An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 083

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Rainbow Community Services**
Registered Capacity:	**Five Young People**
Type of Inspection:	**Announced**
Date of inspection:	**7th and 8th January 2026**
Registration Status:	**Registered from the 19th February 2026 to 19th of February 2029**
Inspection Team:	**Janice Ryan** **Ciara Nangle** **Justin Halley**
Date Report Issued:	**30/04/2026**

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1. Information about the inspection process

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

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 19th of February 2008. 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 with attached conditions condition from 19th February 2023 to the 19th February 2026, those conditions being;

- The improvement plan provided by the registered proprietor is implemented in full by December 2025 as stated in the plan, resulting in improved governance and a fully compliant centre.

- No more than three children are to be admitted to this centre at any one time, until such time as the Agency is satisfied as to the sustained implementation the centre's action plan as provided to the Agency.

The centre was registered to provide accommodation to five young people of all genders from age twelve to seventeen on admission. Their model of care was described as relationship based and trauma informed. There were three young people living in the centre at the time of the inspection.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2

This inspection was conducted to review the conditions, as outlined above, that were placed on the centre's registration by Tusla's National Registration Enforcement Panel (NREP) on the 01st October 2025.

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 9th February 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 report with a CAPA on the 20th February 2026. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this inspection were presented to the National Registration Enforcement Panel, (NREP) on the 4th of April 2025. Following review by the NREP it was deem that the centre was operating in line with its registration. However, the centre will remain under review with the NREP while incrementally increasing the capacity of service, initially to four young people. Following further inspection, consideration will be given to further increasing the capacity of the service, if appropriate.

As such it is the decision of the Child and Family Agency to register this centre, ID Number: 087 without attached conditions from the 19th of February 2026 to the 19th of February 2029 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. Within all these policies there were procedures for staff to follow to safeguard young people and protect them from all forms of abuse. These were recently reviewed in conjunction with an external agency in line with the centre's action plan submitted to NREP.

The centre had a child safeguarding statement (CSS) in place which identified any potential risks to children as required by the Children's First Guidelines, 2017. This had been recently reviewed and approved by the compliance unit within Tusla. Staff in interview demonstrated an awareness of this statement however, they were unable to identify risks contained within this. The inspectors found that two young people were supported to watch a video online in relation child safeguarding with one other young person due to review this in the coming weeks.

The acting centre manager was the designated liaison person (DLP) for the centre however, within interviews with the staff team they were unclear of the DLP role and their responsibilities and further improvement is required. Staff demonstrated within interviews how to report a child protection and welfare concern through Tusla's portal and what type of instances should be reported. From a sample of significant event reports reviewed it was evident that the staff team was reporting concerns appropriately. A child protection register was in place; however, it was not up to date or always recorded sequentially and pages were blank in between each entry. This had been signed off by the Director of Services (DOS).

On review of the centre's training register and personnel files the inspectors found that all staff members had completed mandatory training in Children's First, updated training in the organisations child safeguarding policy and protecting young people in

digital environments. Evidence of their completion was maintained on the staff members personnel files. Training in child sexual exploitation and mandated persons had been completed by the majority of the staff team, and this must be completed by all team members.

Garda vetting was on file for all staff members however, the inspectors found that for three staff members garda vetting had not been reviewed in line with the organisation's policy of two years and this must be rectified.

The inspectors found that there was an increased focus on safeguarding of young people among the staff team. This was evident in interviews with staff and management and from handover records, supervision records and team meeting minutes reviewed. In interview with staff members, they were clear on lone working policy and how this had been updated to reflect the current practice in the centre and safeguard staff and young people.

At the time of inspection, bullying was not presenting as an issue within the centre. There were two recent admissions to the centre and the dynamic among three young people was positive and the inspectors observed positive interactions among the young people. All three young people met with the inspectors and spoke positively about living in the centre, their relationships with staff members and being supported when concerns arose. All young people confirmed they were happy there and that they felt safe.

One young person had a range of safeguarding plans in place which included safety plans, risk assessment and behaviour support plans for the management of concerns around their mobile phone and other areas of risks. These plans had been agreed with all professionals and the young person's phone was subject to regular checks to manage internet and social media access. The young person was also consulted in relation to these plans, and it was clear that their voice was considered. However, the inspectors found that the plans on file reviewed by inspectors were not always up to date with the current measures described by the staff team. On review of the young person's placement plan the inspectors found that the placement goals and measures to meet these goals required more goal orientated steps to guide the staff team to equip the young person to understand areas of vulnerabilities' and how to keep themselves safe.

The inspectors found that work was undertaken with the young people in relation to specific areas however, this was opportunity led and was at times in response to a

concern that arose. When work was completed, it was of good quality, and it was evident that the young people were comfortable in discussing issues with the staff team. However, there did not appear to be proactive planning of key working for the young people in line with the goals of the young person's placement plan. Improvement is required to ensure that work is planned for in relation to young people's needs to support them develop life skills to safeguard themselves in the community.

In interview staff had a good understanding of young people's needs and for two young people who were recently admitted their vulnerabilities appeared low within the current environment. Two young people had full access to their mobile phone and were observed using this in the home with one young person engaging in online gaming platforms. In discussions with the staff team and management the inspectors found that they were not able to identify the possibility of an emerging online risk among this group of young people, nor had they taken into account the previous known risks and behaviours for one young person who was living in the centre for a period of two years and further development in this area is required.

Staff in interview were clear how to make a protected disclosure should they need and the organisation had a policy in place for staff to follow.

Overall, the inspectors found that the organisation had made substantial progress on implementing the action plan submitted to NREP and improvements had been made in providing safe care and support to the young people. However, further strengthening is required as the inspectors found that centre's ability to effectively assess and plan for emerging risk was not robust. It was apparent following the recent admission of two young people who presented with low level needs to centre that consideration had been given on admission to the mix of young people and their needs. However, given the known risks associated with the current young people ongoing consideration was not evident within documents reviewed on how these risks could potentially impact the group.

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

Actions required

- The centre manager must ensure that all staff have up to date Garda vetting in line with the organisation's policy.
- The centre manager must ensure that key working is identified and completed with all young people in line with their placement plan goals.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

As mentioned above the registered provider submitted an action plan to NREP to strengthen the governance and leadership in the centre and organisation. As part of this plan recruitment of three additional posts for the organisation was agreed. These positions were a business support staff member to support the director of services (DOS), a workforce planning and development manager and a quality assurance manager. Two staff members had commenced in post with the quality assurance manager due to commence in their position at the end of January. The inspectors could not determine whether this change to the organisational management structure was effective as it still had not been fully realised. The registered provider must ensure that the organisational organogram is updated and that the identified

governance arrangements and structures clearly set out the lines of authority and accountability in the centre and that these are adhered to at all management levels.

On review of the staffing information sheet submitted as part of this inspection the inspectors found that the internal management structure was appropriate to the size and function of the centre. The centre manager was in an acting post as recruitment was ongoing for a new centre manager. The DOS confirmed that this was an interim measure and advised that a new manager had been recruited in recent weeks. However, this manager had not been accepted by the ACIMS at the time of this inspection due them not meeting the criteria outlined in the Staffing levels & Qualifications for Registrations of Children's Residential Centres (Part VIII, Child Care Act) 1991 guidance. Management training had been sourced and was due to commence this month however, consideration needs to be given to who attends this training in the absence of a full-time permanent manager. Should this position be fulfilled in the coming weeks, a period of implementation is required to support a stable management structure. A new deputy manager had commenced in early October 2025 and there was two full time social care leaders, one part time social care leader and four social care workers. The inspectors found that the rostering pattern in place was sufficient to support safe and effective care. However, should the condition be removed and the centre resume operating at full capacity the staffing levels would not be sufficient to meet the staffing requirements set out in the centre's purpose and function. The centre was utilising one relief staff member to support the day-to-day rostering practices.

The inspectors found that since the previous inspection in February 2025 and following the engagement with NREP that the governance mechanisms in place were not effective in providing safe and effective care. The DOS advised that only one audit had taken place since the previous inspection and this had been completed by an external company. The inspectors found that although the DOS was regularly in telephone contact with the acting centre manager and was visiting the centre on a regular basis, they could not determine what level of governance and oversight was in place from the DOS for the review of centre and young people's records. The acting centre manager confirmed that a twice weekly written handover was provided to the DOS which gave an update on the day-to-day operation of the centre and DOS feedback at times was recorded within. A sample of care planning and behaviour management records including placement plans, risk assessments, safety plans and behaviour support plans were reviewed by inspectors. Inspectors found that measures identified within these plans were at times robust, but this was inconsistent. The inspectors found that while documents were being signed off from

the acting centre manager and the DOS the deficits within these documents were not being identified.

The inspectors were informed that the organisation was in the process of moving all paper files to a new online system as agreed within the action plan however, this was due to be completed in September 2025 but had been delayed. It was anticipated that this would be completed in the next two weeks. The inspectors recommend that with the appointment of new quality assurance manager the registered provider must ensure that an effective auditing mechanism is developed that is aligned to the National Standards for Residential Centre, 2018 (HIQA) that ensures effective governance and oversight of the service as current mechanisms in place were not effective.

The DOS confirmed that the external company had commenced working with the organisation since October 2025 and were visiting the service on a monthly basis however, there were no minutes of these meetings available. The DOS advised their role was to provide oversight and advice to the organisation and support the evaluation, development, and implementation of a quality and safety management system in line with the regulations and standards. The DOS confirmed that their initial focus included the review of the current leadership and governance arrangements for the organisation and to review the action plan submitted to NREP and that a Theme 5 audit would be completed. They were tendered for a period of 36 months with the first nine months concentrating on developing and supporting the management and staff team with the implementation of these new changes and systems. Senior management meetings took place on a monthly basis, and discussions took place around the operation of the organisation including recruitment, staff updates, and feedback in relation to this new project. The inspectors could not determine the impact of this external service on the governance and quality of care provided in the centre as the changes were still in their infancy.

A review of the organisations policies and procedures was undertaken in conjunction with an external consultancy company. Policies reviewed were safeguarding and child protection policy, safe practice and lone working policy, code of behaviour policy, disciplinary rules and behaviour policy, supervision policy and incident reporting and notification of significant event policy. The inspectors found that these were in line with regulatory requirements taking account of the national standards and guidelines. A new online training programme for staff had been implemented to support staff learning and development. The acting centre manager reported that this allowed for effective oversight of the staff teams knowledge and understanding of

the organisation's policies and procedures. The inspectors found that the staff team had engaged with parents/guardians of all young people to inform them of changes to policies and procedures as agreed within the action plan.

Team meetings had been scheduled to occur on a monthly meetings however, these did not always progress and attendance at times was poor. The acting centre manager confirmed that the frequency of these meetings had been reviewed and that they now took place fortnightly and mandatory attendance was required by the staff team with the first meeting taking place following this inspection. A sample of previous team meetings were reviewed; however, records were brief which made it difficult for inspectors to determine what was discussed and how learning was being developed across the team. The inspectors noted that policies were discussed and this was corroborated in interview with one staff member.

The inspector reviewed the centre's training register and found that all staff members had completed training in the organisations risk management framework. The inspectors found that while the risk management framework was being implemented in the centre from a review of documentation it was evident that not all staff members or management were proficient in identifying emerging risk and further development is required. As mentioned above under Standard 3.1 the inspectors found that when a risk was identified this was risk assessed and measures put in place to mitigate against it was robust. However, in interviews the staff team and management found it difficult to identify where potential risks could arise from known behaviours and inspectors did not see evidence of preventative work occurring to mitigate against these risks developing.

The inspectors found that although there was a continued focus on ensuring good safeguarding measures were in place the practical steps to be taken to manage emerging risk required further development to ensure a risk culture is established and maintained in the centre which promotes safe and effective and safe care for the young people.

A new supervision template had been developed and on the most supervision was being completed on a monthly basis as agreed in the action plan. The inspectors found that written records varied across supervisors and that at times there was good focus within supervision on development of practice, reflective practice, training and particularly focusing on child safeguarding. The inspectors found that further development of the staff team is required to support an effective risk and safeguarding culture. The inspectors found that the template had not been reviewed

since implementation to see if this was an effective mechanism. Supervision was not always signed by both parties and at times supervision contracts were not on files.

There was alternative management arrangements in place when the person in charge was absent. The acting centre manager had a delegation log in place which identified relevant tasks and responsibilities for each person. The acting centre manager must ensure that when duties are delegated to a relevant staff member that a written record is kept of when and to whom such duties are delegated to and the key decisions made.

In interview, with the DOS they confirmed that there was an appropriate service level agreement in place with the National Placement Team and updated reports were provided to them in relation to this arrangement.

Overall, the inspectors found that the organisation had made improvements however, there were still improvements required to support effective leadership, governance and management of the centre. While the inspectors found that the actions submitted to NREP had been substantially implemented there had not been sufficient time to assess the implementation of these changes on service provision and governance as these had not been fully realised or embedded in the centre and were still in infancy. Oversight and governance mechanisms were not robust as errors were not being identified within documentation and these continued to exist. Staff knowledge and understanding is sufficient particularly in relation to safeguarding however, development is needed around the identification of risk to support good safeguarding practices.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
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 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that an effective auditing mechanism is developed that is aligned to the National Standards for Residential Centre, 2018 (HIQA) which ensures effective governance and oversight of the service.
- The registered provider must ensure that there is ongoing development of the staff teams understanding of risk management supported by robust governance and oversight mechanisms.

3. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies to Ensure Issues Do Not Arise Again
3	The centre manager must ensure that all staff have up to date Garda vetting in line with the organisation's policy.	A full review of garda vetting records for all staff members was completed by the centre manager. This review confirmed that all staff engaged in the service hold valid garda vetting clearance. Inspectors identified that the centre's local Garda Vetting Policy referenced a two-year renewal timeframe, which was not aligned with updated organisational guidance extending the renewal period to a three-year cycle. The policy has since been reviewed and formally updated to reflect the current three-year vetting renewal period. This action was completed in February 2026.	A centralised Garda Vetting Compliance Tracker has been implemented and is maintained by the centre manager. Renewal dates are monitored in line with the updated three-year policy renewal period. Automated reminders will issue three months in advance of renewal due dates. Any future policy or legislative updates will be reviewed through the organisation's policy governance framework to ensure local procedures remain aligned with national and organisational requirements.

	The centre manager must ensure that key working is identified and completed with all young people in line with their placement plan goals.	All young people have an allocated and identified key worker. A review of outstanding key-working sessions has been undertaken by centre manager. Required key working sessions have commenced and are due to be completed by 31/03/2026). Adherence to the key working schedule will be overseen by the centre manager. Key working implementation was reinforced at a staff meeting held on 11th February 2026. Placement plan refresher training will be delivered in-house to the staff team by the director of services on 04/03/2026. The newly appointed centre manager has received induction from the director of services regarding placement planning, goal tracking, and review processes.	A structured key working schedule has been implemented. Key working responsibilities are now monitored through: staff supervision and team meeting. Monthly file audits by the centre manager. SMART key-working objectives are embedded within the new electronic recording system. These will be reviewed in line with internal audits completed.
5	The registered provider must ensure that an effective auditing mechanism is	A comprehensive audit framework aligned to the National Standards for Children's	A Quality Assurance (QA) Manager will commence in role at the end of March

	developed that is aligned to the National Standards for Residential Centre, 2018 (HIQA) which ensures effective governance and oversight of the service.	Residential Centres, 2018 (HIQA) has been developed. The audit suite includes (but is not limited to): Care planning audits, safeguarding audits, risk management audits, governance compliance reviews. Quarterly audits have commenced, with findings documented and action plans implemented.	2026, and they will have organisational oversight of audit implementation. By March 2026 the QA Manager will monitor audit completion timelines, validate audit quality and track action plan completion. Where operational pressures impact local audit completion, the QA function will undertake audits directly to ensure governance continuity. Audit outcomes are escalated through senior management governance meetings and the organisational risk register.
	The registered provider must ensure that there is ongoing development of the staff teams understanding of risk management supported by robust governance and oversight mechanisms.	Bespoke risk management workshop has been commissioned through an external healthcare governance provider. Training includes: risk identification, risk assessment formulation, emerging risk analysis and incident response planning. This training is scheduled for delivery to all staff and management on the 3rd March 2026.	Risk Management is now embedded as a standing agenda item across governance structures, including: team meetings, staff supervision and senior management meetings. Monthly risk reviews are conducted through the Safeguarding & Risk Committee. All risk assessments are subject to

			scheduled review and sign-off by the centre manager. Learning from incidents and near-miss events is disseminated across the service via handover, team meetings, debriefs, supervisions to strengthen preventative safeguarding culture. Ongoing staff development is monitored through supervision, annual performance review, mandatory training requirements and as needed training identified.