An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 024

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**The Cottage Homes Child and Family Services**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Unannounced Inspection**
Date of inspection:	**5th, 6th and 7th August 2025**
Registration Status:	**Registered from the 31st October 2024 to the 31st October 2027**
Inspection Team:	**Linda Mc Guinness** **Paschal Mc Mahon**
Date Report Issued:	**2nd October 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 31st October 2009. At the time of this inspection the centre was in its sixth registration and was in year one of the cycle. The centre was registered without attached conditions 31st October 2024 to 31st October 2027.

The centre was registered as a multi occupancy service to provide care to four young people from age thirteen and seventeen on admission. At the time of inspection, the model of care was described as relationship based however the organisation was undergoing a transition to a model of care aligned to that in Tusla mainstream residential care. The statement of purpose was to be reviewed upon adaptation of the new model and training of the staff team was well underway and ongoing. There were four young people living in the centre at the time of the inspection with one moving in the week prior to the inspectors visit.

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	5.4
6: Responsive Workforce	6.3

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

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 26th August 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 8th September 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: 024 without attached conditions from the 31st October 2024 to 31st October 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.

At the time of inspection there were up to date care plans or aftercare plans on file for the three young people approaching 18 years old and preparing for independent living. The fourth young person recently moved in, and a date was scheduled for their first statutory child in care review. The inspectors were satisfied the manager and team worked closely with the supervising social work departments and relevant professionals to provide care and support based on their individual and differing needs. Statutory child in care reviews took place in line with the requirements of the regulations and there were progress reports on file that the centre prepared in advance of the meetings to facilitate effective planning. Three of the young people had allocated social workers however the fourth was appointed a social care worker in January 2024 as a liaison person to the social work department. The centre advocated numerous times for allocation of a social work in line with regulations however were informed due to resource issues there was no one available to take up this post. There was evidence that young people participated in the review process or were consulted about their wishes while preparing for review meetings. Parents, where they were involved in their children's lives, were invited to participate in the meetings. The director and manager advocated strongly for more frequent child in care review or strategy meetings if necessary and these were usually responded to positively.

The centre maintained their own record of review meetings and used these to update placement plans and any other relevant documents whilst waiting on care planning documents from the social work department or the Tusla aftercare service. If young people chose not to attend their care plan review meeting their key workers and/or social workers informed them of decisions made at the meeting. Depending on relationships the centre or social work department managed communications with family members and ensured they received regular updates about their progress.

There were systems in place to meet with young people to ascertain their views and receive feedback about the care they were receiving. Unfortunately, none of the young people were available or took the opportunity offered to meet with inspectors. This remains open to them and inspectors continued to liaise with managers, social workers and Guardians ad Litem to encourage them to provide feedback.

Each of the young people had an up-to-date placement plan that was aligned to the goals of the care plan or aftercare plan. This was being progressed for the young person recently admitted, but there was evidence of effective planning in relation to preplacement planning, collective risk assessments and transition to the centre. A planning meeting took place the day after they moved in to determine how best to support them. The supervising social worker stated that when they raised issues relating to the young person's transition that discussions took place and prompt action was taken.

There were written policies and procedures in relation to placement planning, and consultation with young people. The centre was in the process of adopting a new model of care and revised placement planning process. This had commenced, and the team received training and consultation sessions to support the development of revised individual placement plans. Care staff that spoke to inspectors felt it would be a positive move and that it would facilitate measurement of outcomes and progress more effectively. They described how planning would be more focused on specific, measurable and achievable goals. They welcomed the training and support on offer during the transition period as it was a significant departure from previous practices. The director of service and social care manager informed inspectors that documentation and planning documents were being revised to support the transition to the new framework. Care team members interviewed, described how it was the responsibility of all to ensure the goals of the placement plan were targeted. There was a system in place to monitor key working progress through five weekly internal case review meetings and there was evidence that the centre manager and director of service had oversight of this process.

A review of placement plan notes for all young people which recorded work undertaken by key workers or others, evidenced a focus on the goals set out in case review meetings, placement plans and aftercare plans. These included conversations or practical tasks related to independent living skills, good physical and mental health, substance abuse awareness, sexual health and healthy relationships, internet safety, self-regulation and information about community supports amongst others.

Social workers interviewed were satisfied that there was effective communication and that they received timely copies of placement plans, risk assessments, individual support plans, safety plans and other relevant documents related to planning. While there were differing goals and expectations of young people depending on specialist assessments and individual circumstances, social workers who spoke to inspectors were generally satisfied with the efforts of the staff team to implement the stated goals of each care plan. There was acknowledgement that progress was based on individual need and that there were limitations to achieving all identified goals, however, all social workers were satisfied the young people had achieved growth in specific areas while living in the centre. Some young people were not in education however the social workers stated that this was discussed regularly at planning meetings and that the team had identified education opportunities, altered the staff rota and offered supports to encourage a return to education. Review of records corroborated this and showed evidence of discussions with young people about the importance of training and education in respect of aftercare planning, financial support and positive life outcomes.

Inspectors note contrary to the social work opinion, an advocate for one young person was not satisfied with, participation in education, risk management and overall planning. They continued to attend frequent strategy meetings, advocate strongly for the young person, and highlight their concerns to all professionals. Inspectors found while there was high risk and that planning was impacted by various issues and contexts that various efforts being made to meet the young person's needs and keep them safe. There was strong collaborative planning, and inspectors found the young person had made statements about feeling safe and well cared for by the team and did not want to move to an alternative placement.

Across three young people's files there was evidence that the policy of working in close partnership with social workers and families was met in practice. For one young person with complex needs the inspectors found, while collaborative planning was now in place to secure assessments and other required supports, this came very late in their placement. Inspectors recommend more timely escalation if a young person is not making progress and does not have access to the external supports and specialist services they require.

For the other young people, where required, and following recommendations of specialist assessments, they were linked in with appropriate specialist services including mental health and counselling services and ACTS (Tusla's Assessment Consultation Therapy Service) attended a number of team meetings until the

psychologist left their post. There was evidence that the care team had a good understanding of the impact of trauma and adverse childhood experiences and their impact on behaviour. Placement plans and team meeting records viewed by inspectors also included guidance to the care team from other specialist services to help support daily therapeutic interventions.

Inspectors found that some young people chose to spend a lot of time in their rooms and often ate meals there. This was highlighted as a concern in a team meeting in February 2025 although it was not clear what the specific follow up actions were, and if outcomes were reviewed. Inspectors recommend that centre management reviews day to day routines in the house (such as shared meals, routines/computer and phone use) to support improved engagement with young people.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 2.2**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- None identified

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

Theme 5: Leadership, Governance and Management

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Inspectors found there were effective systems in place to review the quality, safety and continuity of care to inform improvements in practices and strive to achieve

better outcomes for the young people. Governance reports aligned to the themes of the National Standards for Residential Care, HIQA, 2018, were completed by the centre managers on a monthly basis. The governance reports captured a wide range of information including planning for young people, information relating to review of incidents and complaints, risk management, child protection and staffing amongst others. The director of services had direct oversight of these governance reports and also of the information that informed them. Inspectors found they monitored records in real time, had daily communication with the centre managers and were aware of all aspects of operation of the centre. They usually attended the team meeting monthly and met with young people and care staff during visits to the centre. Progress and outcomes for the young people in placement was regularly assessed and reviewed with areas of concern identified for action or strategy meetings.

There was a system in place where by the director assessed the centre's practice against the Regulations and the National Standards for Children's Residential Centres HIQA, 2018 on a quarterly basis. Inspectors reviewed a sample of audits across 2024 and 2025 and found that the reports of these visits assessed compliance with regulations and standards, that aspects of good practice were highlighted and areas for improvement were identified. A report was prepared and sent to the centre manager who responded with an action plan to address any identified deficits within a specified timeframe. One recent recommendation related to improving memory books and gathering of mementoes and memorabilia to be provided to young people when they move on from the centre. It was also recommended that the young people have a way of making direct contact with the director should they be unhappy with any aspect of their care. Another audit highlighted some necessary renovation works and improvements to placement planning. All these were discussed between the director and centre managers, and inspectors were satisfied that appropriate follow up actions were taken and signed as closed out with an outcome assessment process. The inspectors found that required actions and recommendations from inspection processes were reviewed regularly by the director and the centre managers and discussed at management meetings across the organisations for shared learning purposes.

There was a centre complaint policy in place that was aligned to Tusla's 'Tell Us' complaints and feedback procedure. There was a helpful flow chart and procedures for managing all levels of complaints clearly established. The managers and team members interviewed were familiar with the stages of the complaints procedure and it was discussed in team meetings.

Young people were made aware of their right to make a complaint through the provision of an information booklet and through individual work to ensure they knew how to raise any concerns about their care and to whom they could report. There was evidence they were supported by staff when they raised any issues of concern and the majority of expressions of dissatisfaction were dealt with at level 1 with 'quick fix' solutions in consultation with the young person. Inspectors found however, that while young people were listened to and prompt action was taken to resolve their issue and prevent reoccurrence, these issues were not always recorded on the complaint register in line with policy. They sometimes were recorded on daily logbook or in the young person's meeting/consultation. This did not facilitate ease of monitoring and tracking of complaints at this level to identify any patterns or trends. Complaints at level 1 were not always maintained on the young person's care record. Inspectors recommend that director of service ensures that practice in respect of recording and tracking of level 1 complaints adheres to organisational policy.

Inspectors found that there were systems in place to track other complaints and their follow up through the governance reports, team and management meetings and service director audits. There was only one higher level notifiable complaint in the centre since the last inspection.

The director of service completed an annual statement of compliance and the actions arising from this were due for review with the centre managers in a scheduled meeting on 20th August. This report was aligned to national standards, and it outlined compliance and progress achieved in 2024 and identified areas of improvement for 2025. These were mostly related to the transition to the new model of care and supporting the care team with relevant policies and templates. It also included review of ways to improve young people's engagement in education and in group meetings. Inspectors found that key areas such as risk management, restrictive, management of significant events, recruitment and retention, staff supervision and staff training were also addressed in the report.

Care staff interviewed by the inspectors were familiar with the internal and external systems in place to assess compliance and the quality of care the children received. They spoke about feedback received from management meetings, significant event reviews and centre audits. There was a system in place whereby a member of the care team attended the significant event review group on a rolling basis for a period. Feedback was sought from the team and all highlighted that this was beneficial.

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

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

Actions required

- None identified

Regulation 6: Person in Charge

Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

The team comprised of a social care manager who was four years in post, the deputy manager appointed in 2022, four social care leaders, a job-share social care leader post and 6.5 wholetime equivalent social care worker posts. There was a strong emphasis on ensuring that where possible, all staff held a social care qualification. Inspectors found that there was low turnover and that only one member of the core team had left since last inspection of this service in September 2024. Nine of the staff team have worked in the centre in excess of three years. Notwithstanding this, the organisation found it difficult to ensure that there was a consistent panel of relief care staff available to cover various types of leave. The centre had experienced a period of high levels of sick leave and despite best efforts to ensure that the same people were rostered inspectors found that 21 different people (additional to the core team) covered shifts in the centre since November 2024. Additionally, there were significant number of days where the agreed quota of four staff per day could not be provided and this impacted shift planning. Recruitment for additional relief staff was underway, and interviews scheduled at the time of inspection.

There were policies and procedures to guide practice and clear lines of authority and accountability within the organisation. Care staff interviewed stated that the manager and deputy provided strong leadership and support and that the director of service visited the centre regularly and was accessible to them. There was evidence that the care team received formal induction and received job descriptions when they took up their roles. There was evidence of a comprehensive probation process with a focus on skills development, decision making and using initiative amongst others. The role of social care leader was discussed and clarified in management meetings.

The inspectors reviewed the centre training records and found that team members received mandatory training in a timely manner with the exception of one who was waiting on training in the agreed model of behaviour management. Inspectors found there was an effective database to record and track mandatory and supplementary training to suport team development.

Team meetings took place on a weekly basis, were well attended and evidenced discussions about child protection, complaints, restrictive practices, placement planning, accountability, and review of and learning from significant events. The effectiveness of the handover meetings to support planning was explored in management meetings and this was monitored by management presence at the daily meeting.

There was a system in place whereby the care team on shift completed a shift evaluation to review their work practice, share information, explore what went well during the day and if any learning could be taken to improve practice or outcomes. Team members interviewed described this as a useful process. The inspectors found team cohesion was discussed in individual supervision and any issues arising were explored at management level and addressed promptly. A team building day was planned for September 2025.

The organisation had a policy which stated that individual supervision took place every four to six weeks for all full-time members of the care team. The inspectors found that improvements were required in how aspects of roles and responsibilities were discussed with the team members during their professional supervision. Supervision of the social care leaders was provided by centre manager, and the deputy manager supervised the social care workers. Inspectors reviewed the supervision records and found that sessions generally took place in line with policy and that a rationale was recorded if sessions were missed. However, there was some confusion during interviews about the model of supervision in use and the records

were limited and did not evidence an emphasis on the differing functions of supervision, mostly focusing on support. Inspectors note that deficits in supervision were highlighted internally at a recent management meeting in July 2025. A decision had been taken to review a number of supervision frameworks and determine which was most suitable going forward, taking into account the transition to a new model of care. Inspectors recommend a review of the proforma form in use, and that records of supervision always include an agenda completed by both parties, a review of the previous session, detail of discussions and clear decisions with persons responsible for identified actions. The record should include more evidence of discussions about staff performance and feedback, workload management, placement planning and key working as well as staff support and development. There was a system in place whereby supplementary supervision was undertaken with staff members to provide debriefing following an incident or an opportunity to reflect if required. Records were not always signed by both the supervisor and supervisee as required.
There was evidence that each staff members performance was appraised on an annual basis once they passed their monitored probation period. Management and team members interviewed described this as a beneficial experience and the records showed that all key aspects of the work were explored. Inspectors recommend that agreed actions are specified more explicitly.

The inspectors found there were policies and procedures in place to support the team to manage the impact of working in the centre. Additionally, the organisation provided access to an employee assistance programme where team members could receive counselling services if required.

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

Compliance with standards	
Practices met the required standard	**Standard 6.3**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that the planned review of supervision takes place and that there is evidence that each staff member is supervised in

line with the chosen model. Supervisors and supervisees should receive relevant training in the model of supervision in use.

4. Corrective Actions and Preventive Actions (CAPA)

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies to Ensure Issues Do Not Arise Again
6	The registered provider must ensure that the planned review of supervision takes place and that there is evidence that each staff member is supervised in line with the chosen model. Supervisors and supervisees should receive relevant training in the model of supervision in use.	We are currently undertaking a comprehensive review of our existing supervision model. The review and subsequent implementation of any changes will be completed by November 25th.	Regular audits of supervision records will be conducted by the centre manager and director of service to ensure that supervision practices are consistently aligned with the established supervision model.