An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 274

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Orchard Residential Services Ltd**
Registered Capacity:	**Six young people**
Type of Inspection:	**Announced**
Date of inspection:	**9th, 11th and 16th February 2026**
Registration Status:	**Registered from 13th December 2024 to 13th December 2027**
Inspection Team:	**Cora Kelly** **Justin Halley** **Tara Heeran**
Date Report Issued:	**26th of May 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 13th December 2024. At the time of this inspection the centre was in its first registration and was in year two of the cycle.

The centre was registered as a multi-occupancy service to provide medium to long term care and accommodation for six young people aged 16 to 17 years. The centre utilised 'The Three Pillars' framework as their model of care; safety, connections and coping. The framework was developed to inform and empower those who live with or work with these young people, but who are not necessarily engaged in formal therapy. There were six 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
1: Child-centred Care and Support	1.1
3: Safe Care and Support	3.1
5: Leadership, Governance and Management	5.2

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, three social workers who were allocated to five of the children and other relevant professionals. Inspectors consulted with four children living in the centre. A fifth child was ill when the inspectors were in the centre, with the sixth child declining to meet formally with the inspectors. 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 11th March 2026. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 24th March 2026. A further review of the CAPA was requested by the inspectors which was received on the 8th April 2026. Due to continuing shortfalls, a compliance meeting was held with the registered provider and centre management on the 22nd April 2026. They were afforded the opportunity to provide a further and final CAPA which was returned on the 29th April 2026 along with supplementary evidence of actions completed and/ or work ongoing. 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: 026 without attached conditions from the 13th December 2024 to the 13th December 2027 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 11: Religion
Regulation 12: Provision of Food and Cooking Facilities
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.1 Each child experiences care and support which respects their diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child.

Information on children's rights was outlined in the centres child safeguarding practices policy and included in the 'young person handbook' that was provided to each young person on their admission to the centre. Additionally, leaflets were readily available that were in the English language and in languages understood by the young people in placement. It was evident to the inspectors that information across all records aligned with the United Nations (UN) Convention on the Rights of the Child. Staff demonstrated in interview how they promoted and respected each of the young people's rights. In speaking with the inspectors four of the young people said they knew about their rights with evidence of this verified by the inspectors during their review of the young people's care records.

Each of the four young people had good English language ability and chose to not have an interpreter present when speaking with the inspectors. Each young person told the inspectors that their dietary requirements were catered for and described how this was planned for. Weekly food plans were agreed at house meetings with each young person having the option to cook their own meals and contribute to the house food shop. Additional monies were provided weekly to the young people to purchase foods of their choice. A young person described the meals they liked to cook from their country of origin for the young people.

The inspectors found that the young people's individual religious beliefs were acknowledged with personal items purchased by the centre to support this. A young person who was struggling with attending to their religious beliefs was encouraged by the inspectors to speak with their key worker and the centre manager about their wishes. The inspectors updated the centre manager too on this feedback.

Each child was actively engaging in various hobbies and activities of preference with staff promoting and facilitating them in attending practices, trainings and matches. The centre manager confirmed that there was no issue in financial resources being available to support the young people's living arrangements and routines. However, two young people told the inspectors they had previously requested personal practical items for their bedrooms that had not yet been provided. The inspectors could not track this during the review of records and suggest that the centre manager revisits this matter with the relevant young people. Through care planning processes, key working and house meetings it was evident overall that the young people living in the centre were actively involved in making decisions about their care.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 11** **Regulation 12** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 1.1**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- None identified.

Regulation 5: Care practices and operational policies
Regulation 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.

It was the inspectors' overall findings that Children First: National Guidance for the Protection and Welfare of Children, 2017 was not fully implemented with centre practices failing to implement its operational policies and procedures. In compliance with a requirement of Children First: National Guidance for the Protection and

Welfare of Children, 2017 the centres child safeguarding practices policy was last reviewed in April 2025 with a further review date set for April 2027. The policy included procedures for working safely with children and young people for example complaints, recruitment and selection, anti-bullying, lone working, and responding to a concern about a staff member. Reporting procedures were included for example those for mandated reporting, non-mandated reporting, responding to protection concerns that did not meet the threshold to report to Tusla, retrospective disclosures and procedures for responding to possible child sexual exploitation (CSE). The anti-bullying policy was found to include procedures for responding to instances of bullying. Staff in interview stated that bullying amongst young people was not currently a feature in the centre.

The centres child safeguarding statement (CSS) was up to date, signed and prominently displayed in the centre which complied with the Children First Act, 2015. The contact details of the regional director as the appointed relevant person were included in addition to the names of the appointed designated liaison person (DLP) and the deputy DLP. Presenting risks were appropriately included in the statement, including those for responding to CSE, however the inspectors found that some control measures were not being implemented in practice in response to identified risks for example safety plans and impact risk assessments. As a CSS requirement the full staff team were listed as mandated persons which aligned to centre policy. However, in consultation with the centre manager, they confirmed that they and the social care leader were registered social care workers with the Health & Social Care Professionals Council (CORU) in
accordance with Part 4 of the Health and Social Care Professionals Act 2005. Another staff had applied and were awaiting an outcome from CORU. Under Schedule 2 of the Children First Act 2015 they are deemed mandated persons. The registered provider must review the centres list of mandated persons to ensure it aligns with statutory requirements.

Key safeguarding personnel in place included a named and relevant person as per the requirements of the CSS, an appropriately trained DLP and a deputy DLP. Staff had completed the mandatory Tusla E-Learning module: Introduction to Children First, 2017, the Tusla E-Learning module: Children First: Mandated Person role and responsibilities training and CSE online training. Staff had also been provided with child protection training by the agency.

The inspectors found that child protection welfare report forms (CPWRF's) were not submitted appropriately and those holding mandated responsibilities failed to fulfil

their statutory obligations. The centre manager, as DLP, held responsibility for maintaining child protection records and had oversight of individual registers in place for each young person via the centres online recording system that were reviewed monthly. These registers accounted for complaints, notifications of significant events (SEN's), incidents and CPWRF's relating to each young person. For CPWRF's that were submitted SEN's were completed too as required. The inspectors found on review of the young people's care records that at least three CPWRF's were not identified by the team or management and as such not submitted to Tusla via the online portal. The centre manager provided the inspector with evidence of two concerns submitted retrospectively during the inspection. The third CPWRF was not submitted at the time of writing this report. Inspectors further identified that some incidents recorded on the young people's registers should have been submitted as CPWRF's and followed up accordingly.

A significant number of expressions of dissatisfaction/ complaints verbalised by the young people were recorded by staff as complaints and entered on the young people's registers. On review of records provided for a sample of these the inspectors could not determine how they were managed and if it complied with their own complaints policy. One of these complaints included one by a young person where they stated they felt unsafe and unsupported by a staff member. The inspectors found there was a delay in a CPWRF being submitted for this. The allocated social worker confirmed they had closed their investigation for that report. The inspectors did not find evidence of the outcome of the complaint on the young person's care record or of any learning to improve practices in the centre. The staff member resigned from their role during the complaint process.

The centre manager confirmed that social workers were not formally informed of any complaints made by the young people which was verified by two social workers. One indicated they would follow this up with the centre manager. A second social worker informed the inspectors they had followed up on complaints with the centre manager and young person they were allocated to.

The inspectors identified that improvement was required in how staff worked in promoting the safety and wellbeing of the young people in conjunction with the allocated social workers. There was little evidence of regular contact between the centre and social workers on the online recording system. Deficits in operational policies and procedures specific to the centres statement of purpose was a contributing factor in addition to a staff team having very limited residential care experience. Section 5 placement plans were in place for five young people however,

there was inconsistent practice in the placement plan review process with some taking place in collaboration with centre staff and others not. Information was not detailed in the centres care planning policy.

The inspectors spoke with three social workers allocated to five of the young people, with one recently allocated to three of the young people one of whom was subject to a full care order. Over the inspection process there was ongoing communication between the inspectors and three allocated social workers to alert them of safety planning findings that required immediate attention. The inspectors found individual safeguards, in the form of risk assessments, put in place to protect the young people were not robust in addressing and responding to identified risks. For one specific safeguarding concern there was no mention of the removal of live nights being reviewed or if individual bedroom alarms were required. A young person told the inspectors that they did not always feel safe in the centre and was proactively ensuring they wouldn't be in a situation where they would be alone in a communal area in the centre. During the inspection the centre manager was directed to implement safety plans in conjunction with the relevant social workers and the young people to ensure staff were clear on steps to follow to ensure the young people were always safe in the centre. While safety plans were provided to the inspector's deficits continued therein. This issue was being actively addressed by the centre manager and the relevant social workers at the time of writing the draft report.

Through key working it was evident that some work was being completed by staff with the young people to develop their knowledge, self-awareness, understanding and skills needed for self-care and protection. There was no reference to any resources being accessed to facilitate and support any of the work. Staff could not demonstrate this to the inspectors either. Four of the young people who spoke with the inspectors confirmed they had key workers with three reporting that they got along with them. A fourth child was not happy with their key worker and would prefer a female one. The inspectors recommend that the centre manager follows this up with the young person. All four young people identified staff they would go to if they wanted to talk about something.

Staff had not established any communication links with parents or guardians of the six young people with allocated social workers holding responsibility for informing of any incidents or allegations of abuse where they arose. The centre had a protected disclosures policy. In interview staff were not clear of the correct channels to whom they could make a protected disclosure to. The inspectors recommend the policy is reviewed with staff.

The inspectors found that there were significant internal and external deficits in oversight, monitoring, auditing and evaluation arrangements. Information relating to complaints, incidents and concerns were not consistently acted on, effectively monitored or analysed to improve the safety and quality of care and support provided to the young people.

During their review of a sample of staff personnel files the inspectors found deficits in the agency's recruitment processes. One staff member was not recruited in line with legislation as it was found that a police check was not conducted which is a significant safeguarding risk. It was since completed during this inspection process. Their qualification was not verified by the agency with the awarding body. Evidence for both was later submitted to the inspectors. The curriculum vitae of another staff lacked sufficient detail to account for their working history, and there was no evidence of one of their references being verbally checked by the agency. These too were rectified during the inspection process evidence of which was provided to the inspectors.

Compliance with regulations	
Regulation met	**Regulation 16**
Regulation not met	**Regulation 5**

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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 3.1**

Actions required

- The registered provider must ensure that all staff are recruited safely in line with centre policy and in accordance with ACIMS guidance documents and legislation.
- The registered provider must ensure that the centres safeguarding policies, procedures and practices comply with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015.
- The registered provider must ensure that staff are fulfilling their reporting responsibilities in line with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015.

- The centre manager, as DLP, must review the young people's registers and files to ensure that all child protection and welfare concerns have been reported.
- The registered provider must review the centres list of mandated persons to ensure it aligns with statutory requirements.
- The regional director must ensure that individual safeguards to protect young people are robust in responding to and managing identified risks.
- The regional director must ensure that information relating to complaints, incidents and concerns are acted on, effectively monitored and analysed to improve the safety and quality of care and support provided to the young people. Young people must be informed of outcomes of complaints.

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2: The residential provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The registered provider had in place systems that supported the operational running of the centre and the provision of care and support to the children. These included management and governance arrangements, policies and procedures and a newly established staff team. The inspectors found that the systems were not robust, were ineffectively monitored and lacked centre and senior management oversight. It was evident too that staff lacked awareness of their responsibilities. As referenced earlier in this report the centre manager did not demonstrate a sound knowledge of their responsibilities under Children First: National Guidance for the Protection and Welfare of Children, 2017 and the centres own policies and procedures.

The internal management structure was not suitable to the size and purpose and function of the centre and there was a lack of consistency and stability in the structure since the centre opened in December 2024. A written record of a delegation of tasks records evidenced duties the centre manager had delegated to each staff member. The inspectors found that the duties delegated were not fully proportionate to the competencies, experience and skills of staff and recommend that review of the delegation of tasks is considered by centre management. The qualified

centre manager had worked as a team leader with the agency prior to their appointment as the person in charge for the centre. They were supported by one social care leader who commenced their position in the weeks prior to the inspection. Two previous social care leaders were demoted from the role since the centre opened. There was no deputy manager with no plan for one to be appointed. A recent arrangement included an acting centre manager from a sister centre supporting the centre manager with administration tasks one day a week on a trial basis. They were the appointed person to step up in the centre managers absence. The staff team comprised of a social care leader, five social care workers and four health care assistants all of whom were new to the agency when they commenced their employment in the centre with all, except for the team leader having no residential care experience. The daily shift pattern comprised of two staff completing 24hr sleepover shifts with a third staff completing a day support shift. On review of the roster there had been occasions where health care assistants were rostered together for 24hr sleepover shifts. This practice is not acceptable and must cease in line with registration requirements.

The inspectors found that the current staff dynamic was negatively influencing how the staff team communicated, collaborated and worked together. It was evident from overall inspection findings that there was a lack of motivation amongst staff members that had resulted in a divided staff team with miscommunication and a lack of consistency in staff practices contributing factors to this. There appeared a divide too amongst some young people with staff they consulted with. As stated earlier in this report a complaint was made by a young person against a staff member who left the centre on foot of the complaint. A formal staff grievance was made by a staff member that was being managed by the centre manager at the time of the inspection. There had been some staff turnover with five staff having left the centre since it commenced operating. The centre manager had not been provided with any feedback from exit interviews conducted nor were they aware if any was provided. The regional manager stated this could be provided to the centre manager.

The centre manager was present in the centre Monday to Friday working normal office hours. Staff in interview described the centre manager as approachable, available and provided them with leadership. In interview with the inspectors the centre manager stated they demonstrated their leadership and management to staff through their oversight of centre records and young people's care files, regular team meetings and staff supervision. As outlined in this report the inspectors found deficits in how the centre manager was effectively managing the centre. They stated in interview that they no longer attended the daily handover meetings. Arrangements

for this included one outgoing staff member providing the handover to two of the three incoming staff. All three incoming and three outgoing staff were not required to attend the daily meeting. This arrangement did not allow for oncoming staff members to resolve any queries or concerns that may have arisen during the previous shift or expectations regarding the forthcoming shift leading. It was evident that this was impacting on miscommunication and inconsistent practices as referred to above.

The inspectors did not see evidence of oversight, feedback or direction provided to staff across several documents reviewed for example daily logs, SEN's and key working records. They found from their review of a sample of team meeting minutes that there were no recorded discussions on standard agenda items such as complaints, SEN's, CPWRF's and risk assessments. There was no reference to audits or placement plans being discussed. Inspectors did not find evidence how staff were supported and guided to develop their skills and practices.

The centre manager was tasked with providing all staff with formal supervision. In interview they spoke of recent changes to the supervision process on a trial basis where staff would be provided with full supervision every second month with a check-in to take place in between. The inspectors reviewed a sample of supervision records and found that staffing issues were not appropriately managed by the centre manager in line with policy or there was no evidence of them being discussed. Supervision must be provided to staff in line with centre policy and in light of the inexperienced staff team.

The centre manager reported to the regional director as their line manager who provided them with supervision and visited the centre regularly. The centre manager was tasked with providing them with governance reports. On review of centre records, via the online recording system, the inspectors did not evidence the regional director's oversight of centre practices on matters relating to the operational running of the centre or care and support provided to the young people.

On review of the centres policies and procedures relevant to this inspection the inspectors found that they were not fully aligned to the purpose and function of the centre. For example, the care planning policy and the admissions policy included procedures for mainstream children residential centres and were not specific to separated children seeking international protection.

The centres risk management policy contained information on the risk management process, the risk matrix utilised, and the types of risk assessments conducted. An

organisational risk register was in place along with a centre risk register that was managed by the centre manager. The inspectors found that improvement was required on how risks were identified, assessed and managed. The centre risk register did not include or track ongoing risks in the centre, risks were not clearly identified on assessment forms, risk levels did not align to presenting risks with control measures either not in place or not adequately responding to the presenting risks. As included in standard 3.1 of this report safety plans were not developed in response to specific safeguarding concerns.

It was evident to the inspectors that effective leadership was required across all management levels to ensure that a child centred, safe and effective service was provided and that a greater focus is placed on creating a culture of learning, quality and safety.

There was an up-to-date service level agreement in place with Tusla, Child and Family Agency.

Compliance with regulations	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 5**

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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 5.2**

Actions required

- The registered provider must ensure that effective leadership is provided across all management levels so that child centred, safe and effective care and support is delivered and to include the development of a culture of learning.
- The regional director must ensure that the internal management structure is appropriate to the purpose and function of the centre.
- To comply with Tusla SCSIP protocol the regional director must improve workforce planning to ensure that there's a mix of skilled, experienced and competent staff to meet the needs of the young people living in the centre at all times.

- The regional director must ensure operational policies and procedures align to the centres statement of purpose and that staff have a good knowledge of operational policies and procedures.
- The regional director must review its current risk management processes to ensure that a robust system is in place.
- The centre manager must review the delegation of tasks record to ensure that duties delegated are proportionate to the competencies, experience and skills of staff.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The registered provider must ensure that all staff are recruited safely in line with centre policy and in accordance with ACIMS guidance documents and legislation.	Conduct a full audit of all staff files against the requirements (Garda vetting, references, ID, qualifications). Update any missing documentation. Discuss with the recruitment department compliance procedures regarding CVs vetting, references, ID, qualifications, verification of qualification. Introduce a standardised recruitment checklist (mandatory before start date). The correct police verification (DBS versus ACRO) ACRO will be utilised going forward. **<u>Time Scales</u>** Staff file audit: **15th May 2026** Discussion with recruitment and compliance checklist: **Completed**	The Human Resource Director along with the Regional Director and senior HR Manager will Introduce a mandatory recruitment compliance checklist that must be fully completed and signed off before any candidate starts work. This should include: • Identity verification • Reference checks • Qualification verification (with evidence recorded) • Garda vetting / ACRO clearance confirmation (as applicable) • Training Records • Interview and selection records No offer of employment will progress to a start date until every section is verified and signed off by both Recruitment, Regional Director or Area Manager.

	The registered provider must ensure that the centres safeguarding policies, procedures and practices comply with Children First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015.	A full review of safeguarding policies will take place to fully reflect Children First legislation and any required updates will be complete. Maintain a current Child Safeguarding Statement that is formally approved, kept under regular review, and prominently displayed in accordance with statutory requirements. Provide mandatory safeguarding refresher training to all staff to ensure ongoing awareness of safeguarding obligations and best practice. Obtain assurance that all staff clearly understand mandated reporting thresholds and procedures, including their individual responsibilities to report concerns promptly and appropriately. **Time Scales** Review of all safeguarding policies: **30.06.26** Updated Child safe-guarding statement: **Completed** Safeguarding refresher training: **18.05.26**	Conduct a yearly policy review schedule. Mandatory Children First training on induction and refresher every 2 years. Include safeguarding compliance in supervision sessions. Regular spot-checks completed by the centre manager of staff knowledge evidenced in team meetings. Regular spot-checks completed by the Regional Director of Centre Manager knowledge, evidenced in managers meetings.

	The centre manager, as DLP, must review the young people's registers and files to ensure that all child protection and welfare concerns have been reported.	The Designated Liaison Person (DLP) has completed a comprehensive retrospective audit of all safeguarding-related files and registers. Any unreported concerns identified through this audit have been retrospectively notified to Tusla as required. For cases where a report was not made, a clear and documented professional rationale has been recorded in line with mandated reporting thresholds. **Time Scales:** A full retrospective audit has been completed. **Completed** Unreported CPWC have now been reported retrospectively: **Completed**	Monthly DLP audit of safeguarding logs. This will be completed by the area manager through the Governance form. Management reviews incidents and concerns through a structured governance framework. This includes quarterly subcommittee meetings, regular board reporting, and ongoing oversight by the Regional Director in collaboration with the CEO. Monthly SERG meetings and internal quality audits further support continuous monitoring and improvement. The CEO provides monthly reports to the Board, highlighting any areas of concern, while also engaging in monthly supervision sessions with the Regional Director to identify and address emerging issues. Monthly supervision for the centre manager from the area manager to note any concerns regarding child protection and safeguarding.
	The registered provider must ensure that staff are fulfilling their reporting responsibilities in line with Children	A system review has been undertaken to identify any gaps where concerns were not reported, and the contributing factors have	Include safeguarding in every team meeting agenda. Use case scenarios in trainings and team meetings.

	First: National Guidance for the Protection and Welfare of Children, 2017 and the Children First Act, 2015.	been analysed and documented. A mandatory reporting culture will be reinforced through team meetings and ensure that staff are aware of their statutory responsibility under the Children First Act. Targeted training and supervision will be provided to support the team and ensure that all staff feel equipped and supported. Escalation pathway will be developed for staff members where there is uncertainty. All staff to be refreshed regarding their child protection to maximise understanding. **Time Scales** Child protection and safeguarding was discussed and addressed at two separate team meetings: **Completed.** Review to be conducted and completed regarding the concerns that were not reported: **15.05.26** Escalation pathway will be developed and implemented along with the revised policies: **01.06.26** Refresher training to be rolled out for the	Address non-compliance through performance management if necessary. The teams understanding of children first will be reviewed at every 6-month juncture to ascertain gaps in understanding.

		entire team: **15.05.26**	
	The registered provider must review the centres list of mandated persons to ensure it aligns with statutory requirements.	The Regional Director will ensure that safeguarding roles and responsibilities are clearly defined, legally compliant, and effectively implemented. This will include cross-checking all roles against relevant legislation, updating and formally documenting the mandated persons list, and clearly communicating roles and responsibilities to all staff to ensure robust individual safeguards for young people. **Time Scales** Update the Child Safeguarding Statement to reference the list of mandated and non-mandated persons. **Completed** Update Safeguarding policy to reflect mandated and non-mandated persons. **Completed**	The list will be reviewed annually and updated as required following any changes in staffing. Maintain compliance through quarterly checks of the child safeguarding statement. This will be completed by the area manager. The internal quality co-ordinator will check the Child Safeguarding statement when the services is being audited.
	The regional director must ensure that individual safeguards to protect young people are robust in responding to and managing identified risks.	Risk Management meeting took place on 24th February 2026, where the standardised templates for risk assessments, safeguarding (safety plans) plans, SENs, monthly risk assessments,	Risk assessments updated after incidents. Monthly SERG Meetings to support learning. Ensure young person voice is included in planning, through the medium of young person meetings, individual work

		daily risk assessments, AMPs and ICSPs were reassessed. All managers were advised on how to implement control measures and identify additional controls which are meaningful. The PIC to share all revised templates and documentation with the team. **Time Scales** Risk Management Meeting: **Completed** The PIC to share all revised templates and documentation with the centre team: **06.05.26**	and key working. Young Persons committee forum provides all young people an opportunity to have their voice heard. Regional Director will bring any concerns regarding risk or safeguarding to the quarterly Human Rights Committee. Where external oversight is provided. Monthly data analysis reports completed by the quality auditor will be made available to the Regional Director for trends and patterns. Governance oversight from the area manager with clear goals and tasks.
	The regional director must ensure that information relating to complaints, incidents and concerns are acted on, effectively monitored and analysed to improve the safety and quality of care and support provided to the young people. Young people must be informed of outcomes of complaints.	An audit of the complaints and SEN register shall take place for each young person to ensure that information is recorded accurately and factually and addressed appropriately. Ensure all staff understand the escalation of complaints and associated time frames in line with the organisational policy. At the young persons' meeting, the internal and external complaints processes	A monthly data analysis report is prepared by the Quality Auditor to systematically track complaints, incidents, and concerns. This report will be reviewed by the Regional Director monthly to identify emerging trends, patterns, and areas requiring improvement. The register of logs will be discussed with the complaints officer monthly in their supervision.

		will be explained to all young people. **Time Scale** The auditing of each individual register will be completed: **11.05.26** At the team meeting discuss and inform staff of the escalation processes: **06.05.26**	Incidents and concerns will be discussed with the centre manager at their supervision sessions with the area manager. The Area manager will discuss incidents, concerns and complaints with the Regional Director at their weekly check-in meeting. SERG meetings will take place monthly and complaints, incidents of concern and escalation process will be discussed and embedded into team. This shared learning will be shared with the team within the service.
5	The registered provider must ensure that effective leadership is provided across all management levels so that child centred, safe and effective care and support is delivered and to include the development of a culture of learning.	The Team Leader has been enrolled in a frontline leadership and management development programme to strengthen leadership capability and promote effective, positive leadership practice. Clear lines of accountability have been established through the appointment of a new Area Manager, providing enhanced oversight and governance. A workshop on a trauma informed lens such as Dyadic Developmental Psychotherapy (DDP) will be explored to	Regular management supervision and appraisal. Promote a learning culture (reflective practice sessions). Annual service review and improvement planning (30.06.26) Clear lines of reporting regarding organisational structure. All staff will be assured at each quarter of the roles of the CEO, Quality Director, HR Director, CFO and Regional Director. The Regional Director to lead with clear

		deliver to the full staff team to support practice through a reflective, relationship-based approach. **Time Scale** Leaders Management Programme: **Date of commencement: 27.04.26 Date of completion 27.07.26.** Dyadic Developmental Psychotherapy: **30.06.26**	direction, good communication, integrity and trustworthiness, empower each staff member and demonstrate a good attitude with adaptability and positive role modelling.
	The regional director must ensure that the internal management structure is appropriate to the purpose and function of the centre.	An additional team leader will be recruited to ensure the internal management structure is appropriately aligned with the centre's purpose and operational requirements. Gaps will be addressed with the assistance of HR / recruitment department. **Time Scale** Commencement of Team Leader: **30.06.26**	The regional director meets with the area managers weekly and succession planning for this centre will remain an agenda item until this has been resolved. The regional director meets with the area managers and recruitment weekly. This service will be prioritised so that the second team leader can be secured.
	To comply with Tusla SCSIP protocol the regional director must improve workforce planning to ensure that there's a mix of skilled, experience and	A comprehensive workforce analysis will be undertaken to assess staff skills, experience, and rota coverage and to identify any gaps impacting service	Introduce a formal workforce planning framework that is reviewed weekly by the Regional Director and Area Manager. This should include:

	competent staff to meet the needs of the young people living in the centre at all times.	delivery. Targeted recruitment will be progressed to address identified workforce deficits, ensuring the centre has the appropriate competency mix and staffing levels. Existing staff will be supported through structured upskilling initiatives, including targeted training, mentoring, and enhanced supervision. An ongoing recruitment pipeline will be established to promote proactive workforce planning and avoid reactive or short-term hiring approaches. **Time Scales** Workforce analysis: **05.05.26** Upskilling staff members: **commencement 05.05.26 – on-going.** Recruitment pipeline to avoid reactive hiring: **Completed and on-going.**	• A skills matrix to track staff competencies and identify gaps in real-time • Succession planning to ensure continuity in key roles. Regular supervision and performance reviews to monitor staff capability and development. Maintain a skills matrix, which will be reviewed weekly by the Regional Director and Area Managers.
	The regional director must ensure operational policies and procedures align to the centres statement of purpose and that staff have a good	The Regional Director will review and strengthen current risk management processes to ensure a robust and effective system is in place. This will include	Annual policy review cycle conducted by the Quality Director, Quality co-ordinator, Regional Director and Area Managers. Policy approval and version control will be

	knowledge of operational policies and procedures.	cross-referencing all relevant policies against the Statement of Purpose to ensure alignment and consistency. Any identified inconsistencies will be updated and formally approved. **Time Scale:** The Quality Director, Regional Director and Area Managers are reviewing all policies: **30.06.26**	maintained under the oversight of the Quality Director and Regional Director. Staff competency checks on policies at the team meeting. This to be conducted by the Centre Manager.
	The regional director must review its current risk management processes to ensure that a robust system is in place.	A comprehensive review of the risk management process has been completed to ensure the framework is robust, effective, and fit for purpose. As part of this review, the risk management framework has been redesigned to ensure the risk register is current, risks are appropriately graded, reviewed, and monitored, and that approved templates effectively support the identification, documentation, and mitigation of all risks. Staff have received training on risk identification and escalation processes, and the Centre Manager and staff are supported to complete risk documentation to a consistently high standard	Monthly risk review meetings. Integration of risk into governance structures. Continuous monitoring and internal audits. Monthly review of risk assessments by the area manager. Quarterly review of risk management tools by the Regional Director

	The centre manager must review the delegation of tasks record to ensure that duties delegated are proportionate to the competencies, experience and skills of staff.	**Time Scales** Review and redesign risk management framework: **Completed** Train staff on risk identification and escalation: **01.06.26** A full review of the current delegation of tasks record. Cross-check each delegated duty against the staff member's qualifications, experience, and demonstrated competencies. Where tasks are found to be inappropriately assigned, reallocate them to suitably skilled staff or provide appropriate supervision until competency is established. Develop or update a staff competency matrix that clearly outlines each team member's skills, training, and experience level. This will become the reference point for all delegation decisions. Review of current delegation log: **15.05.26** Staff competency matrix: **15.05.26**	The Centre Manager will embed regular oversight by: • Reviewing the delegation log as part of routine supervision and team meetings • Including delegation practices in internal audits or quality assurance checks • Updating the competency matrix regularly as staff gain experience or complete training. Ensure the Centre Manager signs off on delegation records periodically, with escalation to senior management if gaps or risks are identified. This creates accountability and helps ensure delegation remains proportionate, safe, and compliant over time.