Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of a Safeguarding Inspection of a Children's Residential Centre

Name of provider:	The Child and Family Agency
Tusla Region:	South
Type of inspection:	Unannounced
Date of inspection:	09 – 10 December 2025
Centre ID:	OSV-0004191
Fieldwork ID	MON-0049046

Safeguarding

This inspection is focused on the safeguarding of children and young people within children's residential centres.

The Child and Family Agency (Tusla) defines child safeguarding as:

> Ensuring safe practice and appropriate responses by workers and volunteers to concerns about the safety or welfare of children, including online concerns, should these arise. Child safeguarding is about protecting the child from harm, promoting their welfare and in doing so creating an environment which enables children and young people to grow, develop and achieve their full potential.

Safeguarding is one of the most important responsibilities of a provider within a children's residential centre. It has a dual function, to protect children from harm and promote their welfare. Safeguarding is more than just the prevention of abuse, exploitation and neglect. It is about being proactive, recognising safeguarding concerns, reporting these when required to the Child and Family Agency (Tusla) and also having measures in place to protect children from harm and exploitation.

Safeguarding is about promoting children's human rights, empowering them to exercise appropriate choice and control over their lives, and giving them the tools to protect themselves from harm and or exploitation and to keep themselves safe in their relationships and in their environment.

About the centre

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

The aim is to provide a residential setting wherein children/young people live, are care for, supported and valued. It provides placements for up to four young people. These young people are aged 13-17 years upon admission to the centre and referrals are open to females with consideration to gender inclusivity. The objective is to provide a high standard of care and support in accordance with evidence based best practice, in a manner that ensures each child's safety and wellbeing and enables them to access the supports and interventions necessary to address the circumstances of their admission to the unit. This is achieved through a supportive, nurturing and holistic living environment that promotes wellbeing, safety, rights, education and community involvement.

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 summarize 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**
09 December 2025	10:00 hrs to 18:00 hrs	Catherine Linehan	Lead Inspector
09 December 2025	10:00 hrs to 18:00 hrs	Sharron Austin	Support Inspector
10 December 1015	08:30 hrs to 14:30 hrs	Catherine Linehan	Lead Inspector

What children told us and what inspectors observed

This was an unannounced inspection of this children's residential centre carried out to assess the centre's compliance with a number of National Standards for Children's Residential Centres, 2018. The inspection focused on the safeguarding of young people living in residential care. The centre is a large, single storey building on its own grounds located in the suburbs of a city. At the time of inspection there were three young people living in the centre; a fourth resident having been discharged the previous day to after care. The young people were aged between 15 and 16 years and were all female residents. Inspectors attempted to engage with the young people about their experience of living in the centre; however, they politely declined to participate and so were furnished with surveys to fill out in their own time if they so wished to express their views. Inspectors use every opportunity during inspection to understand and observe young people's interactions with staff and their experience of living in the centre. During this inspection inspectors had brief opportunities to observe interactions with staff. Inspectors spoke with two social workers and two guardians ad litem[1] (GAL) and one parent.

The centre is well maintained with a large garden and is built around a central courtyard, which provides a natural flow and ease of movement throughout the building. This layout also contributes to good natural lighting and ventilation throughout the centre. In the lead-up to Christmas the centre had a warm, homely atmosphere with seasonal decorations contributing to a festive feel. Young people were observed in festive spirit, wrapping gifts and dressed in Christmas-themed loungewear. Both residents who inspectors met were polite and were observed to engage appropriately with staff. One resident was absent from the centre at the time of inspection due to a planned activity.

Close circuit television was operational in the centre which monitored the outside of the building. There are gates into the grounds which also enhanced the security of the premises. There was a welcoming entrance where visitors sign in and there was easy access to the staff office from here. There were more offices and meeting rooms which were accessible with a fob and so separated the living and the working sides of the house. The centre consisted of four large en-suite bedrooms which have ample storage space for personal items with well-equipped bathrooms.

[1] 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.

There was a large open-plan kitchen-dining area which then led to two comfortable living spaces with large couches, televisions and gaming consoles; areas where young people could relax, engage with staff and have family and friends to visit.

Staff and management in the centre experienced a particularly challenging period in the centre this year, during which escalating behaviours that challenge had a significant impact on the safe operation of the centre, the safeguarding of young people, and staff's ability to carry out their roles safely. The impact was felt by young people and staff alike and the centre was understandably in a period of recovery and reflection.

While young people chose not to engage with inspectors, staff gave a sense of what it was like to work in the centre:

- "everyone brings their own experiences"
- "everyone is very helpful, very supportive"
- new staff are "full of energy"
- staff turnover means... "losing the experience"
- management... "sees the strengths of individual staff members and use those strengths"
- "love working here"
- "love the staff team".

Inspectors also spoke with social workers who described their experience of the centre:

- "turnover of staff is high"
- "handovers don't pass information on"
- "staff have good working relationships with young people".

Inspectors also spoke with GALs;

- "lots of new staff"
- "centre manager and deputy manager are very responsive"
- "there needs to be a consistent approach"
- "all staff need to be saying the same things"
- "they need to take a bit of their authority"
- "they accept easily when …[young person]… won't go to school".

Inspectors spoke with one parent who was satisfied with the care their child received in the centre;

- "no issues".

The next two sections of this report will outline the findings from this inspection.

Capacity and capability

The centre was last inspected in January 2024. At that time HIQA found that, of the nine standards assessed, one standard was compliant, three were substantially compliant and five were not compliant.

In this inspection, HIQA found that, of the seven national residential care standards assessed:

- five were substantially compliant
- two were not compliant.

Inspectors found that governance arrangements required some improvement. There were no auditing systems in place to routinely monitor practice, identify deficits, or drive improvements in service provision. As a result, opportunities to identify emerging risks and support continuous quality improvement were limited. There was a mix of experienced and new staff, with the centre having lost many experienced staff to community projects and so losing the knowledge that extensive experience brings to a centre. Despite this, staff spoke of how the mix of experience complimented each other in terms of approach to staff's interactions with young people and the management of safeguarding issues. Continuity in the management team since the previous inspection provided stability within an ever changing staff team and they were described by staff as accessible. While there was improvement in staffing since the last inspection there continued to be some deficits which were being filled by agency staff. At times, despite the availability of agency workers, staff spoke of having to increase their hours at times to cover deficits, demonstrating their commitment to safeguarding young people.

Staff were proactive in identifying and responding to significant risks within the centre, however, there was a reluctance to identify smart phone use as a possible risk of child sexual exploitation, despite phones being identified in collective risk [2]assessments as an area of concern. Individual risk assessments were in place and restrictive practices were used in the centre in order to safeguard the young people. From documentation reviewed by inspectors, staff and management when employing restrictive practices reviewed these on time and there was no evidence

[2] The risk assessment is a meeting between the social work team leader and the social care manager to consider any issues related to the placement of a young person in the centre and the impact that might have on the young person and on others already in the centre.

of ongoing, lengthy practices. They were employed for the shortest duration possible and only when necessary to safeguard the young person.

Staff demonstrated an understanding of the regulations, policies and procedures for the care of the young people. They had a good awareness of their responsibilities as mandated persons and their responsibility to report child protection and welfare concerns to the social work department and inform all relevant stakeholders. This was found to be timely and appropriate and experienced staff spoke of supporting the newer staff members in these pieces of work.

It was identified by inspectors that communication systems in the centre needed improvement in order to ensure staff were informed of young people's plans and to highlight risk. Inspectors found no evidence that meeting minutes, daily logs and handovers were read by staff and no consistent oversight from management to ensure staff were fully informed. This was highlighted by one young person, as seen by inspectors on the young person's file, as a major deficit and resulted in frustration. Inspectors found that management reviewed significant event notifications and child protection and welfare notifications and had oversight of events in the centre, however, improved records and auditing were required to demonstrate learning, information sharing and improvements in practice.

There was an absence of up-to-date policies, procedures, protocols and guidance across significant areas of practice directly related to children in residential care. HIQA escalated this issue in February 2025 to Tusla's National Director for Children's Residential Services and received assurances, outlining that these policies and procedures were under review at that time. At the time of this inspection, actions to address this non-compliance, had not yet been completed.

Standard 3.3

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

There were policies and procedures in place in the centre for the notification, management and review of incidents in line with national policy. Incidents were managed in a timely manner demonstrating good responsiveness from the staff team and management. Young people's social workers were kept informed signifying good communication with stakeholders. However, while incidents were appropriately identified and reviewed, learning arising from incidents was not evidenced as being shared with staff or young people to mitigate future risk and strengthen safeguarding practices.

While management and staff spoke of reflective practice and extensive discussion taking place in staff meetings where sharing learning takes place, a review of staff meeting minutes by inspectors found that they did not contain evidence of this. Minute taking needed significant improvement if such learning was taking place but was not being captured. While there was a standing agenda to be worked through, inspectors observed that there was no follow through on actions from the previous meeting and meetings were generally used to discuss the young people, with no other areas of learning and practice evidenced as discussed. However, discussion of each young person was noted by inspectors to be thorough.

There were a total of 80 SENs on the Register of Significant Event Notifications (SEN) from January to the days leading up to the inspection, largely attributable to the period of disruption experienced earlier in the year. A review of the register showed that the dates on which relevant professionals were notified of incidents were clearly recorded and this communication was predominantly timely. Child protection notifications were sent where appropriate. However, from the SENs reviewed by inspectors, a life space interview was rarely conducted with the young person following the incident which indicated a gap in support and review processes for young people.

Significant event notification review group (SENRG) meetings took place monthly. These were attended by the regional manager, deputy regional managers, the centre manager, psychologist and social work team leaders. There was also evidence that social care leaders from the centre attended these review meetings for learning purposes. This provided a forum where incidents were reviewed and where senior management oversight of the centre was evident. Any follow up required was acted upon and accepted by the group at subsequent meetings. Inspectors did not find evidence that learnings and feedback from SENRG meetings were communicated to staff in the centre. This did not support shared learning or staff understanding of incident review processes or give any space to collating possible trends or risks which might be emerging and so enhance safeguarding practice. New and less experienced staff would benefit from regular opportunities to share learning within the wider team. This was another area where a more thorough staff meeting record would have benefitted the staff team and as a consequence the young people they were supporting.

The management of the centre had not undertaken any audits, and therefore there was no evidence of learning or quality improvement arising from audit activity. The only audit provided to inspectors was a national audit. As previously mentioned, there was no evidence that learning from incidents was shared at

team meetings. This represented a deficit in governance and a missed opportunity to enhance staff knowledge and improve the quality of care provided to the young people in the centre. It is for this reason that this standard was judged to be substantially compliant.

Judgment: Substantially compliant

Standard 5.1
The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the welfare of each child.

Regulation 5:
Care practices and operational policies

The residential centre had systems in place aiming to ensure compliance with *Children First: National Guidance for the Protection and Welfare of Children (2017)* and the *Child Care (Placement of Children in Residential Care) Regulations,* 1995. The centre manager was clear that staff provided care in line with legislation and standards. Staff demonstrated an understanding of legislation, policies and procedures that promote the safety of young people when interviewed by inspectors. They were familiar with reporting procedures and knew that the designated liaison person (DLP) for Children First was the centre manager. Less experienced staff were supported by social care leaders in submitting notifications. The centre's safeguarding statement was displayed in the centre in line with legislation in a discrete location in keeping with a homely environment.

The centre had moved to electronically maintained files and the use of Tusla's Case Management (TCM) system. While an electronic filing system has the potential to improve efficiency, accessibility and oversight of records, a system is only as effective as the quality and consistency of the information entered by staff. Inspectors noted a number of potential data protection breaches, where personal information relating to young people was not stored correctly in line with General Data Protection Regulation (GDPR) requirements. Inspectors found information relating to other young people on the files being reviewed. This was brought to the attention of the social care leader assisting inspectors on the day. While this did not result in any known harm to young people, it highlighted a gap in staff understanding of the system of record keeping and adherence to data protection procedures. This indicated a need for stronger oversight and strengthened governance to ensure that young people's personal information was consistently protected in line with legislative and regulatory requirements.

Inspectors observed that interactions between staff and young people were relaxed, respectful, and at ease. Young people engaged with staff and appeared comfortable. Some young people were noted to be comfortable enough to seek support and express their views to some staff, indicating that positive and trusting relationships had been developed, supporting young people's wellbeing and reflecting a culture of care consistent with the requirements of standard 5.1. A combination of new staff and new residents also meant that some relationships were in the early stages of building trust and getting to know one another and staff were noted to be respectful in their approach.

While staff sought to encourage participation and support young people to engage in activities and daily life within the centre, for example meal preparation, achieving the appropriate balance between encouragement and direction remained challenging. Inspectors observed that young people were often slow to engage in education and activities in which they expressed limited interest, despite these being identified as beneficial to their development. Although staff demonstrated sensitivity to young people's preferences, inspectors noted that a more consistent and appropriately directive approach was required to support young people to engage in activities that promoted their education, routine, and personal development. Other professionals consulted were in agreement with the inspectors' findings.

Inspectors found evidence of positive working relationships with professionals involved with the young people in the centre. Staff worked alongside young people's social workers, guardians ad litem and therapeutic teams and there was evidence of coordinated efforts to address issues arising for young people. Plans were made by this core group and inspectors saw follow through from staff in the centre, for example, the organising of specialist services in attending staff meeting to discuss how to support one young person. This demonstrated collaboration between professionals to bring about the best possible outcome for young people and the dissemination of information to the staff working directly with the young person. Some frustration was noted by some professionals on issues where it was felt staff could demonstrate more authority and motivate behaviour that would be in the young people's best interests. Greater consistency in staff approach was required to support young people to participate in their daily programmes and partake in activities that would enhance their life skills and development.

The centre's statement of purpose was updated in May 2025 and reflected how the service defined itself and the service it provides.

The centre's safeguarding statement was in line with legislation. However, the centre operated under a suite of national policies which were overdue for review but which continued to inform significant areas of practice within the centre. The duration of time overdue for review varied significantly, with some years overdue, indicating no clear mechanism for a systemic review of such national policies. This has been a general finding of children's residential centre inspections completed by HIQA to date in 2025. In light of this finding, HIQA escalated this issue in February of 2025 to Tusla's National Director for Children's Residential Services and received assurances, outlining that these policies and procedures were under review. However, the review and finalising of relevant up-to-date policies and procedures, despite two extensions to the timeframe proposed for completion throughout 2025, at the time of this inspection, had not yet been completed.

Due to the absence of up-to-date National policies, procedures, protocols and guidance across significant areas of practice directly related to children in residential care, this standard was judged to be 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.
Regulation 6:
Staffing

The centre manager reported to the deputy regional manager, who in turn reported to the regional manager. The centre manager was supported by a deputy centre manager and they had oversight and responsibility for the day-to-day running of the centre, including the supervision of social care leaders. Social care leaders supported the social care workers and provided supervision. Supervision files did not form part of this inspection. Social care leaders spoken to said that they support newer staff with regular check ins, oversight of daily logs and review information uploaded. However, this oversight was not evident when inspectors reviewed documents. It was noted by inspectors that social care leaders did not meet as a group but that the only meetings taking place were staff meetings and the recording of these meetings has already been highlighted as an area of deficit. According to staff, key workers met to discuss the young person as a key working group, however, the minutes of these meetings were not evident on the files reviewed.

There was a written delegation of duties for the centre manager and deputy centre manager, however, there was no clear indication of the roles and responsibilities of the social care leader team. This weakened governance and management arrangements and reduced accountability within the centre. This could result in a lack of clarity for young people about who was responsible for supporting them. Young people voiced frustrations with regard to staff communication and oversight of information sharing as evidenced in daily logs and meeting minutes which were reviewed by inspectors.

Inspectors found evidence of oversight systems in place from centre manager and deputy centre manager signing off on documents, however, some records required development in order to show the quality and effectiveness of the monitoring of the service, for example the signing of staff meeting minutes by staff not present at the meeting needed improvement. This was identified by inspectors to be better in 2024 when records were manual, therefore, the transition from manual to an electronic filing system has had a negative impact on record oversight, as evidence of signed and ratified meeting minutes was not consistently evident within the electronic system. Daily logs were consistently signed by management, and follow up comments were seen regularly, demonstrating effective oversight in this area, as well as accountability and a commitment from management to being informed about the day-to-day experience of young people. This supported timely decision-making and identification of appropriate follow up for young people when required.

Staff files, including agency files, were reviewed to determine compliance with relevant legislation. While some staff files contained all necessary information to indicate safe recruitment practices, other files had deficits such as the absence of international police vetting and an absence of references. An urgent compliance plan was issued following the inspection due to an absence of documentation confirming safe recruitment practices. Matters were followed up promptly and a satisfactory response was received.

Inspectors found that learning from incidents, complaints and day-to-day practice was not evidenced as being shared across the staff team. Staff and the centre manager stated that learning and information was shared in team meetings, however, as already identified, inspectors found staff meeting minutes requiring substantial improvement in recording if this is where learning takes place. A lack of shared learning limits opportunities for collective learning and improvement in service provision and can increase the risk that the same issues could reoccur.

Staff meetings were also indicated as the forum for discussing any changes to policy but again this was not written in the records. Where learning is not effectively disseminated, staff do not have a shared understanding of effective approaches to supporting young people which can contribute to inconsistent approaches and to the frustrations voiced by young people in the centre which will be addressed later in this report. The overall finding was that the structure of staff meetings did not consistently support effective information sharing or collective learning. As a result, key information was not always evidenced to be disseminated to the wider staff team, particularly to those who did not attend meetings. Inspectors also noted that actions agreed at previous meetings were not always clearly recorded, reviewed or followed up which increased the risk that important tasks and practice issues were overlooked. The lack of a structured approach to agenda setting reduced management oversight and weakened governance arrangements. This has a potential implications for the consistency and quality of care provided to young people.

There was no process for auditing in place. Audits are a key governance tool supporting oversight and continuous improvement and their absence is a lost opportunity to pick up on trends and drive service improvement. The last HIQA inspection in January 2024 also found the need for improvements in auditing and a compliance plan was submitted which indicated that managers would be provided with a framework for auditing. In terms of external oversight, Tusla's auditing team, Practice Assurance and Service Monitoring (PASM) had audited the centre in August 2024. The purpose of the audit was to verify service improvement and the completion of aligned actions to the 2024 HIQA inspection. While the audit noted some progress there was a need for improvement noted in respect of the compliance plan. The PASM report noted areas for improvement which this inspection confirmed still have a way to go in terms of meeting full compliance with standards; management oversight, improvement in key working and recording of staff minutes were some areas where further improvement is still required to address these matters.

Staff who spoke with inspectors varied in experience. They were aware of the young people's needs and safeguarding measures in place for each of them.

According to the statement of purpose the staffing complement of the centre consisted of four social care leaders, eight social care workers and two .62 relief social care workers. In reviewing the rosters inspectors identified nine social care leaders (two on extended leave) and eight social care workers with an additional two agency social care workers. Staff operated a 24 hour 7 day a week roster including one staff member awake at night. A review of staff rosters confirmed full

staff cover and any gaps were filled by agency staff. Management were conscious of using consistent agency staff who formed part of this cover.

There was no annual review of the quality and safety of care and support in the centre, in order to measure the centres performance against the national standards to identify areas for ongoing improvement. Inspectors were not informed of any plan to complete this, although it was noted in January 2025 regional meeting minutes that it was due for completion on 27th January, 2025.

Inspectors reviewed the training register for the centre which identified that not all staff had up-to-date training in Children First; 19% of staff were noted on the register as not having up-to-date Children First training completed. The log also showed that many staff had particular training related to safeguarding issues such as child sexual exploitation (76%), First Aid (71%) and complaints (76%). A training needs analysis was completed recently which identified areas of training to be addressed such as mental health first aid and trauma and attachment. Although relevant social media training was identified at a regional management meeting and staff were to be facilitated to attend, no staff participation occurred and this did not feature in the training needs analysis. In the context of identified issues regarding young people's use of phone and social media in the centre, this represented a missed opportunity to strengthen staff capacity to support young people and mitigate risks associated with social media. Given concerns around phone use which were raised in collective risk assessments prior to young people's admission to the centre, inspectors found that the potential risk of child sexual exploitation was not clearly identified or considered by staff as a safeguarding concern. Inspectors did not see any evidence or reference to potential online exploitation despite the fact that young people were noted in the daily logs to be on their phones into the early hours of the morning on occasion. Review of records showed that individual support sessions with young people did not consistently address online safety.

There were two 'need to know'[3] documents reviewed by inspectors. The impact on young people of the information being highlighted in the need to knows by staff was clear and extensive. Placement support plans and risk assessments were updated as a result. Further updates were provided on one 'need to know' four months after its initial submission which provided current information on an ongoing matter for the young person. The second need to know was noted as closed after twelve updates were provided. These were overseen and signed by the regional manager.

[3] Tusla's Need to Know risk escalation policy and procedure which is a process for the escalation and notification of reportable events such as serious incidents.

The service was found to be not compliant with this standard due to the necessity of issuing an urgent compliance plan as a result of unsafe recruitment practices. The absence of a completed annual review as well as the failure to ensure that all staff had completed Children First training were significant findings which led to a judgment of not compliant.

Judgment: Not compliant

Quality and safety

Inspectors observed that the care young people received in the centre was in keeping with their rights and they were treated with dignity and respect. Their privacy was valued and their safeguarding needs were considered. Young people were living in an environment where they felt safe and protected from harm. They were given opportunities to make decisions about the day-to-day running of the centre, despite not taking these opportunities up regularly. The young people were empowered to exercise their rights by encouraging the submission of complaints when they were dissatisfied with their care and they were given opportunities to have their opinions shared and acted upon.

Upon admission young people were given an information booklet which set out the rules and running of the centre and informed them about their rights while living in the centre and who they could depend on to promote their wellbeing. They were given the opportunity to visit the centre and to meet staff prior to moving in which helped them become familiar with the environment, routines and expectations which can reduce the anxiety involved in such a move.

Children were encouraged to participate in their child in care reviews and to form part of the decision making that would impact their care. Staff spoke to young people with respect and demonstrated a balanced approach by regularly checking in with young people while also respecting their need for space and privacy.

Young people were supported and encouraged to eat well, take exercise and engage socially for the benefit of their overall wellbeing. Inspectors observed that staff sought to use mealtimes as an opportunity to promote connection and positive interaction among young people.

Young people were noted to always have a prompt response from staff when they were in need of further support, the prompt organising of doctor's appointments and reaching out to social workers was found by inspectors when reviewing documents.

Some young people were not engaging in day programmes and improvements were needed from staff in motivating young people to make positive choices that would feed in to their long term wellbeing.

The restrictive practices used in the centre were recorded on a register with oversight by the centre manager. They were evidenced by inspectors to be of the shortest duration possible and reviewed on the date suggested. Improvements were needed in seeking the voice of the child around these restrictions which would be giving young people further opportunities to have their voices heard and voice their opinions on matters affecting them.

Placement support plans were updated and contained good detail. The centre manager had oversight and signed off on these documents. They contained the current risks for the young person. The placement support plans reviewed did not capture the voice of the child and it was noted that this was due to the sensitive nature of the issues discussed. There was no placement support plans viewed for one resident who was a relatively new admission.

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

Management and staff spoken with, including long term as well as newly appointed staff, demonstrated a good awareness of children's rights. Upon admission to the centre the young person is given a colourful and informative information booklet which aims to answer any questions they might have about the centre. A review of the information booklet showed that it clearly highlighted young people's rights and outlined the responsibility of staff to care for and support them. It was clear from the review of documents that the young people in the centre were aware of their right to privacy and to complain when they were

dissatisfied about something affecting them in the centre. This was seen in daily logs and individual work records read by inspectors.

Staff spoke very positively and respectfully to inspectors about the young people in their care. Inspectors viewed in daily logs and handover documentation that staff rarely entered a young person's room without first knocking and they were consulted about meals and shopping as well as having a budget for their personal use. Each young person had a spacious bedroom of their own which they decorated-according to their own taste, according to the centre manager. Each bedroom had a spacious en-suite which further promoted their privacy. They had ample storage by way of drawers, lockers and wardrobes and all bedrooms viewed by the inspectors were clean, well-lit and comfortable spaces.

Staff confirmed when asked by inspectors that young people had not availed of the opportunity to review their files, and inspectors did not find evidence that young people had been informed or supported to understand their right to access information held about them within the centre.

There was a weekly house meeting offered to the young people; a forum where they can raise concerns and express grievances, supporting their rights. Young people however regularly refused to attend these meetings, finding them too formal a setting according to staff. Staff instead gathered the opinions of young people through informal discussion over meals or when they were out of the centre on car journeys. They were given choice of what to eat and offered opportunities to assist with the grocery shopping. Staff spoken to said that they were always trying to come up with new ways of making these meetings more appealing, such as having treats available. They were continuing to make efforts to engage young people in house meetings, recognising the importance of this forum to support positive relationships, address shared concerns and promote harmonious living among young people residing together.

In line with young people's care plans and in consultation with their social workers, young people's relationships with friends and family were promoted and supported. Friends and family were made welcome to the centre, which demonstrated that young people experienced the centre as a home-like environment. Inspectors saw evidence of regular family contact being supported, facilitated and encouraged. Young people were facilitated to maintain relationships by inviting peers to the centre, reflecting experiences typical of family home life.

The restrictive practice register contained all necessary information regarding the details of the restrictive practice, the rationale for same, the duration of the practice and its status. Of the restrictive practices records reviewed by inspectors, there was clear rationale for their implementation and they were of short duration. The register required updating to close off restrictive practices to a recently discharged young person.

While positive practices were evident, inspectors identified some areas where greater consistency and commitment was required to fully embed rights-based practice across the service, such as encouraging young people to engage with and review information contained within their personal files or the facilitation of a house meeting that encouraged active and positive engagement from young people. For this reason this standard was found to be substantially compliant.

Judgment: Substantially compliant

Standard 1.3
Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.

Young people were encouraged to engage in activities to support their health and wellbeing as well as their particular interests. Inspectors found that young people were facilitated to engage in activities particular to their individual interests and talents. Inspectors reviewed documents where healthy eating and exercise were discussed with young people and where they were encouraged to seek out staff when they felt in need of support.

Each young person was appointed several keyworkers. This was to ensure they generally had someone on their key working team available to them regardless of staff rosters. Staff spoken to highlighted that new staff were paired with more experienced staff and there was a social care leader on every key working team. It was good practice to mix experienced and inexperienced staff so that more experienced staff could model good practice and newer staff's enthusiasm and energy was identified by experienced staff as being beneficial and providing a fresh perspective. However, as previously mentioned, there was no documentation kept of these key working group meetings and the discussion of the young person they supported. The absence of structured discussion amongst a key working group limits opportunities to review progress made with a young person, identify their emerging needs or any safeguarding risks.

Inspectors reviewed documentation where the complaints process was highlighted with young people and also many conversations were seen on file of the opportunity for young people to make a complaint when they are unhappy about something in the centre. This was seen in individual pieces of work undertaken with children also.

A national advocacy service leaflets were made available to young people and their newsletter was also shared, and inspectors saw evidence of conversations with young people informing them of the advocacy service and how it can support them. The centre manager also highlighted that she informed advocacy groups when a new young person moved to the centre. All young people in the centre had guardians ad litem and an allocated social worker who visited the centre and advocated on behalf of the young people.

Continuity of staffing is an important safeguarding measure for young people. There was an experienced staff team who had built trusting relationships with the young people as well as newer staff who were at the early stages of building relationships and trust. While there were a small number of agency staff employed, the centre manager was cognisant of using consistent agency staff to ensure continuity of care for young people. Continuity of staff is a key feature in safeguarding young people and was something the centre manager was committed to.

Inspectors were aware of the concerns within the centre around smart phone use amongst the young people through the review of collective risk assessments as well as daily logs which referenced young people being on their devices in their rooms until early hours of the morning. Inspectors found that there was no evidence of individual pieces of work completed with young people to explore associated safeguarding risks. As previously highlighted, an opportunity for staff to strengthen their knowledge through social media-specific training offered in September 2025 was not taken up.

Young people were offered opportunities to participate in the day-to-day running of the centre, for example, the opportunity to assist with cooking. While such opportunities were offered, young people did not regularly participate. They were facilitated to spend time with friends and family and to engage in activities they enjoyed such as classes of interest and gym attendance. While young people did not attend house meetings, staff spoke of ways that they continue to try to promote this means of having their voices heard, actively trying to elicit the views and wishes of young people. At this time in the centre, the house meetings were not a forum that young people were particularly interested in partaking in.

Key working sessions took place with young people and were generally opportunistic in nature. While inspectors reviewed records of some positive work taking place there was not sufficient evidence of regular or ongoing individual work being undertaken with young people. Individual work provides an important opportunity for staff to build trusting relationships with young people, support them to explore worries and concerns and help them to understand matters that are impacting on their lives. Individual work allows young people the time and space to express their views, feel listened to and receive support tailored to their individual needs, promoting their wellbeing. At the time of this inspection key working sessions did not feature consistently in the routine and schedule of young people.

Young people would benefit from increased individual work taking place. Where these sessions do not take place consistently, young people may not have sufficient opportunities to express their views, process experiences, or receive targeted supports. This limits staff ability to fully understand young people's needs and respond proactively to risk and support progress in line with their care plans. The absence of regular individual work, alongside young people spending extended periods alone in their rooms during the days, raised concerns regarding missed opportunities for purposeful engagement between young people and staff. It is for these reasons this standard was found to be substantially compliant

Judgment: Substantially compliant

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their wellbeing and personal development.
Regulation 23: Care Plan
Regulation 24: Supervision and visiting of children
Regulation 25: Review of cases
Regulation 26: Special review
Up-to-date care plans were viewed on young people's files with the views of the young people documented. While young people sometimes chose not to attend their child-in-care review, they did provide their views through feedback forms and

through the staff attending. The centre was represented at the young person's child-in-care review and staff formed part of the planning process.

Collective risk assessments were reviewed by inspectors which highlighted safeguarding concerns for young people prior to their admission to the centre. This formed part of the decision making process as to the suitability of the placement to meet each young person's individual needs. Inspectors found that risk assessments were thorough and signed off by the centre manager. Of particular note the collective risk assessments for two young people highlighted concerns which centred on smart phone use. As this information was outlined in the risk assessment, inspectors would expect to see these matters forming part of the individual work undertaken with the young people upon admission to the centre, as well as being highlighted as an issue with the wider staff team, however, inspectors did not see any plans to address the concerns raised in the collective risk assessment and individual work seen by inspectors did not address the concerns around phone use with the young people. Young people were asked to hand in their mobile phones at night; however, where this did not happen, no repercussions followed, which reduced the effectiveness of the measure and weakened safeguarding boundaries.

The care provided in the centre followed Tusla's national approach to providing care to young people in residential centres. This model of care identifies six key areas for young people to work on so as to reach their full potential. As previously identified, inspectors found that individual work with young people and individual key work or one-to-one support sessions were not taking place on a regular basis. This provided limited assurance that young people were being supported in a planned and consistent way indicating a need to strengthen recording and oversight.

Two of the three young people were not engaging in education. Staff were supportive of one young person trying to source an alternative day programme and encouraged and promoted the importance of being involved in education and having a plan. Another young person's attendance in school had significantly declined since their admission to the centre. While it was clear from daily logs that the young person was being called in the mornings for school, there appeared to be no motivation to attend, but rather an acceptance of the young person's disengagement with education and their refusal to attend. Plans were being made with the wider professional group to address this, however, through a review of documentation and discussions with staff, inspectors found that staff engagement in supporting the young person to attend school required improvement.

Placement plans were reviewed by inspectors and were found to contain good detail, however, those reviewed were unsigned. The placement support plan for a relatively recent admission was blank. Action plans and progress reports which are to be completed every six months were requested by inspectors but were found to be blank upon review for one young person. Young people's voices were not captured in their placement support plans but this was due to the sensitive nature of the information contained as explained by staff.

Overall, the centre was found to be substantially compliant with standard 2.2. Inspectors found that care plans were up to date and reflected young people's assessed needs. Collective risk assessments were in place and identified relevant risks within the centre. However, risks identified in collective risk assessments were not consistently translated into individualised work with young people, and there was limited evidence of regular individual work taking place to support young people to understand and manage these risks. Inspectors also found that young people were not consistently engaged in education. While staff encouraged attendance, inspectors found that greater support, structure, and motivation were required to assist young people to attend school and maintain engagement with education in line with their care plans. Young people's voices were not consistently captured within their support plans, which limited evidence of their views informing decision making about their care and support. While no immediate risks were identified, inspectors concluded that improvements were required to ensure care planning was fully individualised, young people's participation was embedded in practice, and education support was delivered in a proactive manner. For these reasons, the centre was found to be 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.

Inspectors found that young people felt safe in the centre. This was clear from their relaxed demeanour, sitting comfortably with staff and moving freely around the centre. Young people were observed to joke and chat with ease with staff. Young people inviting friends and family to the centre suggests they view it as a safe and home-like environment. While young people chose not to speak with inspectors, they were aware that if they had any concerns they had an opportunity to share these and it was clear from documents reviewed that the complaints process was regularly offered to young people.

The centre manager appropriately sought guidance from the social work department to determine whether a child protection notification was required if an issue arose. This demonstrated effective collaborative working, with the manager and staff engaging proactively with external professionals to ensure safeguarding concerns were managed in line with statutory responsibilities. It also reflects a cautious and child centred approach, whereby advice was sought to support informed decision making and ensure that the most appropriate protective response was considered for the young person. However, two child protection notifications seen by inspectors did not demonstrate clear follow up or what plans were put in place to safeguard the young person.

Staff spoken to had a good awareness of their obligations as mandated persons to report any concerns related to the children in their care. They were aware of the steps to take to make a report and who the designated liaison person in the centre was. Social workers spoken with confirmed that they were kept well informed and that referrals and information sharing were timely and appropriate. Guardians ad litem spoken to highlighted that they would only receive a call from the centre for something very significant but acknowledged that the management were very responsive when any issues were raised.

Inspectors found evidence that young people were supported to access appropriate support services to assist them in managing their emotional wellbeing. Inspectors saw regular communication with support services in support of one young person in the centre. Meetings were arranged in a timely manner when incidents of concern arose bringing together all stakeholders to formulate plans to best support the health and wellbeing of the young person. Supports were arranged in a timely manner and reflected individual needs, promoting emotional wellbeing. While this demonstrated that service coordination was in line with standard 3.1, inspectors found that information from support services was not consistently shared with the wider staff team. Staff reported to inspectors that a handover process was in place to support the sharing of information about young people; however, inspectors found that this process was not consistently effective in ensuring relevant information was communicated.

Young people were discussed at length in staff meetings, but it was not clear how management ensured staff who were not in attendance read the minutes and kept themselves abreast with information as there was no clear format for recording the reviewing of minutes. While there was previously a template for staff to sign off on the reading of staff meeting minutes, there was no longer such evidence available since the minutes were now being held electronically. This was also the case with the daily logs, with staff confirming that it was their own responsibility to

read the logs. Inspectors reviewed minutes whereby young people reported that gaps in information sharing about their plans among staff resulted in repeated questioning of young people, indicating that relevant information was not consistently communicated within the staff team, causing frustration to young people. Inspectors saw that staff responded to one young person's frustrations by convening a meeting with social workers to hear the young person's views and to commit to strengthening communication and information sharing practices.

Inspectors found that concerns relating to one young person were thoroughly followed up following a multi-agency meeting involving relevant stakeholders to plan and coordinate ongoing supports. A clear plan was developed for a specialist support professional to attend a staff meeting to support staff engagement with the young person and to enhance their understanding of the behaviours presented and appropriate responses. This demonstrated a strong commitment to promoting the young person's health and wellbeing and to supporting positive outcomes for their future. The issues relating to this young person appeared to be thoroughly assessed and supported by staff. This thorough response evidenced strong management follow-through in addressing clear concerns, however, inspectors found that less obvious risks to children's safety, such as the potential for child exploitation through mobile phone and social media use, were slower to be identified and addressed. The increased vulnerabilities of children in care should be clearly recognised by staff in order to identify and respond to potential safeguarding concerns.

Individual risk assessments were reviewed by inspectors and found to be clear in their assessments of potential harm and the duration of the risk, however, often young people's views of the risk was not noted. As already highlighted, the restrictive practice log recorded the date of the restrictive practice and when it would be reviewed and closed out. Inspectors found that these restrictive practices were short in duration with no open ended practices within the centre. It was again recorded in risk assessments and restrictive practice records that restrictions with phone use were in place to promote better sleeping patterns, however, the opportunity was missed to acknowledge the potential for exploitation through inappropriate phone use.

Incidents of young people going missing from care were well managed. Though not a concern for the centre at the time of the inspection, absence management plans were seen on young people's files with clear plans on how to respond. There was a clear system in place to notify the appropriate authorities of when a young person was missing and when they returned.

Staff spoken to showed an awareness and understanding of the policy and procedure on protected disclosures and were aware of who they report a protected disclosure to without any adverse impact on themselves.

Young people presented as at ease with staff which indicated that positive and trusting relationships were being built. The centre manager showed a cautious and child centred approach to safeguarding by seeking guidance from the social work department when considering the necessity of a child protection notification, demonstrating a collaborative approach to child safety. Staff were knowledgeable about their responsibilities as mandated persons and social workers and guardians ad litem reported to inspectors that they were kept informed of safeguarding matters. Young people were enabled to access relevant support services and communication with support services was evident on files, however, it was not clear how information was shared with the wider team. Staff reported that it was their responsibility to keep themselves informed, however, there was no formal system in place, such as signed confirmation of reading meeting minutes, for example, which would evidence that critical information had been shared and understood. While obvious safeguarding risks were followed up thoroughly, inspectors found that less overt risks, such as risks associated with mobile phone use, were not consistently identified or addressed, which increased young people's vulnerability. Incidents where young people went missing from care were managed in line with procedures. Staff were also aware of the protected disclosure policy.

While effective safeguarding practices were evident, inspectors concluded that greater consistency in information sharing and risk identification were required to fully embed safeguarding practice. For these reasons, the centre was found to be substantially compliant.

Judgment: Substantially compliant

Appendix 1 - Full list of standards considered under each dimension	
Standard Title	**Judgment**
Capacity and capability	
Standard 3.3: Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.	Substantially compliant
Standard 5.1: The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the welfare of each child.	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
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 1.3: Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.	Substantially compliant
Standard 2.2: Each child receives care and support based on their individual needs in order to maximise their wellbeing and personal development.	Substantially compliant
Standard 3.1: Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.	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-0049046
Provider's response to Inspection Report No:	MON-0049046
Centre Type:	Children's Residential Centre
Service Area:	South
Date of inspection:	9 December 2025
Date of response:	4 February 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: 3.3	**Judgment:** Substantially Compliant

Outline how you are going to come into compliance with Standard 3.3:

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

- Where incidents occur, and learning is identified from review this will be brought to the staff team meeting where it will be recorded within the minutes. Feedback to individual young people following incidents where there is learning identified is agreed upon, reviewed and discussed with the young person and recorded in their daily logs or individual work.
  Action due: 4th February 2026.

- Meeting minutes will be more robust through the recording of reflective practice and more detailed discussion points that occurs in staff meetings. The centre will ensure there is both a minute taker and a person to record actions and decisions, so that an accurate decision log is maintained with the meeting minutes. Management will ensure the finalised minutes are accurate and approve same. To improve the standard of minute taking by staff, training will be provided to staff in the appropriate recording of minutes.
  Action due 15th March 2026

- In addition to standing items, all agenda items identified by management and staff will be recorded on the meeting minutes, to ensure learning and practice is discussed and evidenced.
  Action due: 4th February 2026

- As part of management oversight Life Space Interviews will be prioritised as part of significant event notification submissions. To assist staff further in processing incidents with young people refresher training will be sourced on Life Space Interview completion and learning will feature at team meetings where appropriate.
  Action due: 30th April 2026

- Following receipt of significant event notification review group (SENRG) meetings minutes, a copy will be provided to the team through individual email. A hard copy will be made available as required reading with sign off sheet and learning points discussed at team meetings. At present two social care leaders have attended SENRG meetings and there are plans for additional social care leaders to attend where availability arises. Social care leaders who have attended SENRG assist management in governance and oversight of significant event notifications prior to submission to improve quality and standards. The regional office as part of SENRG minutes will issue data collation graphs to the centre each month to assist the centre to identify and review incident trends.
  Action due: 27th February 2026

- In addition to the National Audit, there are additional audits completed by management although not discussed or evidenced in inspection. Health and Safety walkthrough audits are completed quarterly and maintained in the Health and Safety folder. The centre manager completes an annual supervision audit and the next one is due for completion 27 Feb 2026. The centre adheres to the medication management policy where monthly medication audits are completed by centre management and recorded in the medication folder. In addition, the assigned deputy regional manager will complete a financial review of procurement card spending and other associated costs for the centre which is issued by Tusla finance department. This review will continue upon receipt of each report.
  Action due: 27th February 2026

- The centre completed an annual review for 2024 which was not provided to inspectors during the inspection however this remains on file if required for review. Management will be completing the annual review for 2025 and learnings and deficits identified will become part of the service improvement plan for 2026.
  Action due: 13th February 2026.

Proposed timescale:	**Person responsible:**
30th April 2026	**Social care manager, Deputy social care manager, Deputy regional manager**

Capacity and Capability: Leadership, Governance and Management	
Standard: 5.1	**Judgment:** Not compliant

Outline how you are going to come into compliance with Standard 5.1:

The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

- Centre Management will conduct a review of young people's files covering 2025. Any identified GDPR issues or data breaches will be reported immediately in line with policy and measures taken to rectify identified breaches. Management will add data protection to a meeting agenda as part of in-house training and policy review. Centre management will complete a review of data protection training compliance and any deficits identified will be addressed with individual staff members including refresher training where applicable. As part of increased governance and oversight a system has been introduced by management for improved review of documents to ensure no further breaches occur. This includes rotational assignment of document oversight with clear identifiable persons responsible. Where data breaches occur, they will be recorded on the centre's data breach register and will be reported in line with policy.
  Action due: 01st April 2026

- To ensure a more consistent approach around agreed plans for young people including education, management will ensure weekly plans are adhered to and expectations will be reiterated to staff and the young people. Where ongoing difficulties continue around lack of programme engagement, professional meetings will be convened and clinical assistance sought for the team to help support the young people in line with the centres model of care. CRS psychologist assigned to the centre will attend team meetings and include inputs specifically to identified young person's needs. In addition, model of care consultant and centre management will schedule team inputs throughout 2026.
  Action due: 01st April 2026

- Centre Management will maintain contact with school/educational placements and liaise closely with educational welfare officers in the area where difficulties arise with attendance.
  Action due: 13th February 2026

- Management will ensure greater consistency in staff approach to promoting a healthy lifestyle for young people through reviewing daily logs, discussing young people at team meetings, engaging other stakeholders, including social work and clinicians. A review of centre systems and agreed programmes for young people will take place at a team meeting. Social care

leader meetings will be scheduled in the coming weeks for specific discussion on areas of shift planning, consistent approaches to programmes for young people and strategy planning for on-going non engagement or where deficits are identified. Progress will be reviewed by management after an agreed period.
Action due: 30th April 2026

- The National Policies and Procedures for Mainstream Residential Service- Suites 1-5 reviewed and approved and issued in December 2025 for implementation on 1st January 2026. Suite 6 was approved at NPOC meeting in January with final amendments to be made and will be issued in February 2026. An additional Suite (7) is currently being developed on Use of Restrictive Practices.

- The TellUs Policy has been reviewed and will be sent out for consultation in Q1 2026 with expectation to be presented to NPOC at March meeting.

- New National Suite of Policies 1-5 were discussed at team meeting on 28/01/2026 and hard copy of policies are available to staff on site. Staff will review and sign off understanding of policies.

- The review of the Tusla Child Sexual Exploitation Procedure is currently underway in collaboration with other stakeholders including An Garda Siochana. The social care staff in the centre will continue to adhere to and implement the CSE Procedure in the interim and report concerns related to child sexual exploitation. All social care staff in the Centre have had training on CSE and continue to adhere to and implement the CSE Procedure and report concerns related to child sexual exploitation as outlined in policy.

- The updated suite of policies have been issued as required reading for all staff members on 12th January 2026. The policies have been emailed to all staff members individually as required reading and implementation. In addition to ensure clear understanding each staff member will be required to sign their acknowledgement and understanding of the policies which will be maintained by management. The policies will feature for discussion at designated team meetings and if necessary, management can provide additional guidance to staff.
  Action due: 1st April 2026

Proposed timescale:	**Person responsible:**
30th April 2026	**Social care manager, Deputy social care manager.**

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.

- Management acknowledges the ad hoc nature of social care leader meetings throughout 2025. This will be addressed as part of the centre's service improvement plan for 2026. There is a set schedule for social care leader meetings to take place monthly starting 6th January 2026. These meetings will be scheduled and can be viewed on Roster. Minutes will be taken for the meetings, incorporating both standing items and live topics for discussion. Minutes are emailed to all social care leaders individually. Social care leaders' specific roles and responsibilities, as outlined by Regional Manager, will be discussed in full in these meetings and recorded. The assigned deputy regional manager will attend a selection of these meetings to provide additional oversight and support to the team.
  Action date: 11th February 2026

- To assist centre management and social care leaders have a clear understanding of social care roles and responsibilities, a delegation task list will be devised with clear responsibilities and persons responsible recorded. This will be reviewed six months after implementation to ensure it is embedded in the centre and working effectively.
  Action due: 11th February 2026

- To improve governance and provide evidence to support the work undertaken by key workers the key working groups will meet monthly from January 2026. Minutes from the meetings will be reviewed by centre management and held on young person's file in keyworking digital folder.
  Action due: 27th February 2026

- To ensure staff meeting minutes are read and ratified by staff, the finalised minutes will be converted to PDF, made available to all staff members via email and a copy available on the centre's team meeting minutes digital folder. All staff will then be required to sign the digital sign off sheet and this task will be overseen by an assigned social care leader.
  Action due: 4th February 2026

- Centre management will ensure that complaints are reviewed at team meetings as part of a standing agenda item. Work will be carried out with the team to ensure more comprehensive daily handovers take place and where complaints or day to day practice issues arise these will be recorded

in daily logs, handovers and put on the meeting minutes agenda for wider meeting discussions.
Action due: 25th February 2026

- As identified in standard 3.3 management will take measures to ensure improvements are made in the recording of meeting minutes and the lessons learned arising from same. This will be carried out through delegation of tasks, additional training where necessary, procedure review and assigned timelines for management oversight.
  Action due: 30th April 2026

- The service has introduced two new registers, one for each individual young person and the other for centre management governance. These registers will assist management in collating information and identifying trends within specific areas that will further improve practice and ensure compliance. Each area of the young person's individual registers requires management oversight sign off, to improve management governance of key areas for each resident This register was introduced and effective from 1st January 2026, replacing all previous registers.
  Action date: 1st January 2026

- The centre completes scheduled audits for the centre under a nationally agreed audit tool. This was updated and implemented in the centre during 2025. The new format incorporates a clear framework for completion along with action plan tracker to identify and monitor necessary improvements required in maintaining compliance legislation, policy and standards within the centre. The deputy regional manager assigned to the service will discuss the Audits completed as part of governance meetings on a quarterly basis, commencing March 2025.
  Action Due 05th March 2026

- Centre management are currently undertaking the 2025 annual review. This will assist in measuring the centre's performance against the national standards and formulate the centre's service improvement plan for 2026.
  Action due: 13th February 2026

- Training audit is currently being undertaken by centre management, and all training information will now be stored on a standardised centre manager register. Early findings from the training review indicate that data figures noted by the inspectors included staff that were on long term sick leave adding to deficit percentages in key training areas. When fit to return to work each staff member will be required to undertake all necessary training as part of return-to-work process. Any deficits identified in the training audit for staff actively working in the centre will be prioritised and completed.
  Action date: 25th March 2026

- As part of the training review currently being undertaken social media training deficits will be identified within the staff team as some members have completed this training previously. Although not noted in the centres training needs analysis individual staff members also completed their own training needs analysis and submitted this to WLD. Centre manager has submitted funding request and proposed training dates to accommodate untrained staff, young people or other staff members who may wish to refresh in social media skills.
  Action date: 31st March 2026

- Child Sexual Exploitation training will also feature as prioritisation for staff who have not completed it to date. Management will ensure that all staff are trained by 27 February 2026. To support enhanced understanding in the centre, an input on child sexual exploitation will be completed by centre management bi-annually at team meetings. The first team input will take place on 22 April 2026. Individual risk assessments for young people will be updated to include child sexual exploitation concerns where applicable. Staff and management will also ensure through revision of daily logs and interactions with the young people that any child sexual exploitation concerns are reported through the child sexual exploitation reporting process.
  Action date: 22nd April 2026

- In order to provide assurance that staff files are compliant in the centre, all new staff employed in the centre undergo an agreed verification process by a dedicated recruitment department. This verification includes references, garda vetting and practice registration. For staff already working in the centre, human resources have verified staff file compliance, where information was inaccurate or not readily available on file, management, the individual staff members and human resources have worked to rectify the staff file compliance for the service.

  Centre management and the assigned deputy regional manager review staff data on a monthly basis to ensure that required training, garda vetting and practice registration remains compliant. The next scheduled check is due 06th March 2026
  Action due 06th March 2026

Proposed timescale:	**Person responsible:**
30th April 2026	**Social Care Manager, Deputy Social Care Manager**

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.

- All placement Support Plans have been updated and signed by relevant stakeholders. PSPs will be updated monthly in key working group meetings. The young person's voice will be reflected through individual pieces of work and aspects pertaining to the PSP around routine management and behavioural difficulties although of a sensitive nature at times, will be recorded in individual work sheets.
  Action due: 31st January 2026

- Incorporated in the new young person's register is a section identifying when young people read their files or are offered to read the files. This will assist staff in ensuring young people are offered the option to read their files and detailing which file has been reviewed by the young person. As part of key working group meetings this task will be assigned to a keyworker. Centre management are required to sign off on this log as part of their governance. Through individual keyworking and house meetings, young people will be reminded of their right to view their files and encouraged to do so.
  Action due: 1st January 2026

- Restrictive Practice register for 2025 was closed off in team meeting 6th January 2026, The centre has moved to individual young person restrictive practice registers from 1st January 2026.
  Action due: 6th January 2026

- To assist in improving evidencing the young person's voice being sought, keyworkers will review any restrictive practices with the young person and their views will be added to the relevant risk assessment. This will be discussed with the key working group for immediate implementation.
  Action due: team meeting 4th February 2026

Proposed timescale: **06th February 2026**	**Person responsible:** **Social Care Manager, Deputy Social Care Manager**

Standard: 1.3	Judgment: Substantially compliant

Outline how you are going to come into compliance with Standard 1.3:

Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.

- Management will ensure meeting minutes from key working groups meetings are of good standard and recorded on agreed templates. These will be signed off by centre management as part of governance procedures. These records will be reviewed by the deputy regional manager as part of regional governance for the centre. Key working teams will be informed of this at team meeting 11th February 2026.
  Action due: 11th February 2026.

- Management will check evidence of individual working sheets and key working sessions to reflect positive work taking place. Young person's engagement and views sought will be evidenced through these reports. Planning for key worker sessions/individual work will be prioritised in the Key Worker Group meetings. Centre management will ensure review of these, and evidence of same, in Key Worker Group meetings, to inform team of young person's progression. Centre management will sign off on these as part of governance procedures. Where excessive phone use has been identified as impacting on programme engagement, safety and wellbeing; the phone and social media risk assessment will be updated with input from the young person and their social worker included. A phone management plan will be put in place to support the young person with limitations on use implemented where agreed by the multidisciplinary team.
  Action due:27th February 2026.

- As identified in standard 5.2 and as part of the training review currently being undertaken the centre manager has submitted funding request and proposed training dates to accommodate untrained staff, young people or other staff members who may wish to refresh in social media skills. The training for the young people will be tailored to their needs and age appropriate.
  Action date: 31st March 2026

  In line with CRS suite of policies and procedures for the centre, each young person will be encouraged to participate fully in their placement programme. Weekly plans will be completed with each resident factoring in daily routines, social activities and appointments. These plans will be reviewed daily with the young person and form part of shift planning. However, to assist staff to support young people who are reluctant to

engage with staff or who spend extended periods of time in their rooms, staff will conduct agreed interval check ins with the resident in their room throughout each day and continue to encourage them to participate in their daily routines. This plan will be noted on the young persons placement support plan. The updated placement support plan with identified check ins will be completed as part of team meeting.

For young people who consistently decline to engage in their programme plans, centre management will meet them to reiterate centre expectations. The level of young people engagement in centre programmes will feature at both team meeting agenda and multi-disciplinary professional meeting agendas to ensure a collaborative approach is undertaken to address this.
Action date 25th February 2026

Proposed timescale:	**Person responsible:**
31st March 2026	**Social Care Manager, Deputy Social Care Manager**

Standard: 2.2	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 2.2

Each child receives care and support based on their individual needs in order to maximise their personal development.

- Centre management will ensure regular key working group meetings take place to assist in keywork planning. These will address risks arising on the collective risk assessment upon admission to the centre for young and as well as considering risks that present post admission. These will be evidenced in the Key working group meetings minutes, with identified goals and key work sessions/individual work scheduled to support the young person with same, including their views and input. Keywork teams overseen by Case Managers will ensure all aspects within the new individual young person's registers, placement support plan, placement plan reports are updated and evidenced with management sign off for improved oversight.
  Action due: 11th February 2026

- Centre management will ensure staff are supported in delivering more consistent and robust approach to encourage greater programme participation, including school attendance. Through collaboration with the young person, case stakeholders, risk management and improved recording or direct work, evidence of the work being carried out by staff to assist the young person will be more visible. This will be overseen by centre management monthly and reviewed by the assigned deputy regional manager quarterly as part of centre governance.
  Action due: 30th July 2026

- Staff and management will adhere to the centres policies and procedures around engaging with young people who have difficulties in attending education. Each young persons' educational plan will be incorporated into their placement plan and placement support plan. This will be reviewed by keywork teams with oversight from centre management monthly. Where difficulties are identified, centre staff will limit external stimulus during school times and engage key stakeholders to assist to provide additional support to the young person. The updated policies are currently required reading for all staff, and management will reiterate expectations to the staff team at team meeting dated 25th February 2026. The educational welfare service has been contacted for one young person and is working with management to best support reengagement into education. For one young person in the centre, the school is assisting by providing schoolwork to the centre and preparation is underway to support the young person attend scheduled state exams. Although an ongoing issue, it is expected the young person will attend their exams in June 2026. Alternate educational options are to be explored for this young person if the issue persists. Educational plans for the young people will remain an ongoing agenda item for deputy regional manager and centre management governance meetings.
  Action due 20th June 2026

- The assigned case manager will ensure each young person has an up-to-date placement plan, placement support plans, progress reports and action plans. Where relevant, each young person will be consulted and their views input to the plans drawn up for them, including routine planning, risk management and goal focused placement planning. All documents will be completed and signed by all relevant partes by 20th February 2026.
  Action due: 20th February 2027

Proposed timescale:	Person responsible:
30th July 2026	**Social Care Manager**

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.

Improvements to both the daily handover and team meeting formats is currently being introduced by centre management. The daily handover template will be completed more comprehensively to ensure relevant information is contained and available to staff for review when on shift. Management will review and sign off on daily handovers, to ensure that assigned tasks are undertaken and all necessary information is relayed effectively. Where omissions are identified, it will be discussed with individuals and wider inputs will take place with staff at team meetings for improved quality and overall governance in this area.
Action due 28th February 2026

Daily logs are a requirement for all staff to read when on shift, relevant issues or follow up actions will feature on daily handovers and actions pertinent to keyworking will feature at keywork group meetings.

Improvements to the frequency of team meeting as well as the meeting formats further assist in insuring information is provided to the wider team. Staff who are not present at team meetings will receive a copy of the finalised minutes via email from centre management. As the centre continues to move to become more digitised an improved system has been established whereby staff will digitally sign that they have read and understand the content of team meeting minutes on a sign sheet similar to the printed version previously in use. The oversight of this sign off is to be delegated to a social care leader. Any ongoing issues regarding staff not reading or signing off meeting minutes will then be escalated to centre management for discussion with individuals. The system will be reviewed by centre management and assigned deputy regional manager after 4 months to allow for bedding in.
Action due 29th May 2026

In order to develop communication with young people and staff especially around their plans or information sharing, it is envisaged that the new format of team meetings, handover of information and keywork team discussions will assist in ensuring young people receive the information they require. Management will review the system in place by meeting with staff, young people and social workers monthly to get a determination on how the improvements are going. The

assigned deputy regional manager will review the system with centre management as part of governance meeting for the service. Action due 27th March 2026 To improve standards regarding children's safety, staff who have not completed the child exploitation training will undertake this as a priority. Each young person's mobile phone and social media risk assessment will be reviewed by assigned deputy regional manager and centre management. The identified risks will be discussed with each young person as part of individual keywork. Where an identifiable risk is present and restrictions are required to assist in the management of the risk, it will be entered on the young person's restrictive practice log. To assist the young people and staff increase their awareness of risks associated with social media, training in social media is currently being sourced. Action due 1st April 2026	
Proposed timescale: **29th May 2026**	**Person responsible:** **Social Care Manager, Deputy Social Care Manager, Deputy Regional Manager**

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
5.1	The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.	**Not Compliant**	**Orange**	**30th April 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**	**Red**	**30th April 2026**
1.1	Each child experiences care and support which respects their	**Substantially Compliant**	**Yellow**	**06th February 2026**

	diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child.			
1.3	Each child exercises choice, has access to an advocacy service and is enabled to participate in making informed decisions about their care.	**Substantially Compliant**	**Yellow**	**31st March 2026**
2.2	Each child receives care and support based on their individual needs in order to maximise their personal development.	**Substantially Compliant**	**Yellow**	**30th July 2026**
3.1	Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.	**Substantially Compliant**	**Yellow**	**29th May 2026**
3.3	Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice**.**	**Substantially Compliant**	**Yellow**	**30th April 2026**

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