An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 253

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Solis DMC Children's Services**
Registered Capacity:	**Three Young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**22nd, 23rd and 24th July 2025**
Registration Status:	**Registered from 26th July 2024 to 26th July 2027**
Inspection Team:	**Ciara Nangle** **Janice Ryan**
Date Report Issued:	**28th of November 2025**

Contents

1. Information about the inspection process

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

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 26th July 2024. At the time of this inspection the centre was in its first registration and was entering year two of the cycle. The centre was registered without attached conditions from the 26th July 2024 to the 26th July 2027.

The centre was registered as a multiple occupancy centre to provide emergency accommodation for up to three young people aged between twelve and seventeen years. The emergency placements were stated to be for a maximum period of up to 21 days. The aim of the centre was 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 open environment.

There were three young people resident at the time of this inspection. Since the previous inspection in December 2024, two of the young people had remained in placement on a medium to long term basis. Follow on placements had been identified for both young people. In addition to these two young people, the centre had five other admissions since December 2024. Of which, one young person was currently living in the centre having recently moved in, three had remained longer than the twenty-one days prior to being discharged and one placement had been for the intended timeframe.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
5: Leadership, Governance and Management	5.4
6: Responsive Workforce	6.3

Prior to this inspection, ACIMS risk response team had received two escalations of significant event notifications (SENs) relating to two separate incidents within the centre. Due to the nature of these events, and the concerns noted within, inspectors determined that an inspection was required.

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 a sample of centre and care records from current and previous residents, which

inspectors determined were relevant to the themes of this inspection. They 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 15th September 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 6th October 2025. This was deemed not to be satisfactory. Based on the CAPA returned and the inspection findings, a regulatory compliance meeting was held with the registered proprietor on 22nd October 2025. Following this meeting a final CAPA was submitted on 31st October 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: 253 without attached conditions from the 26th July 2024 to the 26th July 2027 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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.

The centre had systems in place to continuously review the quality, safety and continuity of care however the inspectors found that these systems were not being effectively utilised, and deficits identified by the quality assurance manager or within audits and inspections, were not being addressed in a timely or effective manner.

The centre management team prepared a monthly governance report, which reported on the operation of the centre. These reports were very detailed and contained a significant amount of information in relation to the operation of the centre. They were submitted to both the area manager for the centre and the quality assurance manager for their review to support the governance and oversight of care provision.

The governance policy for the organisation set out that through monthly visits to the centre from external management, all aspects of the submitted governance report would be checked, deficits would be notified to the person in charge (PIC) and that a copy of the governance report would be maintained alongside the verification report. While the systems to review were set out within the policy, inspectors could not ascertain if these were being implemented in practice as verification reports were not available. There was no additional commentary recorded from the area manager on the governance reports nor was there a record of the information being verified during visits to the centre by any external manager. There was some feedback at times from the quality assurance manager in relation to the quality of the content recorded within these reports, however there was no evidence that the accuracy of these reports was verified by any level of management outside of the centre manager which was not aligned to the organisations policy.

The absence of this verification had potentially contributed to an oversight on the submission of a Child Protection and Welfare Referral Form (CPWRF) and a significant event notification (SEN) for two residents which had consequently

impacted on placement planning for one young person several months later. From the information reviewed it appeared that the PIC and the staff team had failed to submit a CPWRF relating to one young person and an associated SEN relating to the other. However, this error had not been identified by any layer of external management and the issue was only highlighted by another centre manager during placement planning for one of the young people. Improvement in the oversight of these reports as set out in the organisations policy is required to ensure that they are an effective mechanism for reviewing the operation of the centre and to support governance and oversight in the provision of good quality, safe and effective care.

The centre was supported by an area manager. The centre's governance policy set out the role of the area manager, who was the direct supervisor of the person in charge and reported to the service director. The area manager advised in interview that they regularly visited the centre to support the person in charge in the operation of the centre. The visitors log indicated that since March 2025, the area manager had been present in the centre at a minimum of once per week and throughout June and July the frequency of visits had increased. In interview, the area manager advised that their role involved but was not limited to direct line management of the PIC and supporting them in the operation of the centre, to provide support for staff, attend team meetings, management meetings, meet with the young people, be involved in management of complaints when required, oversee referrals and placements and have oversight of all SENs.

There was evidence of the area management oversight and involvement in the centre through the attendance at team meetings and management meetings and in provision of supervision to the PIC. However, inspectors could not ascertain from the records reviewed what oversight the area manager had on care records and the day-to-day operation of the centre. The area manager advised that a record of their visit to the centre was maintained however there were no records of these visits made available to inspectors when requested. The inspectors could not determine what the oversight within SENs was from the area manager as there was no commentary included. There was no evidence of follow up by the area manager within the centre when the quality assurance manager identified deficits within care records, nor was there evidence of oversight in regard to the follow up on actions from team meetings, management meetings, audits or supervisions. While at times, some of the deficits within records identified during this inspection were identified by the quality assurance manager, there was not an effective system in place to ensure that they were actioned upon identification within a timely manner as they remained outstanding.

There were a number of forums in place within which the provision of care was reviewed. These included team meetings, supervisions and handovers. Records reviewed from these forums indicated that there was good quality discussions occurring in regard to the young people and various aspects of their care including significant events, complaints and daily planning. However, when approaches to practice were agreed following these discussions, they were not being consistently implemented in practice, such as consistently maintaining boundaries with the young people, adhering to shift plans during the day etc. While at times, there was evidence of discussion occurring in regard to these deficits when they presented, the follow up or actions taken to ensure they did not reoccur was not evident or effective as these issues continued to present. Significant event review group meetings occurred periodically to review SENs. These were attended by members of management from each of the centres in the organisation and one SEN from each centre was reviewed. Records detailed identified learnings to be implemented across the organisation from each event reviewed. However, they did not include a mechanism for tracking patterns or trends within SENs.

Management meetings were to occur monthly within the centre and were to be attended by the social care leaders, centre managers and the area manager. Management meetings did not occur in January, February or May 2025. From the records reviewed of the meetings that did occur, care practices were reviewed however when an action was generated from the discussion, it was not consistently recorded as an action for follow up and as such could not be tracked to completion. One example where this had occurred and directly impacted on the young people was in March 2025. The reintroduction of the alarm system was noted as something that may be required following SENs in the centre. The discussion within the management meeting reflected that this would be followed up however was not recorded as an action. Following this meeting inspectors could not ascertain what follow up had occurred from records or interviews completed. Subsequently, there was an incident where the young people absconded unknown to the staff team which may have been prevented had the alarm system been reintroduced. There was no evidence that the inaction around this had been identified and addressed by external management.

Audits completed within the organisation were undertaken by the quality assurance manager. At times they were supported by the service director. Audits were completed on a quarterly basis and were aligned to the National Standards for Children's Residential Centres, 2018 (HIQA). Three internal audits had been completed within the centre since it opened with the two most recent being

completed in March 2025 and July 2025. The audits completed in 2025 had been completed under various standards relating to Theme 1, Theme 2 and Theme 6. The audits highlighted areas of positive practice and areas where improvement was required. When deficits were identified an action plan was generated and the PIC was required to submit a plan for completion. Updates on the implementation of the actions were included within the monthly governance reports. While the audits effectively identified deficits, and highlighted the actions required to rectify these, some deficits remained outstanding. Standard 6.3 had been reviewed in the March 2025 audit and inspectors had similar findings during this inspection indicating that actions had not been implemented satisfactorily to address the deficits. The oversight and tracking of the actions to address the deficits identified within audits was not effective and requires improvement.

Additionally, a number of the deficits identified within the 2024 inspection by ACIMS e.g. provision of supervision, resolution of staff issues and probation reviews remained at the time of this inspection, indicating that the preventative actions agreed to address these issues had not been implemented effectively. Inspectors could not ascertain if these deficits in relation to the implementation of the CAPA had had been identified and what follow up had occurred.

The area manager in interview advised that following audits and identification of deficits in recording and practices within the centre in April 2025, an internal review of the centre was completed by one of the area managers. An action plan was generated from this review which included detailed actions with an assigned owner for completion to address the identified deficits. This plan detailed actions to improve oversight and included a mechanism for review of its implementation through quarterly meetings and an escalation procedure for unresolved actions. The implementation of these actions was only in its infancy at the time of this inspection and the effectiveness of the actions in addressing deficits could not be determined by inspectors.

The centre had a policy for the recording and resolving of complaints made by young people. At the time of this inspection, there was no register of complaints available for 2025, and there was not clarity amongst the team if a register was in place. As set out in the centre's policy a register was required which was to be updated upon a young person making a complaint. From the sample of young people's complaints reviewed, they were resolved in a timely manner and when it related to the lack of a follow on placement being provided in a timely manner, the young person was appropriately given the option to make a complaint through Tusla's 'Tell Us'

complaints process. Complaints were a standing item on the team meeting and management meetings for discussion. In interview staff could identify changes to care practices because of a complaint being made by a young person evidencing that learning was being taken from complaints. There was no formal mechanism in place for reviewing trends or patterns in regard to complaints.

In the days prior to this inspection, one social work team had raised a complaint in relation to the service through the national placement team. The centre management had responded in a timely manner to this complaint and acknowledged some of the deficits the social work team had raised. Some of the issues raised were similar to the findings of this inspection and the internal review completed in April 2025. The social work team indicated that they were satisfied with the response from the centre and action taken. In interview with the allocated social worker, they advised that they had raised similar issues in April 2025, and despite the assurances provided the issues continued which had resulted in this complaint being submitted. A further internal review was completed in response to this complaint by the area manager. The inspectors requested a copy of this review however were not provided with it by the time this report was issued.

An annual review of compliance had not yet been completed as the centre had only been operating for one year at the time of this inspection. The area manager for the centre advised that this was due to be completed in September 2025. However as detailed above, the centres operation had been reviewed in May 2025.

Significant improvement within the oversight and governance systems at all levels of management within the organisation for this centre is required to ensure that they are effective in reviewing the quality, safety and continuity of care provided and in ensuring that deficits are addressed in a timely manner.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

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

Actions required

- The registered provider must ensure the systems in place to support the governance and oversight of operation of the centre are effectively implemented at every level of management.
- The registered provider must ensure that all actions identified from the December 2024 inspection, May 2025 internal review and any other internal reviews and audits are implemented effectively to address the deficits identified to ensure the centre operates in compliance with regulations, standards and centre policies.
- The registered provider must ensure that a register of complaints is maintained in line with the centre's policy.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

Staff interviewed could describe how the centre operated in practice however struggled to link this to policy or to identify what policies would guide them should a particular situation arise. From a review of the young people's care records, staff supervision records and team meetings it was evident that policies and procedures were not consistently being implemented which was resulting in inconsistencies in

the care provision for the young people. This was particularly evident when it came to implementing boundaries with the young people.

Some of these issues regarding adherence to centre policies had been identified within the May 2025 review, and the area manager had identified that a review of the policies specifically for the emergency response service (ERS) was to occur to ensure that they were appropriate for the type of service being offered. This was also noted within a governance meeting with senior managers in May 2025, where it was agreed that a separate set of policies would be required for the ERS service. It was recorded in these minutes that a date to meet to discuss this further would be arranged for July 2025, however at time of inspection this had not progressed any further and the centre continued to operate under the organisations standard suite of policies.

Staff interviewed reported that they were supported and encouraged to avail of training and a culture of learning was promoted. Within supervision records there was reference to the team being encouraged to access training through HSEland relevant to topics identified within the supervision session. However, there was no evidence of these being followed up to completion, or when staff raised a training need in supervision, inspectors found it hard to track if it was provided. Training records on personnel files were limited. The management team advised it was the staff members responsibility to upload their training records to the IT system. However, there did not appear to be any follow up or tracking of this occurring nor were the staff being held accountable for the absence of these records. The PIC maintained a record of dates of some of the mandatory training completed by the team; however, this did not include all mandatory training as set out in the organisations policy or dates of any additional training completed.

Team meetings were scheduled to occur on a fortnightly basis. The records of these varied in terms of the level of detail recorded on the discussions that took place. However, within some records there was good evidence of discussion occurring in relation to the young people and the day to day running of the centre. Staff were encouraged to express their professional judgement and develop plans for the young people. Actions agreed were recorded and reviewed at the beginning of the next meeting, however when actions were not completed month to month there was no evidence of team members being held accountable for these not being completed and it was difficult to track if or when they were resolved.

Within various documents reviewed as part of this inspection, issues in regard to the dynamics within the team were raised. These related to collective working and

consistency in implementing plans. While team issues were discussed in a general sense in individual supervisions, team meetings and within management meetings, there was no clear plan developed to address the issues that continued to present. The area manager attended the April 2025 team meeting and spoke about the need for a cohesive team. Prior to this in March 2025, the use of mentoring within the team from more experienced staff in other centres was agreed as an action to support the team dynamics, however this had not been put in place at the time of this inspection which was not supportive to the forming of a new team.

The absence of a process for managing issues raised by the staff team had been highlighted within the 2024 inspection and the corrective actions detailed within the report noted that there was an escalation process now in place where issues raised by staff would be addressed in a timely manner as per the policies. However, at the time of this inspection, there had been two issues raised by the staff team over six months ago which had not been investigated or resolved. This had been highlighted by the quality assurance manager through their review of records in recent months, indicating that progress on the resolution of the issues raised was required however this remained outstanding and requires action.

There was a supervision policy in place which set out the requirement for supervision to occur every four to six weeks with members of the team and the deputy person in charge. Supervision was to occur fortnightly for the first three-month period of employment. The person in charge was required to be supervised at a minimum quarterly. Supervision was not being provided in line with policy for staff or management and not all staff members had completed supervision training in line with the centres policy. The provision of supervision in line with policy had been highlighted as an issue within the inspection in the centre in December 2024 and it was regularly noted within the centre manager monthly reports that supervision was overdue for some staff. It was also identified within the audit in March 2025. However, despite this being highlighted regularly, improvements within the provision of supervision did not occur until May 2025. Additionally inspectors did not see evidence of consideration being given to increased supervision for members of the team when on-going practice deficits were identified.

In interview staff and management reported that supervision was beneficial and they valued the learning and guidance provided during same. However, there was no evidence of individual staff members being held accountable for their role or practices. Within the PICs supervision there was no evidence of follow up being completed in relation to outstanding tasks or the deficits identified within audits.

Additionally, inspectors did not see evidence of consideration being given to increased supervision or additional support for the PIC given their level of experience and the nature of the newly formed service.

Supervision records were signed off only by the supervisor. Staff interviewed were not aware of the mechanism through which they could sign off on their supervision records, although indicated that they had read them. Inspectors only noted one record signed by bot a staff member and supervisor in the sample reviewed.

There was evidence of the quality assurance manager having oversight of supervision records, and comments were at times included on the records. In some instances, these comments were related to the centre manager's practice and were included on the staff's record which was not appropriate. Within the quality assurance managers comments, actions for follow up from supervision were identified, however again the tracking of these actions to completion was not effective, and oftentimes they remained outstanding.

Appraisals had not yet occurred for members of the team. As the centre was newly operational most members of the team had not been there for a year, and for those who had worked with the organisation for more than a year, appraisals had not occurred. Where probation reviews were required, they had not always been completed in line with the organisations policy and as such the team members performance had not been formally appraised. The delay in completing probation reviews had been detailed within the governance report compiled by the PIC, it was discussed in governance meetings and highlighted within audits completed by the quality assurance manager. It was also identified within the 2024 inspection and preventative actions were agreed to this address this deficit. However, inspectors could not determine what action had been taken to address this deficit as a number of probation reviews remained outstanding at the time of this inspection.

Staff in interview spoke about the possibility of accessing external counselling supports should they require it however were not clear on the details of same. All staff spoken to as part of this inspection spoke about feeling supported in their role.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that all required mandatory training is completed by all members of the team and that records of training are maintained on each staff members personnel file.
- The registered provider must ensure that supervision occurs in line with centre policy, staff are trained in this and that all records are signed off by both supervisor and supervisee in line with requirements set out in the National Standards for Children's Residential Centres, 2018 (HIQA) and the centre's policy.
- The registered provider must ensure that staff are aware of the supports available to them to manage the impact of working in the centre.
- The registered provider must ensure that all issues raised by members of the staff team are investigated and resolved in line with policy.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider must ensure the systems in place to support the governance and oversight of operation of the centre are effectively implemented at every level of management.	Since August 2025, an updated Governance Report has been implemented to strengthen oversight and assurance of the centre's daily operations. The Centre Manager completes the Governance Report monthly and submits it to the Area Manager for review. Actions identified through this review process are directed to centre management to ensure timely follow-up and operational improvement. A new framework of Governance and Oversight will provide enhanced clarity regarding roles, responsibilities, and reporting lines from centre to executive level. This will take place in Q4 of 2025. A new checklist that incorporates all positions within the centre, including the Area Manager have been developed, and are designed to ensure that everyone fully understands their contribution to effective	A revised *Governance and Oversight Framework* has been introduced to clearly define roles, responsibilities, and reporting lines from centre to executive level. Governance checklists have been issued to all key roles to ensure accountability and understanding of each person's contribution to regulatory compliance. Furthermore, quarterly governance review meetings—attended by the Service Director, Area Manager, Quality Assurance Manager, and Person in Charge—are established to track progress on outstanding actions, review risk items, and monitor the implementation of improvement measures. While these meetings are already taking place, additional focus will now be placed on reviewing governance, compliance, and

		governance and regulatory compliance.	quality assurance processes to ensure sustained improvement. Annual governance and compliance training for management and senior staff will reinforce expectations, and lessons learned from audits and inspections will be shared across the organisation to embed continuous improvement.
	The registered provider must ensure that all actions identified from the December 2024 inspection, the May 2025 review and any other internal reviews and audits within the centre are implemented effectively to address the deficits identified to ensure the centre operates in compliance with regulations, standards and centre policies.	Alongside the above changes verification checklists will also be implemented for all governance visits to promote consistency, transparency, and accountability in monitoring practices. The centre management team have developed a schedule of actions that were identified within the 2024 inspection and 2025 inspection review. This comprehensive action tracker includes internal audit recommendations. This schedule has a completion date of the 30th of Nov 2025. Each action has an assigned owner,	The introduction of the action tracker should act as a management tool to monitor all inspection, audit, and internal review findings across the service. Each action has a clearly identified owner, timeframe, and measurable outcome, ensuring accountability and traceability from identification to closure. The Area Manager reviews progress monthly and reports to the Service Director, creating a continuous oversight loop. Any overdue or incomplete actions are escalated through a formal Audit Escalation Protocol to the Senior

		timeframe, and measurable outcome; progress is reviewed monthly by the Area Manager and reported to the Service Director.	Management Team (SMT) within 30 days for resolution. The inspection report, internal report and action plan has become an item on the team meeting agenda to assure transparency of expectations and standards throughout the staff team. These processes embed a culture of proactive monitoring, early intervention, and continuous quality improvement, ensuring that inspection or audit findings are addressed promptly and do not reoccur.
	The registered provider must ensure that a register of complaints is maintained within the centre in line with centre requirements.	As of September 2025, a complaints register is now in place within the centre. This will be updated following each complaint and reviewed and overseen by centre management. Monthly audits by the Area Manager will verify that all complaints are recorded, resolved, and analysed for patterns or themes. Quarterly learning reviews will identify service improvements arising from	The strengthened complaints management system now functions as a continuous quality improvement tool, not just a compliance mechanism. By embedding regular monitoring, verification, and analysis, the organisation ensures that complaints are managed transparently, consistently, and inform service development. Monthly oversight by the Area Manager provides a real-time quality check, allowing

		complaints and these will be shared with all centres in the organisation. These meeting will commence from Nov 2025.	early detection of trends or delays. Outcomes from complaints are systematically reviewed through quarterly learning sessions, where themes and learning points are shared across all centres to enhance collective practice. Complaints data will also inform the organisation's governance and risk management processes, ensuring patterns are addressed proactively at both local and senior management levels. These measures foster a culture of openness, responsiveness, and accountability—preventing recurrence of deficits in complaints recording, review, or follow-through.
6	The registered provider must ensure that all required mandatory training is completed by all members of the team and that records of training are maintained on each staff members personnel file.	The centre has updated the training matrix as of September 2025 which will aid in identifying completion dates and renewal timelines for all staff. This has been incorporated into the monthly Governance report. The HR team now maintains a centralised digital training record, reviewed monthly	Ongoing monitoring through the training matrix and HR system will ensure that all future training needs are identified and addressed promptly. This structure embeds accountability, promotes workforce competence, and prevents any re-occurrence of training deficits.

		by the Person in Charge and verified quarterly by HR. All staff will complete any outstanding training (first aid, child protection, fire safety, etc.) by December 2025.	Additionally, the monthly Governance report highlights a training section to ensure oversight on mandatory trainings.
	The registered provider must ensure that supervision occurs in line with centre policy, staff are trained in this and that all records are signed off by both supervisor and supervisee in line with requirements set out in the National Standards for Children's Residential Centres, 2018 (HIQA) and the centre's policy.	As of September 2025, management have developed a supervision schedule which will assure that all staff receive supervision in line with the centre policy. Supervisors are receiving refresher training (November 2025) on reflective practice, documentation, and follow-up processes. The electronic recording system in use will automatically provide an electronic signature of the supervisor with the supervisee then adding comments to the completed form. The Area Manager will audit a selection (25% minimum) of supervision records monthly to monitor quality and timeliness.	Management alongside the new supervision schedule will include the supervision numbers for each month within the monthly Governance report. This will in turn highlight staff that have reviewed their minutes of each supervision session through the acknowledgement of supervision form. The revised supervision documentation supports greater transparency and mutual accountability, ensuring that actions agreed in supervision are followed through and reviewed. Oversight of supervision quality has been integrated into the centre's governance audits, with outcomes reviewed by senior management on a quarterly basis to identify themes, support staff development, and maintain a consistent standard across all centres. These

			strategies ensure that supervision is embedded as a *core, sustainable practice* within the organisational culture — reducing reliance on reactive measures and preventing the recurrence of missed or inconsistent supervision in future.
	The registered provider must ensure that staff are aware of the supports available to them to manage the impact of working in the centre.	The supports available for staff include on-call support to provide essential support outside of normal working hours by management specifically in the case of emergencies. In addition, monthly supervision is conducted with each staff member, and this includes a reflective piece where they can discuss challenges they have faced in their practice and receive support and guidance regarding same. De-briefing with staff is conducted following an SEN and when requested by the care team. Information on all wellbeing supports have been reissued to all staff and included in induction. This information can be found in the Staff Handbook and Policy	Management to discuss with staff during supervision the employee assistance programme as part of their self-care and stress management if they wish to avail of this service. During the November 2025 team meeting all information contained within the Employee handbook relating to wellbeing supports will be further discussed to ensure that all staff are aware of the supports in place and how to access these supports All employees will be provided with a copy of the employee handbook which outlines all supports provided by the organisation.

		Documents. Mentoring by experienced staff from other centres is being introduced (November 2025) to strengthen team cohesion and consistency.	
	The registered provider must ensure that all issues raised by members of the staff team are investigated and resolved in line with policy.	All outstanding staff concerns have been formally logged and are being addressed through HR in line with policy. Management is fully aware of the complaints procedure in line with centres policy. Issues that are raised by the staff team will be dealt with PIC. A new staff issue escalation process will ensure all future concerns are acknowledged within 5 working days and resolved within 30. The Area Manager will review unresolved matters monthly and report outcomes to the Service Director. If required, any issue or complaint that cannot be resolved by the PIC will be escalated to the Area Manager as per policy. Staff are aware that they can make a complaint regarding issues which can be	To prevent recurrence of unresolved or delayed staff concerns, the organisation has embedded a formalised and transparent escalation framework within its HR and governance structures. This ensures all staff issues are identified, recorded, and addressed in a consistent, timely, and accountable manner. Oversight is maintained through monthly management reviews, during which the Area Manager monitors the progress of all open concerns and provides assurance to the Service Director on their resolution. Patterns or recurring themes will be reviewed quarterly to inform workforce planning, training, and organisational learning. The new staff issue escalation process integrates defined response timelines into standard HR practice,

		done through the electronic recording system. All parties involved will be aware of the complaint process and resolution must be agreed upon before the complaint can be closed in line with centre policy to ensure all staff are familiar with the process.	promoting early intervention and reducing the potential for unresolved matters to impact team functioning or care quality.