An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 179

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Orchard Residential Care Ltd**
Registered Capacity:	**Two young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**17th & 18th February 2026**
Registration Status:	**Registered from 07th October 2023 to 07th October 2026**
Inspection Team:	**Janice Ryan** **Justin Halley**
Date Report Issued:	**27th of May 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 07th of October 2020. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from 07th October 2023 to 07th October 2026.

The centre was registered as a dual occupancy service and provided medium term care for two young people from age thirteen to seventeen years on admission. The model of care was built on a strengths-based approach and was informed by attachment theory and resilience theory. 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. The approach was trauma informed and staff received training to understand the impact of trauma on child development. There were two 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
6: Responsive Workforce	6.1

This inspection occurred due to an escalation being received from the National Placement Team (NPT) by ACIMS following the occurrence of a serious significant event in the centre. The inspectors reviewed a sample of centre and young person's records between the period of September 2025 to February 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 23rd 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 report with a CAPA on the 03rd April 2026, and this was deemed not to be satisfactory to address the identified shortfalls. A second CAPA was provided to inspectors on the 29th April 2026. This was deemed to be satisfactory and the inspection service received evidence to address the issues identified.

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: 179 without attached conditions from the 07th October 2023 to 07th October 2026 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 centre had policies and procedures in place to protect children from all forms of abuse and neglect. The inspectors found that these policies were in line with the National Standards for Children's Residential Centres, 2018 (HIQA) and Children's First: National Guidance for the Protection and Welfare of Children, 2017 and were reviewed at a recent staff team meeting in January 2026 alongside the child safeguarding statement (CSS).

There was a CSS in place, and this had been approved by the Tusla's child safeguarding statement compliance unit in March 2025. The centre manager was the designated liaison person (DLP) for the centre, and they were trained in this role. In interview with the staff team, the inspectors found that the staff struggled to identify the risks within the CSS. The inspectors found from a review of the team meetings that this had been discussed on numerous occasions over the past six months with the staff team. Further development is required to ensure that all staff members understand the importance of this statement in safeguarding all young people.

Inspectors reviewed the centre's training register and a sample of personnel files for staff members. On review of same they found that one staff member had not completed training in Tusla e-learning module: Introduction to Children First, 2017 which had been identified by the quality assurance officer in a recent audit completed in the centre in January 2026. Additionally, not all staff members had completed training in Tusla's child sexual exploitation, and this must be completed.

The centre manager maintained a list of mandated persons. Staff in interview had a good understanding of their statutory role as a mandated person and their responsibility to report disclosures and concerns via the Tusla portal.

The inspectors reviewed various significant events leading up to the escalated concern involving two young people. The inspectors reviewed the child protection register and a sample of child protection concerns and found that these had been reported in line with Children's First guidelines. The inspectors found that there was an ongoing dynamic in recent months between two young people which included bullying behaviours, a serious incident involving physical assault, access to in-appropriate online content and targeting of staff. The centre had an anti-bullying policy in place. Within this policy it identified that a personalised behaviour management plan may be put in place should this behaviour occur. The inspectors reviewed a range of documentation to ensure safe care of both young people which included safety plans, individual crisis support plans (ICSP), individual absent management plans (IAMPs) and risk assessments and found that there was no behaviour management plan in place to manage this concern among both young people as identified within this policy.

From a review of documentation and in interview with staff the inspectors found that not all areas of vulnerability had been identified or assessed for both young people. There was one safety plan in place to manage the known dynamic among both young people however, on review of same the inspectors found that the risk was not correctly identified, it was not robust and it required more specific measures to guide staff in ensuring that both young people were safeguarded.

Risk assessments were not in place for a number of additional concerns identified by inspectors, including the risk of access to online content, phone access, bullying or targeting of staff. A risk assessment was in place in relation to both young people living together and on review of same the inspectors found this assessment required more individual measures for each young person. While it noted that both young people would be shadowed by staff, the inspectors found that while observing staff in the centre and from interviewing staff that the current measure in place was that one staff member would be in the area with a young person while the other young person was in a different room alone. Due to these measures the inspectors found that the young person could access online platforms unsupervised in the communal areas of the house and this risk had not been considered.

Where risk assessments were in place the inspectors found that these required strengthening. Control measures identified within these assessments were too broad and did not contain practical steps or measures to guide the team to manage this behaviour. These assessments were risk rated however, the inspectors found that these ratings were not in line with the seriousness of risks known for both young

people. Additionally, where clinical advice was provided this was not always detailed within young people's risk assessments or plans thus it was not clear what interventions were guiding staffs practice. Within team meeting minutes discussions had taken place around these interventions and that plans should be updated to reflect this advice. However, inspectors found that only certain aspects of the plans were updated and not the whole document which resulted in contradictory information within and these were signed off by centre management.

Inspectors found that individual work was being completed with each young person on their own vulnerabilities and areas of concerns on a regular basis. On review of the young people's meeting minutes the inspectors found that good discussions took place with the young people to address issues that presented for e.g. bullying and respecting each other boundaries. While staff were clear during interviews about how they were managing the risks among both young people, the inspectors found that there was limited recorded evidence on file of work undertaken to build or repair relationships and support them move forward in their placement. This must be reviewed as the current plan in place to keep both young people separate is not sustainable in the long term nor it is conducive to a healthy living arrangement for both young people.

On further review of individual work, the inspectors found that issues raised by young people in relation to peer dynamic, staffing in the centre, and other aspects of service were being recorded as individual work and were not being notified or reported as a complaint in line with the organisations policy. The centre manager must review this to ensure that all complaints are reported in line with the policy.

The centre engaged regularly with professionals when incidences of concern arose, and the staff team provided regular updates including documentation to the relevant social work department. The inspectors found that where responses were not received in relation to requests for professional meetings to take place these were escalated through the appropriate channels within the organisation. In interview, with both social workers they confirmed that there was good lines of communication between them and the centre.

The centre had a policy on reporting protected disclosures however, inspectors found that staff in interview were not aware or clear of same and this must be reviewed with the staff team.

The inspectors spoke with assigned social workers for both young people who confirmed that they were satisfied with the measures the centre had in place to keep both young people safe. They both confirmed that the centre was providing good quality care to both young people.

Inspectors met with both young people with one young person giving them a tour of the home. Both young people told inspectors how this was their home and that they were well cared for and that they liked living there.

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 the staff team understand the Child Safeguarding Statement to support the safeguarding of all young people in the centre.
- The centre manager must review all risks assessments in place and ensure that all risks are identified, assessed, and contain specific steps to support the staff team and young people in managing their behaviour.
- The centre manager must ensure that all complaints are reported in line with the policy on complaints.
- The centre manager must ensure that all staff are aware of and understand the organisation's policy on protected disclosures.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Workforce planning was the responsibility of the director of service (DOS) who had managerial oversight of all services operated by the organisation. The organisation discussed workforce planning in a range of forums including weekly recruitment meetings, team meetings, and monthly governance reports. Recruitment meeting minutes were reviewed and inspectors found that discussions took place around the number of staff required for each centre. On review of these meetings, it was clear that there were deficits in staffing across all centres within the organisation. The minutes were brief and did not provide details of what discussions took place around plans to recruit additional staffing and what controls were required should staffing levels not improve.

On review of the staffing information sheet submitted to the inspectors as part of this inspection the centre was operating with one social care manager, one full time deputy social care manager, one social care leader and five social care workers. The inspectors found that the centre had gone through a difficult period over the past six months with seven staff members leaving for a variety of reasons. During the course of inspection, the inspectors were informed by the young people that certain staff members were due to leave the centre in the coming days however, within discussion with senior management while in the centre this information was not shared freely. The inspectors found that the centre manager was due to start a new post in a sister centre and a new manager was due to start in the coming days. The team leader advised that they would be moving to a sister centre also to start in a new post and at the time of inspection there was no identified person to fulfil this post.

The inspectors found that there was a new team in place who had limited experience in residential care and were in the early days of forming. In interview with both social workers, they all spoke of the centre having an experienced and competent staff team and were unaware of the changes that happened over the past six months. The inspectors spoke with two young people both of whom corroborated that staff were helpful with one young person stating that they were sad that staff were leaving.

The centre implemented a daily roster pattern of two sleep over shifts and one day shift with a varying start time dependent on the needs of the young people. On review of a sample of rosters the inspectors found that there were times that the centre was unable to fulfil a day shift and was supplementing the roster through offering additional shifts to staff members, staff from sister centres and external agency staff. There were three vacancies identified within the core team however, inspectors were advised that two staff members were onboarding and were due to start in the coming weeks. The centre manager advised the centre had one staff member from relief panel available to them however, over the past few months their availability had been limited.

The inspectors found at times staff members were completing back to back shifts totalling 48 hours which was not safe practice, and this had not been risk assessed. The centre manager explained in interview that the majority of these shifts had been completed while they were on annual leave and these had been organised amongst the staff team directly. This practice ceased on their return and had been discussed with the staff team in a recent team meeting. Supervision records reviewed by inspectors also found that this had also been discussed with some staff members as part of their supervision meeting.

The centre had an online system in which all personnel files were contained within. On review of same the inspectors found that not all documentation was up to date or contained on these files for e.g. curriculum vitae's, contracts, and qualification verification letters. The centre manager must review the staff personnel files to ensure they contain all relevant and up to date information.

The organisation had a policy for staff retention which included a list of staff incentives. The centre manager and staff team confirmed that there was a range of incentives available to them including, employee assistance programmes, external counselling if required and refer a colleague bonus. Within supervisions records and team meeting minutes the inspectors' found staff were supported to develop their practice and manage the impact of working in the centre.

The centre had an on-call policy in place. The on call was shared between different social care managers in the organisation. All staff interviewed were aware of the on call procedure.

The inspectors reviewed exit interviews for two staff who had resigned in recent months in which feedback was provided in relation to working in the centre and

working for the organisation. The registered provider must ensure that this feedback is used to support staff retention and wellbeing.

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 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that there is sufficient staffing in place to meet the needs of all young people in the centre.
- The registered provider and centre manager must ensure that all documentation is up to date and held on all staff personnel files.

4. 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 the staff team understand the Child Safeguarding Statement to support the safeguarding of all young people in the centre.	The centre manager will ensure that all staff are familiar with and fully understand the child safeguarding statement. This will be reinforced through discussion at a planned team meeting and further addressed on an individual basis during staff supervision sessions. Completion date: 30.04.2026. Time Scale: Discussion at Team Meeting: Completed 02.04.26. Centre Manager to address this at individual supervision sessions: Completed by: 30.04.26.	The child safeguarding statement will be reviewed quarterly in team meetings with the staff team. It will be also reviewed yearly by the regional director.
	The centre manager must review all risks assessments in place and ensure that all risks are identified, assessed, and contain specific steps to support the staff team and young people managing their behaviour.	Risk Management meeting took place on 24th February 2026, where the standardised templates for risk assessments, safeguarding (safety plans) plans, SENs, monthly risk assessments, daily risk assessments, AMPs and ICSPs were reassessed. All managers were advised on how to implement control	Risk assessments updated after incidents. Monthly SERG meetings to support learning. Ensure young person voice is included in planning, through the medium of young person meetings, individual work and key working. Young persons committee forum provides all young people an opportunity to have their voice heard.

		measures and identify additional controls which are meaningful. The centre manager to share all revised templates and documentation with the team. Time Scales: Risk Management Meeting: 24.02.26 Completed. The centre manager to share all revised templates and documentation with the centre team: 31.03.26 Completed.	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. Governance oversight from the area manager with clear goals and tasks.
	The centre manager must ensure that all complaints are reported in line with the organisations policy on complaints.	An audit of the complaints and SEN register shall take place for each young person to ensure that information is recorded accurately and factually and addressed appropriately. Ensure all staff understand the escalation of complaints and associated time frames in line with the organisational policy. At the young persons' meeting, the internal and external complaints processes will be explained to all young people. Time Scale: The auditing of each individual register will be completed: 11.05.26. At the house team meeting this was discussed and all staff were informed and	A monthly data analysis report is prepared by the quality auditor to systematically track complaints. This report will be reviewed by the regional director monthly to identify emerging trends, patterns, and areas requiring improvement. The register of logs will be discussed with the complaints officer monthly in their supervision. Complaints will be discussed with the centre manager at their supervision sessions with the area manager. The area manager will discuss complaints with the regional director at their weekly check-in meeting.

	The centre manager must ensure that all staff are aware of and understand the organisation's policy on protected disclosures.	reminded of the escalation processes and procedures: Completed. The centre manager will ensure that the staff are aware of and understand the organisational policy on the whistleblowing disclosure. The centre manager will discuss this with the team during a team meeting. Centre manager will speak to staff about this in their supervisions. This will be completed by the 31.05.2026. Time Scale: Centre Manager to hold a team meeting and go through the organisational policy on protected disclosures (whistleblowing): Completed. Centre manager will speak to staff about this in their supervisions: Completed by 31.05.26.	The whistling blowing disclosure policy will be reviewed at each 6 month juncture in team meetings with the staff team. The centre manager will complete spot-checks to be assured that the staff understand the protected disclosure policy.
6	The registered provider must ensure that there is sufficient staffing in place to meet the needs of all young people in the centre.	The registered provider will ensure the there is sufficient staff in place to meet the needs of the young people in the centre. Onboarding is taking place for staff members for this centre and a full staff complement will be in place from early May 2026. Staff members are being	Retention and recruitment initiatives are constantly being reviewed and refreshed to ensure the registered provider has sufficient staffing in place. Rolling advertisements both internally and externally are taking place. Attendance at various conferences such as the SCI

		recruited and start date timeline for two staff members are the 24th and 30th April and for the third staff member will be the 6th May 2026.	conference, visibility at universities is also planned before the college term finishes up. This will be occurring every year going forward.
	The registered provider and centre manager must ensure that all documentation is up to date and held on all staff personnel files.	A full audit of all staff files will be conducted against the requirements (Garda vetting, references, ID, qualifications). Any gaps or missing documentation will be updated and addressed. Compliance requirements will be discussed with the recruitment team regarding CVs vetting, references, ID, qualifications, verification of qualification. A standardised recruitment checklist has been introduced. (mandatory before start date). Time Scales Staff file audit: 15th May 2026. Discussion with recruitment and compliance checklist: Completed.	The human resource director along with the regional director and senior human resources manager will introduce a mandatory recruitment compliance checklist that must be fully completed and signed off before any candidate starts work. This should include: • Identity verification • Reference checks • Qualification verification (with evidence recorded) • Garda vetting / ACRO clearance confirmation (as applicable) • Training Records • Interview and selection records No offer of employment will progress to a start date until every section is verified and signed off by both recruitment, regional director or area manager.