An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 080

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Compass CFS Ltd.**
Registered Capacity:	**Three young people**
Type of Inspection:	**Unannounced Inspection**
Date of inspection:	**13th, 14th & 18th March 2025**
Registration Status:	**Registered from 13th June 2024 to 13th June 2027**
Inspection Team:	**Ciara Nangle** **Janice Ryan**
Date Report Issued:	**14th May 2025**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in August 2015. At the time of this inspection the centre was in its fourth registration and was in year one of the cycle. The centre was registered without attached conditions from 13th June 2024 to 13th June 2027.

The centre was registered as a multi-occupancy centre, to provide care for three young people from age thirteen to seventeen years on admission. Their model of care was described as a relational based model underpinned by the principles of social pedagogy. The basis for this programme was that professionally qualified adults care for the young people in a consistent and predictable fashion. A primary focus of the work with young people was informed and guided by an understanding of attachment patterns.

There were two young people living in the centre at the time of inspection. One of the young people was placed outside of the centre's purpose and function and a derogation had been approved from the Alternative Care Inspection and Monitoring Service. This young person in the process of transitioning out of the placement at the time of this inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3

Prior to this inspection, ACIMS risk response team had received two escalations of significant event notifications (SENs) relating to two separate incidents within the centre. Both escalations were in relation to the management of challenging behaviour within the centre. Due to the nature of these events, and the concerns noted within, inspectors determined that an inspection under Theme 3 of the National Standards for Residential Care, 2018 (HIQA) was required for this inspection. One of the young people to whom one event related was no longer resident in the centre at the time of inspection, however a sample of records relating to this young person were reviewed as part of this inspection.

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 14th April 2025. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 28th April 2025. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 080 without attached conditions from the 13th June 2024 to 13th June 2027 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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

Theme 3: Safe Care and Support

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

The organisation had a suite of policies in place which were aligned to the National Standards for Residential Centres, 2018 (HIQA) and Children's First: National Guidelines for the Protection and Welfare of Children, 2017 to promote the safe care of children placed within the centre. These included policies around recruitment, vetting of staff, child protection policies and employee policies set out in the employee handbook. Within all these policies there were procedures for staff to follow to safeguard young people and protect them from all forms of abuse. These policies had been updated in 2023 and were due for review in July 2024. This review remained outstanding at the time of this inspection.

The centre had a child safeguarding statement (CSS) in place which aimed to identify any potential risks to children accessing the service as required by the Children's First Guidelines, 2017. This had been developed in 2023 and was due to be reviewed in August 2025. It had been approved by the compliance unit within Tusla. Staff in interview demonstrated an awareness of the CSS however were not clear on the risks identified within it. The statement did not identify child exploitation as a potential risk, despite staff identifying that both young people were vulnerable to outside influences. The statement should be reviewed and updated to ensure it captures all relevant risks and should be shared with staff to ensure that they are familiar with the risks and the controls in place to mitigate against these.

The centre manager was the designated liaison person (DLP) for the centre and staff demonstrated an awareness of same during interview. Staff were aware how to report a child protection and welfare concern through Tusla's portal and what type of instances should be reported. Staff had recently completed online mandated person's training and evidence of their completion was held on their personnel file. Staff had completed Children's First online training and from a sample of child protection reports reviewed during this inspection, it was evident that the centre were reporting

these appropriately. Staff had also completed further child protection training provided by the organisation.

At the time of inspection, there was one open child protection referral for the centre. The centre was awaiting feedback from the social workers in relation to the outcome of this referral to update their register. The status of child protection reports were discussed during team meetings and were reviewed as part of monthly quality assurance audits. However, from a review of both records, inspectors found it hard to determine when and what follow up with the social work department had occurred as the update remained unchanged from month to month and the details of the follow up were not recorded on any record.

At the time of inspection, bullying was not presenting as an issue within the centre. While the dynamic between the two residents was at times challenging, this was not classified by the team as bullying and was being managed through behaviour management plans. There were appropriate policies in place should an issue regarding bullying in any form arise in the future.

Both young people had safety plans in place in relation to access to the internet and safeguards were in place. One young person's phone was subject to regular checks and there was a clear plan and strategy in place to manage their access to the internet and social media. The requirement for work in relation to this area was identified within this young person's placement plan. The plans in place for both young people were working well to mitigate against the risks identified in relation to access to the internet and social media.

The centre was appropriately identifying areas of vulnerability for the young people. These were planned for through placement plans, behaviour management tools and risk assessments. In interview staff had a good understanding of the young people's needs.

While the individual needs of the young people were identified within the relevant documentation, there was limited work being undertaken with the young people in relation to these specific areas. When work was completed, it was of good quality and was focused on helping them understand and develop an awareness of their vulnerability and how to keep themselves safe. However, the work was predominantly opportunity led and was in response to a presenting issue rather than planned to support the on-going development of their skills to safeguard themselves in the community.

Risk assessments and risk management plans in place were detailed and contained clear and practical steps for the team to undertake to mitigate against risks identified for the young people. Risk assessments were discussed during team meetings and were referenced within the monthly quality assurance audit completed by the centre manager. Active risk assessments were noted within the young people's practice documentation. Staff and management identified that risk assessments were reviewed during hand overs, however handover was not recorded and as such this could not be verified. While there was reference to the risk assessments in the records listed above there was no documented evidence of these plans being reviewed or altered to become more effective when required. Additionally, when a risk assessment was no longer needed, there was no record of the rationale for this.

Inspectors noted several inaccuracies within risk assessment documents, including management commentary that was not relevant to the assessed risk, date errors and at times the wrong managers signature on the document. As such it was difficult to determine what oversight was in place regarding the risk assessments, or if they were being used as working documents as these deficits in recording had not been identified prior to this inspection. Given the serious nature of some of the risks that had been assessed it is important that the risk assessment document and attached management plan are clear, are up to date, and only reflect information relevant to the specific risk. Evidence of review within the stated time frame should be recorded and the rationale for closing off also noted.

The organisation had a policy in place for the staff to make a protected disclosure should they need to. Staff in interview could identify the pathway to report a concern.

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

The centre had policies and procedures in place that supported the positive management of behaviour that challenged. The centre's model of care and policies and procedures were underpinned by the principals of pedagogy and aimed to positively manage challenging behaviour by implementing consistently applied boundaries to support young people to develop a sense of empowerment in their lives and responsibility for their actions. The centre's policies on behaviour management were due for review in July 2024, however this had not yet occurred.

The model of care had been adapted to the setting as the centre did not have "live in" adults but worked with a shift pattern whereby a lead pedagogue and a social

pedagogue worked in the centre for a 24-hour period and they were supported by another adult, known as a support pedagogue during the day. They worked on a 6-week rotating roster always with the same smaller team. The purpose of these smaller teams was to provide consistency to the young people which was aligned to their policies and model of care.

Nine of the ten core staff working in the centre had a record of having been trained in the model of care. The centre manager reported that the team had scheduled check ins with the model of care trainer on a six weekly basis to support them implementing this model into their practice in the centre. Staff in interview demonstrated a detailed understanding of the principles that underpinned the model of care and how they used it in practice. However, within centre records the implementation of it was not evident and as such the inspectors could not determine the extent to which the model was used in supporting the team to positively manage behaviour that challenged.

All staff were trained in an approved framework for the management of behaviour that challenged, the requirement for which was set out in the organisations policies. Training was provided to refresh the team in the use and implementation of this framework with all staff having completed the required training or a refresher within the last six months. Young people's documents which detailed the steps required to manage challenging behaviour were aligned to this framework and reflective of the approved interventions.

The team was also supported by a psychologist who attended monthly meetings to review the care being provided to the young people and to inform the care approaches implemented by the staff team. Records were maintained of these meetings and provided good insight into the origins of the young people's behaviours that challenged and focused on promoting a positive approach to managing their behaviour from a trauma informed perspective.

Staff were provided with detailed care plans and other relevant assessment reports to support them in caring for the young people. The centre had individual crisis support plans (ICSPs) in place for each of the young people, absent management plans (AMPS) and placement plans which all provided the team with ample information in relation to the young people, the goals for the placement and the appropriate responses to their presenting needs.

The ICSPs for each young person were developed in a child centred way and focused on the positive qualities the young people had while naming and identifying the challenges also. The ICSPs were of good quality and provided clear details to the team on the triggers for the young people and the responses that should be implemented.

Overall, inspectors found that the various documents in place for the young people contained good quality information, however this was not always consistently recorded across the documents. Inspectors found that where discussion in relation to plans or interventions for the young people occurred in team meetings, with the psychologist or in Significant Event Review Group (SERG) meetings the changes identified to practice and the approaches to be taken were not always transferred into the relevant document to guide staff practice. Additionally, inspectors noted several errors within documents maintained by the centre e.g. dates, spelling errors or records being incomplete (daily logs), which had not been identified prior to the document being signed off by management.

One young person was subjected to a number of restrictive practices in the form of physical restraint. In some Significant Event Notification (SEN) records the detail recorded was limited regarding staff responses and interventions and as such it was difficult for inspectors to determine if the young persons ICSP was being followed. At times it appeared to inspectors that during events, physical restraint was relied upon to manage a behaviour for one young person, rather than this being implemented as the last resort in maintaining safety. These incidents were reviewed by the centre manager and regional manager to ensure the physical restraints were aligned to the framework for behaviour management. There was evidence of discussion in the various meetings detailed above reminding staff that physical restraint should be a last resort however from the detail recorded within the SENs this did not appear to be translating into practice.

On two occasions over the preceding twelve months, one young person had been placed in a similar non-routine physical restraint which was deemed to be unsafe by management. Following the first incident in April 2024, it was clearly communicated to the team that this approach to managing a situation should not be used, however a similar incident arose again in December 2024. The incident in December 2024 was escalated to ACIMS due to the serious nature of the incident. On review of the centre response to the incident it was clear that the organisation had responded in a proportionate manner and had followed their policies and procedures in relation to the management of this. However, learnings identified from the review of this incident, which included an additional refresher training for the team in the

framework for behaviour management had not occurred for all team members at the time of this inspection. This young person was in the process of moving placement however it would still be beneficial for a review of their placement and the physical restraints implemented to be completed to identify any learnings to support the development of safe and effective care in the centre and across the organisation.

As detailed in a previous section of the report, when individual work occurred with the young people, it was of good quality and reflected good levels of engagement. This work tended to occur when the opportunity presented such as after an incident, or when an issue arose. There were no schedules in place for individual work or clear guidance on the topics to be covered and the frequency at which it should occur, to ensure that the young people were supported to develop an understanding of their behaviour and to develop alternative strategies to manage this. Further development of the planning of individual work is required to support the young people.

The organisation had a system in place for regional managers to complete thematic audits aligned to the National Standards for Children's Residential centres, 2018 (HIQA) on a periodic basis within the service. However, in 2024, only three themed audits had been completed. An audit under theme 3.2 of the National Standards, in relation to the positive management of behaviour that challenged had been undertaken in April 2024 by the regional manager. Some minor deficits were identified within this and action was required by the centre. The inspectors could not ascertain what oversight was in place regarding the implementation of these actions. Additionally, when the behaviour within the centre escalated and there were more regular incidents of challenging behaviour, inspectors could not determine what, if any, specific auditing in relation to the management of challenging behaviour was undertaken to ensure that this was being managed in line with the organisations policies and the National Standards for Children's Residential Centres, 2018 (HIQA).

The centre was supported by a management team comprising of a centre manager and deputy manager. These were not based within the centre, however at a minimum visited Monday to Friday for handover. In addition to the thematic audits completed by the regional manager, the centre manager completed monthly quality assurance audits which collated data in relation to the operation of the centre and included details in relation to the number of SENs. While these audits provided an overview of the functioning of the centre and presenting issues, they did not provide for review or analysis of the management of behaviour that challenged to ensure it was aligned to policy. Additionally, the audits had not identified some of the deficits in the young people's care records as identified within this inspection, and at times the details

recorded within did not provide enough data to demonstrate the status of a particular area e.g. open child protection notifications were recorded as open with no updates recorded in relation to the follow up completed. It was not clear to inspectors what the oversight of these quality assurance audits was from external management, or how they were verified. Further development of these audits to ensure they are effective in capturing areas for improvement as well as good practice within the centre is required.

As mentioned above, the management team were not based within the centre. The purpose of this was reported to be to create a more homely environment for the young people in line with the centre's model of care. However, the organisation had not developed systems to oversee practice in the centre that were robust and effective. Management being located away from the home reduced their ability to monitor the teams practice through direct observations of the implementation of behaviour management plans, regular observation of interactions with young people or implementation of shift plans. Additionally, opportunities to develop the team's knowledge or skill through role modelling was limited as they were not in the house during significant events or for extended periods during the day. In interview management advised that they did not routinely seek feedback from the lead pedagogues in relation to the other members of the team's performance and as such management were predominately reliant on recorded information and team meetings to inform themselves regarding staff practice within the centre. Further development of the auditing and monitoring systems in place in the centre is required to ensure that the management of behaviour is being managed in a positive way aligned to policy.

In interview staff were clear on what constituted a restrictive practice, and all noted that the use of these was not in line with their model of care and as such they were rarely used. Physical restraint as indicated in young people's ICSPs was recorded as an on-going restrictive practice and was reviewed through their care documentation. Outside of this, at the time of this inspection the young people were not subjected to any routine restrictive practices. Given they are seldom implemented, it would be beneficial to review the policy and procedure around restrictive practice periodically with the team to ensure they maintain a clear understanding of its implementation in practice should the need arise.

Sanctions tended to be used in the form of natural consequences. They were recorded on the young peoples record and a log of sanctions was maintained by the centre. In interview staff demonstrated good insight and understanding into the use of

sanctions. There had been no sanctions implement in 2025 at the time of inspection, and those recorded on young people's files that were implemented in 2024 were appropriate and in line with the organisations policy.

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

Both the staff working in the centre and the management team identified that there was an open culture promoted where both adults and young people were encouraged to raise concerns, report incidents and identify areas for improvement. Team meetings were a forum through which staff were encouraged to raise and discuss issues arising in the centre. Records maintained of these meetings reflected that these discussions were occurring. Young people were consulted through house meetings which were scheduled to occur on a weekly basis. During these meetings the young people were encouraged to speak about issues arising and areas they would like to improve within the centre. Feedback from these meetings was discussed at the staff team meetings. The team meetings had regularly highlighted the importance of these occurring. There was a good level of participation from two of the young people in these meetings and in a sample reviewed they had raised issues such as worries about staff leaving, or the impact they were having on each other and how this could be managed better.

Additionally, the young people were consulted monthly to provide feedback into their plans and goals for the placement. These were recorded through individual work and the young people participated well. The centre manager also advised that she would seek feedback from the young people or speak to them after events to get their views in relation to any aspect of their care. In some instances, this was evident in centre manager comments on SEN records. The young people were encouraged to report complaints if they were dissatisfied with any aspect of their care and there was good evidence of reported complaints being investigated and feedback on the outcome being given to the young people.

One young person spoke with inspectors and reported positively of their experience living in the centre. From observation they appeared at ease within their environment and around the staff team. Their records reflected that they were making positive progress while in the placement. They named their current concerns in relation to the placement and were aware of the measures staff were taking to address these evidencing good communication between the team and the young person.

Parents were regularly updated in relation to the young people's progress and were encouraged to provide feedback to the team. One young person was subject to monthly review meetings and their parents participated and provided feedback on their care during these. For the other young person weekly updates were provided to their parents and through these they could provide feedback. The centre manager noted that they had positive relationships with parents of the young people, and that there was good open communication and feedback was welcomed. In some events such as the young person going missing from care, their parents would be updated immediately, however this was not the practice for all significant events, and it was dependent on the nature of the incident. Inspectors noted that during one incident of a young person going missing in the days preceding this inspection, their parent had expressed dissatisfaction with the timeline they were notified. Attempts had been made by the centre management to follow up in relation to the issue however had not managed to speak with them at the time of the inspection. This incident would suggest that there is an openness with parents to express and raise issues they may have.

The parents for both young people were spoken to as part of this inspection. All spoke positively about their experiences with the centre. They advised they were kept up to date when incidents occurred. One parent who had expressed dissatisfaction following a recent event felt this was a one-off occurrence and did not feel it was reflective of their experience with the centre. All parents spoken to noted they could contact the centre whenever they wanted. They advised that they felt they work together with the centre in the best interests of their child and that they felt included by the team.

There was evidence of regular communication with social workers in relation to both young people. Meetings were convened when issues of concern arose for the young people, and social workers were facilitated to participate in decision making within the centre, such as consequences for the young people. They were notified in a timely manner when there was an incident or allegation made by a young person. Social workers for both young people were consulted as part of this inspection. Both noted that they were advised in a timely manner in relation to significant incidents within the centre. They noted that they regularly visited the centre and the young people they were allocated to liked living in the centre. One social worker noted that the management team was not always available in the centre during their visits which they felt may be beneficial to ensure comprehensive updates in relation to the day-to-day care of the young people were provided.

The centre had a policy for significant events in place which provided clear steps for how staff working in the centre needed to report events and to whom. This, like the other policies referenced in this report was due for review in July 2024 however this had not occurred. Within the organisations policies there was clear procedures for the review of significant events both within the centre and externally by senior management. The policy set out the requirements for SERG meetings and noted that an additional SERG could be requested by a centre manager should they feel this is required.

The sample of SENs reviewed as part of this inspection contained a good level of detail in relation to the presenting behaviour of the young person, however as detailed in a previous section of the report in some notification reports they lacked detail in terms of the staff interventions. As such it was difficult to determine if the young person's ICSP had been followed to effectively manage the incident. At times they lacked consistent timelines which made it difficult to track the event from start to finish. These deficits in recording had not been identified by centre management during their review of events or during external SERGs. Improvement is required in the recording of SENS to ensure they reflect all details and interventions utilised during the incident and do not only focus on the young person's behaviour.

In line with policy, SENs were reviewed by the centre management team prior to them being issued to the other professionals, and there was detailed commentary included on the event notifications from the management team. These comments provided a good quality overview of the presenting challenges for the young people, staff responses and further actions that may be required.

SENs were also reviewed at the fortnightly team meetings in line with policy and the discussions around the events was relevant and insightful. However, for one young person where restrictive practice of physical restraint was regularly utilised the SEN reviews did not identify that the restraints were not effective in supporting this young person to manage their challenging behaviour.

SERG meetings with the regional team were occurring and individual SENs were reviewed during these. While the learning was discussed within team meetings, inspectors found it hard to identify where the discussions and learnings noted in the SERG were recorded within the young people's behaviour management documentation or where changes to practice occurred as a result. Additionally, the mechanisms in place for reviewing SENs did not allow for a broader oversight of tracking of patterns within the SENs in relation to young people's behaviours, needs

or staff practices. Further development of the processes in place for the review of SENs is required to ensure that they effectively identify learning and that this is used to inform and guide practice in the centre.

A detailed review was convened in November 2024 in relation to the SENs for one young person who was subject to physical restraints during the events. This was requested by the then centre manager and was attended by the centre management team, regional manager and the organisations psychologist. This review looked at patterns and trends and identified some changes to practice that would be required. It also noted that a full review of all physical interventions for this young person should be undertaken, however at the time of inspection this had not yet occurred.

Incidents were recorded and reported to the social work team, guardians and management within the organisation in a timely manner. However, there was a period in 2024 where events were not reported to the Tusla Children's Residential Services (CRS) as outlined as a requirement within the organisations policy. This oversight in notification was not identified for several months by the internal or external management team within the organisation. The delay from July to November 2024 resulted in a number of significant incidents not being reviewed by Tulsa's significant event team in a timely manner which impacted on the overall external governance of the centre's management of challenging behaviour. While in this instance it does not appear to have adversely impact the care provided to the young people, it is imperative that SENs are reported to relevant persons in line with the organisations policy and the requirements of Tusla to ensure safe care for the young people in the centre.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1** **Standard 3.2** **Standard 3.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that the Child Safeguarding Statement reflects all relevant risks for the young people and that staff are clear on the risks contained within.
- The registered provider must ensure that where a risk assessment and management plan is required, that the detail contained within is clear, accurate and up to date and that there is a record of review of the effectiveness and need for the plan and a rationale for the closing of the risk is maintained.
- The centre manager must ensure that there is a clear plan for individual work with the young people in place that is aligned to their presenting needs and supports them achieving their goals set out within their placement plans.
- The registered provider must ensure that all learning identified within SERGs, team meetings, therapeutic review meetings or other relevant forums which results in a change to practice, is shared with the team and is also recorded in the relevant young persons document to support a consistent approach to the management of behaviour within the centre.
- The register provider must ensure that all actions identified within organisational reviews or investigations are actioned in a timely manner and responsibility for their implementation is clearly assigned with a mechanism in place for oversight of this.
- The registered provider must ensure that a review of the placements for the two young people who have recently moved on is completed so that any learnings for future practice is identified and implemented within the centre.
- The registered provider must ensure that there are effective mechanisms in place for the oversight, monitoring and auditing of the care being provided within the centre.
- The registered provider must ensure that there is a system in place for the governance and oversight of the quality of recording within documentation to ensure that it accurately reflects the young people's information and strategies in place to manage their presenting needs.
- The registered provider must ensure that daily logs are fully completed prior to sign off by management to ensure that accurate details of the young people's days are maintained.
- The registered provider must provide training to the team to ensure that they have the skills and knowledge to accurately record significant events and capture all details of the event.
- The registered provider must ensure that there is an effective mechanism for reviewing significant events which effectively evaluates and reviews for patterns and trends within the young people's behaviours.

- The centre manager must ensure that all significant events are notified in line with policy requirements.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must ensure that the Child Safeguarding Statement reflects all relevant risks for the young people and that staff are clear on the risks contained within.	The Child Safeguarding Statement will be updated during Q2 2025 with the following risks added: • Safeguarding of children in digital environments • Child sexual exploitation • Trafficking of children for sexual, servitude, forced marriage or other exploitive ends. The updated statement was submitted to the Child Safeguarding Statement Compliance Unit on the same day. On confirmation of acceptance by the CSSCU, this will be reviewed at a team meeting and individual supervision to ensure adults have a clear understanding of all risks contained within. Mandatory training in the organisation's Child Safeguarding Policy will now include training in the Child Safeguarding Statement and the	Team meeting records and supervision records are reviewed immediately by the centre manager. These are further reviewed by the regional manager through the bi-monthly service governance meeting process. The organisations monthly senior management governance meeting reviews internal auditing processes for the centre and CAPA plans to ensure compliance. The Child Safeguarding Statement will be reviewed at least annually with the team through the team meeting and individual supervision process and also reviewed when any updates are made to the statement. The Child Safeguarding Statement is reviewed by senior management in line with regulatory and legislative requirements.

		Child Sexual Exploitation Procedure and the policy will be updated to reflect this.	
	The registered provider must ensure that where a risk assessment and management plan is required, that the detail contained within is clear, accurate and up to date and that there is a record of review of the effectiveness and need for the plan and a rationale for the closing of the risk is maintained.	An enhanced Risk Management Plan template has been developed. This template ensures that all Risk Management Plan reviews include: • Date of review • Rationale for any changes, continuation, or closure • Signature of the Centre Manager and Regional Manager • Confirmation of re-circulation to relevant staff All future Risk Management Plans will utilise this template to ensure clarity, accountability, and consistency in review documentation.	All Risk Management Plans will be reviewed at a minimum of every 72 hours, or sooner if required, in accordance with assessed levels of risk and guidance from relevant professionals. Completed reviews will be shared with the Regional Manager upon completion for oversight and assurance. Risk Management Plans and their review status will be discussed at bi-monthly Service Governance Meetings to ensure compliance with review timelines and documentation standards. A policy on the development and review of Risk Management Plans will be drafted by 31st May 2025 to outline best practice regarding: • Roles and responsibilities

			• Consultation requirements • Sign-off and dissemination • Structured and timely reviews • This policy will ensure consistent practice and support alignment with regulatory requirements.
	The centre manager must ensure that there is a clear plan for individual work with the young people in place that is aligned to their presenting needs and supports them achieving their goals set out within their placement plans.	Monthly schedules of individual work were reintroduced in April 2025. These contain forward looking planned individual work aligned with areas of the Individual Placement Plan and Individual Therapeutic Plan, with assigned responsibility for each piece of work. These are a standing agenda item in team meetings to ensure review and adherence to the schedule and are monitored on an ongoing basis by centre management.	The schedule of individual work is reviewed monthly as part of the internal auditing of the centre. This audit is completed by the centre manager and shared with the regional manager for review. Internal quality assurance is reviewed at bi-monthly service governance meetings with the regional manager. Organisational monthly governance meetings involving the senior management team review actions arising from bi-monthly service governance meetings and adherence to governance requirements.

	The registered provider must ensure that all learning identified within SERGs, team meetings, therapeutic review meetings or other relevant forums which results in a change to practice, is shared with the team and is also recorded in the relevant young person's document to support a consistent approach to the management of behaviour within the centre.	SERG and team meetings, therapeutic review meetings and other forums are required to have an action plan attached that identifies any changes to practice. These actions are shared with the team through the team meeting process, and changes to young people's documents are discussed as a standing agenda item at team meetings. The manager is responsible for implementing all actions and ensuring the young people's documents accurately reflect agreed approaches to behaviour support and practice.	Actions arising from all forums are a standing agenda item for the bi-monthly service governance meeting. The regional manager reviews actions to ensure completion and implementation, and that changes to practice are included in children's care documents. Actions from bi-monthly service governance meetings are reviewed at the monthly organisational senior management governance meeting to track to completion and identify and respond to any delay in this. A Centre Actions Log is being introduced in April 2025 to centrally capture all required governance actions and track them to completion.
	The register provider must ensure that all actions identified within organisational reviews or investigations are actioned in a timely manner and responsibility for their implementation is clearly assigned with a mechanism in place for oversight of this.	All organisational reviews and investigations are now conducted under formal Terms of Reference issued by the Head of Services. These terms clearly outline the scope of the review, the timeframe for completion, the individuals responsible for completing specific	Actions arising from organisational reviews and investigations are reviewed monthly as part of the Centre Manager's internal governance processes. These actions are also examined during bi-monthly Service Governance Meetings between the Centre Manager and the

		actions, and the requirement for a live action plan. The action plan sets out the actions required, assigns a responsible person to each task, and includes timeframes for completion. The Terms of Reference also require that regular updates on the status of the review and the progress of any related actions are provided to the Regional Manager or Head of Services at defined intervals.	Regional Manager. In addition, the organisation's monthly Senior Management Governance Meeting includes a standing agenda item to review all outstanding actions arising from internal investigations, service governance processes, and internal quality assurance. This system ensures that actions are monitored, escalated where necessary, and that the Head of Services maintains oversight and accountability for their timely and effective implementation.
	The registered provider must ensure that a review of the placements for the two young people who have recently moved on is completed so that any learnings for future practice is identified and implemented within the centre.	A review of placement for both young people will be held during Q2 2025. This will be facilitated by the centre manager, senior clinical psychologist, and regional manager, utilising both pedagogical and trauma informed approaches. Learning identified will be recorded as part of the minutes and a review of this learning will be used to inform the care of children within the centre and be reflected in their programme of care documents.	Care and placement reviews are now a standing agenda item in the organisations monthly residential management meeting. This allows the input of the wider management group in care reviews, and ensures learning is shared across services. Actions arising from the placement review are overseen through the service bi-monthly governance meeting and the organisations monthly senior management governance meeting.

	The registered provider must ensure that there are effective mechanisms in place for the oversight, monitoring and auditing of the care being provided within the centre.	A revised organisational governance structure was implemented in January 2025, which included the appointment of an additional Regional Residential Services Manager. This increased capacity ensures a more robust oversight of care practices across the organisation. A structured schedule of monthly themed audits aligned to Themes 1–8 of the National Standards has been developed and rolled out from March 2025, ensuring that all standards are assessed across services during the 2025 calendar year	Senior Management Governance Meetings are held monthly and include a standing agenda item for the review of themed audit findings. These meetings provide strategic oversight, support organisational learning, and monitor compliance across all services. Bi-monthly Service Governance Meetings are held between Regional Managers and Centre Managers, where: • Themed audits are a standing item • Corrective and Preventative Action Plans (CAPAs) are reviewed • Progress on outstanding actions is tracked and monitored An Annual Compliance Review is scheduled for December 2025 to evaluate overall progress, identify systemic issues, and inform quality improvement planning for 2026.

	The registered provider must ensure that there is a system in place for the governance and oversight of the quality of recording within documentation to ensure that it accurately reflects the young people's information and strategies in place to manage their presenting needs.	The team will be provided with training in the organisation's care records during Q2 2025. The centre manager reviews documentation daily and will do so with a renewed focus to ensure all documents accurately reflect young people's information and that strategies to support young people are aligned with current programme of care documents and that practice reflects these strategies.	A revised internal auditing system for the centre assesses alignment between all programme of care documentation. This is reviewed monthly by the regional manager as part of their governance of the centre. Individual supervision for the staff team will include recording as a standing agenda item to support each adult's professional development. The organisation's SERG and auditing processes assess whether documentation reflects that strategies implemented are aligned with the young people's care documents. Bi-monthly service governance meetings and the organisation's monthly senior management governance meetings review internal auditing processes to ensure they accurately capture effectiveness of care provided to young people.
	The registered provider must ensure that daily logs are fully completed prior to sign off by management to ensure that accurate details of the young people's days are maintained.	Expectation regarding completing all sections of the daily logs were outlined at a team meeting on 17.04.25. The manager reviews logs each day. The manager will ensure through ongoing review that clear	The centre manager's monthly programme of care audit is being updated, effective Q2 2025, to include that all sections of daily logs are completed. These audits are reviewed by the regional manager through

		expectations are set and that all sections are completed in full and to the required standard.	the bi-monthly service governance meeting. Daily logs are also subject to review through the themed auditing process. Any identified issues in this area and actions from the service governance meeting and external audits are reviewed through the organisation's senior management governance meeting, which is overseen by the head of services.
	The registered provider must provide training to the team to ensure that they have the skills and knowledge to accurately record significant events and capture all details of the event.	Training on recording of significant events will be delivered by the senior management team in Q2 2025. This will focus on ensuring significant event records include full timelines of the event, that all staff interventions and the child's response to same are recorded, and that strategies used are aligned with the child's current care documents and with the Crisis Prevention Institute behaviour support programme.	The centre manager will ensure, prior to signoff, that significant event records contain all required information. These are reviewed by the auditing and SERG processes, which further assess alignment with required information and current strategies. Actions from the SERG and auditing processes are reviewed through the bi-monthly service governance meeting and the organisation's monthly senior management governance meeting. Individual Supervision for each team member will include a review of their recording of SENs to support their

			development in this area.
	The registered provider must ensure that there is an effective mechanism for reviewing significant events which effectively evaluates and reviews for patterns and trends within the young people's behaviours.	Significant events are now a standing item in the residential management meeting effective April 2025. This intends to identify patterns and trends and assess the need for a response/strategy meeting involving centre and senior management, and relevant professionals. Learning identified will be shared with the team through the team meeting process and an actions list will assign responsibility for ensuring young people's care documents are updated to accurately reflect changes to practice.	The significant event policy is being reviewed by the head of services in Q2 2025. This review will introduce a mechanism and threshold to trigger response/strategy meetings involving centre management, senior management, and external professionals. Actions arising from review of significant event trends and patterns are monitored through bi-monthly service governance meetings and the organisation's monthly senior management governance meeting.
	The centre manager must ensure that all significant events are notified in line with policy requirements.	Since November 2024, all significant events have been notified in line with policy requirements. The reviewed internal auditing system now includes a requirement to ensure all events have been notified to all external parties in line with policy.	The centre's internal audits are reviewed with the regional manager through the bi-monthly service governance meeting, and actions arising and implementation of same are reviewed at the organisation's monthly senior management governance meetings.