Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of a Children's Residential Centre

Name of provider:	The Child and Family Agency
Tusla Region:	Dublin North East
Type of inspection:	Unannounced
Date of inspection:	20 – 21 August 2026 24 August 2026 4 September 2026
Centre ID:	OSV-0004171
Fieldwork ID	MON-0051337

About the centre

The following information has been submitted by the centre and describes the service they provide.

The centre is a teenage parent support centre, providing care for young people under the age of 18 who have had or are due to have a baby, giving them the opportunity to care for and parent their child in a safe and supported environment. In most instances, whilst the mothers are in care, the babies are not in care and are in the care of their mother. The centre can in an exceptional circumstances care for babies in residence with their mother under the guidance of the placement of Under 12's in residential Care Policy.

The following information outlines some additional data of this centre.

Number of children on the date of inspection	3

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings and information received since the last inspection.

As part of our inspection, where possible, we:

- Speak with children and the people who visit them to find out their experience of the service
- Talk to staff and management to find out how they plan, deliver and monitor the care and support services that are provided to children who live in the centre
- Observe practice and daily life to see if it reflects what people tell us.
- Review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the standards and related regulations under two dimensions:

1. Capacity and capability of the service

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service

This section describes the care and support children receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all standards and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:			
Date	**Times of inspection**	**Inspector**	**Role**
20 August 2026	09:45 hrs to 18:45 hrs	Sheila Hynes	Lead inspector
20 August 2026	09:45 hrs to 18:45 hrs	Caroline Browne	Support inspector
21 August 2026	09:30 hrs to 14:30 hrs	Sheila Hynes	Lead inspector
24 August 2026	10:00 hrs to 12:00 hrs	Sheila Hynes	Lead inspector (remote)
4 September 2026	11:00 hrs to 13:00 hrs	Sheila Hynes	Lead inspector (remote)

What children told us and what inspectors observed

This was an unannounced risk-based inspection that took place over two days in August 2026, following inadequate assurances given to HIQA by regional management regarding capacity to deliver safe and effective care. This children's residential centre (CRC) can support up to four young people and their babies. At the time of the inspection, there were three young people and their babies living in the centre and the option for a fourth young person was not being considered.

The centre is situated in an urban area, close to public amenities and transport. The house was well maintained and at the time of the inspection there was upgrade work being undertaken to improve the centre bathrooms.

All young people had the opportunity to speak with an inspector, and two young people choose to do so. An option to complete a survey was also given to the young people and they choose not to complete it.

The young people who spoke with the inspectors had mixed experiences of the service and the support they received from the staff team. They spoke about positive and trusting relationships and experiences of support, as well as the challenges of having inexperienced staff, staff with no experience of caring for babies and a lot of different agency staff working in the centre. They said;

- "(staff member) is brilliant. I can go to her with anything; she always has my back. She will always challenge staff that do not support me or say things that don't help."
- 'able to speak with (deputy social care manager) and social worker every week; coffee every Thursday, if something happens, I go to her (deputy social care manager) for support'.
- "some of the staff are too young and do not know what they are doing, that is ok for residential but not when you have a baby."
- "we are always being told that we are lucky to get the support we get"
- "I have a keyworker and she is great at appointments and all that stuff; but she knows nothing about babies"
- 'don't trust staff, don't feel safe'
- 'go to social worker and GAL if I didn't feel safe'

Young people were aware of the complaints policy and procedure. However, both young people told inspectors that they had lost confidence in the effectiveness of

making a complaint within the centre, preferring to raise their complaints through the social work department or through their Guardian ad litem[1](GAL). They said;

- "I have no idea of what happens to any reports (complaints) I make; they go nowhere. That has changed in the last couple of weeks"
- "I go to my GAL with any problem I have"
- 'never get a written response'
- 'made five written complaints in last three months; let social worker and GAL know and ask for complaints to be sent to my social worker'

Young people talked to inspectors about concerns and that at times they felt judged and unsupported. They said that they were fearful of staff making Child Protection Welfare Reports Form (CPWRF) to the social work department regarding the care they give to their babies. One young person spoke about being terrified that their baby would be taken from them and put into care. They told inspectors; "so many reports have gone in about me, and they are for nothing." Inspectors discussed the young people's concerns with the centre's management team; greater oversight mechanisms had recently been put in place to ensure mandated CPWRF did meet the threshold for reporting and oversight of the support given to the young people.

Inspectors spoke with three social workers and two GAL. They were not successful in contacting the young people's parents. These professionals felt that the service provided to the young people was safe and that they had built some relationships that were having a positive impact on the young people's care. However, they also spoke about challenges the young people experience, such as low threshold for reporting child protection and welfare concerns, practice that was not supportive of the young people's needs, and poor communication leading to conflict between the staff and the young people. They found that some staff were inexperienced and at times made culturally inappropriate comments to the young people. These challenges were described as having a negative impact on the young people's view of themselves and the care they provide for their babies. They expressed concern that the staff did not fully understand that impact of past trauma on the young people and how to implement trauma informed practice. They said;

- "there are relationships that she has benefited from"
- "she needs staff to have a better understanding of her, and how to communicate with her"

[1] A guardian ad litem refers to a person who supports children to have their voice heard in certain types of legal proceedings and makes an independent assessment of the child's interests.

- "(young person) needs to build relationships, feel connected and supported".

They also spoke about issues with communication with staff and noted that these issues have improved recently with the introduction of a weekly meeting to agree young person's plan. However, they spoke about a lack of managerial oversight of records, discrepancies in significant event notifications and CPWRF being submitted without managerial review.

The next two sections of this report provide the findings of this inspection on the governance of the centre and how this impacted on the quality and safety of care provided to the young people.

Capacity and capability

The centre was last inspected in October 2024. In that inspection, HIQA found that of the 11 national standards for children's residential centres assessed: nine standards were compliant, two were substantially compliant. In this inspection, HIQA found that of the seven standards assessed:

- four standard was substantially compliant
- three standards were not compliant.

This inspection found aspects of the leadership, governance and management arrangements required improvement. The internal management structure of the service was appropriate to the size and purpose of the centre, however, there were six frontline staff rather than 14 as is required. This resulted in a high reliance on agency staff to cover vacancies.

Staffing challenges had resulted in the young people not experiencing consistent care and support from a core staff team. Additionally, there were differing approaches to the level of support provided to the young people and training gaps within the team. The young people and professionals spoke about these challenges and the negative impact this has had on their experience of the service.

Inspectors found that while there were mechanisms in place to support staff communication these required strengthening to ensure all staff on duty were clear on the young people's care needs and the operational needs of the centre. Alternative management arrangements were in place for when the centre manager was absent. There was an on call roster that was communicated to the staff team.

There were policies and procedure in place to support the service, however, staff would benefit from additional guidance. The national suite of polices had been reviewed in early 2026 and were in place within the centre. There was not a specific policy in place to guide staff working in this centre on the specific needs and interventions required when caring for mothers. This contributed to inconsistent responses and experiences of care for the young people living in the centre.

The risk management records needed to be improved to allow for clear oversight and assessment of risk. There were comprehensive auditing mechanisms in place, however, these had not been completed.

Inspectors found despite the efforts of centres management, regional manager and Tusla HR, there were deficits in experience and skill mix of the staff team. The centres management and regional management endeavoured to provide consistency and stability for the service. They offered overtime to experienced staff from other Tusla centres in an effort to increase the number of experienced staff in the centre. There was a bespoke recruitment campaign in February 2026 for the centre and another bespoke campaign launched during the inspection. There were arrangements in place to promote staff retention and continuity of care to young people. However, a change in roster from sleepovers to live nights in April 2025 resulted in two staff retiring and four staff leaving their roles in the centre. This was a significant loss in experienced staff.

The management of complaints required improvement. A culture of openness and learning from complaints needed to be fostered within the team. The management of complaints had an impact on the young people's confidence in the system and how their views were considered. The young people expressed dissatisfaction with feedback and the outcome of their complaints. The oversight, management and recording of complaints required improvement. Tusla's practice assurance and service monitoring (PASM) had completed an audit of the centre's complaints the week before the inspection and an action plan was in development to address gaps in practice and quality of management of complaints.

Standard 1.6
Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

The young people in the centre were aware of the complaints policy and how to make a complaint. The young people had used the complaint process and expressed dissatisfaction with feedback and the outcome of their complaints.

Staff who spoke with the inspector were aware of the complaints process and their responsibility in supporting a young person to make a complaint. In a recent team meeting, the staff team were reminded to record all complaints as a SEN and ensure that they were also recorded in the register. The young people were also aware of the external supports such as Ombudsman for Children and Empowering Children in Care (EPIC)[2], the advocacy support service provided to children in care. Some of the young people choose to avail of support from these services.

The centre maintained a register of complaints. There were 23 complaints made in the 12 months prior to the inspection. These complaints were regarding various aspects of the young people's experience, including peer dynamics and concerns about behaviours that challenged within the centre which impacted them and their babies, poor staff practice, and service delivery.

The management of young people's complaints required improvement. Inspectors reviewed a sample of six complaints made by the young people and found that their reported experience of responses and actions taken on foot of complaints, was supported in the findings of the inspectors' reviews. For example, the feedback given to a young person could be recorded in an individual work form and a copy of this was not always filed with the complaint. In other instances, the outcome of complaints was not recorded, along with whether a young person was informed of outcome, if they were satisfied with the outcome or if they were offered the process to appeal the outcome.

The staff spoke to inspectors about a 'culture of complaints' rather than a culture of openness that welcomes feedback and raising concerns. They did not view complaints as a source of information to improve the service and could not link a service improvement to a complaint or a concern raised. Additionally, it was unclear from records provided if practice changes were made following a complaint or a concern raised. However, there was evidence of good practice in relation to managing risk arising out of group dynamics concerns that were also subject of a complaint made by a young person. This included individual work

[2] Empowering Children in Care (EPIC) is an independent Irish children's rights organisation for children and young people in care, aftercare and those with care experience up to the age of 26.

completed with the young people, meetings held with the social work departments of all the young people to monitor the safety of the centre and collaborative weekly planning meetings with the social workers, young people and centre management.

PASM had completed an audit of the centre's complaints the week before the inspection and an action plan was being developed to support the centre management to make improvement to complaints management and recording system. Prior to this audit, there was no evidence of effective managerial oversight of complaints in the previous 12 months, and the system was difficult to follow; with records in the wrong place, not on file and outcome not clearly recorded. Separately, there was an external review of a young person's complaints by a deputy regional manager from another area and that report was recently given to the service.

Overall, the oversight, management and recording of complaints required improvement. A culture of openness and learning from complaints needed to be fostered within in the team. The management of complaints had an impact on the young people's confidence in the system and how their views were considered. For these reasons, this standard is judged as not compliant.

Judgment: Not compliant

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.

Improvements were required in some aspects of the leadership, governance and management arrangements in place in the centre. There were clear lines of accountability for the delivery of care. The centre management were suitably qualified and experienced; however, the core staff team had reduced to six people, two of whom were part time and there was a high reliance on agency staff to cover vacancies. Of the core staff team there was a mix of experience and skills. The demands on experienced staff gave minimum opportunity to mentor and support newer members of the team.

The internal management structure of the service was appropriate to the size and purpose and function of the centre. The statement of purpose and function outlined the organisational structure, to include; centre manager, deputy social care manager, four social care leaders, eight social care workers and 2 relief social

care workers. Inspectors were advised that currently, the roster requires three staff on night shifts and three on day shifts. The number of staff on a day shift or a night shift may increase from time to time if there is a risk or concern that needs additional resources. While there were nine agency staff the centre manager tried to use regularly, this was not always possible. From a sample of rosters reviewed by inspectors, for a two week period, 13 different staff were working there outside of the core staff team. The staff who spoke with inspectors felt that they carried a lot more responsibility while on shift and this was having a negative impact on them.

Inspectors found from speaking with staff, young people and review of records that there were differing approaches to the level of support provided to the young people, resulting in some poor experiences of care for young people. There were training gaps within the team, relating to considerations when caring for and supporting the unique needs of young mothers. This was recognised by the provider, and a bespoke training programme had been designed by Tusla's therapeutic hub to support staff to achieve better outcomes for the young people. This was due to be rolled out in September 2026.

Staff received mandatory safeguarding training and were supported to develop their knowledge of national policies. From the sample of staff and agency records reviewed, all had appropriate training in Children First (2017) and some staff said that had received training in child sexual exploitation. There was an induction programme in place that covered all areas of national policies and procedures and the operation of the centre.

Alternative management arrangements were in place for when the centre manager was absent. At the time of the inspection, the centre manager was absent, and the deputy social care manager was managing the service. The on call roster was in place and supported by the deputy regional manager as required. On call arrangements were communicated to the staff team. There was an agreed delegation of duties, however, there was no written record of this. This was completed shortly after the inspection.

The centre had systems of communication which required strengthening to be effective. Efforts had been made to improve this by introducing new templates and systems. The communication log recorded information which was outside of daily tasks and activities for young people, was an electronic form and used frequently. The handover and shift plan were also in electronic form and was a comprehensive document that covered all areas for the effective running of the centre. From the sample reviewed by inspectors, this document was consistently

used, however, not fully completed. Improvements were required to improve effectiveness and ensure all elements were completed including assigning a person responsible for an action or task noted. Additionally, staff who spoke with inspectors said that poor communication was one of their main concerns and at times decisions from meeting were not communicated in a timely manner. Team meetings took place every fortnight but attendance at some of these meeting was very low, and regular agency staff were not expected to attend. For the staff who did not attend the meeting, there was an expectation that they would read the minutes and sign a sheet attached once read, but this was not consistently completed.

The provider ensured that there are appropriate service-level agreements and contracts in place for the provision of services. These included the use of agency staff, cleaning service, building service and house insurance.

An updated suite of national policies and procedures were provided to HIQA in February 2026. There are policies and guidance regarding supporting the needs of young people in care that are pregnant. However, there is no policy or guidance in supporting young people in care who are mothers. Inspectors were advised that this is in development and the centre manager is part of the group working on this, however, a time frame for competition could not be provided. The staff who spoke with inspectors felt that they would benefit from greater guidance on how best to meet the young people's needs and support them in positive parenting.

The governance and oversight of risk management required improvement. The centres risk register identified five risks in the centre, and these risks had been reviewed in July 2026. The quality of records was poor, the risk assessment supporting document was not completed accurately; with additional controls recorded under existing controls and person responsible and date absent from most of the records. Inspectors were advised by centre management that Tusla's Quality Risk and Service Improvement were providing the service with support on situational risk management plans and indicated that they would seek advice on other aspects of risk management also.

The internal auditing of the service required improvements and possibly additional support for the centre management team with completing the tools. The audit tool was introduced in October 2025 and set out a system of quarterly audits to be completed by centre management. All aspects of the operations of the centre would be covered by the audit annually. Any actions following an audit is inputted into an action log which is then monitored to ensure actions are completed. Inspectors found that first quarter had been completed and the

second quarter had not been started. There were gaps in the first quarter audit with details such as due date, person responsible and status of evidence left blank. The action log of the audit tool was not used, and it was unclear if progress had been made to address issues identified.

Overall, aspects of the leadership, governance and management arrangements required improvement, regarding risk management, oversight and monitoring of the service. The communication systems required strengthening. A policy and procedure to support mothers in care while in development, was not available to staff at the time of inspection. The demands on the core team and experienced staff were having a negative impact on them. For these reasons, this standard is judged as not compliant.

Judgment: Not compliant

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

Regulation 6:
Staffing

The registered provider did not have adequate number of skilled and experienced staff. The centre was not adequately staffed with a consistent, experienced staff team and this impacted significantly on the quality of care and support young people received. The centre's workforce needs were monitored by centre management and regional management team and increasing the staffing compliment within the centre was a key priority. As mentioned earlier in the report, there were high number of vacancies, a high reliance on agency staff, and an over reliance on a small number of experienced staff to meet the needs of the young people.

The centre manager and external management team endeavoured to provide consistency and stability for the service by offering overtime to experienced staff from other Tusla centres. At that time of the inspection, there were two staff members from another Tusla centre on duty and another staff member from another centre was joining the team for eight weeks. There were three new staff onboarding into the service. In addition, there was a bespoke recruitment campaign in February 2026 for the centre and another bespoke campaign launched during the inspection. It was noted by the inspector that the bespoke recruitment campaign was not specifically tailored to recruit staff with experience and knowledge working with pregnant teens or young mothers potentially a missed opportunity to gain relevant experienced staff for the service.

The inspector reviewed a sample of the staff rosters and found there were enough staff to provide a safe service to children. However, the inspectors were informed that this was challenging to achieve at times. Additionally, it was not always possible to have a mix of Tusla and agency staff on duty together meaning at times the centre was staffed completely by agency staff members.

There were arrangements in place to promote staff retention and continuity of care to young people. Management encouraged staff to seek promotional opportunities or take on additional roles. There were systems in place to support staff internally and externally. However, a change in roster from sleepovers to live nights did result in a number of staff choosing to leave the service, impacting significantly on the experience and knowledge amongst the remaining staff team.

Inspectors found that appropriate recruitment and selection practices were in place. The inspectors reviewed a sample of recruitment files for Tusla and agency social care staff. The inspector found that staff recruitment was in line with the relevant legislation and requirements. All relevant documents, such as references and An Garda Síochána (police) vetting were in place. All had either registered with the professional body CORU or had made an application. Clarification regarding one reference was required as it did not correspond to the employee's curriculum vitae. At the time, of issuing this report the inspector was waiting for a response from Tusla human resource department regarding same.

The registered provider did not have adequate number of skilled and experienced staff. Staffing challenges had resulted in the young people experiencing inconsistent and at times poor quality of care and support. The young people and professionals spoke about these challenges and the negative impact this has had on their experience of the service. For these reasons, this standard is judged as not compliant.

Judgment: not compliant

Quality and safety

The young people's rights were respected, and staff were aware of and promoted their rights. However, there were gaps in knowledge regarding supporting young people rights and balancing this responsibility, with their responsibilities to ensure safe and effective care of the babies living in the centre. The young people are provided with a booklet about the centre which outlines the policies and procedures of the service, along with the contact details of external services that can provide additional support. Young people were aware of their rights, were aware of how to advocate for themselves and there were systems in place to support this.

The young people were supported to purchase food appropriate to their culture and wishes. Their religious values and beliefs were respected. However, there were times when a young person felt that their culture was not respected and understood.

The service operated in line with the requirements of Children First. All staff were trained in Children First and the staff who spoke with the inspector were clear on their role as mandated persons and how to make a report through Tusla's reporting portal. However, improvements were required to ensure staff fully understood their responsibilities as mandated persons with respect to caring for and supporting the young people in their roles as young mothers. There was an issue, reported by the young people and professionals with regard to some staff members inappropriate threshold for what constituted harm. Some staff had made child protection reports to Tusla unnecessarily and this, understandably, had a negative impact on the young people and their relationships with staff.

The centre management and young peoples allocated social workers effectively worked together to monitor the safety of the young people. The young people's individual areas of vulnerability were identified; safeguarding measures were put in place and recorded as required. All young people had a care plan, placement support plan and safety plan were necessary. All young people had absent management plans in place.

There was a positive approach to the management of behaviour that challenged. Each young person was supported to develop an understanding of their behaviour that challenges and respecting others. Restrictive practices were appropriately managed, and young people were not subjected to unnecessary restrictions.

Significant events were notified in a timely manner, however, there were improvement to be made in quality assurance of records before they are submitted to the social work department. The practice in place to support young people to learn from significant events required improvement as records of conversations and supportive interventions were poor.

The staff and management engaged in practices that promoted the life, health, safety and welfare of the young people. Their rights as parents were respected and they were supported to develop positive parenting skills. An external agency came to the centre to provide the young people with parenting support. The young people were encouraged to live a healthy lifestyle. They were supported to go the gym and get involved in exercise. Healthy eating was supported in the house, and mealtimes were a positive social event. Individual work was completed with young people that included independent living skills. Young people were supported to return to education when appropriate to do so. A lot of individual work was based on opportunity rather than a planned session. However, young people's experience of care was at times poor, and this had had an impact on their well-being.

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.

Regulation 10:
Religion

Regulation 4:
Welfare of child

The staff in the centre were aware of and promoted and respected the young people's rights to be protected from harm as prescribed in the United Nations Convention on the Rights of the Child (1989). The staff who spoke with the inspector were aware of and promoted children's rights and the young people's rights as parents.

Young people were aware of their rights, were aware of how to self-advocate and there were systems in place to support this. Young people on admission, were provided with a booklet about the centre which outlines the policies and procedures of the service, along with the contact details of external services that can provide additional support. This information booklet also outlines that the purpose of the placement is to support the young person and to develop parenting skills. Young people attended weekly meetings with the centre management and social worker to agree a plan for the week ahead and were encouraged to attend

their child in care reviews. Young people were encouraged to engage with an advocacy service and some of the young people choose to do so. Young people also used the complaints process to raise concerns.

The young people meetings were planned to take place fortnightly, but these meetings did not occur. There was a gap of six months were there were no record of young people's meetings and no explanation as to why this had occurred. When young people's meeting did occur, sometimes they were held as a group and other times this was an individual conversation. Inspectors were told that this decision was based on the group dynamics on each week, decided based on the best interest of individual young people and to ensure each young person's voice was heard.

The young people were supported to purchase food appropriate to their personal preferences, culture and wishes. They were involved in meal planning for the week. They were also supported by a chef once a week to learn to create balanced meals for their babies.

The young person's religious values and beliefs were respected. Religious occasions were celebrated and their families were welcome to centre for celebrations. Young people were supported to attend places of worship or of religious significance. However, there were times when a young person felt that their culture was not respected and understood. There appeared to be gaps in staff's knowledge of how the young person expressed their culture and their preferences. These concerns were followed up by centre management; however, the young person was not satisfied with the outcome, and they were being supported to address this ongoing concern by their GAL.

Overall, the young people's rights were respected. However, not all young people were satisfied that their rights relating to their culture and identity were effectively supported. There was a gap of six months in the young people's meetings records and reason for the gap was not recorded. For these reasons, this standard is judged as substantially compliant.

Judgment: Substantially compliant

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

The provider has policies and procedures in place to protect children from all forms of abuse and neglect. The centre operated in line with the requirements of *Children First* (2017), however, there were concerns regarding the low threshold for making mandated reports.

Child protection and welfare concerns were managed as required in line with the requirements of Children First. All staff were trained in Children First and the staff who spoke with the inspector were clear on their role as mandated persons and how to make a report through Tusla's reporting portal. However, there were concerns regarding staff making a CPWRF that did not meet the threshold of harm; as a result, prior to inspection, a decision was made that all CPWRF are reviewed by the centre management before submission. Additionally, if a CPWRF was submitted in relation to a baby, the centre management would inform the young person rather than the staff on duty. It was evident that the practice around reporting CPWRF, on concerns that did not warrant such a report had impacted negatively on the young people and their relationships with staff.

There was a child safeguarding policy in place which included guidance for staff on identifying, preventing, and managing incidents of bullying behaviour. Staff had completed training in child sexual exploitation and managing complaints. Individual work with the young person showed that staff were supporting the young person in developing skills of self-protection. The staff who spoke with the inspector were knowledgeable in the provider's policy and procedure on protected disclosures and how to make a disclosure.

The centre management and social workers of the young people work together to monitor the safety of the young people. When necessary, individual safety plans were put in place and reviewed regularly. There were collaborative meetings with the centre management and social workers of all young people to address group dynamics in the centre. These meetings have been effective and actions that have been put in place are addressing concerns. Another meeting was scheduled for early September 2026 to review the group dynamic in the centre and the impact of actions put in place.

The young people's individual areas of vulnerability were identified, and safeguarding measures were put in place and recorded in the care pare, placement support plans and safety plans were necessary. All young people had absent management plans in place.

The service operated in line with the requirements of Children First. Safety plans that were in place were responsive to the young people's vulnerabilities and review regularly. However, there were concerns regarding staff making a CPWRF that did not meet the threshold of harm; this was having a negative impact on the young people and their relationships with staff. It is for this reason that this standard is judged to be substantially compliant.

Judgment: Substantially compliant

Standard 3.2
Each child experiences care and support that promotes positive behaviour.

Staff and management provided care and support to young people that promoted positive behaviour. Practice was supported by policies and procedure. Staff had up-to-date training regarding behaviour management.

Each young person was supported to develop an understanding of their behaviour that challenges and respecting others. Individual crises management plans (ICMP) were detailed and up to date. Behaviour support plans were also put in place to support a young person with a specific issue or concern.

The young people were only subjected to restrictive practices that were assessed as necessary, reviewed regularly and for the shortest period possible. In the previous 12 months, there were four restrictive practices that were put in place and recorded in the restrictive practice register. During the inspection, there were two restrictive practices, and these were supported by detailed safety planning document and developed in consultation with the young person's social worker.

The quality assurance of significant events required improvements. Significant events were notified to the young people's social worker in a timely manner, however, there were errors in some of the records which needed to be amended and resubmitted. Quality assurance on SENs were completed by centre management, however, internal significant event review group (SERG) picked up more errors including; type of incident was incorrectly recorded, incorrect SEN number and record of staff on duty. The SERG focus was largely on quality assurance and there was limited learning from an incident that would inform staff practice.

Improvements were required to support young people to learn from significant events. Following a significant event a conversation usually takes place between

staff and a young person, to discuss events and learn if anything could have been done differently. From the records reviewed by inspectors, it was difficult to follow if this was completed, as many conversations were recorded in an individual work or over several individual works. As a result, the learning or future planning was often not collated, recorded or communicated effectively amongst the team.

Overall, the plans that were in place to support and promote positive behaviour were of good quality. However, there were improvement to be made in quality assurance of records before they are submitted to the social work department, the practice regarding post significant event conversations with the young people and ensuring these records are clear. It is for this reason that this standard is judged to be substantially compliant.

Judgment: substantially compliant.

Standard 4.1
The health, wellbeing and development of each child is promoted, protected and improved.

Regulation 11:
Provision of food and cooking facilities

The staff and management engaged in practices that promoted the life, health, safety and welfare the young people. However, as outlined earlier in the report, the young people and external professionals spoke about the impact of having inexperienced staff and large number of agency staff had on the young people's experience of the service and their well-being. While many of the core tasks of caring for the young people on a day to day basis were in place; this occurred within the context of an inconsistent staff team.

The health of young people in pregnancy and post-partum was supported by the service. The young people were supported to attend their appointments. Public Health Nurse (PHN) visited the centre and meet with young people and their babies. Young people were supported to attend their general practitioner (GP) and dentist. Some of the young people had therapeutic support outside of the centre and this was also supported. However, there were times when due to low staffing or not having a driver available, alternative arrangement had to be made for transport to and from appointments. This was a cause of concern and distress to the young people who spoke with the inspectors.

An external agency came to the centre to provide the young people with parenting support, and this was largely focused on the early stages of motherhood. The

centre had organised baby message for the young people and their babies, and this was a positive experience for them.

The young people were encouraged to live a healthy lifestyle. For the young people who smoked; they were offered smoking cessation support. Young people were supported to go the gym and get involved in exercise. Healthy eating was supported in the house, and mealtimes were a positive social event. Inspectors observed healthy options for meals and the fridge was well stocked. A chef came to the centre once a week and supported the young people to develop their cooking skills and ideas for food for weaning their babies. Young people also cooked their own food, did food shopping and completed their own laundry.

There were records of individual work regarding managing money, independent living skills, healthy lifestyle, use of illegal substances and self-administration of medication. The centre was using the agency model of care which was a programme that ran over a 12 week cycle. However, it was noted that many of these individual work sessions were opportunity lead rather than planned. Greater planning would ensure that the young people benefited from all aspects of the model of care.

Young people were supported to return to education when appropriate to do so. There were records of staff exploring the young people's areas of interest and researching education courses. They were assisted in finding a creche to care for their babies when they return to education. Some of the young people had an aftercare worker and they were actively supporting them in making plans for their future.

The staff and management engaged in practices that promoted the life, health, safety and welfare the young people. External supports and expertise are organised by the service to support they young people. While individual work is carried out, greater focused should be placed on ensuring planned aspects of the provider's model of care are completed. The young people would benefit from a consistent team. It is for this reason that this standard is judged to be substantially compliant.

Judgment: Substantially compliant

Appendix 1 - Full list of standards considered under each dimension	
Standard Title	**Judgment**
Capacity and capability	
Standard 1.6: Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.	Not compliant
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.	Not compliant
Standard 6.1: The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.	Not compliant
Quality and safety	
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.	substantially compliant
Standard 3.1: Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.	substantially compliant
Standard 3.2: Each child experiences care and support that promotes positive behaviour.	substantially compliant
Standard 4.1: The health, wellbeing and development of each child is promoted, protected and improved	substantially compliant

Compliance Plan

This Compliance Plan has been completed by the Provider and the Authority has not made any amendments to the returned Compliance Plan.

Compliance Plan ID:	MON-0051237
Provider's response to Inspection Report No:	MON-0051237
Centre Type:	Children's Residential Centre
Service Area:	Dublin North East
Date of inspection:	20 – 21 August 2026 24 August 2026 4 September 2026
Date of response:	13 October 2026

Introduction and instruction

This document sets out the standards where it has been assessed that the provider is not compliant with the National Standards for Children's Residential Centres 2018.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which Standard(s) the provider must take action on to comply.

Section 2 is the list of all standards where it has been assessed the provider is not compliant. Each standard is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider has not complied with a standard and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to

the safety, health and welfare of children using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the standard in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that standard, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Capacity and Capability: Leadership, Governance and Management	
Standard: 1.6	**Judgment: Not compliant**
Outline how you are going to come into compliance with Standard 1.6: Each child is listened to, and complaints are acted upon in a timely, supportive and effective manner. • All staff will complete "Tell-us" revised policy briefing and complaints training on HSEland. Date for completion 31.10.2026. • Management will complete audit of complaints submitted within the past 12 months to ensure these have been reviewed effectively with outcomes evidenced. This includes ensuring individual works (IW) completed with young people are attached to the complaint to evidence outcome when local resolution has been achieved. Date for completion 30.11.26. • Management will complete monthly audit of the complaints register to ensure effective governance and oversight, ensuring that the outcome is recorded and evidenced for each complaint alongside an indication of the young person's level of satisfaction. The next audit is due for completion by 31.10.2026 • Management will review and update quarterly centre audit tool to ensure effective governance and oversight of records in Clannad. Date for completion 31.10.26. • Complaints will be reviewed as a standing item on the agenda for team meeting to ensure effective learning is shared in terms of staff response to and the outcome of a complaint. Date for next meeting is 14.10.2026. • An understanding of the appeals process will be completed with young people in upcoming key-working sessions. Date for completion 30.11.2026. •	
Proposed timescale: **30.11.2026**	**Person responsible:** **Centre management**

Standard: 5.2	Judgment: Not compliant

Outline how you are going to come into compliance with 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.

- A bespoke recruitment campaign has been rolled out and interviews for these positions will be held. Date for completion 22.10.2026.
- EOI has been circulated within the region to encourage staff to relocate to Clannad. Date completed is 30.09.2026
- Rolling recruitment campaign is in place for social care workers across the region. Regular contact is maintained with Tusla Recruit for updates. This action is ongoing.
- Staffing levels will be reviewed to ensure staff to young person ratios are sufficient. Date for completion is 31.10.2026
- All staff will complete refresher training in the Tusla approved model of care to ensure a consistent approach when delivering safe, child-centred and effective care. Date for completion is 31.12.2026.
- Management will schedule regular consultations with the model of care consultant to promote consistency in staff approaches and to ensure alignment with the Tusla approved model of care. Since the inspection two consultation sessions have been completed; 05.10.26 and 07.10.26.
- Staff team will continue access support from the therapeutic hub to promote a consistent approach to the support offered to our young mothers and their babies in order to achieve better outcomes. This action is ongoing.
- Training audit and subsequent action plan will be completed and reviewed every quarter thereafter to identify training needs for the staff team in Clannad. The next training audit is due to be completed by 31.12.2026.
- The shift co-ordinator is identified daily to oversee the delegation and completion of all tasks as per daily handover. A staff member is allocated to each daily task and evidence of task completion is noted on the handover form. The centre management team is regularly included in shift planning during their working hours.
- All staff will complete child sexual exploitation training on HSEland. Date for completion 30.11.26.
- 'Delegation of tasks' list has been completed and implemented in Clannad following the inspection. This will be reviewed quarterly with the first review due by 31.12.2026
- Regularly employed agency staff will be invited to weekly team meetings. In the event that any staff member cannot attend team meetings, they will be directed to review and sign team meeting minutes. Minutes for previous meetings will be reviewed at each subsequent meeting, and attention will be brought to the requirement for all staff to read and sign the minutes. This action was completed by 30.09.2026 and is ongoing.
- The development of a centre-specific policy in relation to the care of young mothers in children's residential centres is currently in development with National Policy Manager for Alternative Care, Child Protection and Welfare. An update will be requested by 31.10.2026. Date for completion 31.06.2027.
- The centre management team will complete audit of centre's risk register and associated risk assessments quarterly. Management will ensure that all sections of

risk assessment forms are completed. This will improve the quality of quality of records with regards to centre risk assessments. Date for completion 31.12.2026. • Management will complete quarterly the centre audit tool to ensure that any issues identified are clearly recorded and evidenced in the audit tool action log. Any issues will be brought to the attention of the assigned Deputy Regional Manager for the centre and reviewed during centre governance meetings which will take place bi-monthly. The next audit will be completed by 31.10.2026.	
Proposed timescale: **31.12.2026**	**Person responsible:** **Centre management / staff team**

Standard: 6.1	**Judgment: Not compliant**
Outline how you are going to come into compliance with Standard 6.1: The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support. • A bespoke recruitment campaign has been rolled out and interviews for these positions will be held 22.10.2026. • An Expression of Interest has been circulated within the region to encourage staff to relocate to Clannad. This action was completed by 30.09.2026. • Staffing levels will be reviewed in advance of any potential new admissions to ensure staff to young person ratios are sufficient. • All new staff will complete an induction programme which will introduce them to the policies procedures, standards of practice and will clarify service expectations in relation to the delivery of safe and effective care. It will include details of any mandatory and essential training. This action will be on-going. • Management will review the training audit for all staff focusing on mandatory and essential training. An action plan will be developed should any gaps in training be identified. Date for completion 31.03.2027	
Proposed timescale: **31.03.2027**	**Person responsible:** **HR department Tusla** **Centre management**

Quality and Safety: Child-centred Care and Support	
Standard: 1.1	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with 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.

- Management will discuss the importance of completing young people's meeting every 2 weeks at upcoming team meeting on the 7th of October. Young people's meetings will be put in the centre diary every Tuesday fortnightly as a reminder to staff to complete. This action was completed 07.10.2026.
- A review of the current practice regarding young people's meetings will take place by centre management and will include input from the young people with a focus on inclusion, participation, function, and feedback. Date for completion 31.10.2026.
- The allocation of a shift co-ordinator will provide governance and oversight of assigned daily tasks as per handover to ensure tasks are complete or handed over effectively. Centre management will be included in the development of shift plans. This action was completed 30.09.2026. The inclusion of centre management is on-going.
- Management to source cultural diversity training in line with young people's needs and to provide the team with additional information regarding cultural identity. This will improve the delivery of child-centred, safe and effective care and support. Management have sourced training 'Attitudes and approach working in multicultural spaces" on the 22nd of October. Management will contact community-based traveller support services to look at appropriate supports and information sessions for the team to support their care of the young people. Date for completion 28.02.2026.
- Management will schedule risk and wellbeing training as part of centre's training in the Tusla approved Model of Care for the team. Date for completion 28.02.2026
- Key-working planning to be reviewed to ensure it includes cultural needs and interests of the young people. The young people will be consulted with when developing plans that relate to their identity and culture. This action will be ongoing.
-

Proposed timescale:	**Person responsible:**
28.02.2027	**Centre management / staff team**

Quality and Safety: Safe Care and Support	
Standard: 3.1	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 3.1: Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

- All child protection and welfare referral forms (CPWRFs) will be reviewed by the designated liaison person (DLP) before they are submitted. A review of all previously submitted child protection and welfare referral forms (CPWRFs) to take place with participation from the centre management, Deputy Regional Manager, quality risk and service improvement manager (QRSI) and regional significant event review group (SERG) chairperson. Findings will be shared with the team to encourage learning and professional development. Findings will further be shared at Area and Regional SERG to promote learning and development within the region. Date for completion 28.02.2027.
- All child protection and welfare referrals (CPWR) are notified as a significant event. They are in turn are reviewed by centre management before circulating to the relevant parties. This provides additional oversight and governance systems to mitigate the risk of child protection and welfare referral forms (CPWRF's) being submitted that do not meet the threshold of harm. This action was completed 30.09.2026.
- Management will communicate the submission of CPWRF's with young people residing in Clannad in a timely manner to mitigate the risk of any impact on relationships between young people and the staff team. Date for completion 31.10.2026.
- Management will source training on the harm matrix and signs of safety for the team. Date for completion 28.02.2027.
- Life space interviews (LSI) and individual works (IW) are completed with young people at the recovery phase of a significant event to promote reflection and learning for the young person and the team. This will be discussed with staff at team meeting on the 7th of October. Where a YP declines to engage, significant event notifications (SENs) are updated to include this information. This action was completed 07.10.2026.
- Learning from Life space interviews (LSI) and individual works (IW) is incorporated into the young person's placement support plans (PSPs) to ensure learning and future planning is effectively communicated across the team. The keyworker for each young person will update their PSPs accordingly. Date for completion 31.10.2026.

Proposed timescale:	**Person responsible:**
28.02.2026	**Centre management / staff team**

Standard: 3.2	Judgment: Substantially compliant
Outline how you are going to come into compliance with Standard 3.2 Each child experiences care and support that promotes positive behaviour • All significant event notification's (SENs) are reviewed by management before submission in order to assure quality. This action is now in place and is ongoing. • Significant event notification's (SENs) are reviewed during centre significant event review (SERG), and any issues/learning is brought to the staff team meetings. This action is in place and is ongoing. • All significant event notification's (SENs) are reviewed at each team meeting. This action is in place and is ongoing. • Life space interviews (LSI) and individual works (IW) will be completed with the young person at recovery phase of significant event to promote reflection and learning. This will be discussed with staff at team meeting on the 7th of October. If a young person declines to engage, SEN to be updated with this information. Date for completion 31.10.2026. • Learning from LSI/IW's will be incorporated into the young person's PSP to ensure learning and future planning is effectively communicated across the team. Keyworkers will update PSPs accordingly. Date for completion 30.11.2026.	
Proposed timescale: **30.11.2026**	**Person responsible:** **Centre management / staff team**

Standard: 4.	Judgment: Substantially compliant
Outline how you are going to come into compliance with Standard 4.1 The health, wellbeing and development of each child is promoted, protected and improved • Key working goals are planned in line the Tusla approved model of care and the young person's needs and interests. This is evidenced on the young person's 12 week placement plan to show pre-planning. A review of key-working goals for all young people will take place with input sought from the young person, their social work teams, Guardian-ad-Litem and family members where appropriate. Date for completion 30.11.2026. • Management continue to provide governance and oversight of the young people's placement plans. They are reviewed with key workers before implementation to ensure effective governance and oversight of young person's key working goals, and to ensure that planned sessions are included in line with model of a care and the young person's needs. This action is ongoing.	
Proposed timescale: **30.11.2026**	**Person responsible:** **Centre management / key workers**

Section 2:

Standards to be complied with

The provider must consider the details and risk rating of the following standards when completing the compliance plan in section 1. Where a standard has been risk rated red (high risk) the inspector has set out the date by which the provider must comply. Where a standard has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The provider has failed to comply with the following standards(s).

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
1.6	Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.	**Not compliant**	orange	30.11.2026
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.	**Not compliant**	orange	31.12.2026
6.1	The registered provider plans, organises and manages the workforce to deliver child-centred, safe	**Not compliant**	orange	31.03.2026

	and effective care and support.			
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.	**Substantially compliant**	yellow	**28.02.2027**
3.1	Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.	**Substantially compliant**	yellow	**28.02.2027**
3.2	Each child experiences care and support that promotes positive behaviour.	**Substantially compliant**	yellow	**30.11.2026**
4.1	The health, wellbeing and development of each child is promoted, protected and improved	**Substantially compliant**	yellow	**30.11.2026**

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