflected within the planning documents. Inspectors observed the young people interact and engage with ease with staff and management. The centre had an open office policy, and inspectors observed staff to generally spend most of their time in the living areas with the young people. There was a warm welcoming atmosphere within the home and staff spoke positively and knowledgably about the young people throughout the course of the inspection.

The reviewing process for the young people's risk registers had improved since the last inspection. The register maintained included dates of review, the risk rating, if the risk remained opened or closed and associated significant events notifications (SENs) which informed the risk rating. The register was reviewed monthly by the management team and it was evident that these reviews were occurring.

The risks identified within the risk register had an associated risk assessment document which was maintained on the young person' care record while the risk was open and when closed the date of closure and reason for same was recorded on the document. The initial risk assessment was of good quality and contained a clear description of the risk, the control measures, the rating and additional measures in placement to mitigate against the risk. However, the risk assessments were not reviewed or updated to reflect the changes evidenced in the risk register. So, when a risk rating was reducing on review from the risk register, the risk assessment did not correspond with a reduced risk rating. Risk assessments were discussed within team meetings and staff could identify various risks for the young people.

Ongoing development and improvement in the recording and review of the risk management framework is required to ensure that they are consistent across the various documents within the risk management framework.

Overall, inspectors were satisfied that the registered provider had substantially implemented the actions agreed under this standard to address the identified deficits. However, inspectors found that further implementation and development of the actions, particularly relating to the risk management framework and personnel files was required.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1**
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 5.4 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.

Issue Requiring Action:

- The registered provider must ensure that all staff are trained in the centre's complaints policy and Tusla's Tell Us Policy and are competent in its implementation.
- The registered provider must ensure that individual work is completed with the young people in relation to complaints; both the centre's policy and Tusla's Tell Us policy, on a periodic basis to ensure they are aware how to make a complaint should they wish to.
- The registered provider must ensure that the various forums in place to review the quality, safety and continuity of care within the centre are aligned and learning from these forums is shared and applied in practice within the centre.
- The registered provider must undertake an annual review of compliance with the centre's objectives as per the National Standards for Children's Residential Centres, 2018 (HIQA).

Corrective Actions:

- The registered provider has discussed the complaints policy with all staff in their team meeting on the 24.05.24 and directed staff to the complaints policy where Tusla's Tell Us policy is mentioned.
- Individual key work was completed with the young people to remind them on their right to make a complaint and how to make a complaint. They were also informed about Tusla's Tell Us policy.
- The registered provider has engaged the services of a behaviour analyst to review the quality, safety and continuity of care within the centre through the monthly Significant Review Group (SERG) meetings. This will ensure that reflection and learning for the team can be more easily reviewed and evidenced.
- The registered provider has engaged an external consultant to support the service in undertaking an annual review of compliance. This will be completed August 2024.

Review Findings:

The registered provider had regularly undertaken reviews of the complaints policy with the staff team to ensure that they were clear on what constitutes a complaint and how it should be recorded and reported. As detailed above, training days on the centre's policies and procedures were completed with the team. In interview the team were clear around the complaints procedure and how to respond to the young people should they raise an issue of concern. From the sample of complaints reviewed, it was evident that these were reported in line with the policy. A SEN was completed and timeframes for follow up were adhered to. Feedback to the young people was provided and their views on the outcome recorded. During a sample of team meeting records reviewed, inspectors noted that discussions had occurred in relation to significant conversation records/daily logs where incidents were recorded however the complaints process had not been implemented when it should have been. These had been incidents identified by the registered provider. These were shared as learning opportunities with the team and the staff interviewed could identify the learning they had taken from these discussions.

For the young people, there was documented evidence of the complaints policy being discussed with them on their admission to the centre and records of them being provided with the young person's booklet where information on the complaints process was contained. For those who had been resident for an extended period of time, there was evidence of complaints being discussed periodically with them to ensure they were aware of the centre and Tusla's Tell us process. In meeting with the young people as part of this inspection, they could clearly articulate the steps to take to raise a complaint and who to speak with if they were not satisfied with any aspect of their care.

During the inspection in March 2024, the centre had an external behaviour analysist consulting with them and facilitating the monthly significant event review group (SERG) meetings. Changes within the format of these meetings had occurred following the last inspection, with the aim of them being clearer in terms of identifying the learning for the team so that it could be applied to practice. Within these meetings, the external clinician was supporting the team in identifying the underlying reasons for behaviours the young people presented with and identified steps to be taken by the team to support them more effectively. All staff were required to attend the SERG meeting and if absent to review the minutes. The external clinician ceased working with the centre in March 2025. Since that time the SERGs had been facilitated by the registered provider. On review of the minutes of these meetings, inspectors noted that the minutes did not clearly outline the identified

changes to practice required or learning nor did they identify trends or patterns within the events.

As part of this review inspection, the acting centre manager provided inspectors with a new template they intended to introduce to guide their SERG meetings. The acting centre manager and registered provided had identified that the SERGS and the records of these were not effective. This new template to guide the meetings provided for a more comprehensive review of specific SENs, with clear actions to be recorded at the end. These meetings would be led by the registered provider, continue to occur monthly with mandatory attendance required from the team. As this was only a new template inspectors were unable to verify at this time if it was effective in reviewing and improving the quality, safety and continuity of care.

An annual review of compliance for 2024 was completed by the registered provider and acting social care manager with support and guidance from an external consultant. This review considered the centres operation against each theme of the National Standards for Children's Residential Centres, 2018 (HIQA). It identified areas where further development within the operation and care provision was required to improve the level of care provided and included an action plan with timeframes for completion. A review of the implementation of this action plan was scheduled for July 2025 and was to be completed by the external consultant to identify what had been completed and what remained outstanding. Within the action plan, while timeframes were included, there was no identified person to complete the action. Further development of this process would support the effectiveness of the annual review.

Overall, inspectors were satisfied that action had been taken to address the deficits identified within the inspection in line with the agreed action plan. However, ongoing development of these actions within the centre will support the centre in the provision of good quality care.

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

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

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.

Issue Requiring Action:

- The registered provider must ensure that there are clear plans and structures in place to support the professional development of the team through reflective learning and training.
- The registered provider must ensure that staff's performance is formally appraised at least once a year in line with the National Standard's for Children's Residential Centre's, HIQA (2018).

Corrective Actions:

- The registered provider will implement an inhouse training day every six months to support staff development and to reflect on service delivery identifying strengths and weaknesses. To be start in September 2024 and take place every six months thereafter.
- The administrator will inform the centre manager and individual staff of when their appraisal is due for completion and the end of the staff probationary period and at the end of the employees first year. The management team will complete the staff appraisal with the individual employee.

Review Findings:

As detailed under the findings of standard 3.1, the registered provider had implemented staff 'inhouse' training days at least every six months. These were focused on the implementation of policies and procedures. They did not incorporate a reflective learning aspect. However, there was evidence of reflective learning being completed when reviewing the placements of two young people who have since moved on. Individual supervision with the team included some reflective aspects to support the team to develop insight into their own practice and support their professional development. Staff in interview reported an openness to training within the organisation and that they were encouraged and supported to attend training on an on-going basis. Training records indicated that there was an openness to training within the centre.

Additionally, the team had started to work with a clinician who had completed one session. This was a reflective piece of work to look at the young people's presentations and to help the team to understand the young people's needs and how this was impacting on them and their responses. This will be taking place monthly to support the team and develop their practice in line with the model of care. As this work had only commenced, and one session occurred prior to this inspection taking place, inspectors could not determine the effectiveness or quality of this intervention.

The centre manager was in an acting position and was completing one to one management training with an external facilitator to support their professional development. The acting manager had identified a number of areas they planned to work on developing within the service as they became more established in their role. At the time of this review inspection, there was no clear delegation of tasks between the registered provider, who was the person in charge, the acting centre manager and the newly appointed deputy manager. Development of a clear delegation of tasks is required to ensure that there is clarity for both management and the team in relation to who is responsible for what tasks. This will support the professional development of the newly appointed management team within the centre so they can be clear on their roles, responsibilities and develop in line with them. It will also allow for clear lines of governance and accountability within the management structure in the centre.

Staff appraisals had been occurring at periods aligned to probation reviews or annually dependent on the length of time in post. The date these appraisals were due was noted at the top of each staff supervision record and from the sample reviewed they appeared to be occurring in line with the required timeframes. The appraisal

noted areas to be worked on over the upcoming year and provided feedback to staff members of where they had progressed since the last appraisal was completed.

Probation reviews were completed with members of the team when required. However, these were documented on the same pro forma as the yearly appraisal and in the sample reviewed did not refer to the probation period and what the outcome was. In interview with the acting centre manager, they advised that this was something they themselves had identified and were working on developing.

Within the risk response inspection in October 2024, it was noted that one member of the team was working in a capacity other than they were qualified to. They were not working supernumerary on shifts. The registered provider advised that this would no longer occur. However, on review of the rosters on this inspection it was evident that they were continuing to work in a capacity outside of their qualifications. Within that staff members supervision records, probation review or appraisal there was no reference to them working outside of their qualification or any additional supports being provided to them in light of this. The member of the team achieved the required qualification in June 2025. Additionally, for a second staff member a complete record of their qualifications was not on their personnel file and as such inspectors could not ascertain if they had the required qualification for the role they were employed in.

The registered provider must ensure that only suitably qualified staff, who have been recruited and vetted in line with policy are employed to work in the centre as part of the core team. Staff employed as support workers, who are supernumerary on shift, as per the ACIMS regulatory notice regarding Minimal Staffing Levels and Qualifications for Registered Children's Residential Care Centres, August 2024, should only work within that capacity, and this should be clearly discussed and reflected within their supervision, probation, appraisal and other relevant personnel records.

Overall, inspectors were satisfied that steps had been taken to address the deficits identified within the March 2024 inspection. The system of staff appraisals was effectively implemented, and the actions relating to the professional development of staff members, reflective practice and training had been substantially implement. However, the registered provider must ensure that staff members only work in roles that they are suitably qualified for.

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