An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 027

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**Daffodil Care Services Ltd**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Unannounced**
Date of inspection:	**3rd and 4th of September**
Registration Status:	**Registered from the 23rd of May 2022 to the 23rd of May 2025**
Inspection Team:	**Eileen Woods** **Mark McGuire**
Date Report Issued:	**26th November 2024**

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 23rd of May 2013. At the time of this inspection the centre was in its fourth registration and was in year two of the cycle. The centre was registered without attached conditions from the 23rd of May 2022 to the 23rd of May 2025.

The centre was registered to provide short to medium term care to four young people aged between thirteen and seventeen years of age. The model of care was the systemic therapeutic engagement model (STEM) which provided a framework for maximising positive interventions with young people. The model took a strengths-based approach focusing on relationships and resilience. There were two 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
3: Safe Care and Support	3.3
4: Health, Wellbeing and Development	4.2
7: Use of Resources	7.1

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 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 10th of October 2024. 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 management team returned the report with a CAPA on the 24th of October 2024. This was deemed to be not satisfactory and further evidence was sought inclusive of discussion around the details of the planned property improvements, this was received in November 2024. If the property works and staffing recruitment are completed, as committed to, and in compliance with the relevant regulations and guidelines the centre will be deemed to have satisfactorily completed the actions. The property will be reviewed by inspectors post the planned works.

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: 027 without attached conditions from the 23rd of May 2022 to the 23rd of May 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

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

There were policies in place on the notification of significant events,(SENS) and on complaints. Inspectors found that overall, the policy knowledge displayed by staff was clearer regarding significant incidents rather than complaints. Complaints were a category of incident listed in the policy for notification and inspectors found a lack of identification of matters that would have reached a threshold for notifying externally. Examples included a possible breach of a young person's privacy, complaints related to external bodies or about dissatisfaction with a placement. The centre manager and staff must complete a review of all complaints for learning regarding what is notifiable and what can be resolved locally.

A review of the significant incidents recorded in 2024 evidenced improved recording and follow up. There was a structure of reflecting and linking actions related to follow up post incidents in supporting young people positively, creating or updating risk assessments where needed and updating behaviour management plans. There was positive feedback from external professionals and family on the role of management in this regard.

The timeframes for notifying the relevant persons were mainly in line with the three day policy timeframe. The template for the SENs required updating as it referenced roles within Tusla that no longer apply in receiving SENs, these were the monitor and the alternative care manager. There was also a lack of consistent identifying of notification to parents/guardians. One parent confirmed that they were told by phone or in person about any incidents and was aware that these were written reports shared with professionals. They were happy with the manner in which they were kept updated and that the team respected their specific wishes in this area. Two social workers and a guardian ad litum were also satisfied with the standard, speed and type of reporting completed. This included appropriate use of the child protection reporting portal where necessary.

There were two types of SEN review completed, one at team level and the second taking place at a monthly regional significant event review group, (SERG). A review of a sample of team meeting minutes found that they did not evidence the discussion, actions and learning however the most recent team meeting minutes had improved in this regard and this must continue. The regional SERG learning was being brought back to the team by the centre management but again the recording of this on the team meeting minutes and the awareness of it displayed by staff must also be improved.

The significant events were tracked through a register and stored within the young people's care records. Inspectors found that there were some organising and tracking that the managers must attend to in filing and organising the care records. Inspectors found that it was difficult to track the daily co-living experience and impact for the young people. One young person gave feedback to inspectors that people did not respect each other and that they would like things to be quieter at the centre. Supporting documentation and reporting regarding suspected bullying or intimidation was evident and there were plans in place to minimise opportunities for incidents between young people, but inspectors found that there should be an increase in anti-bullying resources for the team to implement. The team had good practices in place regarding support sessions and individual work post incidents, this was mainly delivered by experienced staff and role modelled and supported for staff newer to the role.

Other avenues of learning for staff were being completed such was debriefing following incidents. This type of follow up and outcomes from it were not always being captured and the centre management should consider how they would do this to support further team growth and development. The staff inspectors interviewed were happy with the support provided and learning shared during difficult and challenging practice matters arising at the centre. Social workers, family and guardian ad litem found that the team had created an environment that responded to escalation and strove to maintain placements in a safe manner.

The company had mechanisms in place to promote the raising of concerns through complaints procedures, regular employee forums and team and young people meetings. Young people had been asking questions about specific matters at key points early in 2024 and these comments were addressed through an internal complaints process at the centre. A staff member inspectors met with reflected on this period of time and underlined the learning from it in terms of young people being able to positively raise concerns and have those listened to. The staff members

interviewed stated that they knew who to go to within the company to ask questions or raise issues. The care team had good knowledge of the company structure and the persons at every level, they knew how to contact them and were participating in the employee forum. Inspectors found that the centre did not have access to an organisational formal mechanism for seeking feedback from families, young people and professionals and this must be considered.

The centre management team changed in May and July of 2024, the new centre manager started in May joined by a new deputy manager in July, the regional manager commenced in their post in April of 2024. Inspectors found that the regional manager and centre management team worked well together in identifying and tracking improvements through visits, supervision, management meetings along with monthly audits and reporting. There were regional managers meetings re-established after a short gap with records evidencing a robust and comprehensive process and forum.

Thematic areas for improvement identified and agreed between the regional manager and the centre manager included the quality and content of paperwork, recording standards, systems and policy compliance, repairs and recruitment as well as evidencing feedback from significant event reviews at team level. Inspectors found that these matters were ongoing areas of development with plans in place that sought to address them. Training formed part of this approach.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
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 3.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must ensure that they implement formal mechanisms for seeking feedback from families, young people and professionals.

- The centre management and staff must complete a review of all complaints for learning regarding what is notifiable and what can be resolved locally.
- The organisational management must ensure that the template for the significant event reports is updated regarding persons to be notified. There must also be consistent identifying of notification to parents/guardians.
- The centre management and staff must ensure that there are anti-bullying resources and behaviour management support for the team to implement.

Regulation 10: Health Care
Regulation 12: Provision of Food and Cooking Facilities

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

The young people's plans contained sections relating to their health, wellbeing and development needs. There were also young people's medical folders in place and goals were outlined in the placement plans in support of actions in this area. Both young people maintained their existing GP's which was a positive factor in their ongoing health care and they also had their medical cards on file. The records overall were found to be inconsistent in how they reflected that dental and optical care was completed for all young people. The folders present on the day of this unannounced inspection did not have a copy of previous assessments for a young person.

The centres model of care promotes the use of needs assessments and creating practice guidelines which were a type of personal profile of that young person. The needs assessments were on file and described relevant actions and follow up related to young people's health and development including mental health and substance misuse concerns. They were specific regarding renewed referral into previous services such as child and adolescent mental health services, substance misuse prevention services and therapy. There were action plans attached but these required timeframes for same. They also needed to be dated and to identify the persons completing them. The practice guidelines were well developed, dated and regularly reviewed. These identified the young people's needs and challenges well along with the supports the young people prefer as well as input from professionals.

There was evidence of the centre following up with the social workers regarding the young peoples ongoing needs including additional assessment or onward referral.

There had been clinical and therapeutic supports sourced by the social workers and available for the young people to attend. The staff team displayed good insight into how they would support specific needs for a young person with regard to day to day communication style and supports. The young people had been attending specialists supports, completing or pausing attendance in line with the programmes or their wishes. A social worker confirmed the ongoing work on referral and funding for the next stage of supports. Another social worker and a GAL outlined that they were re-engaging with a specific Tusla clinical service to hopefully work with the team.

Inspectors reviewed the measures in place for addressing well being and safety in the event of substance misuse. The centre management, a social worker and a GAL indicated that there was good oversight of this aspect of the young people's care but that all parties were aware of the need to respond should the situation escalate. Inspectors found it is essential that observations of any type of intoxication be more clearly tracked and recorded in case further safety interventions are required or an emergency occurs. The team did have an understanding of the need to take action in contacting emergency services but it would be beneficial that the team have additional team training in substance misuse their effects and risks.

The centre had an administration of medications policy in place. The staff team were required to complete the safe administration of medications training as mandatory. At the time of the inspection three core staff and one relief staff were awaiting the completion of this training. The team were also required to complete first aid response training and two staff along with one relief were awaiting this. The centre management team were tracking and booking in training as those slots became available. At the time of the unannounced inspection the team had two vacant full time posts. Whilst compliance with training was generally good inspectors found that three staff not being trained yet in medication administration did present a risk factor, for example at weekends when other trained staff were not present. Staff at interview were aware of their responsibilities in this regard and knew who could and could not administer medications without a trained staff present.

The young people had medication folders in place in which prescriptions and over the counter medications lists were recorded and counted. The centre manager identified to inspectors that the audit checks included in their existing systems were not being completed in full as of yet on the medication form itself but were being counted and tracked in daily medication checks. The centre manager was committed to implementing the relevant audit system in full.

Compliance with Regulation	
Regulation met	**Regulation 10** **Regulation 12**
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 4.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must ensure that all staff are trained in the administration of medications and medications management system must be fully implemented in line with centre policy.
- The centre management must ensure that the team have access to information and training in drugs their effects and risks.

Regulation 7: Staffing

Theme 7: Use of Resources

Standard 7.1 Residential centres plan and manage the use of available resources to deliver child-centred, safe and effective care and support.

Inspectors found that damage to the property had been a recurring behaviour for some young people in the past. Many areas of the house displayed previous damage that had been repaired in a way that was not of a uniform appearance for example, in door frames, architraves, walls. There was also evidence of a need for review of the fire doors and consultation on closing mechanisms for the fire doors. The centre manager commenced action on the fire door review as soon as the matter was raised with them and has committed to keeping the inspectorate up to date on progress regarding the fire doors. The centre manager was aware of expenditure planned for the centre for external painting and upgrading, due to take place in 2025, they also had access to expenditure requests for specific items as they arose.

At the time of this inspection the staff team was comprised of a centre manager, a deputy manager and six social care staff along with three relief staff. This placed the

centre under the minimum required number of eight full time social care staff as outlined in the ACIMS Regulatory Notice on Staffing (revised) August 2024 'Minimal staffing level and qualification for registered children's residential centres'. There was evidence of two named persons due to complete vetting processes that had been identified and accepted posts at this named centre. The company had responded to the challenges in recruitment and retention by augmenting recruitment practices, adding additional employee benefits and funding staff wellbeing packages. The staff inspectors met with were committed to their work in their presentation during interviews.

There was positive feedback from external persons regarding the work completed by the team and inspectors found that the voice of young people was being heard at the centre. The young people responded to questionnaires shared by inspectors and within these they stated that staff knew them and their likes and dislikes. They also noted that they were listened to when unhappy and knew who to go to even if not always happy with the outcome. The young people liked the activities they undertook with staff and a young person named that they were assisted in acquiring life skills.

Inspectors found that contact with parents was recorded, and parental wishes were known and respected. There was positive feedback from a parent on good collaboration on visits home, assistance with other access and contact to and from staff.

The centre manager and deputy manager provided access to and an explanation of an updated petty cash system that had been implemented. The staff and management tracked spending through an App and receipts were uploaded to this App. There was evidence of purchasing of fresh foods, activities and outings. The structure allowed for additional expenses to be requested for the centre, items such as new beds and the driver theory test were provided for separately. There were templates on the young people's files to track spending on clothing and other items, these had not been maintained up to date. Inspectors found that while there were no formal complaints regarding finances from the young people or the staff that a young person did let inspectors know that they felt they did not have enough clothes and were unhappy about this. An external professional also noted that a young person was not happy with their clothing allowance. Inspectors recommend that the centre staff team speak with the young people and look at their personal needs and solutions around budgeting for clothing. There was a regular amount allocated for clothing, and this was supplemented at key times.

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

Compliance with standards	
Practices met the required standard	**Not applicable**
Practices met the required standard in some respects only	**Standard 7.1**
Practices did not meet the required standard	**Not applicable**

Actions required

- The organisational management and centre management must ensure that they inform the inspectorate of when they enter compliance with the staffing requirements for this centre in a timely manner.
- The registered proprietor must provide a plan for the refurbishment of the centre to a cohesive and well presented standard.
- The centre manager must provide an update on the progress of the review of the fire doors and their mechanisms.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered proprietor must ensure that they implement formal mechanisms for seeking feedback from families, young people and professionals.	Exit interviews are in place and are completed with young people who leave the service. YP placements including strengths and challenges of the placement are reviewed at a team meeting following any discharge for reflection and centre learning. Regular meetings take place with all professionals where feedback is sought on if the Placement is meeting the YP needs. Parents are requested to attend any Child in Care reviews to express their feedback also.	Mechanisms are in place in respect of seeking feedback from young people, these include but are not limited to regular young people's meetings, regular keyworking sessions, awareness of complaints policy, and a proactive ethos supportive of acting on feedback received. Mechanisms are in place for seeking feedback from families which include regular contact with family members, open relationships with centre management promoting feedback, engagement within formal review meetings, centre visits, awareness of complaints policy and process. Mechanisms are also in place in respect of professionals. These include professionals meetings, regular child in care review meetings, regular and proactive engagement with professionals promoting

			an open co-operative approach to care.
	The centre management and staff must complete a review of all complaints for learning regarding what is notifiable and what can be resolved locally.	Centre Management reviewed complaints policy and reviewed all young person's complaints submitted within the previous 6 months. (18.09.2024) Following review of policy, complaints arose after this date with YP and management adhered to feedback from inspectors regarding escalation. Both complaints were recorded as notifiable (30.09.2024).	Complaints policy has been reviewed at team meeting via pop quiz and scenarios (16.10.2024) Complaints policy will be reviewed quarterly at team meeting. Complaints policy will be discussed during supervision to ensure understanding and compliance with staff team. Management will ensure to adhere to feedback regarding threshold for escalation of complaints. Complaints policy and procedure was also discussed at a senior management meeting on 12.09.24 with a full review of this along with the currents complaint form due to take place on 24.10.24 with the goal of creating a simpler process to ensure clear understanding and consistent application.
	The organisational management must ensure that the template for the significant event reports is updated regarding persons to be notified. There must also be consistent identifying of	SEN form has been reviewed and updated following this feedback- Monitor and ACM have been removed and Regional manager and other section have been added to notification section. This form will go live	All organisational forms will continue to be reviewed and updated regularly, overseen by the company's Compliance Officer and Director of Governance and Quality Assurance.

	notification to parents/guardians.	and replace all previous versions on organisations recording systems on 04.11.24 Centre management consulted with both YP Social work departments and confirmed desired process of parents notifications on 01.10.2024 and 07.10.2024 this was also discussed with staff team on 18.09.2024 and all monthly documents updated to reflect confirmed notifications.	SCM and DSCM will oversee and ensure all SENS are communicated and notified to parents as confirmed, ensuring this is recorded before any SEN is submitted.
	The centre management and staff must ensure that there are anti-bullying resources and behaviour management support for the team to implement.	Anti-bullying champion has been reallocated to designated staff member (16.10.2024). These resources will be discussed via IWR's. ICSP and PG have been updated for both young people to reflect possibility of bullying within the centre and how to appropriately respond to same (11.09.2024). SCM has consulted with ACTS team currently working with 1 YP on 12.09.2024 and requested a workshop be completed with the staff team to further support	Centre management will have continued oversight and ensure that anti-bullying resources are displayed throughout the centre and recorded in IWR's by reviewing same. This will form part of the centres updated Compliance report. Anti-bullying champion will identify resources and display same throughout the centre. Anti-bullying champion / staff team will ensure to promote positivity within the centre and respecting one another via IWR's and young person's meeting.

		management of YP challenging behaviours. YP continues to engage in this service fortnightly.	Bullying policy will be reviewed at team meeting's quarterly or as necessary based on needs of centre. Anti Bullying champion review takes place Bi-annually as per organisation's Auditing schedule with the next review scheduled for February 2025.
4	The centre management must ensure that all staff are trained in the administration of medications and medications management system must be fully implemented in line with centre policy.	Outstanding staff that require SAMMs training have been booked on this training (30.10.2024 - 1 staff, 29.11.2024 - 1 staff). Centre management completed review of young person's medical folder and ensured that any previous assessments are displayed in folder (14.10.2024).	Centre management will ensure that any new staff members will be booked on next available SAMMs training upon start date. Centre management to ensure that admissions / check up appointments are scheduled / attended (dental / optical). IWR's to be completed regarding refusal of attending these appointments. Admission's appointments will be scheduled within one month of a new admission to the centre. Refusal to attend, appointments will be rescheduled each month following. IWR's will be conducted to reflect encouragement of attendance and rationale for refusal. Check up appointments will be booked bi-annually or as necessary.

	The centre management must ensure that the team have access to information and training in drugs their effects and risks.	Centre management have requested and secured Alcohol and Drug Awareness training for management and staff team which will be delivered by Social Care training Ireland on 04.12.2024. Risk assessment re young person in case of presenting under the influence was created on 06.09.2024 and reviewed with the staff team on 18.09.2024, to ensure all were fully aware of the risk management plan and escalation required if necessary.	Management to ensure that all staff have attended scheduled training. Management to secure further training should any new supports be required if there is escalation in alcohol / drug misuse occur. A risk assessment will be created for any and all young people who engage in any form of substance abuse going forward.
7	The organisational management and centre management must ensure that they inform the inspectorate of when they enter compliance with the staffing requirements for this centre in a timely manner. The registered proprietor must provide a plan for the refurbishment of the	Advertising and recruitment campaign remains in place for vacant positions. SCM and RM are in daily contact in relation to same and continue to complete regular interviews for suitable candidates. External painting for house and entrance was completed on 09.09.2024	Regional Manager completes a weekly Recruitment update which is followed by a weekly regional meeting with the recruitment Department. Staffing levels will remain on the Organisational risk register until centre is in full compliance. This is discussed at each monthly Senior management meeting. A full and comprehensive walkaround of the centre will be completed by Senior

	centre to a cohesive and well presented standard.	Glazier contacted on 16.10.2024 to fix glass in patio door which is awaiting confirmation date for repair. Staff office was fully painted on 11.09.2024 Maintenance request submitted 22.10.2024 regarding repairs to architraves and door frames.	management to ensure any areas needing to be updated will be completed. Maintenance department have hired additional staff members to ensure that maintenance requirements are responded to in a timely fashion with additional capacity for centre upgrades.
	The centre manager must provide an update on the progress of the review of the fire doors and their mechanisms.	New fire Seals have been ordered by maintenance dept (06.09.2024). Maintenance team are scheduled to fit replacement fire seals on 29.10.2024. Centre management have been approved funding for automatic magnetic door release (24.09.2024) Awaiting confirmation on date for installation by maintenance dept (planned installation date 29.10.224)	Fire Officer to ensure that all scheduled inspections are completed on fire doors monthly / daily and any issues arising are reported to centre management. Centre Management to ensure continued oversight of fire folder and addressing any issues that arise.