An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 268

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Laragh Family Support Ltd**
Registered Capacity:	**One Young Person**
Type of Inspection:	**Announced**
Date of inspection:	**19th & 20th of March 2025**
Registration Status:	**Registered from the 29th of November 2024 to the 29th of November 2027**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
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 an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 29th of November 2024. At the time of this inspection the centre was in its first registration and was in year one of the cycle. The centre was registered without attached conditions from 29th of November 2024 to the 29th of November 2027.

The centre was registered to provide single occupancy from age thirteen to seventeen upon admission for emergency, short term or medium-term care as required. The stated aim of the centre was to provide a high standard of individual care in a trusting and safe environment that promotes positive learning and positive life experiences. There was a young person aged twelve residing in the centre prior to its registration, the centre had been operating as a special emergency arrangement/SEA for two years. The ACIMS require that all children under their thirteenth birthday, where it is not in accordance with the registered purpose and function of that centre, apply for a derogation to the ACIMS in order for that young person to reside in that centre. The registered provider was made aware of this process and they have applied for a derogation. There was one child living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young 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 departments on the 16th of April 2025. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 30th of April 2025. A compliance meeting had been held with the proprietor on the 4th of April 2025 on foot of the onsite inspection findings. The CAPA submitted in response to the draft report was not deemed to be fully satisfactory, the inspection service received evidence of the issues addressed with that CAPA. A second CAPA was provided on the 20th of May 2025 with additional evidence provided. Ongoing communications continued regarding the status of staffing and recruitment and the verification of vetting.

Whilst the CAPA was accepted in part, with the staffing information continuing to be updated, findings were referred to the ACIMS' National Registration Enforcement Panel (NREP) for review. The registered provider was met with and directed that the implementation of the submitted CAPA must be realised and specified that the following actions must be evidenced by the 30th of September 2025:

- A full qualified staff team in place.
- A full suite of updated policies and procedures.

A follow up inspection of the service will be completed to ensure that the agreed actions have been implemented.

The findings of this report and assessment of the submitted CAPAs and evidence 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: 268 without attached conditions from the 29th of November 2024 to the 29th of November 2027 pursuant to Part VIII, 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.

Inspectors found that the case of the young person aged twelve, who resided in the centre, had not been subject of a monthly child in care review as per the requirements of the Tusla 'National Policy in relation to the placement of children aged twelve and under in the care or custody of the Health Service Executive'. The social worker informed inspectors that they had not been made aware of this policy and had completed a care plan two months after admission and at six months after that, meaning that a child in care review was booked for the week after the inspection, just outside the six month timeframe. They stated that the case was reviewed monthly before the courts and the young person had a Guardian ad Litum/GAL.

The care plan was on file at the centre and minutes had also been completed and issued by the social work department. There was evidence that the young person had been invited to their care plan meeting and had been visited by their social worker and consulted with about their wishes and views. These were then reflected in the care plan and related documents. The social worker stated that the centre had worked in close consultation with them and took direction around the needs of the young person. The social worker informed inspectors that they or in their absence a colleague visited the young person every month at the centre and that there was evidence that the young person was progressing well. The young person was positive about their social worker and knew they could talk to them.

The goals of the care plan took account of the age and stage of development the young person was in and accounted for any specialised interventions that were required. Inspectors found that there was evidence through ongoing outcomes and daily logs that the core care plan goals identified for the centre around education, activities and safety including attendance at specialist appointments were completed by the team. The single occupancy placement was deemed suitable for a period of time until

assessments and interventions had been completed with the young person. The property was also only suitable for one young person residing at any given time.

There was a placement plan on file and this reflected the goals of the care plan. The placement plan format was suitable and was discussed with the young person as being their plan. The plan itself was found by inspectors to be underutilised and required more active updating. The staff were not sure if there was a policy on placement planning or a process, for example timeframes for completion or review, and in fact the centre had no policy or procedure referring to placement planning.

There was no policy or procedure relating to the role of a key worker in either the policy handbook or the social care staff job descriptions. There was a key worker and co key worker assigned and they had completed key work sessions with the young person. Although not numerous where they took place they were geared to building safety and resilience with the young person and there was evidence of open communication and a trusting relationship with the young person during these sessions. The key work recorded had recently moved from responsive/reactive to include elements of proactive/planned sessions for which appropriate materials had been sourced. All were age and stage appropriate, and the key worker and centre manager took account of any professional guidance provided to them as to boundaries in who was best placed to address what specific matters.

The centre staff recorded daily logs and significant event reports, these were digital records and inspectors accessed these at the centre. Whilst doing so it was found that previous young peoples records were not secured or removed from the main staff drive that they used for daily recording. The inspectors requested that action be taken on the day of the inspection to secure the records, the centre manager stated they had been removed and secured with the director of service records. The director acknowledged the need for a more robust system of securing files and identified that they would be returning the records of previous young people to their relevant social work departments.

The centre policies did reference the recording of all contacts, for example with family, social workers, schools but no such contact records were kept by staff or management. The young persons social worker stated that the centre manager communicated and collaborated well with them in the child's best interests and that they were happy with the standard of service being provided. Contact with family took place through the social work department and there was evidence of them being consulted with for the care planning process.

Inspectors observed items honouring the young person's family at the centre. Inspectors received written feedback and spent some time with the young person and they showed inspectors some of their items and how they spent their time at the house. They liked their house which they called "home" and knew their key worker, they knew who would help them if they had a problem. They were clear about the rules and the good things they could work towards and had a long list of interests that they pursued. They knew their social worker and how to contact them. This young person felt well cared for at this centre, they had friendships and activities as well as full time education in place.

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

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

Actions required

- The director of service and centre manager must ensure that there is suitable training and support provided in the expected practices and recording in placement planning and the role and tasks of the key worker.
- The centre manager must ensure that adequate record keeping is in place for all contacts and meetings held relating to the young person.
- The director of service and centre manager must ensure that electronic or digital files maintained for the young people are securely stored and archived appropriately and safely until such time as they are returned to Tusla.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The centre had an acting centre manager in post since registration in November 2024, they had a level 8 qualification in a relevant area but did not have three years post qualifying full time experience in a children's residential centre as set out in the ACIMS 'Regulatory notice on staffing requirements in children's residential centres' August 2024. The centre manager was exploring with CORU registration if they can be classed as a social care worker and did not currently have other plans to train in this sector. They had been working in the centre since it commenced as a special emergency arrangement in the summer of 2023 and had become the manager prior to registration of the centre. The director of service, who is the registered proprietor, met with the centre manager on a weekly basis. Inspectors found that there were records maintained of that meeting, however the records did not contain the level of detail required in terms of the ongoing planning and development needs of the centre as a registered centre. The meetings also did not highlight the risk factors being experienced around the staffing deficits, which will be discussed under Theme 6 of this report. Key elements related to ongoing works required for the property were not reflected either, these related to the installation of fire doors and some privacy fencing for the rear yard along with the need for a washing machine to be purchased for the centre. Both acknowledged that more structured planning was required.

The director of service had a service level agreement for the provision of a placement through the Tusla special emergency arrangement process. The centre manager was completing shifts in the centre on an ongoing basis, this was initially said to be due to staff shortages but now is also impacted by funding the director stated. It was Tusla's expectation that the funding provides for a centre manager. The centre manager was found to be committed to the role and at an early stage of transitioning to the requirements as set out under the standards and regulations related to the role. The director must now provide a plan for how governance, oversight of practice and delivery of development will take place following any change in the centre managers working arrangements.

Inspectors found that the policy and procedure document had not been benchmarked to or guided by the National Standards for Children's Residential Centres HIQA 2018. Inspectors found that this created key knowledge gaps, as noted in placement planning and key working. Inspectors examined the records maintained at the centre and interviewed staff and found that sanctions were not tracked and recorded and there was no knowledge regarding any policy guidelines relating to purpose and fairness of sanctions and how they should be used, the same applied to restrictive practices. Inspectors acknowledge that there were good practices evident day to day overall, there were weekly planners in place and structures around phone use and friends. Where sanctions were used on occasion they ran over a week, which would require a good guiding policy and recording system that notes why, for how long and the outcome as well as the young person's view, and whether they met the criteria as a restrictive practice or not.

Inspectors interviewed staff and management related to policy knowledge and in the child protection and safeguarding area found significant deficits. Staff were not confident regarding the role of a mandated person or who holds that role or not on their team. Knowledge regarding who was a designated liaison person/DLP was limited and staff were not aware of how to report a child protection report through the relevant Tusla portal for same. The centre manager was not trained in the DLP role and no one had been trained or assigned as deputy DLP. There must be a trained and assigned DLP known by all staff, it must also be named on the child safeguarding statement who will hold the role in respect of this centre.

Staff had completed a programme of mandatory training in first aid, fire safety, crisis intervention and the national 'Introduction to Children First' eLearn module. Inspectors were informed that policy was discussed at induction and at team meetings thereafter, inspectors did not find evidence recorded that this had occurred at team meetings. The meetings were held every two weeks and the minutes maintained, and structures of the meeting were limited and not always adhered to. Therefore, inspectors could not see where staff could revert to regarding detail of discussions or point of note regarding policy and practice and how they link together.

The centre manager had a risk management policy and risk management procedure that they followed. There were risk assessments in place for the young person that had been developed appropriately, colour coded and reviewed every two months or as required should something significant occur. Inspectors found that the process may benefit from the addition of a rating matrix to further enhance and guide the process.

The centre manager had a risk register, this should be expanded to note issues such as staffing, property, policy or other ongoing or pending risk factors for the centre.

The centre manager had recently delegated some tasks to staff members and there was a record of this established. It was not clear however who would formally deputise for them in their absence and that the person or persons identified would be trained in the role of DLP also.

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

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

Actions required

- The director of service must enhance their governance role within the centre and evidence oversight of management and staff practices. They must submit a plan for how the daily operation of the centre will be overseen and developed.
- The director of service must ensure that there are a full set of appropriate policies and procedures in place. Training in policies and procedures must take place and thereafter there must be evidence in team meetings and in supervision of policy and practices being reviewed and discussed.
- The centre manager and director must ensure that all staff complete training in mandated persons role and function and that they have additional training in the centres child protection and safeguarding policies.
- The centre manager must complete training in the role of designated liaison person and ensure that when they are absent that there are clear arrangements as to which suitably trained persons will deputise DLP role.

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.

This centre was registered with a complement of a centre manager and seven qualified full time staff at the end of November 2024 for the purpose and function of a single occupancy centre. During this inspection, the centres first, in March 2025 there was a centre manager and five full time staff. Upon inspection at the centre it was a relief staff member who was assigned key work responsibilities along with the centre manager, this staff worked on a regular roster and was chosen by the young person. Inspectors found that overall a list of sixteen names, recurring, worked at the centre over the three month period since registration. These were staff based between two centres, one registered and one operating as a special emergency arrangement. The staff inspectors met with were committed and were knowledgeable about the young person's day to day needs and the safeguarding plans in place. They had not been trained in and were not knowledgeable in policy, procedures and child protection responsibilities in line with their role. The majority of the team were not experienced in children's residential care before joining the special emergency arrangement in 2023.

Inspectors reviewed the daily handover records and daily logs as well as rosters and found that on multiple occasions the names of staff coming on and off shift were scribbled out or a new name added without clarity as to why. Workforce planning was not evident to inspectors in how the roster was organised and there was limited awareness of the numbers of staff rotating shifts at the centre. Also, the daily handover records displayed staff completing back to back sleepovers and on occasion the records suggest three may have been done back to back along with a possible fourth in one seven day period by a person, this practice must cease. This does not represent good governance or safeguarding and the director must develop knowledge of the Working Time Act 1997 where it relates to roster planning. The records therefore indicted multiple double shifts, a triple shift and the splitting of shifts. In the month of March, the centre manager had completed three sleepovers, the completion of which were not cited as work connected to the development of staff practices. There was also some evidence of unqualified staff working together or with students who form part of the relief team. The inspectors did not find that these had

been recognised as risks that required governance and oversight and had not been alerted to the ACIMS regional manager as was stipulated in the letter granting registration.

There was on call provided mainly by the centre manager, a manager of another centre and the director of service. There was reference to bringing another person into the on call provision at times, this person had not yet completed their post graduate qualification in order to meet the criteria for inclusion as a suitably qualified staff for a registered children's residential centre.

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**

Actions required

- The director of service must ensure that there is a governance and risk system in place that records and tracks suitable staffing and rostering in the best interests of the young person in placement.
- The director of service must provide a plan of action to address the provision of staff team for this centre in order to meet the regulatory requirements as set out in the ACIMS regulatory notice on staffing requirements.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The director of service and centre manager must ensure that there is suitable training and support provided in the expected practices and recording in placement planning and the role and tasks of the key worker. The centre manager must ensure that adequate record keeping is in place for all contacts and meetings held relating to the young person.	Centre manager will work closely with key worker. Centre manger and key worker developed a plan from May-September with scheduled key-working. The planned key-work is centred around care plan and transition period from primary to secondary education. Centre manger has a digital record of professional contacts which was implemented 07th April 2025.	Centre manager will have recorded oversight of keywork and will record oversight for director of services input/feedback. Centre manager will continue to record professional contacts via Excel. Director Bi-Weekly Audit Added to Record of Professional Contacts, director has access to Contact sheet to give oversight. "Actions Required" recorded after each call/meeting" and updates from this given during team meetings/ staff update emails if urgent. For example, CICR Meeting-decisions will result in staff update given and risk assessment updated and in-person run through with staff during handovers by centre manager.

	The director of service and centre manager must ensure that electronic or digital files maintained for the young people are securely stored and archived appropriately and safely until such time as they are returned to Tusla.	Digital copies have been removed from centre laptop. Hard copied of files are archived/stored in main office in locked filing cabinet. Centre Manager to arrange return to TUSLA before 30.05.25. Completed.	Arrangements made for 29th May 2025 for Documents for previous YP hardcopies to be returned to TUSLA child and family agency. Preventative measures- will ensure data protection appropriate measures are taken if YP exits care of the centre.
5	The director of service must enhance their governance role within the centre and evidence oversight of management and staff practices. They must submit a plan for how the daily operation of the centre will be overseen and developed.	Manager monthly audit introduced and will be implemented 01st May 2025. Copy of template provided. This ensures oversight on daily running of the house, risk management, supervision, Care Plan, Care Plan Review Meetings, Strategy Meetings, training, maintenance, significant events, admissions. This will be recorded by centre manager throughout the month and sent to the director at the end of every month for feedback/developmental plans.	Manager monthly audit will be done every month. Feedback given will be reflected in management meeting minutes.
	The director of service must ensure that there are a full set of appropriate policies and procedures in place.	Policies and procedures training done with staff using workbook on current policies and procedures. Workbook provided and	Oversight & feedback from director will ensure continuous work on staff knowledge and implementation of policies and

	Training in policies and procedures must take place and thereafter there must be evidence in team meetings and in supervision of policy and practices being reviewed and discussed. The centre manager and director must ensure that all staff complete training in mandated persons role and function and that they have additional training in the centres child protection and safeguarding policies. The centre manager must complete training in the role of designated liaison person and ensure that when they are absent that there are clear arrangements as to which suitably trained persons will deputise DLP role.	minutes. Director and centre manager will be updating the policies and procedures and updated training on these procedures will be reflected in team meeting minutes. Timescale: every 3 months through strategy meetings, and that in between these meeting we respond appropriately to meet the needs of the young person staff and unit. All staff completed mandated persons training on Tusla.ie. Team meeting on child protection policy and child safeguarding statement- team meeting minutes provided. Centre manger & staff member completed Tusla online DLP training, but this training is not certified. Webinar booked for these persons on DLP role with a training company. Course date: 27.06.25	procedures in the centre. Restrictive Practice Policy completed as identified as gap in policies and procedures. Centre Manager and director will continue to develop policies to improve the running of the centre. Induction policy reviewed & amended to improve efficiency and oversight of induction and probation period Director of services and management resource mandatory and any additional training that may be beneficial to support staff to meet the needs of each Young Person. This training is recorded to ensure that all training is up to date.
6	The director of service must ensure that	Rostering and safe working hours	The director and centre manager utilise

	there is a governance and risk system in place that records and tracks suitable staffing and rostering in the best interests of the young person in placement.	oversight: Two shifts per staff-full time. Weekly reviews of the rota are conducted by the Director and centre manager to prevent staff from being over-rostered or double-booked. Any instances of non-compliance (e.g. excessive weekly hours or insufficient rest) are immediately corrected. Staff Deployment and Coverage: Shift model has been revised to operate on a 24-hour basis (10am–10am), always with two staff present in the house. Overnight, both staff sleep-in on-site—there are no waking night shifts in place. Relief staff are used to fill in for planned or unplanned absences, ensuring double staffing is consistently maintained. There will be a centre manager and eight staff once recruitment is completed. A list of staff provided to ACIMS.	rostering controls and compliance safeguards. Continued use of a digital rostering platform allows real-time monitoring and early flagging of any compliance risks. All rota submissions are reviewed by the Director in advance to ensure safe scheduling and adherence to the Organisation of Working Time Act 1997. Rest periods and max hours per week are built into rota templates as standard. There is a staffing policy for double cover. A formal policy mandates that a minimum of two staff must be on duty at all times. Rota templates and approval processes are structured to ensure this standard is met without exception. Double cover levels are recorded in the daily log and reviewed during weekly audits. Director and management follow a interview format, all candidates CV s are reviewed before interviews are offered. This is to ensure only suitable candidates receive offer for interview. Director of service ensures all staff are

			familiar with the terms of their contract prior to signing. Director of services ensures that all reference request forms are complete and followed by verbal reference completed by phone. Director and management offer exit interview to all staff at the end of their employment. Director of services and management resource mandatory and any additional training that may be beneficial to support staff to meet the needs of each Young Person. This training is recorded to ensure that all training is up to date. Director of Services and management ensure that all staff complete the centre induction process.
	The director of service must provide a plan of action to address the provision of staff team for this centre in order to meet the regulatory requirements as set out in the ACIMS regulatory notice on staffing requirements.	Strengthening staffing through recruitment: Two new full-time staff are currently in the final stages of recruitment and will be joining the team June 2025 to strengthen capacity and stability. An active job advertisement is live to recruit appropriate candidates for our relief panel, ensuring we have a continuous pipeline of qualified staff available to maintain cover.	There is protected managerial capacity. Manager's availability is protected during 9–5 to perform all assigned tasks including leadership, quality assurance, and external liaison. Routine care duties are not assigned during these hours to prevent disruption of managerial focus. Delegation protocols are in place to transfer responsibilities to a Deputy or senior staff

		Centre Manager's Availability: The Centre Manager now works a fixed 9am–5pm, Monday to Friday schedule and is not included on the care rota. Managerial tasks (supervision, audits, care plan reviews, reporting) are given protected time during the working week. For out-of-hours issues, the centre manager & team lead is accessible via on-call phone.	in the manager's absence. Director of service and management conduct interviews for suitable candidates for the roles of Social Care Workers. Director of Services and management ensured that all mandatory training is sourced and completed by staff, this is recorded and tracked to ensure all training is completed and updated as needed. Staff complete an induction process which they are introduced to policies and procedure, model of care, safeguarding statement, risk management and daily routine. An introduction to young persons social, psychological and emotional needs and history prior to meeting young person.