An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 013

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Orchard Residential Care Limited**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**30th & 31st January 2026**
Registration Status:	**Registered from 25th September 2023 to 25th September 2026**
Inspection Team:	**Janice Ryan** **Justin Halley**
Date Report Issued:	**27th of May 2026**

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 2007. At the time of this inspection the centre was in its sixth registration and was in year three of the cycle. The centre was registered without attached conditions from 25th September 2023 to 25th September 2026.

The centre was registered to provide multi-occupancy, medium to long term residential care for four young people from age thirteen to seventeen years on admission. The centre aimed to help young people recover from adverse life experiences. The model of care was built on a trauma informed approach, informed by attachment and resilience theories. The staff team aimed to increase protective factors and promote resilience by providing a safe environment, access to positive role models, opportunities to learn and develop skills and to build a sense of attachment/belonging. There were three young people living in the centre. One young person had been discharged days prior to this inspection.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.2
6: Responsive Workforce	6.3

This inspection occurred due to an escalation being received from the National Placement Team (NPT) to the ACIMS department following the occurrence of a series of significant events in the centre. The inspectors reviewed a sample of centre records and young person's records between the period September 2025 to January 2026.

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 13th March 2026. 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 CAPA on the 25th March 2026. The inspector's reviewed this it was deemed to be not satisfactory. Feedback was provided and a second CAPA was submitted on the 9th April 2026. Due to deficits found within a compliance meeting was held with the registered provider and centre management on the 22nd April 2026. It was agreed as part of this meeting that the CAPA was to be resubmitted to the inspection service on the 29th April 2026 along with supplementary evidence of actions completed/and or work ongoing. 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: 013 without attached conditions from the 25th September 2023 to 25th September 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

The centre was situated on the outskirts of a main town. The premises was a detached two story house and had a large front and rear garden to facilitate young people engaging in recreational activities. Inspectors found that the layout and design of the centre was suitable for providing safe and effective care for three young people living there and was suitable to meet the needs of each child. The outdoor space and gardens were well maintained, and they contained a basketball hoop and a goal post where inspectors observed one young person playing football with a staff member.

The house was spacious, well lit, ventilated and heated. There was a large open plan kitchen which contained a range of cooking appliances for young people to use. Adjoining this was a large dining area for young people to enjoy meals together and an open plan living area which contained a couch for young people and staff to sit on. The inspectors observed over the course of the inspection two young people cooking their food in a confident manner while engaging with the staff team in conversation. There was a games room and an education room for young people to spend time within and a separate living area. The games room contained age appropriate equipment for the young people for e.g. a pool table, and a free standing arcade machine.

Inspectors met with two of the three young people living there. Both children confirmed that they had their own bedroom and adjoining ensuite facility. They stated that they had sufficient storage facilities for their personal belongings however, when asked by inspectors to view their room they declined. The centre had two additional bathroom facilities available to the young people and staff if needed. There were two additional bedrooms which were used for staff to sleep overnight in.

The inspectors found that although the house was spacious, it was not well maintained or clean. It lacked a homely feeling and there were no personalised items or soft furnishings throughout the home that would create a more, homely and welcoming environment. The centre manager confirmed that there had been significant property damage over the preceding months however, the inspectors found that the general cleanliness of the centre required significant improvement. In interview with two social workers, they also confirmed that the property was in disarray following recent incidences of property damage. Within the games room the inspectors found that a television had been broken weeks previously and remained on the main wall and had yet to be removed. Furniture within hall areas was mismatched and appeared to have no purpose of being there. The walls in the main communal areas, hall and landing required cleaning and painting and some press doors in the kitchen required hinges replacing. The light fitting in the main hallway upstairs had a wire exposed and this must be rectified immediately. Overall, the inspectors found that the presentation of the centre was not acceptable and this must be addressed immediately by the registered provider.

Within the maintenance log reviewed the inspectors found that some of the deficits in relation to the presentation of the house had not been identified. In interview with staff the inspectors found that they were unable to describe how maintenance issues were requested or tracked to completion. The inspectors reviewed the maintenance log and found that timescales were good however, when work was completed, this was not always documented and improvement was required. Weekly cleaning checks were in place and although these were signed off by staff they did not address or identify issues detailed above.

The inspectors reviewed the safety statement for the centre and found that it had been recently reviewed in November 2025 however this was not signed by the centre manager or the staff team. Inspectors reviewed the fire, health and safety records for the centre. The inspector found that an external company was contracted to complete relevant checks of the fire equipment in line with legislation. The centre had also designated one staff member who was responsible to complete fire checks in the centre. These were signed off by the staff member and at times the centre manager. There was also a system in place to review risks and hazards in the centre. The purpose of these weekly checks was to identify any hazards or issues within electrical items or any trips, slips or falls. The inspectors observed that fire doors were propped open with a door stop which was not safe and in line with fire safety legislation. This practice should cease. Within these checks the inspectors found that they did not address any deficits highlighted within this report. An audit had been

completed in January 2025, and a quality improvement plan (QIP) had been developed however, within this plan it identified actions to be taken to address improvements in the property which included daily walkabouts to be completed by management. As already discussed above numerous deficits were identified by inspectors in relation to the premises and within the QIP reviewed the inspectors could not see where daily walkabouts were taking place that would address the deficits noted above nor could they determine how this was being tracked or overseen by external management.

Centre records reviewed by inspectors found that fire drills were completed by the staff team in line with the centre's safety statement. The inspectors noted within management meeting minutes reviewed that it was identified that any new young person admitted to the centre should participate in a fire drill. The inspectors found no evidence that a fire drill had taken place following the admission of one young person weeks previously. Additionally, within the training records reviewed the inspectors found that not all staff had completed up to date fire training. The registered provider must ensure that these actions are addressed and completed by all staff members and young people immediately.

The centre had a system in place for the recording of accident/injuries to staff and young people and these were appropriately reported. On review of records the inspectors found that in recent weeks two accidents had been recorded within this register which had been reported appropriately and met the criteria for referral to the Health and Safety Authority.

The centre had a centralised online system in place where all care and centre records were digitalised. This system provided real time access to all records within the centre and allowed for different management levels to review and audit these files. The inspectors found that while the system contained a range of information, they found it difficult to navigate as all records were not readily available or up to date. On review of the centre's QIP it identified specific timelines for the uploading of records to this system however, the inspectors found that this was not being adhered to, nor could they see where this issue was being addressed by external management. The registered provider must review this system to ensure that this system is used in line with its purpose.

The centre had two vehicles which were taxed, insured, roadworthy and regularly serviced. In line with best practice the centre manager must ensure that emergency

equipment contained within both cars should be secured in the boot should a breakdown or accident occur.

The centre had up to date insurance in place.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **Regulation 17**
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 2.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must submit an action plan detailing work to be completed in relation to the property to ensure that it is child centred and homely and promotes the safety and wellbeing of each young person.
- The centre manager must ensure that all staff members complete up to date centre specific fire training and fire drills are completed in line with legislation and best practice.
- The registered provider must ensure that the governance system and procedures in place to review risks and hazards in the centre are fit for purpose.
- The registered provider must ensure that the online system in place for the review of centre, staff and young people records are robust and contain all relevant and up to date information which provides robust oversight of the day to day running of the centre.

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

Theme 3: Safe Care and Support

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

The organisation had a policy in place to support a positive approach to the management of behaviour, and this was reviewed in April 2025.

On a review of the staffing information sheet submitted as part of this inspection the inspectors found that the centre had undergone significant staffing changes since the previous inspection in August 2025 and that there was a new team in place that had limited experience of working in residential care. The inspectors found that within documents reviewed and interviews with the staff team and management they identified that at times it was difficult to support the young people when dysregulated due to the inconsistency among the staff team which is discussed below under standard 6.3. Staff members cited handover as a place where information was shared to support them understand and manage behaviours and plan for the young people daily. However, inspectors found that from handover records reviewed that these records did not capture pertinent information relevant to guide the team as the information documented was brief and was not reflective of what was described in interviews by the staff team. The inspectors observed a white board in place on the staff office wall which included more information around the care of the young people to prompt staff in relation to daily tasks. Within team meetings the inspectors found that handover was discussed as an important tool to communicate information, and it was important to ensure that these were of a high standard. However, the inspectors found that the information documented on these tools was not sufficient to guide a new and inconsistent staff team in providing safe and effective care to all young people.

There were a range of behaviour management tools in place which included individual crisis support plans (ICSP), individual absence management plans (IAMP), risk assessments and safety plans. The inspectors found from a review of these tools that the majority of these plans contained relevant information to guide the staff team in managing behaviours of concerns. However, on some plans reviewed including IAMPs and ICSP they were too lengthy and contained too much descriptive information that was not relevant to the purpose of these plans.

Additionally, the inspectors found that the centre did not have the recommended joint reporting missing in care absence management plan (AMP) on file which includes information on the young person's curfew times. The centre must ensure that these tools contain only information relevant to the purpose of this document.

A sample of significant events were reviewed and the inspectors found that these were reported in line with the organisation's policy. At times within the body of these events that they did not contain descriptive details or interventions utilised by staff to manage behaviours of concern. This made it difficult for inspectors to determine whether staff were fully implementing the behaviour management plans that were in place for each young person. One social worker in interview advised that they were unhappy in relation to the management of an incident where young people had gone into each other's bedroom and that staff were downstairs not supervising them and this was not in keeping with the plan in place. Furthermore, inspectors found that where interventions were implemented and where these were not aligned to the agreed plans these practice deficits were not identified by the centre manager or addressed in any external management feedback on the incident. Social workers also confirmed in interview that they were updated promptly when incidents arose via email or telephone call.

Significant events were reviewed in an external significant event review group meeting (SERG), and this was attended by managers from other centres within the organisation and external management. The inspectors reviewed two meeting minutes which had taken place since September 2025 and found that the detail recorded within these minutes were brief. The centre had an increase in significant events over the previous four months due to the complex behaviours of the young people living there and the inspectors found that within the meeting minutes reviewed that there was no evidence of these incidences being reviewed to identify trends or to improve future practice in the centre. The inspectors found that from each meeting minute reviewed a theme had been identified however, the inspectors were unsure how this theme was identified and from what centres or significant events. The centre manager informed inspectors that it was their responsibility to discuss their own significant events from their service and provide oversight of this event within the Serg meeting however, from records reviewed this was not apparent. The inspectors recommend that SERG process is reviewed to ensure learning is identified to inform the development of best practice and actions are taken to improve the care in the centre. Furthermore, the inspectors found that where themes had been identified within team meeting minutes reviewed, they found limited documented discussion around this as minutes were brief.

The inspectors found that due to ongoing dynamic among the young people that limited planned work had taken place among the young people in line with their placement goals. Furthermore, where complex behaviour presented, the inspectors found no evidence of documented work completed with the young person to address this concern and support the young person to understand their reason for this behaviour and how to develop better coping strategies to manage same. One young person had been subjected to bullying from other residents in the centre and this had been reported by the staff team appropriately. However, the inspectors found that where plans had been agreed by all professionals and put in place to mitigate against this concern and support the young person this plan at times could not be consistently implemented due to the staff team having to manage other complex presenting behaviours. In interview, with the relevant young person they also confirmed that this had been the case.

Team meetings took place on a fortnightly basis with a set agenda in place. On review of these minutes the inspectors found it difficult to determine what level of discussion took place around the young people's behaviours or what support was provided to the staff team to guide their practice and develop them in their role. As mentioned above, minutes were brief with limited discussion recorded in relation to feedback from SERG meetings and improvement is required.

The inspectors found that no audits had taken place since the previous inspection in line with the National Standards of Residential Centres, 2018 (HIQA). The centre manager submitted monthly governance reports to external management. These reports contained information in relation to the day to day management of the centre including staff information, young people's care and centre records. External management confirmed that on receipt of these reports a check was completed and feedback was provided in relation to any deficits identified and a corresponding timeline for the completion of same. These reports at times contained actions to be completed however, inspectors found it difficult to see how these actions were followed up on, by whom or when completed as this was not always documented on these reports. Furthermore, the inspectors found that where the centre were operating outside of agreed procedures for e.g. supervision timelines, they could not see where this was being addressed by external management having signed off on these reports.

Restrictive practices were in place in various forms for example door alarms on bedrooms and room searches. In interview with the staff team inspectors found that they were unclear of what constitutes a restrictive practice and the reason for

implementing same. A restrictive practice register was in place however, the inspectors found no corresponding individualised risk assessments in place for each restrictive practice. Furthermore, where restrictive practice was categorised on the centre's risk register as a risk the review of same was not in line with the National Standards for Residential Centres, 2018 (HIQA).

Overall, the inspectors found that the systems in place for the management of behaviour were not robustly implemented. Whilst the inspectors acknowledge that the care team were managing a complex dynamic, doing so in the absence of clear plans combined with an inexperienced team, did not ensure safe care was consistently provided to all young people.

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 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must review the behaviour management tools in place specifically the IAMP and ICSP to ensure they contain relevant information and robust measures.
- The registered provider must review the significant event review group meeting to ensure these meetings support learning, identify trends and patterns which are used to support the development of best practice.
- The centre manager must review restrictive practices and ensure that they are assessed and reviewed in line with the National Standards for Children's Residential Care, 2018 (HIQA).
- The registered provider must review the auditing mechanisms in place to ensure they are robust and fit for purpose and where actions have been identified as part of an audit that these are implemented and tracked to an outcome.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

The inspectors found that the centre had undergone recent changes within the staff team and that a new team was very much in the early stages of forming since the previous inspection in August 2025. Five new staff members had recently commenced working in the centre with the other staff members having limited experience of working with children in residential care. The staff team consisted of two social care leaders and five social care workers with additional shifts being covered from a sister centre within the organisation or from an external agency. The staff team confirmed that at times it was difficult to provide consistency in care and ensure plans were followed with the instability of the staff team. This was also highlighted by two social workers in interview. The inspectors found that from conversation with staff members and within the staffing information sheet submitted as part of this inspection that some staff members had moved centres within the organisation and the reason cited was due to the impact of working in the centre.

In interview and conversations with the staff team the inspectors found that the staff team were trying to understand their roles and responsibilities of working in residential care. The centre manager confirmed that the induction programme took place over a six month period. From a review of personnel records the majority of the staff team had no residential care experience previously and were recruited from another jurisdiction. Prior to commencing in the centre, in interview the staff members confirmed that they had completed training in the organisations model of behaviour management and the organisations internal child protection policy. The inspectors found that the organisations induction and performance management policy did not clearly outline mandatory trainings to be completed prior to commencement in the centre. On review of personnel files the inspectors found that training remained outstanding for new staff members and records had not been updated to reflect training completed by existing staff members. The inspectors reviewed the centre's monthly governance report and found that this had not been identified or addressed as a concern. The centre management must ensure that these training deficits are addressed without delay.

Staff advised inspectors that on arrival to the centre they had an initial one day induction programme which consisted of reading all centre and young people's records and the following day the staff member would commence working with the young people. The inspectors found that the initial part of this induction was not sufficient to support staff members who did not have prior experience in residential care to prepare them with sufficient skills or knowledge to support them manage the complex and challenging behaviour that was currently presenting in this centre. Furthermore, the inspectors found that the staff team were unable to develop in their role as they were constantly responding to a crisis driven environment and development of practice was limited. Additionally, the inspectors found that due to the cultural and variance in practice across residential care in other jurisdictions that the organisation had not properly prepared the new staff members for working in residential care in Ireland. They also found that these staff members had not completed additional training in cultural awareness to support them working with young people in Ireland.

Two young people who had presented with complex behaviours had been discharged from the centre and a new young person was admitted during the inspection period under review. On review of management meetings, the inspectors found that there was no documented evidence where consideration had been given to provide the staff team with additional time or support following discharges from the centre to allow the new team to develop and understand their responsibilities, performance expectations and organisational policies and procedures that guide their practice. Nor had consideration been given to the variance in cultural practices and how this may impact, how staff respond to or manage behaviour that challenges. Additionally, the inspectors did not see any consideration being discussed in relation to the instability or in-experience of the staff team and how the management of complex behaviours may impact the staff team and overall staff retention.

Team meetings were in place on a fortnightly basis. Following a review of same the inspectors found that details recorded within were brief. Furthermore, the inspectors found limited documented evidence where the staff team were supported to learn and understand their practice while working in residential care. There was no documented evidence of discussions to support reflective practice, or a culture of learning and development among a new staff team.

The organisation had a supervision policy in place. Supervision was provided to the staff team by centre management. The inspectors reviewed a sample of supervision records and found at times supervision was not always conducted in line with the

organisations policy and records were brief. It was clear from records reviewed that the centre manager was utilising supervision as a supportive tool to support staff following recent incidences in the centre and that development of practice had yet to be explored in this forum. All supervisee's had supervision contracts in place however, some of these required updating in relation to who was their supervisor.

Inspectors were informed that employees were subject to a six-monthly probation review. On review of a sample of personnel files the inspectors found that due to staff only commencing in the centre in recent months there were no performance review of staff practice completed.

The organisations had a range of mechanisms in place to support the staff team to manage the impact of working in the centre. The staff team had access to the employee assistance programme, refer a friend programme, counselling if required and within the centre additional supervision or debriefs following significant events. All staff members in interview confirmed that they were supported through difficult events from internal management. Following a serious incident in the centre which resulted in two staff members being assaulted the inspectors found that a meeting was convened with external management and the staff team. Due to the sensitivity of this meeting, there was limited discussion recorded within, so the inspectors could not determine how this meeting supported the team.

Overall, the inspectors found that due to the instability and inexperience of the staff team the organisation had not sufficiently prepared or supported the staff team to develop and deliver child centred, safe and effective care to the young people living in the centre and significant improvement was required.

Compliance with Regulation	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

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 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must review the current induction programme to ensure that it is robust and effective to support new staff members joining the organisation and takes account of the inexperience of staff team.
- The centre manager must ensure that all training is up to date and in line with requirements outlined in the organisations policy.
- The centre manager must ensure that supervision is conducted in line with the organisation's policy to support development of the staff team.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies to Ensure Issues Do Not Arise Again
2	The registered provider must submit an action plan detailing work to be completed in relation to the property to ensure that it is child centred and homely and promotes the safety and wellbeing of each young person.	Internal painting to be completed within the house: All to be completed by 15.05.2026: • Utility room • Kitchen • Living room • Main office • Stair way/landing area • Hallway (outside main office) Touch up painting required: • Front sitting room 1 (Education room) • Main entrance hall. Skip to be ordered to remove all unused furniture to be completed by 30.4.2026. Soft furnishing to be purchased for house to improve overall homely atmosphere: To be completed by 30.4.2026. New couch for living room: purchased 10.3.2026. Young persons individual touches of their choice	The maintenance team will implement and adhere to an annual maintenance schedule. The regional director will ensure that the centre is included in this schedule each year to maintain the property to an appropriate standard. In addition, the area manager will conduct monthly walk-around inspections to ensure the house remains child-centred, homely, and safe.

		have been explored through individual work this will be an ongoing agenda on young person's meeting going forward. Completed. New "chill out" room for both young people and staff members on level 2 of the house. This will provide better oversight and supervision of all residents. Completed.	
	The centre manager must ensure that all staff members complete up to date fire training and fire drills are completed in line with legislation and best practice.	All core staff are now up to date with fire training. The centre manager to ensure that fire drills are held in line with legislation and best practice. The centre manager will review the fire book monthly to ensure that fire drills are being completed in line with legislation. Time Scales: Any gaps in training will be rectified as a matter of priority: 31.5.2026. The fire book held on site will be updated when fire drills are completed: Completed.	The training database has been transferred to a shared drive, with access provided to the area manager, regional director, quality coordinator, and quality director. The behaviour management trainer has access to the training matrix and will monitor it on an ongoing basis to ensure that all staff training remains current. This oversight will help to prevent any training from expiring and ensure compliance with required standards is consistently maintained. The training matrix will be reviewed monthly to ensure that all staff training remains current and that no expiries or lapses occur. As part of the governance and oversight the area manager will conduct a monthly check of

			the fire log book.
	The registered provider must ensure that the governance system and procedures in place to review risks and hazards in the centre are fit for purpose.	A comprehensive review of the risk management process has been completed to ensure the framework is robust, effective, and fit for purpose. As part of this review, the risk management framework has been redesigned to ensure the risk register is current, risks are appropriately graded, reviewed, and monitored, and that approved templates effectively support the identification, documentation, and mitigation of all risks. Staff have received training on risk identification and escalation processes, and the centre manager and staff are supported to complete risk documentation to a consistently high standard. Time Scales: Review and redesign risk management framework: Completed. Train staff on risk identification and escalation: 01.06.26	Risk assessments updated after incidents. Monthly SERG meetings. Monthly risk review meetings. Integration of risk into governance structures. Continuous monitoring and internal audits. Regional director will bring any concerns regarding risk or safeguarding to the quarterly human rights committee. Where external oversight is provided. Monthly data analysis reports completed by the quality auditor will be made available to the regional director for trends and patterns. Monthly governance oversight from the area manager with clear goals and tasks.
	The registered provider must ensure that the online system in place for the	A comprehensive audit of the online electronic system is currently underway to	A dashboard function is used by the centre manager and the deputy manager to

	review of centre, staff and young people records are robust and contain all relevant and up to date information which provides robust oversight of the day to day running of the centre.	identify any gaps, outdated records, incomplete entries, or inconsistencies across centre records, staff files, and young people's files. All records will be reviewed and updated to ensure they are accurate, complete, and current, with priority given to safeguarding-related and high-risk documentation. Data entry practices will be standardised by correcting inconsistent formats, terminology, and removing any duplicate records to support reliability and ease of oversight. Appropriate access permissions will be confirmed for all relevant staff, ensuring they can securely input, retrieve, and review required information without unnecessary barriers. Provide immediate refresher guidance to staff on correct system usage and documentation expectations. A comprehensive guidance document is being developed for all staff outlining the completion of standardised records within the online system. Time Scale: Conduct a full audit of the online system: 31.05.26. Review and update records to	monitor, in real time, the completion status of daily logs, key working sessions, incident reports, and young people's records. The area manager will oversee this process to ensure that all documentation is in line with regulation expectations. The system generates automated alerts and notifications for incomplete, overdue, or missing records, allowing for immediate follow-up. The centre manager and deputy manager will assure that they are monitoring this to ensure full oversight. The quality coordinator will undertake a review to ensure all documentation is consistent, appropriately aligned, and accurately reflects all relevant and pertinent information.

		ensure they are robust and contain all information: 31.05.26. Design comprehensive guidance document for all staff: 06.05.26.	
3	The registered provider must review the behaviour management tools in place specifically the IAMP and ICSP to ensure they contain relevant information and robust measures.	A risk management meeting was held on 24th February 2026, during which standardised templates for risk assessments, safeguarding and safety plans, SENs, monthly and daily risk assessments, AMPs, and ICSPs were formally reviewed and reassessed. All managers were provided with guidance on the effective implementation of control measures and on identifying additional, meaningful controls to strengthen risk management. The centre manager will circulate all revised templates and associated documentation to the staff team to ensure consistent understanding and implementation in practice. Time Scales: Risk / Behavioural Management Meeting: Completed. The PIC to share all revised templates and documentation with the centre team: 06.05.26.	Monthly risk review meetings will be conducted to support proactive risk management. Risk considerations are integrated into governance processes by the area manager monthly. Ongoing monitoring and internal audits are undertaken to ensure compliance and continuous improvement. Behavioural management practices will be reviewed monthly by the area manager, with a further quarterly review of behavioural management tools conducted by the regional director.

	The registered provider must review the significant event review group meeting to ensure these meetings support learning, identify trends and patterns which are used to support the development of best practice.	A new template has been developed and was introduced at the March 2026 Significant Event Review Group (SERG) meeting. This tool will support the identification of emerging trends and patterns, as well as the recognition and capture of best practice going forward. Time Scale: Information to evidence learning, support, trends and patterns identified from the SERG meetings will be captured more robustly with the new template: Completed.	The area managers and regional director will ensure that meeting minutes are accurately recorded, comprehensive, and robust in content. Prior to circulation, the area manager and regional director will verify that all information has been fully and factually documented. The centre manager will ensure that feedback from the Significant Event Review Group (SERG) is included as a standing agenda item at team meetings to promote shared learning and support the prevention of future incidents. In addition, the area manager will attend team meetings on a quarterly basis to ensure effective dissemination of information and to support a culture of shared learning and continuous improvement.
	The centre manager must review restrictive practices and ensure that they are assessed and reviewed in line with the National Standards for Children's Residential Care, 2018 (HIQA).	A full review of all current restrictive practices in use within the centre will be undertaken. This review will ensure that each restrictive practice is clearly documented, risk assessed, time-limited, and appropriately authorised in line with	The regional director will complete quarterly audits of restrictive practice records. The area manager will ensure monthly reviews are conducted to ensure restrictive practice is implemented in line with the National Standards of Residential

		organisational policy and HIQA standards. Any records identified as incomplete or lacking justification, review dates, or approval signatures will be updated without delay. Restrictive practices that are no longer necessary will be formally identified and discontinued, where safe and appropriate to do so. All staff will be briefed to ensure they understand the current approved restrictive practices in place and the associated protocols governing their use. Time Scales: Full review of current restrictive practices: 08.05.26. Update records factually and accurately: 08.05.26. Discuss restrictive practice at the team meeting to ensure that all staff understand their role in this process: 08.05.26.	Centres, 2018 (HIQA). Within the monthly governance and oversight checks, the area manager will: • Ensure restrictive practices are always linked to individual care plans and risk assessments. • Review them during key working sessions and multidisciplinary meetings to ensure necessity and proportionality. Where restrictive practices are identified as a concern, the regional director will escalate these matters to the human rights committee for review. The human rights committee convenes on a quarterly basis and is independently chaired by an external professional, ensuring objective oversight and governance.
	The registered provider must review the auditing mechanisms in place to ensure they are robust and fit for purpose and where actions have been identified as part of an audit that these are	A revised audit schedule has been implemented to ensure the service is subject to regular and systematic internal audits in line with recommended standards and best practice.	The auditing schedule will be reviewed and reassessed at monthly quality meetings to ensure its continued effectiveness. Centre governance will be included as a standing agenda item at these meetings,

	implemented and tracked to an outcome.	An enhanced approach to the review of quality data has been implemented through the establishment of a monthly quality day, chaired by the director of quality. This forum strengthens governance, oversight, and strategic quality improvement across the service. Monthly governance reports will be formally reviewed on a scheduled basis to ensure effective tracking, monitoring, and closure of actions over time. Clear reporting and escalation guidelines will also be issued to the centre manager to support the consistent implementation, monitoring, and completion of all identified actions. Time Scales: Auditing schedule: Completed and circulated. Desktop Quality Audit: 31.03.26. In person internal Quality audit: 30.04.26. Quality day chaired by Director of Quality: 06.05.26. Change to monthly Governance forms: 01.06.26. Reporting Guidelines will be sent to the Centre Manager: 13.05.26.	providing a structured forum for oversight. This additional layer of governance will enable the area manager to review progress and address any outstanding or unrectified actions in a timely and accountable manner.
6	The registered provider must review the	We are currently undertaking a full review	Embed continuous feedback loops

	current induction programme to ensure that it is robust and effective to support new staff members joining the organisation and takes account of the inexperience of staff team.	of the current induction programme, including content, duration, delivery methods, and alignment with regulatory requirements and organisational policies. The induction will assess whether the programme adequately supports new staff, particularly in key areas such as safeguarding, behaviour management, record keeping, and understanding roles and responsibilities. The revised induction programme to include: • A structured induction schedule • Mandatory training modules prior to or immediately after start • Clear learning objectives and expected competencies The induction programme is linked to the 6-month probationary period. The full induction will take 6 months. Evidence of this will be seen in supervision sessions and at the probationary check in at the 3 month and then 6-month mark.	• Gather feedback from new staff about the induction process. This will be done when the quality co-ordinator completes quality audits. • Use this feedback to continuously improve the programme. Regular audits of induction effectiveness • Review compliance and quality of delivery, not just completion. The area manager will provide monthly supervision to the centre manager, during which the induction process will be reviewed and discussed as staff progress through it. This will ensure appropriate oversight and ongoing monitoring of induction delivery within the centre. In addition, the induction process will be formally reviewed on a quarterly basis as part of the managers' meeting agenda to support continuous improvement and consistency of practice. The regional director will discuss the induction process with the area manager at their supervision.

		A staff survey (that included induction questions) has recently been circulated internally. The findings will be published by the quality director. Time Scales: Review of Induction process: 12.05.26. Minutes from supervisions and probationary meeting to be uploaded to the online system: Completed Staff survey findings: 01.06.26.	
	The centre manager must ensure that all training is up to date and in line with requirements outlined in the organisations policy.	The centre manager will conduct a full review of all staff training records to identify any gaps, overdue training, or non-compliance with organisational policy requirements. The centre manager will ensure the training matrix is fully accurate, up to date, and reflects all completed, in-progress, and outstanding training for each staff member. Any expired or overdue mandatory training will be prioritised and scheduled for immediate completion.	The training database has been transferred to a shared drive, with access provided to the area manager, regional director, quality coordinator, and quality director. The trainer in behaviour management has access to the training matrix and will monitor it on an ongoing basis to ensure that all staff training remains current. This oversight will help to prevent any training from expiring and ensure compliance with required standards is consistently maintained. The training matrix will be reviewed monthly to ensure that all staff training remains current and that no expiries or lapses occur. The area manager

		Time Scales Full review of all training: Completed Where there were gaps, the Centre Manager has identified these, and staff have been booked onto their mandatory training. 31.05.26.	will undertake a robust monthly inspection as part of the governance framework to ensure ongoing compliance, and quality assurance, are consistently met across the service.
	The centre manager must ensure that supervision is conducted in line with the organisation's policy to support development of the staff team.	All staff will receive supervision within a four- to six-week cycle. The centre manager will implement and maintain a formal supervision schedule with immediate effect to ensure all staff receive regular and timely supervision. Time Scales Supervision schedule: Completed	The regional director will provide monthly supervision to the area manager. This will include a structured review of governance findings, service performance, and supervision arrangements to ensure that all staff are receiving appropriate and effective supervision in line with organisational requirements. The quality coordinator will be responsible for leading and maintaining the quality assurance audit function across the service. The quality coordinator will analyse audit findings, identify areas for improvement, and produce detailed reports with clear recommendations and action plans. They will also monitor the implementation of corrective actions, track progress against

			agreed targets, and escalate any persistent areas of concern through the governance structure to ensure continuous quality improvement and regulatory compliance.