



An Ghníomhaireacht um  
Leanaí agus an Teaghlach  
Child and Family Agency

## Alternative Care - Inspection and Monitoring Service

### Children's Residential Centre

**Centre ID number: 208**

**Year: 2025**

## Inspection Report

<b>Year:</b>	<b>2025</b>
<b>Name of Organisation:</b>	<b>Three Steps</b>
<b>Registered Capacity:</b>	<b>One young person</b>
<b>Type of Inspection:</b>	<b>Announced Inspection</b>
<b>Date of inspection:</b>	<b>26<sup>th</sup> and 27<sup>th</sup> of June 2025</b>
<b>Registration Status:</b>	<b>Registered from 16<sup>th</sup> September 2022 to 16<sup>th</sup> September 2025</b>
<b>Inspection Team:</b>	<b>Mark McGuire Sinead Diggin</b>
<b>Date Report Issued:</b>	<b>27<sup>th</sup> August 2025</b>

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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 16<sup>th</sup> of September 2022. At the time of this inspection the centre was in its first registration and was in year three of the cycle. During the cycle the centre moved premises to a new location. The centre was registered without attached conditions from the 16<sup>th</sup> of September 2022 to the 16<sup>th</sup> of September 2025.

The centre was registered as a single occupancy service for young people of all genders aged thirteen to seventeen upon admission. The model of care was described as attachment and trauma informed, rights focused and delivered through a person-centred approach. It aimed to foster therapeutic alliances within a structured home like environment. The care team was supported by experienced clinicians to assist in responding appropriately to the complex needs of young people. At the time of inspection there were no young people in placement. One young person had been discharged two weeks prior to the commencement of the inspection and a new admission was pending approval with the Tusla National Placement Team.

## 1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.5
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.1

The pre-inspection notification identified that standards 2.5, 3.1, and 5.4 would be examined during this process. However, due to the centre's staffing numbers and the subsequent impact, the remit of the inspection was expanded to include an examination of standard 6.1, which was explained to centre and senior management during the inspection process.

Inspectors looked closely at the experiences and progress of the young person who had recently been discharged from the centre. They considered the quality of work and the difference it made to the young person's life. They reviewed documentation, observed how professional staff worked with the young person and with each other,

and discussed the effectiveness of the care provided. Inspectors conducted interviews with relevant persons including senior management and staff, the allocated social worker and other relevant professionals. Wherever possible, inspectors consult with children and parents. In this inspection, feedback was also obtained from the young person who had recently been discharged from the centre through a completed questionnaire. Inspectors also considered how well the centre understood its own performance, how it was doing, and what improvement it could 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 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 24<sup>th</sup> of July 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 7<sup>th</sup> of August 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: 208 without attached conditions from the 16<sup>th</sup> of September 2022 to the 16<sup>th</sup> of September 2025 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 2.5 Each child experiences integrated care which is coordinated effectively within and between services.**

Inspectors found that there was evidence of regular and consistent communication between the centre staff team, the allocated aftercare worker, the young person's social worker and Guardian ad Litem (G.A.L), in relation to the discharge of the young person. Records indicated that planning had commenced back in 2024 prior to the placement ending, and that professionals remained in communication on a range of matters, including the young persons emotional wellbeing, behavioural presentation and emerging needs as they approached the age of leaving care.

Independent living skills and training opportunities were also a key focus during this time. The young person experienced a period of relative stability and progress in the latter stages of their placement which was supported by a reduction in high-risk behaviours. Inspectors also noted the significant emotional impact of a personal tragedy that the young person experienced towards the end of 2024. This event disrupted transition planning to some extent; however, it is of note that, while the young person exhibited an increase in presenting risks following the trauma, they did not revert to the more serious patterns of behaviour that had been evident earlier in the placement. During interviews with inspectors, the young person's social worker and G.A.L. attributed this to the strong working relationship and commitment of the care team to the young person.

Although a formal discharge plan had not been developed, inspectors found evidence that the centre had worked collaboratively with the social work department to implement a flexible and phased transition to the young person's follow-on accommodation. The young persons views were considered during this process, their preferences regarding contact, visits, and practical arrangement were taken into account. Records demonstrated that staff had maintained efforts to include the young person in aftercare planning, notwithstanding some difficulties in always engaging with the team and multi-disciplinary supports. Inspectors found that outreach support was offered post-discharge to assist the transition, and that staff facilitated visits to the receiving placement to promote continuity and support the young

person. Issues raised by the young person during the transition phase were responded to sensitively and in a timely manner.

The young person refused to take part in an exit interview that was offered to gather feedback from them post-discharge. Inspectors recommend that the centre make further efforts to complete an exit interview with the young person or to obtain feedback on their experience in a manner that is accessible and tailored to their communication style. For example, the young person completed a questionnaire as part of the inspection process to provide feedback rather than engaging in a meeting with inspectors. Gathering this feedback would support reflective practice and service development.

Inspectors were informed through interviews with staff and management of how the young person was provided with mementos of their placement in the form of photographs and gifts from the care team. They were also provided with practical supports to help them as they transition to semi-independence in the form of items such as a chest of drawers, a headboard, and other items of furniture for their new home. A thoughtful leaving party was also facilitated by the team which the young person expressed gratitude for with staff members preparing balloon displays, a cake and photo memories for them to keep affirming their time in care.

Inspectors found that a clear plan and policy was in place for the archiving of the young person records in line with Tusla’s requirements, and the files had been temporarily retained in the centre to facilitate a review by the inspection team. Inspectors were informed that an end of placement report was still required and the service manager committed to ensuring this was developed post inspection.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 5 Regulation 17</b>
<b>Regulation not met</b>	<b>None Identified</b>

<b>Compliance with standards</b>	
<b>Practices met the required standard</b>	<b>Standard 2.5</b>
<b>Practices met the required standard in some respects only</b>	<b>Not all standards under this theme were assessed</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

## **Actions required**

- No actions identified.

### **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 was found to have a suite of policies in place relating to child safeguarding such as policies on the identification and reporting of child protection concerns along with child sexual exploitation (CSE) as examples. The policy document also outlined relevant legislation, national policies and regulations that were adhered to as part of their child protection practices. There was a policy on bullying and staff were able to articulate the procedures relating to same, as well as the policy on harassment by staff. There were no current concerns in this regard. Staff also demonstrated awareness of policies relating to online safety. No policy was observed by inspectors relating to the management of risks associated with visitors to the centre and this should be developed by the service and included in the safeguarding policy suite.

Inspectors found that overall staff demonstrated a general awareness of child protection policies and procedures during interviews as part of the inspection; however, there were identified gaps in knowledge across key areas. In particular, some staff members were unfamiliar with the centre's policy on CSE and the associated internal and external reporting procedures. Inspectors recommend that centre management facilitate a comprehensive review of all child protection related policies with the care team, with particular attention to the CSE policy, to ensure consistent understanding and implementation across the service.

Inspectors saw evidence of good practice also of CSE concerns being responded to by the care team and reported to the social work department, along with targeted key work sessions to support the young person following such incidents. However, during the inspection, inspectors reviewed records and incident logs and found examples where CSE concerns should have been escalated for discussion with the social work department but were not. Additionally, there was evident confusion among staff regarding the expected procedures for reporting CSE related risks, including

alignment with the CSE response flow chart issued to providers by ACIMS in February 2025.

Despite the noted gaps, inspectors found that child protection and welfare concerns were being reported regularly, and that follow up with the social work was generally appropriate. A review of child protection and welfare report forms (CPWRFs) showed that the centre manager, who was the designated liaison person (DLP), maintained oversight and took active steps to ensure reports were progressed and status updates obtained from social work. These practices reflected a strong safeguarding ethos and a dedicated staff team who remained focused on the young persons welfare. There was clear evidence that the team worked consistently to support the young person through complex and high-risk periods, with continued emphasis on promoting their growth, development and emotional safety.

However, inspectors found that in some cases where there were multiple persons of concern, separate CPWRFs were not submitted as required. This practice could potentially impact the clarity and traceability of safeguarding notifications. Inspectors recommend that the centre retrospectively review these cases and liaise with the allocated social worker to determine whether additional reports are required.

In a separate matter, inspectors noted that a concern relating to an allegation against a staff member had not been formally reported by the DLP, despite the centre's internal policy clearly stating that all such concerns should be reported through the standard notification procedure. While the incident was documented in the DLP's decision log and had been discussed with the allocated social worker, it remains essential that the centre follows its own safeguarding protocols. Inspectors acknowledge that, notwithstanding the reporting omission, there was evidence of a robust and timely response to the allegation. Appropriate steps were taken to address the matter with the staff member concerned, and actions were in line with the centres internal HR and safeguarding frameworks. Oversight of this matter from senior management was also observed by inspectors in the care records. Nevertheless, centre management must ensure compliance with its own child protection policies relating the management of allegations against staff.

Inspectors also saw how the young person had experienced significant periods of vulnerability and risk. The care team remained committed to their care and safety and continued to provide consistent support throughout this time. It was clear for inspectors to see that the young person engaged well with staff on sensitive matters,

and key working records demonstrated attempts to help them develop insight, reflective capacity, and improved self-care strategies. This highlighted the presence of trusted relationships and an understanding of a trauma-informed approach to engagement by the team. Multiple therapeutic supports were also offered, however the young person refused to engage with these. Both the social worker and G.A.L. for the young person named to inspectors that the care team provided dedicated and consistent care throughout the placement and that they felt this directly impacted the reduction in high-risk behaviours towards the end of the placement.

Inspectors reviewed the centre's Child Safeguarding Statement (CSS) and found that while it was reviewed within the required two-year timeframe, it required further development to ensure it was fully understood and effectively implemented in practice. The CSS did not reflect recent changes in key personnel and did not adequately align with current guidance on risk-assessing CSE. Inspectors also noted that the printed copy of the CSS on display was not accessible due to excessively small text, limiting its visibility and impact. During interviews with inspectors, staff were familiar with the DLP and deputy DLP but demonstrated limited understanding of the specific risks outlined in the CSS. Staff themselves reported that a refresher would be beneficial in promoting a shared understanding of the CSS and safeguarding responsibilities. The CSS must be updated to reflect the current personnel and revised guidance on CSE, and a clearly legible version must be made available to promote accessibility and ensure compliance with Children First guidelines.

The CSS outlined that all incidents were to be subject to multidisciplinary, centre based post-incident review, with serious events escalated to a formal serious incident review (SIR) conducted at service management level. Inspectors found that only one SIR had taken place for the young person, despite several serious child protection concerns having occurred. Additionally, post-incident reviews were not consistently carried out following significant events, particularly those related to child protection concerns. This represented a missed opportunity for learning and reflective practice. The templates in use for incident review were found to be of good quality, and their full and consistent use is recommended, particularly for CPWRF related incidents along with complaints, where structured learning could further strengthen safeguarding practice. The service manager committed to reviewing this post inspection and implementing a more robust system for post incident review and to align the CSS with the revised system that is put in place.

Inspectors found that staff access to the Tusla portal for reporting child protection concerns was inconsistent. Some staff were found to be unclear whether access was provided through shared or individual accounts and were using personal email accounts in some instances to submit CPWRFs. This practice presents potential data protection and confidentiality risks. Inspectors advise that the centre review portal access arrangement to ensure a standardised and secure process is in place. In addition, the use of personal email addresses for submitting reports should be recorded in the centre’s risk register, with appropriate control measures identified, such as adherence to the staff code of conduct and confidentiality protocols. Greater clarity on access protocols will support improved oversight of submitted reports and promote accountability with the centre’s safeguarding system.

Inspectors found that all staff had completed the e-learning module on Children First and that the service also provided the care team with additional in-person child protection training with only one staff member awaiting this due to having only recently started their employment. However, inspectors noted significant gaps in other key areas of safeguarding training. According to the centres training log, only one staff member had completed CSE, despite CSE being a relevant and persistent concern in the centre. There were several gaps in safety intervention training and the service did not have mandated persons training as part of their core training curriculum. It is important that the staff team completed all of the core training required to support safeguarding practice in the centre.

The training log showed that additional training relating to safeguarding the young person was provided to the team with good participation seen in training on suicide intervention, drug awareness, as well as the trauma and attachment.

The centre did not maintain a list of mandated persons, and the current policy referenced mandated status in a vague and generalised manner. The policy stated that all staff were considered mandated persons “on the basis that they are on of the named professional categories e.g. social care worker registered with CORU (pending)”. This definition lacked specificity and failed to identify other professional roles employed within the centre who may also be deemed mandated persons. Inspectors recommend that a clear and up to date list of mandated persons be maintained and that the policy be revised to reflect the full range of professional roles working within the service.

Inspectors reviewed risk assessments and support documentation and found that individual areas of vulnerability for the young person were well documented. There

was evidence of multiple layers of planning in place, including behaviour support plans, situation management plans and risk management plans. Inspectors noted a marked reduction in high risk-behaviours towards the end of the young persons placement, which was a positive development. Despite experiencing a significant personal tragedy during their placement, they did not revert to previously observed levels of high-risk behaviour.

Communication with the social work department was generally strong with the social worker noting to inspectors that they felt they always knew what was happening and were kept well informed. Centre management, social work and the G.A.L noted to inspectors that weekly and sometimes bi-weekly strategy and safety planning meetings took place to address the young persons safeguarding concerns. However, inspectors found that strategy meetings were not consistently tracked through the recording of minutes or clearly outlined decisions and agreed actions. Inspectors recommend that the minutes of strategy meetings be documented and retained on file to ensure transparency and facilitate ongoing planning and accountability.

The centre had a protected disclosure policy in place, and inspectors found that staff were confident in describing its purpose and the appropriate channels for reporting concerns. This contributed positively to the safeguarding culture within the centre.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 5 Regulation 16</b>
<b>Regulation not met</b>	<b>None Identified</b>

<b>Compliance with standards</b>	
<b>Practices met the required standard</b>	<b>Not all standards under this theme were assessed</b>
<b>Practices met the required standard in some respects only</b>	<b>Standard 3.1</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

### **Actions required**

- Centre management must ensure that all staff are familiar with the centre’s child protection policies and procedures, including those relating to child sexual exploitation (CSE), and provide refresher training where gaps in knowledge have been identified.
- Centre management must retrospectively review all CPWRF submissions where multiple persons of concerns were involved and clarify with the

allocated social worker whether separate CPWRF and CSE notifications are required.

- The registered proprietor must update the child safeguarding statement (CSS) to reflect current personnel, designated roles (DLP and DDLP), CSE risks and any relevant organisational changes. A legible, accessible copy must be displayed prominently in the centre.
- Centre management must ensure that all significant incidents, particularly those involving safeguarding concerns or CPWRF's, are subject to centre-based post-incident review, with serious incident reviews (SIRs) conducted in accordance with the thresholds outlined in the CSS.
- Centre management must review staff access arrangements to the Tusla portal to ensure a standardised, secure, and accountable reporting process. The use of personal email addresses for report submission must be risk assessed, recorded in the centre risk register, and supported by clear control measures.
- Centre management must ensure that a policy is in place to address risks associated with visitors to the centre.
- Centre management must maintain an up-to-date list of mandated persons employed in the centre.
- Centre management must ensure that all strategy meetings are recorded with clear minutes that include decisions taken and actions agreed.

#### **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 the centre had some effective systems in place for review and oversight, with team meetings being used to support reflective practice and promote learning. Inspectors viewed minutes of team meetings and noted that complaints and significant events were regularly discussed. The significant event notification (SEN) template also contributed to learning through its focus on insight and follow up work. In additions inspectors found that centre management provided high quality commentary and oversight across incident and SEN records, supporting a culture of accountability and improvement in the centre.

While these internal structures demonstrated a commitment to learning, as previously mentioned in this report, inspectors found the Serious Incident Review's (SIRs) had not been carried out consistently. Only one SIR had been completed for the young person despite other serious incidents occurring that would have met the threshold for a SIR according to the centres CSS. These, along with the post-incident reviews previously mentioned, needed to be consistently used to ensure thorough review of care practice and to help inform improvements and achieve better outcomes for children.

Inspectors reviewed a sample of internal audits and found them to be clearly structured, well aligned to the National Standards for Children's Residential Centres (HIQA, 2018), and triangulated through file review, staff interviews and direct observation. The corrective and preventative action (CAPA) process linked to the audits was found to be well maintained, with actions tracked to completion. The processes supported on going quality assurance within the centre to assess the safety and quality of care provided. However, inspectors noted that the centre would benefit from adopting a high-risk based approach to auditing along with the planned themed audits that take place. For example, during a period of increased risk for the young person, a targeted Theme 3 audit on child protection and safeguarding could have highlighted shortfalls in child protection reporting practices noted in this report. Introducing risk-responsive audits would allow the service to proactively address emerging concerns and improve compliance.

In relation to complaints, inspectors found that the centre maintained a comprehensive log which allowed for clear tracking of individual complaints, the actions taken in response, and the level at which each complaint was reviewed and resolved. Complaints forms were well completed and showed that the young persons concerns were taken seriously and responded to in a supportive and child centred manner. However, inspectors note that in some instances the complainant's response to the outcome – whether acceptance, disagreement or refusal to engage – was not recorded on the complaint form or in the log. Inspectors recommend that this step be consistently implemented to evidence closure and to support reflective learning. Staff demonstrated mixed understanding of the complaint's procedure and the Tusla Tell Us process. While this may be in part due to staff inexperience, a policy review and refresher is recommended to ensure that all staff are confident in the complaints process, including roles involved.

Despite these gaps, it was positive to see that the young person had used the Tusla Tell Us platform to raise concerns with external professionals. Also, the notification

of complaints through the SEN portal was well evidenced and the young persons social worker noted to inspectors being well informed of complaints and their resolution.

Inspectors reviewed the centres annual compliance report and found it to be a comprehensive and professionally presented document. Notably, the report included feedback from external professionals, contributing to a multi-perspective assessment of the centres service quality. The document highlighted several areas of concern, including staffing shortfalls and associated regulatory non-compliance. However, the improvement plan section and the report had not been utilised to outline actions in response to these findings. In addition, the centres existing audit and reporting systems had not identified deficits in the completion and submission of CPWRFs previously noted in this report. Inspectors recommend that the oversight of safeguarding notifications be strengthened, and that the improvement plan section of the compliance report be fully used to drive corrective action.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 5 Regulation 6</b>
<b>Regulation not met</b>	<b>None Identified</b>

<b>Compliance with standards</b>	
<b>Practices met the required standard</b>	<b>Not all standards under this theme were assessed</b>
<b>Practices met the required standard in some respects only</b>	<b>Standard 5.4</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

### **Actions required**

- Centre management must utilise the improvement plan section of the annual compliance report to document actions taken in response to identified shortfall and areas of regulatory non-compliance.

## 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.

At the time of inspection, the centre employed one social care manager, four full time social care workers, and one part-time social care worker. This staffing arrangement did not meet the Child Care (Placement of Children in Residential Care) Regulations, 1995, and the minimum requirement set out in the ACIMS Regulatory Notice: Minimum Staffing Levels and Qualifications in Children’s Residential Centres, which stipulates the minimum number of staff that are required to provide 24-hour care in registered centres.

Inspectors were informed by both centre and senior management that workforce planning meetings had taken place along with several recruitment drives, and that staffing was a standing agenda item for review. However, at the time of inspection, there were no candidates actively progressing through the recruitment process to address the staffing shortfall. While a loose plan was outlined to move a social care leader and a full-time social care worker from another centre within the organisation, no definitive timeline had been established, and this proposal would still fall short of meeting the required staffing compliment.

Inspectors also noted that the centre had previously included the roles of deputy social care manager and social care leaders as part of its governance and operational structure. Senior management advised that the deputy social care manager would not be reinstated following the departure of the person who previously occupied this role. Given the presence of the role in the centres safeguarding and management procedures, inspectors recommend that all policies and governance documents referencing this role be reviewed and revised to ensure alignment with current structures.

Inspectors were advised during the inspection that a referral for a new young person was under consideration in consultation with the Tusla National Placement Team. Both centre and senior management acknowledged that the current staffing deficits must be addressed to ensure that a young person could be safely cared for. Inspectors found that the current team did not meet the required number, nor did it provide a

sufficient mix of experience, competencies, and skill to meet the assessed and potential needs of a new young person.

As a result of the non-compliance identified with staffing under the Child Care (Placement of Children in Residential Care) Regulations, 1995, the matter was escalated to ACIMS senior management, who subsequently wrote to the registered proprietor. A formal request was issued for an action plan detailing how the centre intended to provide a compliant staffing model in line with the centre’s regulatory requirements, capable of delivering 24-hour care. A response was received on 8<sup>th</sup> July 2025 which outlined a plan to bolster the staffing numbers in the centre, along with a targeted recruitment drive for additional social care personnel, prior to a new young person moving into the centre, which was deemed to be a satisfactory response by ACIMS.

<b>Compliance with Regulation</b>	
<b>Regulation met</b>	<b>Regulation 6</b>
<b>Regulation not met</b>	<b>Regulation 7</b>

<b>Compliance with standards</b>	
<b>Practices met the required standard</b>	<b>Not all standards under this theme were assessed</b>
<b>Practices met the required standard in some respects only</b>	<b>Standard 6.1</b>
<b>Practices did not meet the required standard</b>	<b>Not all standards under this theme were assessed</b>

### **Actions required**

- The registered proprietor must ensure that staffing levels are maintained in advance of the admission of a new young person, in accordance with the plan submitted to ACIMS.

## 4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	<p>Centre management must ensure that all staff are familiar with the centre's child protection policies and procedures, including those relating to child sexual exploitation (CSE), and provide refresher training where gaps in knowledge have been identified.</p> <p>Centre management must retrospectively review all CPWRF submissions where multiple persons of concerns were involved and clarify with the allocated social worker whether separate CPWRF and CSE notifications are required.</p> <p>The registered proprietor must update the child safeguarding statement (CSS) to reflect current personnel, designated roles (DLP and DDLP), CSE risks and any relevant organisational changes. A</p>	<p>Centre Manager has completed revision training of the centre's child protection policies and procedures, including those relating to child sexual exploitation during team meeting.</p> <p>Completed: 30/07/2025</p> <p>Centre Manager reviewed all CPWRF's submitted for previous resident and discussed same with allocated social worker, who advised it was not necessary to resubmit separate notifications.</p> <p>Completed: 06/08/2025</p> <p>Centre Manager has displayed a legible, accessible copy of the centre's child safeguarding statement in the office in Lima House.</p>	<p>Centre Manager will ensure policy testing is completed more regularly during team meetings and supervisions to ensure all staff are familiar with policies and procedures.</p> <p>Commencing: 13/08/2025</p> <p>New Director of Care and service management are reviewing the process of monthly child protection meetings to identify if submissions have been correctly submitted.</p> <p>Commencing: 13/08/2025 at Service Management meeting.</p> <p>New Director of Care and service management are completing full review of organisational structures and relevant policies and procedures.</p>

	<p>legible, accessible copy must be displayed prominently in the centre.</p> <p>Centre management must ensure that all significant incidents, particularly those involving safeguarding concerns or CPWRF's, are subject to centre-based post-incident review, with serious incident reviews (SIRs) conducted in accordance with the thresholds outlined in the CSS.</p> <p>Centre management must review staff access arrangements to the Tusla portal to ensure a standardised, secure, and accountable reporting process. The use of personal email addresses for report</p>	<p>Completed:30/07/2025</p> <p>New Director of Care and service management have made a commitment to update the child safeguarding statement to reflect current personnel, designated roles (DLP and DDLP), CSE risks and any relevant organisational changes by the 22/08/2025.</p> <p>Going forward Centre Manager will ensure that post incident reviews are completed with care team members following all incidents that involve safeguarding concerns that meet the threshold.</p> <p>Commencing: 30/07/2025</p> <p>Centre Manager has reviewed and added access arrangements to Tusla portal to the centre risk register that includes risks associated with a breach of GDPR and confidentiality.</p>	<p>Commencing: 13/08/2025 at Service Management meeting.</p> <p>New Director of Care and service management are completing full review of organisational structures and relevant policies and procedures. Post incident review forms will be reviewed in full at this time.</p> <p>Commencing: 13/08/2025 at Service Management meeting.</p> <p>New Director of Care and service management are completing full review of organisational structures and relevant policies and procedures including policy on staff access arrangements to Tusla portal.</p>
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	<p>submission must be risk assessed, recorded in the centre risk register, and supported by clear control measures.</p> <p>Centre management must ensure that a policy is in place to address risks associated with visitors to the centre. Centre management must maintain an up-to-date list of mandated persons employed in the centre.</p> <p>Centre management must ensure that all strategy meetings are recorded with clear minutes that include decisions taken and actions agreed.</p>	<p>Completed: 06/08/2025</p> <p>Centre Manager will discuss the current visitor's policy with senior management to ensure the updated policy includes risks associated with visitors to centres. Centre Manager has developed a list of all mandated persons employed in the centre and this will be maintained in the office on the notice board.</p> <p>Completed: 06/08/2025</p> <p>Centre management will ensure that all strategy meetings that take place are recorded and include decisions and actions.</p> <p>Completed: 30/07/2025</p>	<p>Commencing: 13/08/2025 at Service Management meeting.</p> <p>New Director of Care and service management are completing full review of organisational structures and relevant policies and procedures including the policy to address risks with visitors to the centre.</p> <p>Commencing: 13/08/2025 at Service Management meeting.</p> <p>Service management to develop a recording tool to ensure meetings are recorded with clear minutes that include decisions taken and actions agreed.</p> <p>Commencing: 13/08/2025 at Service Management meeting.</p>
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5	Centre management must utilise the improvement plan section of the annual compliance report to document actions taken in response to identified shortfall and areas of regulatory non-compliance.	Centre Manager has utilised the improvement plan section of the annual compliance report to document actions taken in response to identified shortfall and areas of regulatory non-compliance.  Completed: 06/08/2025	Senior Management will review the annual compliance report as part of their governance and oversight of the centre and ensure actions taken in response to shortfalls are captured.  Commenced: 14/08/2025
6	The registered proprietor must ensure that staffing levels are maintained in advance of the admission of a new young person, in accordance with the plan submitted to ACIMS.	As per response to ACIMS management on the 8/7/2025, plans have been put in place to address staffing levels prior to new admission.  Completed: 08/07/2025  Deputy centre managers position has also been approved for the centre and advertised internally and externally.  Completed:06/08/2025	Human Resources have implemented an ongoing recruitment drive to ensure staffing deficits across the service are filled.  Currently commenced.