An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 230

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Solis GMC Children's Services**
Registered Capacity:	**Twelve Young People**
Type of Inspection:	**Unannounced**
Date of inspection:	**10th and 11th February 2026**
Registration Status:	**Registered from 26th October 2023 to the 26th October 2026**
Inspection Team:	**Lorna Wogan** **Linda McGuinness**
Date Report Issued:	**08th of June 2026**

Contents

1. Information about the inspection process

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

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 26th October 2023. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from the 26th October 2023 to the 26th October 2026.

The centre provided accommodation for separated children who were seeking international protection (SCSIP). Referrals were received from Tusla's SCSIP social work department who determined the suitability of referrals to the service. In December 2024 the centre applied to Tusla's alternative care inspection and monitoring service to expand the service provision from eight to twelve young people with the addition of four single-use bedrooms contained within a separate apartment beside the previously registered premises. Consequently, the centre was registered as a multi-occupancy centre for twelve young people, male only, aged sixteen to seventeen years on admission.

The objective of the centre was to provide a place of safety and support for the young people. The aims of the centre were to provide a high-quality standard of care that was responsive to the individual needs of young people, within a child-centred, supportive and safe environment. The individualised programme of care aimed to assist young people to develop physically, socially, morally, emotionally, cognitively and educationally. The promotion of positive and effective relationships was underpinned by staff training with an overall focus on developing resilience. There were 12 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
4: Health, Wellbeing and Development	4.1
6: Responsive Workforce	6.4
8: Use of Information	8.1

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 17th April 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 30th of April 2026. 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: 230 without attached conditions from the 26th October 2023 to the 26th October 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 10: Health Care
Regulation 12: Provision of Food and Cooking Facilities

Theme 4: Health, Wellbeing and Development

Standard 4.1 The health, wellbeing and development of each child is promoted, protected and improved.

The centre had developed a written policy on health and wellbeing however the inspectors found that aspects of this policy were not aligned to the purpose of the centre for example references to maintaining young people where possible with their previous educational placement and general practitioner. Regarding centre practice, the inspectors found that the staff promoted the health, safety, development and welfare of each young person placed in the centre. The social workers interviewed by the inspectors confirmed they were satisfied the staff were good advocates for the young people and promoted their development and improved the quality of their lives. The inspectors met with four young people and received written feedback from five young people through inspection questionnaires. Four young people were recently admitted to the centre within a two-week period prior to the inspection. The young people interviewed by the inspectors expressed satisfaction with the care they received. They expressed their gratitude for the support provided to them from both the centre managers and staff members. The inspection questionnaires completed by the young people in their first language indicated they were satisfied with their care.

There was evidence that the managers and staff cooperated with other service providers and other statutory and non-statutory agencies to promote their health and development for example the local youth service, youth mental health services, community centres and the education training board. A record of contacts with external agencies and support services was maintained on the young people's individual care records. Apart from the recently admitted residents all the young people were engaged in education. Most of the young people attended a secondary in the nearest large town, two of the young people continued their second level education online and one young person was engaged in a local education training programme.

There were several young people who did not have a Tusla section 5 placement plan on their care records. The relevant social worker stated they would forward them to

the centre. There were four young people recently admitted to the centre and the allocated workers had not yet developed their placement plans. They confirmed they would develop the plan in consultation with each young person. The centre staff had developed placement plans for the young people which set out the goals of their placement including their health, wellbeing and development needs.

Key staff were appointed to support the young people and develop and implement their centre placement plans. The inspectors reviewed a sample of care records and found that individual work was completed with the young people in relation to self-care, wellbeing, online safety and safe relationships and awareness of risk. Guidance and advice were provided by key staff for some young people in relation to consent and Irish law however further work was required to be undertaken around other sensitive topics which will be outlined further in this report.

There was evidence that the young people were provided with adequate quantities of food of their choice that was prepared mostly by themselves in their apartments. The young people were supported and facilitated by the team to purchase their groceries and plan their own menus in line with their cultural and religious beliefs and food preferences. Planning for meals and grocery requirements was undertaken at the house meetings and with the young people in individual work with the care staff. While the young people cooked and shared meals in their individual apartments staff offered them opportunities to share meals with the team members at weekends or on special occasions such as birthdays or festive times of the year. Where young people required assistance with cooking and menu planning this support was provided by the staff team. Several of the young people showed the inspectors their apartments and bedrooms that were observed to be clean, comfortable and nicely furnished and met their needs for privacy as required. The young people receive a range of allowances including incentive money to ensure their living spaces were maintained in good condition. The social workers were satisfied that monies the young people received was sufficient and appropriate and staff supported the young people to manage their finances and budget appropriately in preparation for leaving the centre.

In most instances the centre managers received minimal information about the health status of the young people referred to the centre or of their past medical history. All young people were referred to the Tusla health screening service for separated children over sixteen years of age. However, there were significant delays in getting these appointments. In the meantime, the staff team secured medical appointments locally. The managers and key staff members provided help and support to ensure the young people secured medical cards where they were eligible or

get access to a doctor while awaiting their personal public service number (PPSN). Access to dental and ophthalmic services were sought privately if required while they awaited their medical cards and PPSN. Translators were sought for medical appointments. There was evidence that staff members were sensitive to the welfare needs of the young people and their anxiety where their application for international protection was denied. The staff were alert to trauma responses and mental health concerns and sought referrals to appropriate services where required and actively followed up on these appointments. Safety plans were developed and on file for some young people as required and these were forwarded to the allocated Tusla workers. There was no evidence of bullying in the centre, and the staff and managers interviewed stated the young people got on well together. The centre managers undertook their own risk assessments in relation to who shared rooms and apartments based on information on referral, which was often very limited. They also used their experience and knowledge as a provider of separated children's services to match the young people in apartments and shared rooms.

The young people were supported and encouraged to develop skills in preparation for leaving care. Some of the young people were supported to complete their driver theory test, undertake driving lessons and apply for their driving test. Through the placement planning process and through daily and weekly routines the team helped the young people to develop the necessary life and social skills and establish the appropriate support networks for when they leave the centre at eighteen. One young person was leaving the centre at the time of the inspection, and they spoke to the inspectors about how they were supported by the team as they moved on from the centre. The inspectors observed the staff members marking the young person's birthday with gifts that the young person was delighted to show to the inspectors. The warm and caring connection between key staff members and the young person was evident as they said their goodbyes.

The young people were encouraged and supported to continue with their education and training. Staff encouraged the young people to develop curriculum vitae and apply for parttime jobs in the community. They had free time away from the centre and were encouraged to exercise autonomy in decision-making, managing money and making appointments. They were encouraged to plan their routines on a weekly basis and were offered opportunities to engage in community activities based on their interests such as going to the gym, boxing classes, football or walks with the team members in the local area.

The centre had secured an English tutor to support the young people to develop proficiency in the English language. There had been some delays in this tutor commencing their work in the centre however they had commenced classes at the centre at the time of the inspection. Inspectors observed the young people coming to the communal area of the centre for their language class. The centre must continue to support all the young people with English classes from the point of their admission.

Compliance with regulations	
Regulation met	**Regulation 10** **Regulation 12**
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 4.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The service co-ordinator in collaboration with the centre manager must review the centre policies to ensure they are aligned to its purpose and function.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

The staffing complement for the centre was sixteen care staff, three social care leaders, the centre manager and deputy manager. The centre manager had a relevant qualification and was sufficiently experienced to undertake the role. There were three care staff vacancies at the time of the inspection however there was an active recruitment process underway. The service coordinator was the external line manager for the centre. There were four care staff on duty daily, and three social care

leaders covered shifts across the duty roster and at weekends. Two staff provided live night cover, one live night staff in each apartment block and two sleep over staff. Staff morale was reported as low in the previous year due to staffing deficits and staff turnover. At the time of the inspection the team had stabilised, and the team were working collaboratively.

Staff personnel files were reviewed to ensure that staff qualifications were in line with the Tusla alternative care inspection and monitoring service protocol for the registration of SCSIP centres. The inspectors found that the centre had the required number of staff with a social care or relevant qualification. The inspectors found that some staff who were appointed as support workers were identified as social care workers on their contracts and on the job descriptions on file. The registered proprietor must ensure that job descriptions and employment contracts accurately reflect the staff members role in the centre either as social care worker, residential care worker or support worker.

The centre had written policies to support induction training and staff training. The inspectors reviewed the systems in place to evidence that staff undertook mandatory training and that continuous professional development was provided to staff to deliver child-centred, safe and effective care and support to the young people. There was evidence that staff had completed their mandatory training and staff members confirmed they were supported and facilitated to attend mandatory and additional training. Induction training was evidenced on the staff records. Training certificates evidenced mandatory training completed. The social care leader confirmed they received specific induction into their internal leadership role. Staff members also completed additional training relevant to the needs of the cohort of young people they cared for. They received training on trauma informed care, child sexual exploitation, harmful cultural practices, diversity awareness and suicide awareness training. Managers were encouraged and facilitated to further develop their management and training skills. Specific training needs associated with the presentation of one young person was identified and was being explored at the time of the inspection. The deputy manager had also facilitated training for the team based on their knowledge and skills. Managers were provided with training to undertake their staff supervision role.

Staff training was also evidenced and recorded on the centre managers monthly governance reports and further commented on in the external managers oversight of these reports. Where gaps in training were identified training was evidenced as facilitated or scheduled as required. New improved systems were implemented to

monitor and track staff training in February 2026. A colour coded system was used on the training dataset to evidence staff training in date, out of date or scheduled.

Staff training was also discussed at management meetings. Staff training for the months ahead were identified in areas such as child sexual exploitation, first aid and behaviour management core training and refresher training. The meeting records also evidenced planned training in their model of care and report writing in the months ahead. There was evidence that the service co-ordinator requested managers to identify future training needs for the team. The staff supervision process also incorporated the identification and review of staff training needs.

For some of the young people who resided in the centre for over twelve months the inspectors found limited individual work in areas such as sexual development, healthy relationships and sexuality. Some staff informed inspectors they would not feel confident to undertake this work. The inspectors noted there were limited resources available in the centre to guide staff and undertake this work. In addition, the inspectors found there were limited resources or guidance documents to guide staff to develop a structured leaving care programme for the young people. The managers must ensure that resources and training for staff members is sourced to build their knowledge, skills and competencies to undertake specific work with the young people in placement. The inspectors advise that where health information is being sourced online it must be from a reliable source. Centre records evidenced that earlier in the year staff members struggled to support some young people who presented with behaviours that challenge. The centre had access to a clinical psychologist who had previously provided training to the team. To further improve and develop competencies within the team, aligned to the cohort of young people in placement, specific workshops and more regular clinical support should be built into the staff training and development programme.

Compliance with regulations	
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 6.4**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must ensure that job descriptions and employment contracts accurately reflect the staff members role in the centre either as social care worker, residential care worker or support worker.
- The service coordinator and the centre manager must ensure that resources and access to health education programmes is made available for staff members to build their knowledge, skills and competencies to undertake specific work aligned to the needs of young people in placement.
- The service coordinator must ensure that clinical support and guidance is built into the staff training and development programme.

Regulation 17: Records

Theme 8: Use of Information

Standard 8.1 Information is used to plan, manage and deliver child-centred, safe and effective care and support.

Overall, the inspectors found that this standard required improvements in some aspects. There were structured systems in place that ensured information was recorded, shared appropriately to inform decision making and promote improvements to the service. This was evidenced in the daily logs, handover meetings, team meetings, management meetings, centre managers monthly governance reports, debrief meeting record, health and safety meetings and staff exit interviews. Team meetings were well attended and staff found them to be good forums for sharing information within the team. The inspectors found there was a system in place for undertaking a quarterly assessment of the centres compliance with the National Standard for Children's Residential Centres (HIQA) 2018. There was evidence that deficits or gaps in compliance were actioned or in process of being actioned. These compliance audits focussed mainly on records and recording practices to evidence compliance and required improvement in terms of including commentary on the quality of the practice in the centre. The service coordinator completed a monthly deficit report following completion of the monthly governance report by the centre manager however it was not evident from these reports that deficits identified were addressed. In addition, deficits reports were not signed or dated and a quality auditors notes submitted to the inspectors was not signed or dated to evidence who took the notes.

At the time of the inspection the service coordinator had drafted an annual compliance report for one part of the service where eight young people resided, and this draft report was made available to the inspectors. The service coordinator informed the inspectors that a separate annual compliance report was currently being drafted for the additional registered accommodation that provided four other placements as requested by the director of services. The inspectors recommend that the annual compliance report for the centre must encompass the entire centre as the accommodation is registered as one entity for twelve young people and is managed under the one single management and team structure. The draft copy of the annual compliance report outlined the centres compliance with the National Standard for Children's Residential Centres (HIQA) 2018 and set out the objectives of the quality improvement plan (QIP) for 2026. The inspectors found that the draft annual compliance plan required improvements as aspects of the QIP were too broad and did not specify how identified gaps in compliance will be specifically addressed. Additionally, the report did not identify how the centre met its own objectives and implemented its own policies and procedures throughout the year or outline the improvements in service provision throughout the previous year.

The inspectors reviewed the young people's care records that were maintained in an individual main file and monthly folders. Overall, there was evidence of poor oversight of the files and their content, the placement planning documents were found to be cumbersome, and information was difficult to track across the various files and folders. The inspectors recommend that the service managers review how they store and manage the young people's records. Individual monthly folders were kept for each young person thus tracking of individual work and individual work schedules over a period of months was challenging. This in part was due to the monthly folders being stored securely in another location in the premises due to the number of files and the constraints on space in the staff office. This resulted in them being less accessible to managers for tracking, monitoring and oversight purposes. The inspectors found several individual key work schedules that were signed off by the manager however there was limited or no evidence on the individual work schedule that the planned individual work was completed. Sections of several placement plan templates were incomplete. There was no evidence of follow-up by the centre manager in relation to this. The inspectors also found there were generic topics set out on the placement plans that were not relevant to all the young people. In some instances, there was evidence that information was copied and pasted from one document to another and some documents were dated incorrectly. The inspectors also found that individual work was recorded as completed on the placement plan and in other instances it was recorded as completed on the individual

work schedule therefore it was difficult to track what work had been completed as it was not evidenced in a consistent way. The inspectors also found that the placement plan template was more aligned to children and young people in mainstream care. The service coordinator and the centre manager must ensure that the placement plan template and the placement planning systems are reviewed to ensure they are relevant to the specific cohort of young people and that they are accessible to the young people and incorporate their identified placement goals.

There was evidence that the young people were aware that staff members maintained a record of their care, and they confirmed they were aware of this. There was evidence that information about the young people was shared on a need-to-know basis with school personnel and other service providers. The centre manager confirmed that students on placement in the centre did not have open access to the young people's records. Placement plans, progress reports and incident reports developed by the centre staff were shared with the Tusla social workers/allocated workers and the social workers were satisfied they were kept informed in a timely manner about the young people's care. The social workers/allocated workers confirmed that significant events were reported to them. The inspectors found that when the young people were admitted to the centre there was limited information known or available about them following their arrival into the country. Information that was available was shared with the team through copies of the Tusla eligibility form and Tusla's section 5 placement plan. As previously stated, in many instances the section 5 placement plan was not on file and for the most recent admissions was not yet developed. There was no evidence on file that section 5 placement plans were being formally reviewed every six months with the young people and their allocated social worker, and the centre manage must liaise with the social workers to ensure these reviews are scheduled for the young people.

There was evidence that staff were alert to trauma and potential risks associated with the young people and risk assessments were completed as required. Safety plans were also completed and evidenced as shared with social work personnel however on the day of the inspection previous copies of a safety plan requested by the inspectors could not be located on the records. There was also evidence that a young person was involved in an altercation in the community and the safety plan was not updated to reflect this additional risk. Again, the centre manager must ensure that the care records are maintained in a manner that ensures information is updated and accessible. There were no instances of young people missing from care in the current resident group however the inspectors found the individual absence management

plans were not reviewed and signed off monthly as required under the Tusla/Garda missing child from care protocol.

There were systems in place to receive feedback from the young people and from social workers who placed young people. There was evidence of positive feedback from all relevant parties. The centre did not have a system in place to receive or record feedback from the young people on their discharge. The centre manager must ensure that there is a system in place that is child centred and provides the opportunity for young people to comment on the care they received while living in the centre. This should inform service improvements and be noted in the centre's annual compliance report.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 8.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The service coordinator must ensure that the centre's annual compliance report encompasses the entire centre as the accommodation is registered as one entity for twelve young people and is managed under a single management and team structure.
- The centre manager must ensure there is robust oversight of the care records and follow up with staff members where records are inaccurate, incomplete or not completed to the required standard.
- The service coordinator must ensure that when actions are identified on monthly oversight of governance reports there is evidence they have been addressed and that quarterly compliance audits also focus on the quality and standard of practice as well as the systems in place to evidence compliance.
- The service coordinator and the centre manager must ensure that the placement plan template and the placement planning systems are reviewed to ensure they are relevant to the specific cohort of young people and that they are accessible to the young people and incorporate their identified placement goals.

- The centre manager must ensure there is evidence on file that the individual absence management plans are reviewed monthly in line with the Tusla/Garda missing from care protocol.
- The centre manager must ensure that there is a system in place to undertake exit interviews with the young people and provide them with the opportunity to comment on the care they received while living in the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
4	The service co-ordinator in collaboration with the centre manager must review the centre policies to ensure they are aligned to its purpose and function.	Following inspection findings, the specific misalignment identified (reference to admission from other sister centres) has been amended in April 2026. The updated policy has been reviewed and signed off by the Service Coordinator/Director by end of May 2026.	An annual policy review schedule will continue to be implemented, with the next review due December 2026. A policy control log (version control register) will be introduced by May 2026 to record: • Version number • Date of review • Recommendations made • Sign-off authority The Service Coordinator will conduct a mid-year audit (June, annually thereafter) to ensure policies remain aligned to the centre's function, particularly in response to changes in service delivery or cohort.
6	The registered proprietor must ensure that job descriptions and employment contracts accurately reflect the staff members role in the centre either as social care worker, residential care	A full HR review of all staff contracts and job descriptions is currently underway. All roles will be aligned to: • Social Care Worker • Residential Care Worker	Annual personnel file audits (January each year) will be completed by the service coordinator to ensure continued compliance.

	worker or support worker.	• Support Worker Revised contracts/job descriptions will be issued and signed by all staff by 31st May 2026.	Any title and / or role changes will be informed by relevant employment law.
	The service coordinator and the centre manager must ensure that resources and access to health education programmes is made available for staff members to build their knowledge, skills and competencies to undertake specific work aligned to the needs of young people in placement.	A targeted training programme focusing on: • Sexual health • Healthy relationships • Consent and Irish law will be sourced and delivered to all staff by 30th June 2026. Appropriate resource materials (approved and evidence-based) will be introduced in the centre by June 2026 to support structured key work/ individual work.	A training needs analysis will be completed bi-annually (June & December). A training matrix will include specialist topics aligned to SCSIP needs. Only approved sources (e.g. HSEland, recognised agencies) will be used for health-related information. Keywork audits will include review of quality and relevance of individual work topics.
	The service coordinator must ensure that clinical support and guidance is built into the staff training and development programme.	Engagement with an external psychology service has been formalised. Quarterly clinical support sessions will commence from May 2026, delivered via: • Attendance at team meetings (in person or via Teams) • Case consultation and guidance	A quarterly clinical support schedule will be embedded into the annual training plan. Clinical input will inform: • Behaviour support strategies • Placement planning • Staff training topics Records of clinical sessions will be maintained and reviewed during monthly

			governance oversight.
8	The service coordinator must ensure that the centre's annual compliance report encompasses the entire centre as the accommodation is registered as one entity for twelve young people and is managed under a single management and team structure. The centre manager must ensure there is robust oversight of the care records and follow up with staff members where records are inaccurate, incomplete or not completed to the required standard.	The existing compliance reports will be merged into one comprehensive report reflecting the full 12-bed service. The revised report will be completed by 31st May 2026. A full audit of all care files will be completed by centre manager by 31st May 2026. Immediate actions: • Completion of outstanding placement plans • Correction of errors/inconsistencies • Standardisation of recording practices The internal office space has been reconfigured to improve accessibility and oversight of files.	A single annual compliance report structure will be standardised going forward. The report will include: • Clear quality improvement plan (QIP) actions • Measurable outcomes • Review of service objectives The service coordinator will complete an annual review each January. The centre manager will implement: • Monthly file audits (minimum 2 files per month) • Weekly spot checks of key documentation A recording checklist/tool will be introduced to ensure consistency. Staff will receive refresher training in report writing by June 2026. Audit findings will be included in monthly governance reports. The new storage system ensures: Immediate accessibility for management

		All care records are being reorganised into a structured and accessible filing system by 31st May 2026.	oversight, secure and GDPR-compliant storage and improved tracking and audit capability. File storage arrangements will be reviewed quarterly as part of governance audits.
	The service coordinator must ensure that when actions are identified on monthly oversight of governance reports there is evidence they have been addressed and that quarterly compliance audits also focus on the quality and standard of practice as well as the systems in place to evidence compliance.	A deficits/action tracker will be introduced by May 2026. All actions from governance reports will: • Be assigned to a responsible person • Include a completion date • Be signed and dated	Monthly governance meetings will include formal review of all open actions. Quarterly audits will include: • Quality of care practice (not just records) All oversight documents will be: • Signed • Dated • Stored centrally
	The service coordinator and the centre manager must ensure that the placement plan template and the placement planning systems are reviewed to ensure they are relevant to the specific cohort of young people and that they are accessible to the young people and incorporate their identified	Placement plan templates have been reviewed and updated (April 2026) to reflect: • SCSIP needs • Individualised goals • Accessibility for young people	Placement plans will be: • Reviewed monthly in keywork sessions • Formally audited quarterly Young people will be supported to actively contribute to their plans. Templates will be reviewed annually. Absence management plans will be

	placement goals. The centre manager must ensure there is evidence on file that the individual absence management plans are reviewed monthly in line with the Tusla/Garda missing from care protocol. The centre manager must ensure that there is a system in place to undertake exit interviews with the young people and provide them with the opportunity to comment on the care they received while living in the centre.	 Monthly review system implemented immediately (April 2026). Monthly emails to social workers will: • Confirm no changes or • Request updates All plans will be signed and dated monthly. A standardised end of placement feedback template will be implemented immediately. All young people leaving the service will be offered an end of placement feedback form to complete.	included in: • Monthly audit checklist A tracking log will be maintained to ensure no missed reviews. Exit interview feedback will be: • Recorded • Reviewed quarterly • Incorporated into the annual compliance report Participation rates will be monitored by the centre manager and information contained will inform practice.