An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 165

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Daffodil Care Services**
Registered Capacity:	**Four Young People**
Type of Inspection:	**CAPA Review**
Date of inspection:	**13th and 14th of October 2025**
Registration Status:	**Registered from the 31st of October 2025 to the 31st of October 2028**
Inspection Team:	**Linda Mc Guinness** **Paschal Mc Mahon**
Date Report Issued:	**17th December 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 on the 31st 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 from the 31st of October 2022 to the 31st of October 2025.

The centre was registered to provide short to medium term care for four young people between the ages of thirteen and seventeen. The centre operated under a therapeutic support model which provided a framework for positive interventions with young people. The aim was to develop relationships focusing on achieving strengths-based outcomes through daily life interactions. There were two young people living in the centre at the time of the CAPA review.

1.2 Methodology

The inspectors examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated 13th, 14th and 15th February 2024. This review was conducted through a review of centre records, a visit to the centre to observe how care staff worked with young people and each other and a review of personnel and supervision records. Inspectors also interviewed relevant persons including the regional manager, the person in charge, two care staff and the allocated social workers for both young people being cared for.

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 CAPA review 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 28th of October 2025. The findings of the CAPA review were used to inform the registration decision.

Following the CAPA review process the centre submitted additional information in relation to their staffing, which indicated that they made some progress with the Child Care (Standards in Children's Residential Centres) Regulations, 1996, Part III, Article 7 as outlined in ACIMS Regulatory Notice on Staffing Levels & Qualifications for Registered Children's Residential Care Centres, August 2024. Six staff commenced in the centre since October 2025, and recruitment was taking place for a further two vacant posts.

The inspector also received assurances in respect of improved auditing, staff training and processes for the implementation of inspection action plans.

The findings of this CAPA review have determined the centre to have substantially implemented the required actions and therefore 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: without attached conditions from the 31st of October 2025 to the 31st of October 2028 pursuant to Part VIII, and 1991 Child Care Act.

3. Review 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.

Issue Requiring Action:

- The centre manager must ensure that all staff members have up to date training in the recognised behaviour management framework.
- The registered provider must review the risk management plans and the implementation of same to ensure they are relevant, up to date and contain descriptive strategies to support effective care.
- The centre manager must ensure that all planning documents are clear and concise and are understood by the staff team.
- The centre manager must ensure that all staff have completed relevant training in the organisations risk management framework.
- The register provider and the centre manager must ensure that where actions are identified from previous inspections that these are responded to appropriately and implemented effectively in the organisation.
- The centre manager must review the centre's risk register and ensure that all risks are identified and categorised correctly to ensure safe planning for this young person and the staff team.
- The registered provider must ensure that an audit under Standard 3.2 of the National Standards for Residential Centres, 2018 (HIQA) is completed in the centre.
- The registered provider and centre manager must review all restrictive practices in the centre and ensure they are correctly identified and reviewed in line with the National Standards for Children's Residential Centres (2018), HIQA.

Corrective Actions:

- All staff members have been booked on behaviour management courses, both full and refresher courses are scheduled over Mid-April – beginning of May. All will be fully trained by 01.05.2024.
- An individual risk assessment has been developed to outline risks associated with staff members who are not fully trained in core training requirements. Completed 20.03.2024.
- The centre manager has updated and simplified its planning documents, specifically its practice guidance and behaviour management strategies. This development ensures that strategies are clearly understood by staff team. This was implemented on 08.03.2024 and reviewed by team at team meeting on 11.03.2024.
- The centre manager has scheduled training for all staff in the organisations risk management framework. This will be completed by 30.04.2024. All staff members will be training in the Risk Management Framework by the 30.04.2024. This will be evidenced in their on personnel files.
- Actions identified through this inspection will be discussed within centre management and with senior management, so they are actioned within the timeframe outlined.
- Social care manager will complete a full review of centre risk register by the 22.04.2024 to ensure that all risks are identified and categorised correctly.
- A restrictive practice and behaviour management audit will be conducted and complete by the 30.04.2024 by regional manager. Feedback will be given to social care manager and deputy social care manager in relation to follow-up actions.
- All restrictive practices will be broken into separate individual risk assessments to allow for review, evaluation, and escalation regularly. This will be completed by 30.04.2024. These risk assessments will be shared with the professional multi-disciplinary team, along with regional manager for review, feedback, and shared risk management.
- A restrictive practice audit will be completed by 30.04.2024. Findings will be actioned and shared with centre staff.

Review Findings:

Inspectors found that there were significant improvements in the identification, assessment, recording, management and review of risk in the centre. Review of the organisation's risk register evidenced that risk was identified in a timely manner and that categorisation of issues or concerns had improved with the implementation of individual risk assessments. Each young person had a range of up-to-date planning documents that included placement plans, individual absence management plans (IAMPs), individual crisis support plans (ISCP), risk assessments/safety plans, and practice guidance documents to support their care and management of risk. Social workers for both young people stated that despite challenges in respect of having a stable and consistent staff team, risk was identified, discussed regularly and managed well through collaborative safety planning.

Where a specific issue of risk was identified in respect of challenging behaviour or interactions between young people, there was evidence of discussions at team meetings, consultation with supervising social workers and timely implementation of safety plans with measures to eliminate or reduce risk. Care staff interviewed were able to describe the risk management framework and matrix in use, as well as current concerns/issues arising for each young person and the strategies being implemented to mitigate against any potential harm. Notwithstanding this, inspectors found that training of the care team in the risk management framework and in the chosen model of behaviour management was impacted by the high turnover of staff in the centre. There were eighteen staff changes since last inspection in February 2024, so ensuring members of the care team were trained in all required courses to provide safe and effective care remained a challenge. At the time of this CAPA review, the care team consisted of a centre manager, two social care leaders, three social care workers and two relief staff available to cover all types of leave. Recruitment was ongoing and three new social care workers were onboarding depending on vetting checks and HR processes. Young people, care staff and social workers all spoke to inspectors about the negative impact of staff changes.

There were occasions when mandatory training of care staff was postponed due to staffing deficits and the needs of the service having to take priority. This included training in child protection and in behaviour management both of which are mandatory and essential when providing a service to young people with complex needs or experiences of trauma. The CAPA submitted following the inspection in 2024 indicated that risk management training would be provided as part of the induction of new staff to the centre. Inspectors did not find that this was being

implemented in practice and centre management must ensure that this is actioned as a matter of priority.

While there were good systems in place to track training of the care team and any deficits were escalated to senior management, some training in behaviour management, first aid and the model of care were delayed or remained outstanding at the time of this CAPA review. Additionally, the company contracted to provide training did not always have the required training available when it was needed. This should be reviewed and addressed by senior management.

Inspectors found that there were systems in place whereby learnings from inspections of centres across the organisation were discussed and issues requiring attention nationally were identified for action. This was a standing item at the senior management meeting and managers and care staff confirmed that they received feedback from these meetings. However, inspectors recommend that this is included in auditing of centres by external managers/quality assurance departments to ensure that actions have been followed through. A CAPA action relating to an audit of 3.2 of the National Standards for Children's Residential centres, 2028, HIQA was implemented in April 2024 as required. The preventative actions submitted in the CAPA proposed that a behaviour management/restrictive practices audit would take place twice annually however, only two of four scheduled audits were provided to inspectors, and this was not highlighted through any quality assurance oversight of the centre or follow up of CAPA actions as stated above.

There was evidence of a significant event review group whereby there was analysis of incidents to determine learning from review of triggers, any contributory factors, interventions and outcomes. The learnings identified from this forum was discussed at team and management meetings and information was used to update relevant planning documents if required.

There was good evidence of comprehensive review of restrictive practices in place to determine if they were still required. Implementation of restrictive practices was determined in consultation with supervising social workers and young people were provided with explanations for the reasons they were required. The centre manager reported on any restrictive practices through their centre monthly governance report, and they were discussed at management meetings however two of the biannual audits mentioned above did not take place as proposed.

Overall, inspectors found that actions agreed within Theme 3, Standard 3.2 were being substantially implemented within the centre however, ongoing work is required to ensure that the care team are trained in a timely manner, auditing of behaviour management and restrictive practice takes place as agreed in the CAPA and that there is more robust follow up of implementation of actions arising from inspections. This will be monitored through future inspection activity.

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

Compliance with standards	
Practices met the required standard	**Standard 3.2**
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 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 review the current audit mechanisms in place to ensure that they are fit for purpose and are addressing the deficits or improvements in practice to achieve better outcomes for young people.
- The registered provider must ensure that when actions are identified that these are achievable, timely and implemented in the centre effectively.
- The centre manager must ensure that all team meeting minutes contain details of all discussions that occur to improve the safety and quality of care in the centre.
- The registered provider and centre manager must ensure that incidents reviewed as part of the significant event review group (SERG) are analysed for

learning, trends and patterns and these are evaluated and communicated to staff working in the centre.

Corrective Actions:

- The regional manager provides oversight into the practices in the centre through their monthly reports. In addition, focused audits comprising of documentary review, interviews with staff members and observations, which are based on the National Standards, and the organisation's policies and procedures to ensure that the young people are provided with a high level of care and opportunities to achieve better outcomes through the implementation of processes and supporting the team's application of same. Feedback is provided to the centre management team, who in turn provide this to the team. All actions identified through these processes remain under review until they are verified as being responded to.
- Social care manager will review compliance report timeframes and actions which are outstanding and ensure that a timeframe is identified and achievable. This will be discussed within the team meeting on the 26th February 2024 with the staff team to ensure a high standard of care and better outcomes for the young person.
- Team meetings will be completed fortnightly as per organisational policy. The agenda of these meetings will be planned prior to the meeting being held. Agenda will include compliance report, young person's risk, and planning documents, SERG feedback, along with restrictive practices.
- Social care manager and deputy manager will ensure that the feedback from regional SERG meeting is added to the team meeting agenda to be discussed in detail with the team monthly. Patterns and trends will be analysed for staff learning.

Review Findings:

Inspectors found that while there was evidence of good leadership by the centre manager with support from the regional manager, further work is required to develop and implement systems of governance and oversight to ensure compliance with regulations and National Standards for Children's Residential Centres, 2018, HIQA. Inspectors were satisfied that actions were taken to ensure that records of team meetings were improved. As stated previously there was also evidence that there was a comprehensive framework for the review of significant events and that they were reviewed and analysed for learning, trends and patterns that were communicated to staff working in the centre. Care staff interviewed were able to provide examples of

how this was discussed at team meetings and changes to planning documents and approaches to care were implemented.

Inspectors found that there was an auditing framework in place that saw the centre manager audit personnel files, medication and conduct safety audits. They also compiled a significant event review report and provided a monthly centre governance report to senior management and the quality assurance department.

The regional manager was expected to complete ten audits per year relating to complaints, information management, child protection, supervision, risk/ behaviour management and restrictive practices. They also conducted visits to the centre and remotely reviewed centre records to prepare a monthly report.

Inspectors found that since the last inspection, five of these regional manager audit reports were completed. Additionally, five regional manager reports were prepared since the last inspection in February 2025. Inspectors found that aspects of some standards under themes 1, 2, 3, 4, 5, 6 and 8 of the National Standards for Children's residential centres 2018, HIQA were reviewed and commented under 'areas of strength' or 'goals for growth'. They also commented separately on areas such as risk, significant events, rosters, staffing and recruitment, finance, health and safety, complaints and provision of on call support. While some key areas were reviewed, this level of auditing and oversight was not in line with the organisations own schedule of auditing and many aspects of standards under individual themes were not audited at all.

The quality assurance department were responsible for compiling a monthly compliance report. They also tasked with conducting analyses of audits of child protection, exit interviews risk and behaviour management, medication and complaints audits. Inspectors requested but only received the analysis of exit interviews. Inspectors found that the monthly compliance reports were directly based on information provided by the centre manager and lacked evidence of analysis or quality assurance of the information provided. For example, this report repeats information provided by the centre manager such as policies discussed at meetings, follow up action to complaints or numbers of meetings. There was no methodology included and no way to determine if the information was checked, challenged or affirmed by the quality assurance department. Inspectors reviewed eight compliance reports across 2025 and only found three minor issues identified for action. However, inspectors found that the centre monthly governance reports (that informed these compliance reports) highlighted a number of issues requiring attention relating to

health and safety that were repeated month on month from January to September with no evidence of escalation or definitive action taken.

It was inspectors' assessment that issues relating to the premises and compliance with standard 2.3 were not attended to in a timely manner. There were recurring issues highlighted both on the maintenance log and the monthly governance report. These ranged from painting and decoration of the premises and maintenance of the outdoor spaces to issues with heating, sewage and electric wires that were not responded to despite some being flagged as health and safety risks.

Overall inspectors found that some actions agreed within Theme 5, Standard 5.4 were being implemented within the centre however, further work is required by senior management within the registration cycle to ensure more effective auditing and assessment of compliance with relevant regulations and national standards. This will be monitored through future inspection activity.

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

Compliance with standards	
Practices met the required standard	**Standard 5.4**
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 centre manager must ensure that all required documentation is maintained on the personnel files for all staff members in the centre.
- The registered provider must ensure that there is a sufficient management support structure in place to ensure the effective running of the centre.
- The centre manager must ensure that staff supervision is carried out in line with policy and that newly recruited staff receive regular supervision when they commence employment in the centre.
- The registered provider and centre manager must ensure that when a concern that impacts care practice is identified as part of the supervision process that the appropriate measures are put in place to ensure that safeguards are implemented for both staff and young people

Corrective Actions:

- Social care manager, supported by deputy social care manager, will complete a personnel file audit by the 30th April 2024 in addition to a thorough review of all personnel files and ensure all certificates and support/development plans are on file. Completed plans will be reviewed and brought to supervisions with staff members to work towards achievement. Timeframes not met will be detailed and development plan can be revisited.
- Deputy social care manager has returned from planned leave and there is a sufficient management structure in place to support the running of the centre currently.
- A supervision schedule is in place between deputy social care manager and social care manager whereby supervision is divided between the two. Supervisions will encompass feedback, roles and responsibilities, development, training and support. This has been implemented in March 2024 and will continue in line with organisational policy.
- A centre risk assessment was put in place with the specific staff member 01.03.2024 to address concerns that may impact care practice. A specific support plan has also been put in place to ensure this issue is addressed thoroughly. This will remain in place until all aspects of the plan are complete.

Review Findings:

Inspectors found that there were good systems in place to ensure that there was oversight of personnel files. Those reviewed by inspectors during this CAPA review, with the exception of training not yet completed, held all required information. The centre manager regularly audited files and reported on any issues arising to their line manager. Vetting and references were compliant with requirements and

organisational policy and there was evidence of probation, supervision, risk assessments and professional support plans where required.

Supervision was generally taking place in line with organisational policy and inspectors found it was of a good standard to support care staff in their work. They described how the centre manager supported them through formal and informal channels. There was evidence of debriefing and informal supports by centre management to help staff manage the impact of the work during challenging times.

The centre's statement of purpose described the staffing complement as a social care manager, deputy manager, three social care leaders, seven social care workers and two relief social care workers. At the time of this CAPA review the team comprised of the social care manager, two social care leaders and three social care workers. Inspectors were informed that interviews were taking place for deputy manager and social care staff the week of the CAPA review. As such, the CAPA action relating to management of the centre remains open and centre management must notify the alternative care inspection and monitoring service when staff have been recruited and commence in the centre. Inspectors reviewed analysis of exit interviews across the organisation from December 2024 to August 2025. 111 people had left the employment but only 32 exit interviews were completed. Senior management should explore ways to increase participation in exit interviews to inform further developments of retention strategies across the organisation. Discussions relating to workforce planning and management of centres was evident at management meetings.

Overall inspectors found that most actions agreed within Theme 6, standard 6.3 were implemented and evident in practice, but further action was required to ensure there is an appropriate internal management structure and stable staff team in place. This will be monitored through future inspection activity.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 6.3**
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**