An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 131

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Compass Family Services**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Unannounced**
Date of inspection:	**3rd, 4th, 5th March 2025**
Registration Status:	**Registered from 15th September 2023 to 15th September 2026**
Inspection Team:	**Linda Mc Guinness** **Lorna Wogan**
Date Report Issued:	**23rd June 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 on the 15th September 2017. At the time of this inspection the centre was in its third registration and was in year two of the cycle. The centre was registered without attached conditions from 15th of September 2023 to the 15th of September 2026.

The centre was registered to provide medium term care for four young people between the ages of thirteen and seventeen on admission. The centre's care approach was underpinned by the principles of social pedagogy with a focus on learning, teaching and providing consistency of care from key adults. A primary focus of the work with young people was informed and guided by the understanding of attachment patterns observed in young people. The staff members were referred to as adults and focused on the existing strengths of each young person and sought to develop their sense of internal control and self-efficacy. At the time of inspection, there were four young people living in the centre.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.3

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 7th 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 18th 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: 131 without attached conditions from the 15th of September 2023 to the 15th of September 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their wellbeing and personal development.

Inspectors found that there was effective planning and the young people received safe and effective care. There was evidence that each child had made progress at their own level. The organisation had developed a new information technology system and inspectors found that this was a great improvement to facilitate effective planning.

At the time of inspection there were up to date care plans on file for three of the young people and they were waiting on a care plan for the fourth following a recent statutory child in care review. The social worker confirmed to inspectors that it was waiting to be signed off and circulated. Inspectors found there were some gaps in respect of monthly reviews of placements of two young people before they turned thirteen years of age as required under the *National Policy in Relation to the Placement of Children Aged 12 Years and Under in the Care or Custody of the Health Service Executive*. Notwithstanding this, there was evidence that this was escalated to senior management and there was evidence of regular communication with each social work department and no deficits in planning were highlighted during inspection. Any delays in receipt of care plans resulted in an escalation within the social work department from senior managers in the service.

There was evidence that the centre manager and key workers met with the young people to ascertain their views and ensure that their voice was brought to child in care review meetings even where they chose not to attend. One young person who spoke to inspectors confirmed that they were able to bring their issues to their child in care review and that they received feedback on any decisions made at the meetings.

Key workers prepared progress reports in advance of the review meetings and inspectors found that strategy meetings took place between the centre and the social work departments if required. Two parents who spoke with inspectors confirmed that

they were very satisfied with the care being provided to their children and that they received regular updates from key members of the team and the centre manager. They confirmed that they were invited to participate in child in care review meetings and also that they were notified of recent staffing changes in the centre. One parent would like their child to be encouraged to engage in more activities outside the centre. Inspectors found that this was already built into placement planning and being discussed with the organisations' clinical psychologist to explore all options. The team made great efforts to include families in planning and to maintain or repair key relationships. All communication with families was detailed with any follow up action identified.

The inspectors found that placement plans for each of the young people were up to date and reflected the identified goals as set out in their care plans. There was evidence that these plans were regularly reviewed and updated as required. Staff interviewed by inspectors were clear how the placement plans were formulated and described the development of a monthly schedule to target key pieces of work. While records of individual work viewed by inspectors evidenced a focus on the placement plan goals, some pieces of work were carried over month on month with no evidence that attempts were made to have discussions with young people or analysis why this did not take place. Inspectors recommend that all efforts to engage young people in key working are recorded.

Placement planning was discussed at regional managers meetings. There was an effective case management system in place which evidenced oversight of placement plans and individual work. Inspectors found that staff members were being held accountable for work assigned to them and there was an expectation of an equal distribution of tasks among the team. Inspectors found that key workers advocated effectively for the young people at team meetings and other staff forums.

Inspectors spoke with the young people in placement and reviewed questionnaires completed by them. It was evident that, in general, young people were very happy living in the centre, and that the adults helped them and cared about them. There was evidence that potential negative peer dynamic was addressed and responded to promptly with risk assessments and strategy meetings.

In support of a positive group dynamic the team completed a neurodiversity project directly with young people and there was evidence that young people engaged well and that there were positive outcomes from this proactive work. The team were also

provided with training targeted to support them to understand and meet needs of young people with specific presentations/diagnoses.
The allocated social workers for all young people commented on the high quality of care being provided and stated that it was *'an excellent service'* and *'an example of a best practice in residential care'*. These sentiments were echoed by the court appointed Guardians ad Litem (GALs) for two young people who also commented on the trusting relationships between them and the adults caring for them.

Assessments took place or were planned to determine needs and identify required specialist supports. Inspectors found that the young people were referred to or linked in with appropriate specialist services in line with their care plans such as play therapy and other psychological supports. Monthly planning meetings were held with the psychologist to direct and support the work of the team for all young people. Two young people received direct support from the organisations' clinical psychologist and placement plans viewed by inspectors included guidance from them to support the team in their work.

Inspectors found that the team also worked closely with the young people's schools to support their placements and identify any additional supports required. One young person was involved in preparing an individual plan to bring to their new school to help them get to know them and support their transition to second level education.

From review of centre records, inspection interviews and feedback from external professionals, inspectors found good evidence of collaborative working. Records reviewed showed details of effective communication between the team and supervising social work departments to facilitate all aspects of planning. Social workers confirmed that they received copies of a variety of monthly documents including placement plans, progress reports, individual absence management and support plans as well as therapeutic plans and safety plans if required. Regular feedback from external professionals indicated they were satisfied the centre was meeting the needs of the children placed there.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 2.2**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- None identified

Regulation 5: Care Practices and Operational Policies

Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Inspectors found that management and team meetings, internal systems governance reports, placement plans, and progress reports all evidenced the review and oversight of the quality and safety of care being provided. Notwithstanding this, some existing policies such as those relating to complaints, governance and supervision were not being fully implemented and this was not highlighted through the centre's own governance systems. In addition, inspectors found that the suite of policies and procedures were due for review in July 2024, and this had not been undertaken to date.

At the time of last inspection in September 2023 there were effective systems in place to monitor the quality and safety of care in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA). The findings during this inspection indicated that the centre had experienced a period of instability due to some staff and management changes and that this resulted in deficits in the planned schedule for undertaking compliance audits.

The person assigned as regional services manager was reassigned to other necessary duties during 2024 and the auditing and oversight responsibility was shared between the regional manager and the head of service across the year. Inspectors found that since then, there were deficits in auditing to assess compliance and determine what improvements, supports and resources were required to improve the service. Across 2024, there was evidence that only one full theme and two individual standards from the National Standards for Children's Residential Centres 2018, HIQA were audited. Of the audits that were completed there was a clear link between these, and the national standards and any corrective actions required were implemented in a timely manner. However, other deficits relating to practices such as supervision and appraisals, significant event review, implementation of some policies and procedures, and the recording, management and monitoring of complaints were not highlighted or identified for action.

At the time of inspection, the organisation had undergone some recent restructuring of the governance and management structure with the appointment of a second regional residential services manager. The previous residential service manager was appointed to this role and held direct responsibility for this service to facilitate oversight and assessment of the quality of care. It was hoped that this would address the resource issues and ensure effective auditing to assess compliance with national standards.

Inspectors found that the newly appointed centre manager received a comprehensive induction into their new role and had a clear understanding of their role and responsibilities. At the time of the inspection the focus of the new manager was to familiarise themselves with the staff and young people.

Inspectors found several instances where management responsibilities and tasks were delegated to staff outside of their job description and level of responsibility such as governance reports, supervision of staff, oversight of records. The organisations' governance policy stated that '*the residential services manager may from time-to-time delegate certain management tasks to the deputy residential services manager or house staff*" however, inspectors found that this was a regular and long-standing practice and not just from time to time as stated. This practice of regular downward delegation must be reviewed at all levels across the organisation to ensure that assigned responsibilities are in line with job description, level of position, experience and competency each person holds.

The centre manager and deputy manager were primarily based in an offsite office. They generally visited the centre for a few hours on week days, sometimes to attend handover and to meet staff members and young people. They also had access to centre records and reviewed these remotely. There was evidence that the recently appointed centre manager was spending more time in the house to get to know young people and the team. To ensure robust governance and oversight inspectors recommend that an increased management presence is maintained in the centre. Inspectors found that the external line managers had not visited the centre in line with the policy which stated they would visit at least monthly. Additionally, in the absence of auditing in line with policy there were insufficient records to show what tasks senior managers attended to or what advice, direction and support was provided during their visits to the centre. Organisational policy set out the process for reviewing serious incidents at a dedicated significant event review group however, this was not taking place in line with policy and the regional manager who previously held responsibility for this centre had highlighted this as an issue that needed to be addressed. This issue was also referenced a number of times at management meetings but did not result in corrective action.

A review of regional and senior management meetings evidenced some discussions on the safety and quality of the care and support provided to the young people.

Inspectors found that there were deficits in the recording, management and oversight of complaints. The registers and young peoples care records were not an accurate source of information and often the process of managing and investigating the complaint to conclusion was not recorded. On occasion the incorrect conclusion was documented on the record.

Despite being clearly set out in policy, there was limited evidence of discussions at regional managers meetings or senior managers meetings about complaints. There was no auditing of compliance with the requirements of national standards relating to management of complaints and it was not evident that complaints of all levels were regularly monitored, reviewed and acted on in line with organisational policy.

Inspectors found that an annual review of compliance/service improvement plan was prepared by the residential service manager for the year 2023 to 2024. This was based on a comprehensive analysis of the centre's compliance with the themes of the National Standards for Children's Residential Centres, 2018 (HIQA) and reports/ actions arising from Tusla alternative care inspection and monitoring inspections of the centre. This report was comprehensive and reported on areas of good practice

and identified some actions for attention. There was evidence that all actions were completed or in the process of being addressed and were discussed with the service manager through their supervision with their line manager.

The annual review of compliance/service improvement plan for 2024 to 2025 was provided to inspectors. While there was evidence of review and follow up of previous goals and new goals were established for 2025, as mentioned previously, only very limited auditing of the standards took place across 2024, so some issues highlighted during this inspection were not targeted for action in the coming year.

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 5.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must ensure that the quality and safety of care is assessed and reviewed in accordance with the requirements of relevant regulations and National Standards for Children's Residential Centres, 2018 (HIQA).
- The registered proprietor must ensure that policies and procedures are reviewed and updated within the scheduled timeframes and that implementation of these is subject to oversight and monitoring.
- The registered proprietor must ensure that the practice of routine downward delegation for management tasks is reviewed.
- The registered proprietor must ensure that that there is effective oversight of the recording, management and learning from review of complaints.

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.

Inspectors found that at the time of inspection there was a committed staff team caring for the young people. There was one recent vacancy, and recruitment was underway to fill that position. All those interviewed by inspectors confirmed they received induction training and were provided with a written job description. They had a clear understanding of their roles and responsibilities. Despite some recent changes, there were clear lines of authority and accountability within the organisation and staff interviewed stated that the residential service manager and newly appointed regional residential service manager were supportive and accessible to them. There was evidence that changes in staffing and management were handled sensitively taking account the impact on young people who had long standing relationships with key people. Inspectors found that there were three staff on shift at all times to support the varied plans of young people and efforts were made to have a fourth at key busy times.

Inspectors found evidence that the new service manager was qualified and experienced and was settling into their position with the support of the regional manager.

There were procedures in place to protect staff and to minimise any risk to their safety including training in a recognised behaviour management programme, individual support plans, de-briefing following incidents, group supervision, team supervision in the model of care and an effective on-call system. There was evidence that staff familiarised themselves with policies and procedures during their induction and staff interviewed stated they periodically reviewed policies at team meetings. The service manager must ensure that where policies are reviewed at team meetings this is reflected in the team meeting records.

Inspectors found that while there was a policy relating to probation this was limited in its scope and did not set out the length of probation period, how performance was assessed or how feedback and support was to be communicated to care staff. It did

not properly set out the process to ensure candidates employed were suitable for the position they held.

There was evidence of probation discussions with some staff members in their regular supervision but not for others, and a clear process relating to probation periods and expectations of staff and management was not evident. The policy relating to probation was limited in that it stated *there would be 'dialogue between the manager and employee with regard to performance, conduct, attendance and any other issues and that issues may also be addressed formally by way of a probation review meeting'.* The policy and procedure must be reviewed to ensure that all employees are clear on the process and how issues arising are to be addressed, managed and followed up. There should be dedicated probation meetings that are explicitly recorded and signed by both parties.

Inspectors found there was a good team morale at the time of inspection and that the care staff were committed to the young people, and they stated they were confident to challenge a colleague's practice. It was clear that they felt supported in their work through team supervision by the clinical psychologist and that this contributed to progress young people were making in their placements. The previous manager addressed any potential difficulties in an open and transparent manner and there was evidence that they were both supportive and challenging in addressing issues. Those interviewed stated they received adequate training, were confident in their practice and they reported that they were encouraged to exercise their professional judgment providing examples to inspectors.

From review of training records and inspection interviews inspectors found evidence that the organisation provided formal training and development opportunities for managers and care staff.

Regular team meetings took place however inspectors found that on occasion there was poor attendance. This was highlighted at a recent meeting by the centre manager at that time. Records of meetings evidenced updates for young people, clinical guidance, good initial review of significant events and discussions relating to behaviour management and key working schedules. While care staff and members of the management team described a culture of learning and reflective practice within the centre inspectors found that improvements were required to evidence this in centre records and handover meetings. More detail was required to ensure that care staff who were not present were appraised of learning from the day-to-day reflection of care practice and approaches to care in line with the model of care.

The centre had a supervision policy which stated that all staff members were individually supervised by the service manager every six weeks. As mentioned previously this was frequently delegated to others. Supervisee training was to be provided upon commencement of employment however some delays were highlighted during regular internal systems audits by the recently departed deputy residential service manager.

Inspectors reviewed samples of seven supervision records that included the supervision of the residential service manager and the former deputy manager and found that the frequency of supervision was not in line with centre policy. The internal systems governance reports completed during 2024 regularly highlighted this as an issue of non-compliance however it remained an issue requiring attention at the time of inspection. Individual staff had a supervision contract however the frequency of supervision was not set out and several contracts or supervision sessions were not signed by both parties as required. Where it was taking place regularly with some of the team, there was a set agenda, and both the supervisor and supervisee brought items for discussion and there were some examples of sessions that were comprehensive and detailed. All care staff must receive professional individual supervision in line with policy.

There was a comprehensive policy and process for formally appraising care staff members' performance on an annual basis. Inspectors found that this was not being implemented in practice, and this was not highlighted by senior managers as part of their oversight of the service.

The organisation had good support systems in place to manage the impact of working in the centre with a strong emphasis on self-care and staff health and wellbeing. A working group and staff survey was established to determine how the team felt they could best be supported. Staff interviewed confirmed there were effective supports in place to assist with their well-being including supportive management and employee assistance programmes. Additional supports identified included team clinical supervision and team consultation relating to the model of care as discussed previously.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
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 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must ensure that the probation policy is reviewed and that dedicated probation meetings take place that are explicitly recorded on the personnel file and signed by both parties.
- The registered proprietor must ensure that all care staff receive individual professional supervision in line with policy.
- The registered proprietor must ensure that all care staff receive a formal annual appraisal of their work and that this is recorded on their personnel file.

4. Corrective Actions and Preventive Actions (CAPA)

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	None identified		
5	The registered proprietor must ensure that the quality and safety of care is assessed and reviewed in accordance with the requirements of relevant regulations and National Standards for Children's Residential Centres, 2018 (HIQA).	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

	The registered proprietor must ensure that policies and procedures are reviewed and updated within the scheduled timeframes and that implementation of these is subject to oversight and monitoring.	A full suite of organisational policies and procedures was implemented in Q3 2023. This review is now being prioritised, with all overdue policies to be reviewed and updated by Q3 2025, led by the head of services. Updated policies will be reissued with revised review dates and version control.	inform quality improvement planning for 2026. A policy review group will be established by June 2025, comprising members of the senior management team. The purpose of this group is to provide a dedicated organisational space for the ongoing oversight, coordination, and planning of policy and procedure reviews, in line with best practice and regulatory expectations. The group will ensure that: • Policies are reviewed in accordance with the organisational schedule • Upcoming review dates are monitored • Any required updates due to changes in legislation, guidance, or practice are identified in a timely manner

	The registered proprietor must ensure that the practice of routine downward delegation for management tasks is reviewed.	The practice of downward delegation was formally reviewed at a senior management governance meeting on 11 March 2025, with clearly defined management responsibilities agreed in line with each role's function. A written summary of these role-specific responsibilities has been shared with individual service managers to ensure consistency of practice. As of March 2025, the centre manager holds full oversight and responsibility for the monthly service systems audit, and the centre management team now retain responsibility for the supervision of all full-time staff.	The regional manager meets with the centre manager and deputy manager as part of established bi-monthly service governance meetings, where the delegation of core management responsibilities is reviewed and monitored. Any changes to delegation practices are discussed at these meetings and must align with agreed role responsibilities. Oversight of delegation practice across services is supported through the organisation's monthly senior management governance meetings, where emerging themes or inconsistencies can be addressed at a strategic level.
	The registered proprietor must ensure that there that there is effective oversight of the recording, management and learning from review of complaints.	The current approach to complaint management and oversight has been reviewed by the head of services and regional managers as part of the organisation's governance review in April	Oversight of complaints is now a standing item at bi-monthly service governance meetings between the regional manager and centre manager. All complaints are also reviewed at

		2025. The centre manager is responsible for ensuring that all complaints are recorded, responded to, and closed in line with the organisation's policy. The regional manager now reviews all complaints at bi-monthly service governance meetings to ensure appropriate follow-up and closure. A review of all complaints logged since January 2024 will be completed by 31 May 2025 to ensure all documentation is complete, appropriately closed, and any required actions have been implemented.	monthly senior management governance meetings to identify trends, track learning outcomes, and ensure follow-through. Where learning is identified, actions are agreed and recorded in the centre's team meeting minutes and supervision records to ensure feedback loops are closed. The head of services will retain oversight of this governance structure and ensure that learning from complaints is embedded into service development and staff practice.
6	The registered proprietor must ensure that the probation policy is reviewed and that dedicated probation meetings take place that are explicitly recorded on the personnel file and signed by both parties.	A comprehensive probation policy will be developed by 31 May 2025, outlining the probation period, key review points, and documentation requirements, led by the head of services. Once finalised, the policy will be circulated to all managers with guidance on implementation and timeframes.	Implementation of the new policy will be monitored by regional managers through existing bi-monthly service governance meetings, where probation processes will be reviewed as part of operational oversight. The head of services will review the effectiveness of the policy and its implementation as part of ongoing governance planning, with updates

	The registered proprietor must ensure that all care staff receive individual professional supervision in line with policy.	An immediate supervision audit was completed in April 2025 by the centre manager and regional manager, which identified gaps in recorded supervision and missed sessions. All staff now have an assigned and suitably qualified supervisor. A supervision schedule has been developed for each team, outlining dates for all remaining sessions in 2025. This schedule has been shared with relevant supervisors and managers. Outstanding supervisions are being prioritised for completion, with follow-up led by the regional manager.	discussed at senior management governance meetings. Annual supervision schedules are now required across all services and will be reviewed and updated each January. Supervision compliance is reviewed at bi-monthly service governance meetings, where the regional manager confirms that supervisions are taking place as scheduled and documentation is complete. Where supervision falls behind schedule, the issue is escalated to senior management for follow-up and an action plan is agreed. The head of services maintains oversight through existing governance processes and will review patterns of non-compliance, where applicable, as part of ongoing quality assurance.

	The registered proprietor must ensure that all care staff receive a formal annual appraisal of their work and tis is recorded on their personnel file.	An immediate audit of appraisal records was completed in April 2025 by the centre manager and regional residential services manager, identifying staff requiring priority appraisals. A 2025 appraisal schedule has been developed and implemented by the centre manager, with target dates assigned for each staff member. The completion of appraisals is reviewed during bi-monthly service governance meetings between the centre manager and regional manager to ensure timely follow-up and documentation. All completed appraisals are stored on the relevant personnel file in accordance with policy.	A formal annual appraisal schedule is now required across all services and will be reviewed each January to ensure it is up to date and aligned with staffing changes. Compliance with appraisal completion is monitored during bi-monthly service governance meetings as part of routine operational oversight. Where appraisals are not completed within the scheduled timeframe, the issue is escalated to senior management, and an action plan is agreed to address delays. The head of services maintains oversight through the governance framework to ensure appraisals are embedded into practice and consistently completed across services.