An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 280

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Future Foundations Services Ltd.**
Registered Capacity:	**Six young people**
Type of Inspection:	**Announced**
Date of inspection:	**19th and 20th May 2025**
Registration Status:	**Registered from the 9th January 2025 to the 9th January 2028**
Inspection Team:	**Anne McEvoy** **Joanne Cogley**
Date Report Issued:	**7th July 2025**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 9th January 2025. 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 the 9th January 2025 to the 9th January 2028.

The centre was registered to provide multiple occupancy care for six young people seeking international protection aged sixteen to seventeen years on admission. The stated objectives of the centre were to build a sense of belonging for the young people. The centre aimed to achieve this by providing them with a stable placement that fostered positive attachments and provided opportunities for them to participate and contribute to the daily living space whilst integrating into their new community. There were six young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.1
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2

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 people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

At the time of this inspection the centre was registered from the 09th January 2025 to the 09th January 2028. This is a draft report and the decision regarding the continued registration status of the centre is pending.

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 16th June 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 26th June 2025. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 280 without attached conditions from the 9th January 2025 to the 9th January 2028 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 11: Religion
Regulation 12: Provision of Food and Cooking Facilities
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.1 Each child experiences care and support which respects their diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child.

Five of the six young people who were living in the centre at the time of this inspection met with inspectors and were very complimentary of the care they were receiving. One young person spoke with inspectors with the assistance of a translation app, but the remaining young people had a good level of English. They stated that they were made aware of their rights and were given support to understand what their rights were and how to challenge any issues if they felt their rights were not being upheld. The sixth young person indicated in their questionnaire that they were happy that they were given access to information in their own language and knew who to contact should they have a concern or a complaint. They were familiar with the United Nations Convention on the Rights of the Child (UNCRC). They stated that they were treated with dignity and their individual religious practices were supported and facilitated. They confirmed they were informed of their right to make a complaint about any aspect of their care. One young person had made a complaint, and inspectors found that this was recorded on the care record, notified appropriately and resolved to the young person's satisfaction.

The centre had policies underpinning the rights of each young person to be treated with dignity and respect. The staff team demonstrated an awareness of the young people's rights in accordance with the UNCRC and advocated for them to have their needs and rights met. Inspectors observed interactions between the staff team and the young people and found that there was a curious approach from the staff team which facilitated them to learn more about each young person and their individual culture and belief systems. Inspectors were advised that staff had undertaken training on cultural awareness and additional training on inclusion, diversity and equality was scheduled post inspection.

Inspectors found that the young people had access to written information about the centre and its operation that was translated into their respective primary language. Important young person records such as placement plans were also translated into the young person's native language to ensure they were fully aware of the content.

Inspectors reviewed house meeting minutes and found that young people engaged well and were proactively informed of their rights in these meetings. These meetings also discussed the cultural differences between young people resident in the centre and the importance of respecting those differences. All young people interviewed stated that there were no issues of bullying and everyone, including the staff team and other young people, were very respectful of cultural identities. Individual key work was undertaken with the young people around their rights and documented in their care records.

The advocacy agency, EPIC (Empowering People in Care) had visited the centre and young people were made aware of their role in advocating for the rights of young people. All young people residing in the centre had either an allocated social worker or allocated social care leader from Tusla Child and Family Agency. In interview with these allocated workers, inspectors were told that they were satisfied with the care being provided to the young people living in the centre. The individual social workers and social care leader were confident that each of the young people they were responsible for were aware of their rights and were treated with dignity and respect. Each young person had their own personal mobile phone to contact family and their allocated Tusla worker independent of staff. Where contact details were provided, the centre manager had appropriate contact with family members via email.

Inspectors found that each young person's dietary requirements, social, cultural and religious beliefs were considered in the daily activities of the centre. Staff members ensured there were culturally appropriate food options available to the young people who required it. There were appropriate arrangements in place to facilitate religious observance of fasting for some of the young people, with unrestricted access to the kitchen to prepare meals at required times. Inspectors found that care records referenced dietary requirements as well as cultural and religious beliefs and values for each young person.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 11** **Regulation 12** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 1.1**
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**

Actions required

- None identified.

Regulation 5: Care Practices and Operational Policies

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

The centre had a suite of policies and procedures outlining the management of child protection and safeguarding concerns. These were to a good standard however, inspectors noted that there was no centre policy outlining how the organisation responded to, and managed allegations of abuse made against staff members. In interview, staff members were not clear on how an allegation against a staff member was to be managed. Prior to the completion of this inspection, the registered provider and centre manager informed inspectors that this policy was developed and evidence of same was received.

The centre had developed a child safeguarding statement (CSS) and this was displayed in a communal area in the centre. This statement contained relevant risks, however in interview, not all staff were familiar with the risks or control measures and inspectors recommend that this is reviewed in team meetings.

Inspectors reviewed a sample of personnel files for those staff who began working in the centre post registration. Inspectors found that the recruitment process in operation at the centre was not sufficiently robust. All staff members were appropriately vetted. However, inspectors found that written references provided were not always followed up with a verbal verification. Where verbal verifications were carried out, they were not always signed by the individual undertaking the verification. One staff member obtained their own reference and there was no evidence to support that the centre had objectively sought to obtain the reference. The registered provider must review their recruitment processes and ensure that appropriate measures are introduced and upheld to provide assurances that staff references are robustly verified.

Inspectors reviewed training certificates and found that staff members had each completed the introduction to Children First e-learning programme, 2017. Staff members had an awareness of child sexual exploitation (CSE) and in interview provided examples of potential indicators of CSE. The centre had an appointed designated liaison person (DLP) and deputy designated liaison person (DDLP) and staff were familiar with the individuals holding each position. It was identified that the centre manager was the appointed DLP and while they had undergone DLP training for vulnerable adults, they were not trained in the responsibilities as the DLP for a children's residential centre. In interview staff members were aware that they were mandated persons and had an awareness of their role and responsibilities as such, however mandated person training was not completed by any member of staff in the centre. Additionally, it was noted that staff members had not completed training on the centre's own child protection and safeguarding policies. Inspectors found that not all staff members interviewed were aware of how to submit child protection and welfare report forms (CPWRF) through the online portal for Tusla Child and Family Agency. The registered provider and centre manager must ensure that relevant child protection and safeguarding training is undertaken by staff members.

Inspectors reviewed child protection and welfare reports that were submitted through the Tusla portal and found that the reports did not identify the individual reporting the concern, but the name of the organisation. The registered provider and centre manager must ensure that the individual who received the concern and is making the report is named on the CPWRF report.

The centre had policies and procedures in place to address all forms of bullying and internet safety. Each of the young people who spoke with inspectors confirmed that

they felt safe and were treated with respect in the centre. They identified that individual key workers had completed work with them around the dangers of cyberbullying and how to protect themselves while engaging with social media platforms. Inspectors found that this individual work was not always evident in the young people's care records and recommend that the centre manager undertake a review of individual work to ensure that work carried out is captured and recorded in young peoples' records. There was good evidence that topics such as bullying, diversity and cultural respect were referenced regularly in young people's house meetings. All young people, through questionnaires and in interview, stated that they felt that the centre manager and staff members were approachable and they were confident that they were listened to if they had any issues. This was confirmed in interview with allocated social workers and social care leader.

Inspectors reviewed young people's records and found that while there were completed risk assessments on file for each young person, these were generic in nature. Some of the risk assessments were not relevant to the young person named and inspectors found that there were other areas of vulnerability specifically for one young person that required a risk assessment, but the risk had not been identified as such and no risk assessment was completed. The centre manager must review the current risk assessments and determine their relevance for each young person and where areas of vulnerability are identified ensure that appropriate risk assessments are completed.

To date, the centre had not experienced challenging behaviour being displayed by any of the young people in the centre. To develop individual crisis support plans (ICSPs), each of the young people in the centre were actively encouraged to participate and identify how they believed they would present if they were becoming dysregulated. While the inclusion of the young people was evident, inspectors found that the ICSP's needed to be reviewed and updated to offer more guidance to staff should a young person be dysregulated and not just how they would present. The ICSP's in their current form would not offer appropriate guidance on how to manage behaviours should a young person become dysregulated. Inspectors recommend that the centre manager undertake this review as soon as possible.

Individual absence management plans (IAMP) were completed on admission for each young person but inspectors found that they were not reviewed monthly in line with the Children Missing from Care - A joint protocol between An Garda Síochána and HSE (Tusla). Inspectors also found that the IAMP's failed to provide specific guidance to staff on the procedure to follow should any of the young people be

missing in care. The centre manager must ensure that IAMP's are reviewed and updated to provide guidance to staff members on the procedures to follow and also that they are reviewed monthly in line with the joint protocol.

The centre had a policy and procedure on protected disclosures. This document highlighted the procedures to follow should a staff member have any concerns in relation to care practice, financial management or safeguarding within the centre. It outlined appropriate external agencies that staff members could contact. In interview, staff members were not clear on the procedure around protected disclosures or who they should contact, though they were aware of the policy and noted that they would consult the policy should they have a concern. Inspectors recommend that this policy and procedure is reviewed again by all staff members.

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

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

Actions required

- The register provider must review their recruitment processes and ensure that appropriate measures are introduced and upheld to provide assurances that staff references are robustly verified.
- The registered provider and centre manager must ensure that relevant child protection and safeguarding training is undertaken by staff members.
- The registered provider and centre manager must ensure that the individual who received the concern and is making the report must be named on the CPWRF report.
- The centre manager must review the current risk assessments and determine their relevance for each young person and where areas of vulnerability are identified ensure that appropriate risk assessments are completed.
- The centre manager must ensure that IAMP's are reviewed and updated to provide guidance to staff members on the procedures to follow and also that they are reviewed monthly in line with the joint protocol.

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

Theme 5: Leadership, Governance and Management

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

Inspectors were provided with the service level agreement in place with the funding body and this was renewed and in date. The centre had an established organisational structure with the centre manager as the identified person in charge. Inspectors found that the centre manager was aware of their role and responsibilities.

In addition to the centre manager, the centre had an identified deputy manager and five social care workers. At the time of this inspection the centre did not have a full staffing cohort 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. In interview, the registered provider advised that recruitment was ongoing, and interviews had taken place with additional interviews scheduled to fill the staffing deficit. In interview, the centre manager advised that gaps in the roster were filled by relief staff, the manager and the deputy manager also completing shifts. Following this inspection, the lead inspector wrote to the registered provider advising that they must notify the inspectorate when full staffing was achieved.

In interview, staff members were aware of the organisational structure and the lines of authority in place. Each described that they were provided with a job description and from a review of personnel files, inspectors found that on change of role or function, a new job description was issued to the staff member. Young people told inspectors that they knew who the person in charge was and knew who they could speak to if they had any areas of concern.

The centre had a suite of policies and procedures in operation within the centre and these were under review at the time of this inspection. Inspectors found that the organisation had established a review group comprising of managers and deputy

managers who were undertaking the review and reporting back to the registered provider for ultimate approval. The registered provider advised inspectors that they were appointing a quality assurance (QA) manager in quarter three 2025. The QA manager was to form part of the policies and procedures review group in addition to conducting audits on centres within the organisation. The appointment of a QA manager was to address deficits identified by the organisation in the completion of audits and overall compliance with the National Standards for Children's Residential Centres 2018 (HIQA). Inspectors found that audits undertaken to date were not robust and did not identify issues and deficits found by inspectors as part of this inspection, such as the issues regarding verification of verbal references. The registered provider must ensure a robust audit system is implemented.

The centre had a risk management framework in operation and the centre manager and staff interviewed were familiar with the risk matrix. However, as identified in standard 3.1, inspectors found deficits in the risk assessments completed for individual young people and the centre manager must undertake the action previously identified above to ensure that the system in place effectively manages risk. The centre held a central risk register noting risks in the centre such as fire risks and health and safety risks. Inspectors found that there was no risk assessment in place for the staffing deficit being experienced by the centre. The centre manager and registered provider must ensure that risks posed to staff and young people as a result of low staff numbers are identified and list the mitigation measures implemented to limit the risks until such time as full staffing levels are achieved.

There was an on-call system in operation at the centre to provide alternative management arrangements for when the person in charge was absent. This was appropriately managed by staff members who were experienced and knowledgeable in the role. However, inspectors found that there was no consistent record maintained of guidance offered to staff members who phoned the on-call manager. The centre manager must ensure that a system is introduced to record the guidance provided to staff members when they utilise the on-call system. The centre manager had delegated aspects of their role to the deputy manager such as the supervision of staff members. This was discussed and recorded in supervision.

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 centre manager and registered provider must ensure that risks posed to staff and young people as a result of low staff numbers are identified and list the mitigation measures implemented to limit the risks until such time as full staffing levels are achieved.
- The centre manager must ensure that a system is introduced to record the guidance provided to staff members when they utilise the on-call system.
- The registered provider must ensure a robust audit system is implemented.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	None identified		
3	The register provider must review their recruitment processes and ensure that appropriate measures are introduced and upheld to provide assurances that staff references are robustly verified.	We acknowledge the importance of robust reference verification in safeguarding children and ensuring high standards in recruitment. Following the inspection, we conducted an audit of all current staff files to ensure that references were complete, verified, and followed up appropriately. Any missing verifications were promptly addressed, with documented confirmation now in place.	To prevent recurrence, we have revised our recruitment policy and implemented the following measures: A recruitment policy has been put in place and staff completing recruitment will receive training to ensure safe recruitment practices. Our **verbal check form** has been reviewed with an added section for signing to confirm that all verbal checks have been complete prior to commencement of employment. The compliance checklist has been updated to include a mandatory double-check of compliance file by the operations director. Reference audits will now be conducted quarterly as part of our internal compliance review in collaboration with our quality assurance manager.

	The registered provider and centre manager must ensure that relevant child protection and safeguarding training is undertaken by staff members.	All staff have completed mandated person training on Tusla website. Child protection and safeguarding discussed at team meeting 24.06.2025. (All staff have signed off on the TM minutes). Centre manager has completed in house TOK (test of knowledge) on safeguarding which centres on recognising abuse, how to report and roles and responsibilities. The centre manager undertook DLP training on the 6th June 2025.	Child protection and safeguarding will continue to be discussed periodically in team meetings to ensure staff remain up to date on knowledge. Safeguarding training is currently being implemented based off of our own policy. We expect to conclude this training by the end of July 2025 with our current cohort of staff. all onboarding staff will undertake this training during their induction. A training matrix is maintained and will be reviewed monthly by the centre manager to ensure all training remains in date. Staff will receive refresher training every 2 years, or sooner if there are updates to national policy or guidance. The centre manager will monitor training compliance and report quarterly to the registered provider.
	The registered provider and centre manager must ensure that the individual who received the concern and is making the report must be	Discussed at team meeting on 24.06.2025 (All staff have signed off on the TM minutes). Centre manager has completed in house TOK (test of knowledge) on	The centre manager delivered a refresher briefing to all staff on the correct completion of CPWRFs and the importance of accurate, accountable

	named on the CPWRF report.	safeguarding which centres on recognising abuse, how to report and roles and responsibilities.	reporting. Reporting protocol for submissions has been issued to the centres and will be discussed during the induction process for new staff. The centre manager/DLP will review all CPWRF's before submission to ensure that staff names are clearly noted in the report.
	The centre manager must review the current risk assessments and determine their relevance for each young person and where areas of vulnerability are identified ensure that appropriate risk assessments are completed.	All risk assessments reviewed for each young person although there are shared risks among young people there are also person specific risks for example: driving lessons YP2, Access to large quantity of money YP4. Director of care and centre manager have reviewed risk assessments and comments/recommendations implemented. Risk assessments discussed at the team meeting 24.06.2025 to assess staff members perspective on risk assessments.	Implementation of health and safety representative in centre to review risk assessments in collaboration with centre manager. All updated assessments are signed off by the centre manager and discussed at team meetings to ensure consistency in staff awareness and response. Risk assessment audits will be conducted as part of our internal compliance review in collaboration with our quality assurance manager.
	The centre manager must ensure that IAMP's are reviewed and updated to	IAMP guidance sheet implemented for team members. This discusses the	IAMPs will now be formally reviewed on a monthly basis by keyworkers and centre

	provide guidance to staff members on the procedures to follow and also that they are reviewed monthly in line with the joint protocol.	following: The definitions of MCIC, absent at risk, absent without risk. Procedure to follow for MCIC, absent at risk, absent without risk to support the staff. These are stored in the YP folders for staff to access additionally sign off sheet implemented to ensure all staff have read and confirmed same.	manager collaboratively to ensure consistency and shared understanding. IAMPs added as a standing agenda on the team meeting minutes this will ensure they are reviewed monthly in line with the joint protocol.
5	The centre manager and registered provider must ensure that risks posed to staff and young people as a result of low staff numbers are identified and list the mitigation measures implemented to limit the risks until such time as full staffing levels are achieved.	Low staffing levels added to the centre risk register. Relief staff utilised in the centre to support with the staffing levels. Agency has been contacted with supporting to limit the risk until full staffing levels. Management review rostering system to ensure if agency is utilised a familiar team member is supporting also. Agency staff provided with IAMP, ICSPs and YP background on entry to the centre.	Director of care completes weekly support visits to centre. Section added to weekly operations report for "WTE Staffing" to ensure all stakeholders are aware of the staffing levels. Ongoing recruitment is prioritised and monitored closely, with a streamlined onboarding process in place. Staff wellbeing is supported through additional debriefs, supervision, and flexible time-off where possible. A staffing contingency plan is now in place and will be reviewed monthly or following any significant staffing change. Weekly operations report template updated to include the section on staffing.

	The centre manager must ensure that a system is introduced to record the guidance provided to staff members when they utilise the on-call system.	On-call register implemented for management and for staff members to utilize. This includes the following information • Date & time of call • Manager on-call • Reason for call • Advice provided • SEN ref (If applicable) • Does ICSP need to be updated after this incident • Managers sign off Managers to ensure that handover is completed following on call to ensure all areas of concern are addressed.	A clear procedure has been implemented outlining the expectations for documenting all on-call interactions. This includes responsibilities for both staff and on-call managers. The centre manager will conduct weekly reviews of on-call logs to ensure completion, accuracy, and that any safeguarding issues are addressed. The quality assurance manager will have oversight of this when completing monthly internal audits. On-call guidance rolled out to all staff during a team meeting on the 24.06.25
	The registered provider must ensure a robust audit system is implemented.	Quality assurance manager is currently onboarding to complete regular internal audits, provide feedback and training to centre managers and staff to improve service provision and assure high quality service provision. Weekly operations report form has been reviewed and	The onboarding of quality assurance manager. Responsibilities include developing a comprehensive audit framework, conducting quarterly compliance reviews, and supporting the service in meeting national standards. A review and update of the audit framework

		updated to ensure continuous monitoring and auditing of weekly operations.	will be completed by the quality assurance manager and senior management aligned with Children's Residential Standards and Tusla requirements. The framework will include both scheduled and unannounced audits, using standardised tools and outcome-focused reporting. Audit findings will be logged in a central audit action tracker, reviewed monthly by senior management. Non-compliances will be assigned with timeframes and tracked through to resolution. Staff will be engaged in learning from audit outcomes via team meetings and audit review meetings with the quality assurance manager.