An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 244

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Spring Life Ltd.**
Registered Capacity:	**Two young people**
Type of Inspection:	**CAPA Review**
Date of inspection:	**23rd & 24th April 2025**
Registration Status:	**Registered from 7th May 2024 to the 7th May 2027**
Inspection Team:	**Anne McEvoy** **Sinéad Tierney**
Date Report Issued:	**11th August 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 07th May 2024. At the time of this CAPA review the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from 07th May 2024 to the 07th May 2027.

The centre was registered as a multi-occupancy service. It aimed to provide care for two young people from age thirteen to seventeen years. The centre had adopted a recognised model of care and it aimed to assist young people come to terms with their past and prepare for a brighter future through nurturing the growth and development of the young people in their care. There was one child living in the centre at the time of the inspection.

1.2 Methodology

Inspectors examined the progress made by the centre with the implementation of the CAPA from the previous inspection dated the 07th and 08th October 2024. The CAPA review was conducted through a review of centre records, a two-day visit to the centre and interviews with relevant persons including the director of service, the person in charge, one care staff member and the allocated social worker for the young person being cared for. Inspectors also observed a handover meeting on Wednesday 23rd April 2025 and attended a staff team meeting on Saturday 26th April 2025.

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 person, 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 department on the 30th of May. Based on the findings of the draft report, a regulatory compliance meeting was held with the registered provider and the person in charge on the 9th of June. The registered provider was required to address the practices highlighted in this report that did not meet the required standard, and the Inspectorate received evidence of same on the 18th of July. A follow up unannounced inspection visit was conducted on 30th July to verify the evidence received.

The findings of this CAPA review and the subsequent steps 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: 244 without attached conditions from the 7th May 2024 to 7th May 2027 pursuant to Part VIII, and 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their wellbeing and personal development.

Issue Requiring Action:

- The registered provider and centre manager must ensure that a centre register is developed in line with the Child Care (Placement of Children in Residential Care) Regulations, 1995.
- The registered provider and centre manager must ensure that information relating to the young people residing in the centre is recorded in a way that promotes appropriate sharing of information with care staff and good care planning for any young people residing in the centre.
- The registered provider must ensure that centre records containing personal information is treated as confidential and protected.
- The registered provider and centre manager must ensure that the centre develop a placement plan for young people in their care outlining the child's needs and supports required, as identified in the care planning process. This process must be captured in centre policy, identifying timeframes for the completion and updating of placement plans.
- The registered provider and centre manager must ensure that young people in the centre are provided with opportunities to be involved in the placement planning process and provide input into their placement plan.
- The registered provider and centre manager must ensure that there is effective communication by centre staff to the allocated social worker notifying them of information relevant to the care experienced by the young person to ensure continuity of care and adherence to the child's care plan.

Corrective Actions:

- The centre manager updates the centre register immediately upon the admission or discharge of any young person to ensure compliance with the

Child Care (Placement of Children in Residential Care) Regulations, 1995. Register is reviewed annually and updated as necessary.

- The recording of information was standardised on the 5th November 2024 to ensure appropriate sharing among care staff and alignment with care planning requirements. Information was disseminated effectively through structured handovers and team meetings. Regular reviews during team meetings were introduced to ensure the shared information supports good care planning. Standardised templates for recording information about young people will be maintained and regularly reviewed to ensure they promote effective communication and care planning. Weekly team meetings and daily handovers will continue to be used to share relevant information regarding young people's care. Annual training sessions will be conducted to reinforce staff understanding of effective recording and sharing practices.
- Physical records containing personal information were secured in lockable filing cabinets with restricted access. Policies were updated on the 2nd of December 2024 to reinforce the confidentiality requirements, and centre managers were tasked with overseeing compliance. Confidentiality procedures were evaluated to address any risks. Personal records will continue to be securely stored in lockable cabinets with restricted access to authorised personnel only. The confidentiality policy will be reviewed annually to ensure it remains comprehensive and aligned with current best practices. Monthly checks will be carried out to ensure adherence to confidentiality policies and to address any breaches immediately.
- Placement plans were created for each young person's admission, reflecting needs and supports outlined in the care planning process on the 9th of November 2024. The process was formalized into centre policy, specifying a three-month timeframe for updates with next review date of 25 January 2025. Placement plans were integrated into team meeting discussions to ensure alignment with evolving needs. Placement plans will be developed for each young person within two weeks of their admission, reflecting their needs and supports. Reviews and updates to placement plans will occur every three months or earlier if the young person's circumstances change. Policies detailing the placement planning process will be reviewed annually to ensure they continue to meet regulatory requirements.
- Opportunities were provided for young people to review and provide feedback on their placement plans during scheduled key worker session on the 27 November 2024. Feedback mechanisms were implemented, allowing young people to contribute meaningfully to the planning process. Placement planning meetings incorporated their feedback to ensure active participation

and ownership of their care plan. Young people will be given regular opportunities to provide input to their placement plans during key worker sessions. Feedback mechanisms will ensure that young people's perspectives are consistently captured and integrated into their plans. Quarterly reviews will ensure that young people's involvement in the planning process is meaningful and effective.

- A communication protocol was established to notify social workers within 24 hours of significant developments in a young person's care on the 15th of October 2024. Weekly updates to social workers were implemented, with additional updates as required for urgent matters. A designated communication log was maintained to ensure transparency and adherence to the protocol. A communication protocol will be maintained to notify social workers of any significant developments within 24 hours and provide weekly updates on progress. A designated staff member will monitor and log all communications with social workers to ensure accuracy and accountability. Biannual evaluations of the communication process will be conducted to identify any potential areas for improvement and ensure alignment with care plans.

Review Findings:

At the time of the CAPA review, the registered provider had not developed a centre register in line with Child Care (Placement of Children in Residential Care) Regulations, 1995. Inspectors noted that the registered provider was not aware of how to develop this register and guidance was offered while undertaking the CAPA review. Prior to writing this CAPA review report, the registered provider had developed a centre register containing the relevant information and the centre manager was aware of how it ought to be updated and stored.

Inspectors found that information relating to the young person in the centre was not recorded or shared with care staff in a way that promoted good care planning for the young person. Inspectors reviewed all team meeting records since the last inspection and there was no standardised template in operation as per the information provided by the registered provider. Inspectors found that the team meetings were not occurring weekly as stated in the CAPA document but were occurring monthly. The minutes of these meetings did not consistently discuss the care planning or information relating to the young person such as significant events, progress reports or crisis support plans. Inspectors attended the scheduled team meeting of the 26th April and found that while the most recent significant event was noted, there was no

discussion relating to it. This meeting occurred via an online platform and engagement from care staff was very limited.

Inspectors found that the registered provider had lockable filing cabinets in use in the staff office. One filing cabinet was maintained for young people's care records and for centre records and the second filing cabinet was maintained for the purposes of the centre manager and deputy manager and contained appropriate and relevant records such as care staff supervision and personnel files. The registered provider stated that they had found these cabinets open on occasion and had addressed it with care staff, however they noted that this was not recorded in any centre records, either audits or supervision records so inspectors cannot confirm that the monthly checks as per the preventative actions stated were in operation. Inspectors were provided with training certificates for the majority of care staff confirming that they had received training in data management and storage. There were five staff members who still needed to complete this training. As stated earlier, inspectors attended the team meeting held on the 26th April and found that there was a significant risk of a data breach occurring. All care staff attended this meeting via an online platform and only the centre manager and the deputy manager consistently had their cameras turned on. When requested to switch cameras on, one care staff member stated that they were in their own home and inspectors later became aware that another care staff was working in a different residential centre at the time of the team meeting. There were no assurances sought that the care staff were in a private location or that they were able to ensure that the young person's information remained confidential and shared only with those who required it. Post inspection, the centre manager was instructed to ensure that care staff were familiar with the general data protection regulations (GDPR), and to ensure that information pertaining to any young people in the centre was held confidentially by implementing procedures to manage any meetings that may take place in an online platform.

Inspectors found that the centre had developed a policy around the completion and updating of placement plans for young people. However, within the policy itself there were conflicting timeframes, suggesting in one sentence that the placement plans were to be reviewed every three months and the following sentence stated that they were to be reviewed monthly. Regardless of the difference in the policy, neither timeframe was adhered to as the placement plan for the young person resident in the centre was dated the 15th October 2024 and it was not scheduled for a review until twelve months later, on the 15th October 2025. The placement plan reviewed by inspectors, listed goals that the care staff hoped to achieve, however these goals were not in line with the care plan goals and were not realistic given the presenting needs

of the young person. The placement plan did not track any progress made or identify any barriers to progress. Inspectors found that the placement plan was not purposeful in identifying goals and was not aligned to the care plan and the current circumstances of the young person. Inspectors found that care practices were significantly impacted as a direct result of vague and confusing policies. The policy relating to placement plans required significant work to clarify timeframes for the development and updating of plans.

Inspectors found that the young person did not have any input into their own placement plan. Inspectors reviewed the placement plan and reviewed key work records and found that there was no evidence that the young person had been engaged in discussion around the plan or in identifying goals that they wished to achieve. The centre did have a policy on placement planning referencing that placement plans would be completed in consultation with the child / young person but inspectors did not find any evidence to support this in practice. Inspectors were not provided with the minutes of any placement planning meetings to assess if the young person's input had been brought to the meeting. Feedback mechanisms referred to in the CAPA document were in relation to general care and routines within the centre and were not conducive to representing the young person's views regarding goals they wished to achieve. The centre manager and registered provider confirmed that the quarterly reviews referenced in the CAPA were not taking place.

The communication protocol referenced in the CAPA outlining the communication streams to the allocated social worker was not provided to the inspectors. The centre manager stated that there was constant communication with the social worker both verbal and written. The centre manager stated that they emailed the social worker weekly and included the daily logs for the previous week. This was confirmed in interview with the social worker however, it was noted that a short weekly update would be more beneficial to the social worker and prior to the completion of this inspection activity, brief weekly updates were being provided. None of the preventative actions identified in the CAPA document relating to this action were in place at the time of this inspection activity.

Compliance with Regulations	
Regulation met	**Regulation 17**
Regulation not met	**Regulation 5**

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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 2.2**

Regulation 5: Care Practices and Operational Policies

Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.3 Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

Issue Requiring Action:

- The registered provider must ensure that all policies and procedures are relevant to the purpose and function of the centre.
- The registered provider and centre management must ensure that there are suitable opportunities for care staff and young people to raise concerns and identify areas for improvement.
- The registered provider and centre management must ensure that the policy on the reporting, recording and reviewing of incidents is assessed and enhanced to identify timeframes for reporting of incidents, participation in RERRG and how learning will be used to inform best practice.
- The registered provider must ensure that a behaviour management framework is adopted in the centre and that all staff are trained to implement it.
- The registered provider and centre management must ensure that all restrictive practices are recorded on a restrictive practice register, that they are discussed with the allocated social worker, that risk assessments are completed and that all restrictive practices are reviewed on an ongoing basis to determine their ongoing need.

Corrective Actions:

- All policies and procedures were reviewed and updated 15th of October 2024 to ensure alignment with the centre's purpose, function, and care model. A comprehensive audit of policies was conducted, and updates were approved by management 25th October 2024 to ensure their specificity to the Welltree Model of Care. Ongoing review processes were established to ensure that policies remain relevant and reflective of the centre's objectives. A biannual review schedule for all policies and procedures has been implemented to ensure they remain relevant to the centre's purpose and the Welltree Model of Care. A designated policy oversight team will monitor changes in regulations and best practices, incorporating necessary updates promptly. Staff training sessions will include briefings on policy changes to ensure full understanding and compliance. All staff are required to sign after reading.
- Regular staff and young people's feedback sessions were introduced to provide suitable opportunities for concerns to be raised. A suggestion box was implemented to allow anonymous submission of concerns and improvement ideas on the 25th of November 2024. Feedback from these sessions are now discussed in monthly team meetings and documented in action plans for follow-up. Quarterly feedback sessions for staff and young people has ensured discussions of concerns and identifying areas for improvement. The anonymous suggestion box is monitored monthly, and submissions are reviewed in management meetings for action planning. A dedicated staff liaison officer oversees the resolution of concerns raised and communicates outcomes effectively.
- On the 5th of November 2024 the incident reporting policy was revised to specify timeframes for reporting minor incidents within 24 hours and major incidents within 1 hour. Quarterly reviews of all incidents to identify patterns and areas for improvement were implemented. Root cause analysis for significant incidents have been established to understand underlying issues. Participation in the Risk Escalation and Response Review Group (RERRG) was formalized, with regular attendance and updates being incorporated into the policy. In addition, learning review mechanism was introduced to ensure that incident analysis informs best practices and staff training. Clear timeframes for incident reporting and review is reinforced through staff training and included in the centre's operational manual. Participation in the (RERRG) has been reviewed quarterly to ensure adherence and to evaluate the effectiveness of learning mechanisms. Incident review findings are integrated into annual staff development plans to promote continuous learning and improvement.

- A behaviour management framework, aligned with the WellTree Wellbeing Outcomes Framework, was adopted and integrated into the centre's policies. On the 10th of November 2024 all staff completed a training session on implementing the behaviour management framework effectively. Annual refresher training is scheduled to maintain staff competency and understanding. Ongoing staff training on the behaviour management framework is conducted annually, with additional support offered as needed. The framework is reviewed and updated annually to ensure alignment with emerging best practices and regulatory changes. Behaviour management practices are discussed in monthly team meetings to ensure consistent application across all staff members.
- A restrictive practice register was established to ensure all practices are documented comprehensively. Protocols were introduced for discussing restrictive practices with the allocated social worker, completing risk assessments, and reviewing the need for practices regularly. A monthly review meeting is now held to evaluate the necessity and appropriateness of all restrictive practices, ensuring their alignment with best practices and regulations. The restrictive practice register is reviewed monthly to ensure all practices are documented and assessed for necessity. A system for mandatory consultation with social workers on restrictive practices is formalized. Risk assessments and reviews of restrictive practices are conducted quarterly to evaluate their appropriateness and impact on young people.

Review Findings:

Inspectors found that the policies and procedures were updated in March 2025 and a copy of these were provided to the inspectors. A sample of policies were reviewed, and significant deficits were found. There were notable errors throughout the policies reviewed and it was found that the policies in their existing condition were confusing at best and offered no clear guidance to care staff on practice within the centre. There was no evidence that care staff were provided with training on the updated policies, with no reference to policies and procedures in the team meeting minutes reviewed. The updated policies referred to the model of care in operation in the centre, however inspectors found that there was no discussion regarding the model of care in any other centre record or young person documentation and no training was provided to staff on the model of care in use within the centre. A designated policy oversight team was referred to in the CAPA documents and consisted of the registered provider, the centre manager and the deputy manager, however the centre manager and deputy manager confirmed that to date they had not been part of the policy review.

Inspectors found that there were limited opportunities for care staff and young people to raise concerns and identify areas for improvement. There were two separate documents provided to inspectors outlining the centre's feedback mechanisms. The second titled "feedback mechanisms 2025" outlined seven areas for seeking feedback. The inspectors found that the centre had implemented a suggestion box, however this had not been utilised by any care staff or by the young people who had resided in the centre and the other six methods of seeking feedback were not found to be in operation. The inspectors were not provided with any documentary evidence to support that the care team had scheduled weekly group meetings with care staff and young people to discuss care practices. There were no completed staff surveys or questionnaires provided to inspectors. The centre manager confirmed that they were unable to undertake regular supervision with the care staff due to being rostered to work with the young person and undertaking duties of a social care worker. A review of management meeting minutes did not evidence any discussion on feedback or concerns raised from staff or young people. The centre manager confirmed in interview that there were no young person's house meetings taking place in the centre. The centre manager advised that care staff were proactive in emailing them if they had any concerns or had any suggestions for improvement, but this was not formalised in practice. There was a dedicated staff liaison officer in place to oversee resolution of concerns raised but this post was ineffective given the limited opportunities available for staff and young people to raise concerns or identify areas for improvement.

The CAPA document returned to inspectors stated that the policy underpinning the management of incidents was revised on the 05th November 2024. Inspectors found that the revised policy did not reference the required timeframes as was stated in the CAPA document and was vague regarding the reporting, recording and reviewing of significant events. The centre policy required that significant event notifications (SEN's) be completed as soon as possible but at the latest before the care staff finished shift. A review of centre records and SEN's evidenced that this policy was not being followed. A review of the management meeting dated 20th March 2025 recorded that SEN's were to be completed and sent to the social work department before the end of the week. This was not in line with centre policy. The inspectors sampled seven SEN's and found that the form was not always accurate noting that the notification was forwarded to the social worker before the event took place in two notifications sampled and highlighting delays of between four and fourteen days in six others. The social worker confirmed in interview that the centre was verbally reporting incidents in a timely manner, but there were delays in the follow-up documentation being forwarded. Inspectors found that there was no operational

review of SEN's taking place in the centre, despite the policy stating that incidents would be reviewed in team meetings and the CAPA document stating that there were quarterly reviews of all incidents to identify patterns and areas for improvement. Minutes of RERRG (risk escalation and response review group) were provided to the inspectors but these were found to be minutes of consultation meetings with external professionals involved with the young person's care where guidance was offered on behaviours that challenge and presenting concerns as opposed to a review of an event that had occurred and a critical analysis of what worked and what could have been done differently. Inspectors found that no member of care staff or management were aware of the learning review mechanism referenced in the CAPA document and there were no documents to support the implementation of any learning review mechanism.

The centre policy regarding the behaviour management framework was incoherent and completely detached from the care practice in the centre. The policy referenced three different behaviour management frameworks and used these frameworks interchangeably throughout the policy. A review of staff training files evidenced that while there were attempts to train care staff in one behaviour management framework, this was not the framework referenced predominantly throughout the policy. The policy stated that the individual crisis support plans (ICSP) for young people were to be developed and aligned to one behaviour management framework, however inspectors found that the ICSP was not developed in this way, it did not reference if restraint was permitted and had not been reviewed since its initial development in September 2024 despite SEN's referencing that the ICSP required updating following incidents.

The registered provider stated that they had developed a restrictive practice register and this was provided to the inspectors. This document was not found to be effective as a register in that it did not evidence if restrictive practices were reviewed or if the social worker was made aware of them or when they were removed / reduced. There were no risk assessments undertaken to demonstrate the requirement for the restrictive practice to be in place. The inspectors found that there was evidence that the centre manager had considered and reviewed the restrictive practice in place and had signed and dated these documents. The social worker confirmed in interview that they were aware of the restrictive practices being utilised, however there was no documentary evidence supporting the consultation as was referenced in the CAPA document.

Compliance with Regulation	
Regulation met	**Regulation 16**
Regulation not met	**Regulation 5**

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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 3.3**

Regulation 6: Person in Charge

Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Issue Requiring Action:

- The registered provider must notify Alternative Care Inspection and Monitoring Service when they have a full staffing complement and achieve compliance with the Tusla ACIMS staffing regulatory notice, Minimum Staffing Level and Qualifications for Registration of Children's Residential Centres, dated August 2024.
- The registered provider must ensure that the working hours of care staff is in compliance with the Organisation of Working Time Act 1997.
- The registered provider must ensure that accurate records of staff on duty and the times they start and finish shift are maintained.
- The registered provider must ensure that the child safeguarding statement is updated to identify the name of the designated liaison person in the centre and that all staff are trained to understand their roles and responsibilities for child safeguarding.
- The registered provider must ensure that the on-call duty is undertaken by qualified and experienced members of staff and that a record of guidance given is maintained in the centre.

Corrective Actions:

- The registered provider has notified ACIMS of achieving a full staffing on the 18th of November 2024 in compliance with the Tusla ACIMS staffing regulatory notice dated August 2024. Compliance was achieved by ensuring all roles are filled with qualified staff as per regulatory requirements. All remaining staff must ensure compliance by January 10th, 2025. ACIMS are notified if the centre has any changes to staffing compliance. Regular internal reviews of staffing levels are conducted to ensure ongoing adherence to the Tusla ACIMS staffing regulatory notice.
- Staff schedules were revised on the 9th of October 2024 to ensure full compliance with the Organisation of Working Time Act 1997. Ongoing monitoring has been established to ensure staff do not exceed legal working hours, and records are reviewed monthly by management. Staff rosters are reviewed weekly by the centre manager to ensure compliance with the Organisation of Working Time Act 1997. A monitoring system remains in place to flag any deviations from the permissible working hours.
- A system for recording staff attendance, including start and finish times, was implemented using a centralized log on the 9th of October 2024. Daily oversight by the centre manager ensures that all staff sign in and out accurately. All staff were required to read and sign the clear guidelines on attendance documentation. A robust log system is maintained to record the start and finish times of all staff on duty, with oversight by the centre manager. Arbitrary monthly audits are conducted to ensure the accuracy of attendance records. Clear guidelines on attendance documentation are distributed and reinforced during staff induction and refresher training.
- The child safeguarding statement was updated on the 13th November 2024 to include the name of the designated liaison person (DLP) in the centre. All staff have completed child safeguarding training, ensuring they understand their roles and responsibilities. The child safeguarding statement is reviewed and updated annually to ensure the designated liaison person (DLP) details remain current. Staff receive child safeguarding training as part of their induction, with refresher sessions conducted annually. Audits of safeguarding procedures are carried out biannually to verify staff understanding and compliance.
- Only qualified and experienced staff are now assigned on-call duties, and their qualifications are verified before assignment. A structured log for recording guidance provided during on-call duties was implemented on 25th November 2024 and is reviewed monthly to ensure completeness and accuracy. A qualification verification process is implemented for all staff assigned to on-

call duties. A formal training program is established for staff to prepare them for on-call responsibilities. Logs of on-call guidance are reviewed monthly by the centre manager to ensure completeness and adherence to best practices.

Review Findings:

The registered provider notified the Alternative Care Inspection and Monitoring Service in November 2024 that they had achieved compliance with the staffing regulatory notice dated August 2024 and stated in the CAPA document that they were to notify ACIMS if the centre had any changes to staffing compliance. At the time of this CAPA review, the inspectors found that the centre were not in compliance with the regulatory notice and had not notified ACIMS. The centre was operating with one manager, two deputy managers, one social care leader and three social care workers. The team were supported by four health care assistants who were supernumerary to the core team. Inspectors were advised that one deputy manager had tendered their resignation and prior to the completion of this inspection activity, the inspectors were informed that the social care leader was also in the process of resigning. Inspectors found that the centre manager was working the duties of a social care worker including being rostered on to cover live nights and sleepover shifts. This impacted significantly on the centre manager's ability to complete managerial tasks, such as the provision of supervision, the oversight of centre records and oversight of care planning for the young person residing in the centre. At the time of drafting this report, the centre had one manager, one deputy and three social care workers as their core team and were not in compliance with the Tusla ACIMS staffing regulatory notice, Minimum Staffing Level and Qualifications for Registration of Children's Residential Centres, dated August 2024.

Inspectors reviewed the rosters for January and February 2025 and found that in January 2025, six staff members including the centre manager completed in excess of their contracted working hours of 160 hours monthly. Additionally in interview inspectors were told that there were two members of staff who completed shifts in other organisations. Both of these staff members were included in the six staff who had already worked in excess of their contracted hours. The centre manager was responsible for devising the roster but post inspection stated to inspectors that they were not aware when staff were working in other centres and by default were not in a position to ensure that staff were provided with necessary and appropriate rest times in line with the Organisation of Working Time Act 1997. One staff member worked 36 hours starting on Friday 21st February 2025 at 10am and finishing on Saturday 22nd February at 10pm. They then returned to complete a waking night on Sunday

23rd February working 48 hours in three days. Another staff member worked 60 hours in one week from the 17th to the 23rd February 2025.

Since the last inspection in October 2024, the registered provider had implemented a digital recording system to track staff attendance, including start and finishing times. Inspectors were given a practical demonstration of how this system worked and this was confirmed by staff members working in the centre over the course of the inspection. Staff members were alerted to log in to a downloaded app on their phone when they arrived at the centre and on leaving the centre, it alerted them to record the time of departure. This information was digitally recorded and notified to the administrators of the app. These were the centre manager, director of services, human resources and payroll.

Inspectors reviewed the child safeguarding statement (CSS) and found that it was updated to include a named designated liaison person (DLP). However, the person named as the DLP was on extended leave and there was no named deputy designated liaison person (DDLP). Staff were not advised who they needed to contact should they have a concern or query in the interim. At the time of this CAPA review, the DLP had not undertaken any training on the responsibilities of the role and this was highlighted as a deficit at the time of the last inspection in October 2024. The updated CSS was found to have significant deficits; there was no reference to the four areas of abuse, no reference to child sexual exploitation and the relevant person was not named on the CSS. It also failed to outline the services and activities provided to children. While the CSS did not specify the procedures in place for maintaining a list of mandated persons, this list was provided to inspectors and was accurate and up to date. Inspectors found that there were no guidance documents in place to guide non mandated persons as to the procedures they must follow in the event of a concern arising. Inspectors found that the majority of staff members had completed Tusla's Children First e-learning programme: Introduction to Children First. Throughout the course of this CAPA review, inspectors found it challenging to ascertain correct and accurate information relating to training. Personnel files were not maintained in an accessible format and inspectors found it difficult to corroborate what training was completed. Inspectors found that while the centre had a policy on child safeguarding, there was no evidence that this was discussed with staff members and inspectors did not find any reference to any training on child sexual exploitation.

Inspectors reviewed the on-call register for January, February and March 2025 and found that the registered provider, the centre manager and the two deputy managers were the rostered staff to provide on call support. These were all appropriately

qualified and experienced. Inspectors found that despite the CAPA document stating that there was a structured log for providing guidance since November 2024, this was not fully embedded in the centre with only some on call enquiries recorded on the centre's digitalised system. There were no audits or analysis completed of the on-call register and guidance provided. There was no formal training programme for staff undertaking on-call responsibilities and on-call logs were not reviewed monthly by the centre manager. This was confirmed by the centre manager in interview.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 6.1**