An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 287

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Meas Mór**
Registered Capacity:	**Two young people**
Type of Inspection:	**Announced**
Date of inspection:	**29th, 30th September & 1st October 2025**
Registration Status:	**Registered from the 7th March 2025 to the 7th March 2028**
Inspection Team:	**Paschal McMahon** **Anne McEvoy**
Date Report Issued:	**18th December 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 7th March 2025. At the time of this inspection the centre was in its first registration and was in year one of the cycle.

The centre was registered as multi -occupancy service to provide long-term mainstream residential care for two young people aged 0 to 12 years on admission. The centre aimed to provide a safe and homely environment where children are protected and safeguarded and where possible to improve the lives of the children during their placement. There was one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.2
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.1

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 person, 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 relevant social work departments on the 5th November 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 service director returned the report with a CAPA on the 19th November 2025. After further communication and amendments to the CAPA, it 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: 287 without attached conditions from the 7th March 2025 to the 7th March 2028 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

The inspectors found this standard was met in relation to care planning. While the inspectors found deficits in the governance and oversight structures which will be outlined later in the report the inspectors found that the care planning processes were not compromised due to this issue. There was an uptodate care plan on file for the young person and evidence that monthly statutory child in care reviews had taken place in the timeframes set out in the legislation and in compliance with the *National Policy in Relation to the Placement of Children Aged 12 Years and Under in the Care or Custody of the Health Service Executive*. There was good evidence of planning prior to the young person's admission and there was comprehensive referral information on file. The care plan reviewed by the inspectors was comprehensive and detailed the aims and objectives of the placement. The allocated social worker confirmed they were satisfied that the tasks assigned to the centre manager as part of the care planning process were being implemented. While the young person declined the opportunity to participate in their child in care reviews their view was recorded in progress reports which were sent to the social work department prior to each monthly review. All communications with the young person's parents were managed by the allocated social worker.

There was a placement plan on file which was developed by the centre manager and key worker with input from the care team. The inspectors found that the goals of the placement plan were aligned to the statutory care plan. There was evidence that goals such as education, health, family contact, and safety were identified in the placement plan and reviewed on a monthly basis. The inspectors found that the young person had made good progress in meeting some of their identified goals since their admission. The centre did not have a key working schedule in place that identified specific pieces of work to be undertaken by named staff members. The inspectors reviewed the individual work records on file and found that they required improvement. While there were some good examples of individual work being

completed which were focused on learning, most individual records on file were merely a record of conversations which took place with the young person. Inspectors found some instances where actions for follow up were identified in individual work records, however there was no evidence that these actions were completed. There was limited commentary recorded by the centre manager offering guidance to care staff. Inspectors recommend that the service director ensures that all of the care team undertake training on key working to ensure it is purposeful. In addition, the centre manager should ensure that they comment on the quality of the individual work and ensure that any identified follow up work is completed.

Inspectors viewed care records and found evidence that the young person had access to external supports and specialist services in line with their needs. The team was receiving guidance from a clinical specialist service to guide them in their work with the young person which they reported was beneficial in understanding and supporting the young person. In interview, the allocated social worker outlined the need for additional assessments to ascertain the young person's needs and the plans in place to access these assessments.

Inspectors were satisfied from a review of the care records and interviews with management, staff and the allocated social worker that there was effective communication between all parties. There were records on file of the managers correspondence with the social worker including providing them with updates on the young person's progress and requesting documentation for the young person's care record. The social worker was satisfied with the level of communication with the care team. They confirmed that they visited the centre on a regular basis to meet with the young person and there was evidence on file that they had signed centre records. The social worker confirmed the young person had not raised any issue of concern or complaint about their care in the centre.

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

Compliance with standards	
Practices met the required standard	**Standard 2.2**
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 3.2 Each child experiences care and support that promotes positive behaviour.

The centre had policies in place that supported a positive approach to the management of behaviour that challenges. All of the care team had received training in a recognised model of behaviour management in January 2025, five months prior to the centre opening. Six monthly refreshers were required to meet training requirements, but this requirement had not been met as none of the care team had received refresher training. Inspectors were informed by the service director that a risk assessment was in place in the absence of this core training and refresher training was scheduled to take place in November 2025.

The centre had a number of written documents to assist and support the care team in the management of behaviour. These included an individual crisis support plan (ICSP), behaviour support plans (BSPs) and an individual absence management plan (IAMP). While there was evidence that the BSP had been subject to review , inspectors found that despite several significant event notifications (SENS) directing that a review of the ICSP was necessary, it had not been reviewed and updated. Furthermore, the ICSP permitted the use of physical restraint as a last resort;

however, the specific restraint techniques that were to be utilised were not documented. The IAMP on file also needed to be reviewed as it did not contain all the required information. The service director must ensure that all supporting documents to assist the care team in the management of behaviour are reviewed and updated in collaboration with the allocated social worker.

Inspectors found from a review of individual work records and SENS on file that when the young person was admitted the care team did not demonstrate an understanding of the possible underlying causes of behaviours of concern and how to respond to challenging behaviour in a positive manner. However, it was evident that the care teams practice improved over time, they developed good relationships with the young person and there was a reduction in the number of recorded incidents of challenging behaviour in the period prior to inspection. This was evident to inspectors who observed the young person interacting with staff in a positive manner during the inspection. The young person also spoke with inspectors and told them that they were happy living in the centre.

The care team had access to an external support service that offered them specialist advice and support in their work with the young person. This service had met with the care team on a weekly basis to review the young person's progress and provided them with appropriate strategies and interventions in managing and responding to challenging behaviour. All those interviewed stated that this clinical support was very beneficial in guiding their practice and there was an improvement in the young person's behaviour. Inspectors noted that this clinical guidance was not recorded and recommends that moving forward a written record is kept for the benefit of those not in attendance and as a future resource. There were also a number of life space interviews conducted by the young person's key worker to help the young person to manage their behaviour and discussing alternative ways of responding to stressful events. Acknowledging the fact that the care team was still in the process of formation, inspectors could see evidence that the level of team cohesion was improving over time with a more consistent approach in their work with the young person. The allocated social worker and the young person's Guardian Ad Litem both confirmed this highlighting the positive relationships the young person had developed with the care team and how their capacity to manage the young person's behaviour had improved.

There was evidence that the allocated social worker for the young person had provided sufficient pre-admission referral information to the centre and a pre-

admission risk assessment was undertaken to identify and address areas of vulnerability for the young person.

The centre supported natural consequences for unacceptable conduct and consequences were recorded on a register. While the care team made efforts to ensure that natural consequences were linked to the behaviour of concern, inspectors found that some consequences were not age appropriate, of a long duration and there were instances when more than one consequence was in place simultaneously. Inspectors recommend that the centre manager ensures that all consequences are age appropriate and for the shortest duration.

There was no effective monitoring system in place to review and learn from significant events. There was evidence that the centre manager consistently signed SENs, significant conversations and individual work reports but there was limited evidence of commentary on these documents noting if incidents were handled appropriately, if alternative strategies could have been used or if any follow-up was required. A number of significant event review group (SERG) meetings had taken place to review incidents but the minutes of these meetings did not record an in-depth analysis of behaviours or learning for the care team. Inspectors also reviewed a sample of staff supervision records and found no evidence of any learning or review of SENS. The centre manager reported that they discussed all SENS with the service director and there were some discussions in regards to SENS at team meetings. However, there was no evidence on file of the service directors' oversight of SENS or auditing the centres approach to managing behaviour. This is discussed in more detail under standard 5.2 of this report.

There was a policy in respect of the use of restrictive practices which inspectors found was not understood by the care team. All restrictive practices that were recorded were safety measures in place to safeguard the young person. The one restrictive practice that was in place was the permitted use of physical restraint which was not recorded. The service director must ensure that the restrictive practice policy is reviewed with the management and care team and any restrictive practices in place are recorded.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 16**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that the care team receive refresher training in behaviour management without delay and refresher training takes place within the required timeframes.
- The service director must ensure that all supporting documents to assist the care team in the management of behaviour are reviewed and updated in conjunction with the allocated social worker.
- The service director must ensure that there is an effective monitoring system in place to review and learn from significant events.
- The service director must ensure that the restrictive practice policy is reviewed with the management and care team and any restrictive practices in place are recorded.

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

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered 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 centre had a written policy on leadership and management. This policy stated that the organisation would ensure that there were clearly defined governance arrangements and structures in place that set out the lines of authority and specified the roles and responsibilities of all the staff in the centre. Inspectors found that this

was not evident in practice. A centre manager, a service director, and the registered providers made up the organisation's management structure. The centre manager was well regarded by the staff in terms of the support and guidance they provided. They reported to the service director who was in daily contact with them and visited the centre a number of days a week. The centre manager reported that the service director was supportive of their role and provided them with regular supervision. Staff in interview confirmed that they met with the service director on a regular basis but were unclear as to their specific role and responsibilities and the purpose of their visits. The service director reported to the registered providers and there were records of monthly meetings taking place.

The centres leadership and governance policy stated that the service director would ensure that they had appropriate governance and oversight of the centre by regular internal auditing and reviewing weekly governance reports. However, this policy had not been implemented. Inspectors found that there were no service director audits undertaken and they were no weekly governance reports being completed by the centre manager. There were two internal audits on file which were completed by the centre manager. These audits assessed the centres level of compliance with two themes of the National Standards for Children's Residential Centres, 2018 (HIQA). Inspectors found that these audits were not fit for purpose as they were focused solely on a document review. Staff interviews were not a part of the process and neither audit had an action plan to address identified deficits. There also did not appear to be any system implemented by senior management to validate the information being presented by the centre manager.

The centres clinical governance policy stated that team meetings were to take place weekly. There was evidence that when the centre opened in June 2025 staff meetings took place initially on a weekly basis and subsequently every fortnight. Inspectors found that due to annual leave there was one occasion when no staff meeting took place for a month. Inspectors recommend that the centre manager ensures that team meetings take place weekly in accordance with policy. The manager should also ensure that there is a review of the previous meeting actions at the start of meetings and consideration is given to including a number of standing agenda items to ensure that key areas are covered.

At the time of this inspection the centre were applying for a contract with the funding body and there were regular visits to the centre by Tusla personnel to monitor the young person's progress.

All of the care team received training in the centres policies and procedures during their induction process prior to the centre opening. Staff confirmed in interview that there had not been any discussion or review of policies and procedures in team meetings and supervision records since then. The service director must ensure that a mechanism is in place to support the ongoing implementation of policies and procedures with the care team.

The centre had a risk management policy and framework in place. There were individual risk assessments on file and a risk register was maintained. A risk matrix was to be used to measure all risks and mitigation measures identified. In interviews with care staff, inspectors found that that they did not demonstrate an understanding of the framework in terms of the categorisation and scoring of risks and the risk assessments on file were not scored using the risk matrix. The registered provider must ensure that the risk management framework is reviewed with the management and staff to ensure they are aware of the framework and understand how to implement it. They must also ensure continued oversight of risk management to ensure effectiveness.

The centre had an internal management structure in place appropriate to the size and purpose and function of the residential centre. This consisted of a centre manager, deputy manager and a team leader post. At the time of inspection, the deputy manager was covering shifts on the roster due to staff shortages. The centre manager was due to go on planned leave, and the deputy manager was due to take on the acting manager role. There were arrangements in place for the deputy manager to assume responsibility for the centre when the manager was on leave.

The manager reported that they had delegated tasks to staff members when they took leave but there was no delegation record maintained. The centre manager must ensure that a written delegation record is kept of when and identify to whom tasks have been delegated and the key decisions made.

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

Actions required

- The registered provider must ensure that all of the care team are aware of the governance and oversight arrangements in the organisation and the roles and responsibilities of senior management.
- The registered provider must ensure that the governance and oversight arrangements outlined in the centres leadership and governance policy are adhered to. The registered provider must also ensure where the centre manager is carrying out their own audits that there is a quality assurance system in place to ensure information is validated and accurate and that an action plan emulates from same.
- The registered provider must ensure that a more robust auditing system is implemented to assess the safety and quality of care being provided against the National Standards for Children's Residential Centres, 2018 (HIQA).
- The service director must ensure that a mechanism is in place to support the ongoing implementation of policies and procedures with the care team.
- The register provider must ensure that the risk management framework is reviewed with the management and staff to ensure the risk management framework is implemented. They must ensure continued oversight of risk management to ensure effectiveness.
- The centre manager must ensure that a written delegation record is kept of when and identify to whom tasks have been delegated and the key decisions made.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

The inspectors found that workforce planning and recruitment was discussed at all senior management meetings. At the time of this inspection the staffing complement consisted of the social care manager, deputy manager, one team leader and four social care workers. Inspectors found that there were not sufficient staff numbers to meet the needs of the young person in placement. Inspectors were informed that the deputy manager appointed when the centre opened had since resigned and one social care worker who was recruited when the centre was registered three months prior to the centre opening never took up their post. In addition, the centre had been unable to recruit any relief staff to provide cover for annual leave and other types of leave. The centre was understaffed as a result and providing the necessary double cover arrangements to staff the centre was challenging. While inspectors were satisfied from a review of staff rosters that there was always double cover, this led to the staff having to work extra shifts to fill in the gaps in the roster along with the use of agency staff. As previously highlighted the deputy manager was also covering shifts which limited their capacity to carry out their managerial functions. Staff recruitment and retention was the responsibility of the service director. The service director told inspectors that recruitment was ongoing and they had engaged the services of a recruitment agency to assist the company in their recruitment efforts. At the time of inspection, inspectors were informed that three new staff members were in the process of onboarding.

Inspectors found that while all staff were appropriately qualified there was limited experience amongst the care team in regards to children's residential care. Supervision was identified as a measure to support the care team and to promote continuity of care. Following a review of a sample of staff supervision files the inspectors found that supervision was primarily focused on offering support to the manager and staff team. Inspectors recommend that both the service director and the centre manager should place more emphasis going forward on key responsibilities, feedback, and training and development in the supervision process. The service director informed inspectors that there were plans in place to introduce pensions and a number of other incentives going forward to promote staff retention.

There was a formalised on-call system in place to support staff at evenings and weekends which the care team found supportive. This was provided on a rotational basis by the centre manager, deputy manager, team leader and a social care worker. Inspectors found that the social care worker did not have sufficient experience to provide on call support and the service director confirmed to inspectors' post inspection that they were no longer part of the on-call service.

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

Actions required

- The registered provider must ensure that there are sufficient numbers of staff and relief staff employed in the centre to meet the needs of the young person and the centres statement of purpose.

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 the care team receive refresher training in behaviour management without delay and refresher training takes place within the required timeframes.	The care team attended behaviour management refresher training on 24th October 2025. We await certificates from the external trainer which will be kept on file.	From 24 October 2025, a digital reminder will be sent to the service director 60 days prior to expiry. Relevant training will then be discussed at next meeting with centre manager and booked, with copies of booking email(s) placed in Training file in the centre.
	The service director must ensure that all supporting documents to assist the care team in the management of behaviour are reviewed and updated in conjunction with the allocated social worker.	At the Child in Care meeting on 19 November 2025 SENs, behaviour management and plans were reviewed and updated in conjunction with the allocated social worker. The Care Team Meeting Agenda has been amended to include SENs/behaviour plans/management of behaviour.	The centre manager and social workers have fortnightly (in person) meetings at the centre. At the meeting on 12 November 2025, it was agreed that SENs, behaviour management and plans will be discussed at these fortnightly meetings. A document record of these meetings was started on 12 November 2025.
	The service director must ensure that there is an effective monitoring system	From 17 November 2025 a weekly cycle of meetings with service director and centre manager will include a review of SENs	Formal recording of service director and centre manager meetings has been put in place since 10 November 2025 . SEN

	in place to review and learn from significant events. The service director must ensure that the restrictive practice policy is reviewed with the management and care team and any restrictive practices in place are recorded.	with a care team member. Learnings and outcomes will be brought to the Care Team meetings. At the team meeting on 18 November 2025 the service director presented at care team meeting on the restrictive practice policy. Presentation will made available on Data Library for care team, and referenced in Induction, by 19 December 2025.	reviews and learnings will be included as part of Audits review (by 31 December 2025). Restrictive Practice Register has been amended as discussed during Inspection.
5	The registered provider must ensure that all of the care team are aware of the governance and oversight arrangements in the organisation and the roles and responsibilities of senior management. The registered provider must ensure that the governance and oversight arrangements outlined in the centres leadership and governance policy are adhered to. The registered provider must also ensure where the centre manager is carrying out their own audits that there is a quality assurance system in place to ensure information is	On 2 December 2025, the service director will present at care team meeting on governance and oversight policy including roles and responsibilities. A calendar has been created from policies and procedures to ensure all governance and oversight arrangements are set out and completed in a timely manner. Weekly governance reports will be completed by centre manager for service director.	Presentation will made available on Data Library for care team, and referenced in Induction, by 19 December 2025. A calendar will ensure the timely adherence to governance arrangements. This calendar will commence on 1 January 2026. A weekly governance report will be completed by centre manager and sent to service director, commencing on Friday 21 November 2025.

	validated and accurate and that an action plan emulates from same.		
	The registered provider must ensure that a more robust auditing system is implemented to assess the safety and quality of care being provided against the National Standards for Children's Residential Centres, 2018 (HIQA).	The service director will ensure that centre managers audits are checked and commented on, within two weeks of audit, by service director. Audit Action Plans will ensure follow up of any issues by relevant person.	Audits being reviewed (by 31 December 2025) to include reference to team meeting discussions, care team input and service director comments/oversight. An Audit Action Plan will be added to Audits. New Audit suite will be operated from 1 January 2026. From 1 January 2026, a quarterly review will be implemented by service director.
	The service director must ensure that a mechanism is in place to support the ongoing implementation of policies and procedures with the care team.	Policies have been added to the care team meeting agenda. Centre manager and service director will propose specific policies to the care team meeting agenda based on their weekly meetings.	Before team meetings, the specific policy being discussed will be highlighted to staff in the communications book. and made available on the Data Library. Knowledge of policies to be added to review of audits (by 31 December 2025).
	The register provider must ensure that the risk management framework is reviewed with the management and staff to ensure the risk management	On 2 December 2025 the service director will present at care team meeting on the risk management framework.	Weekly risk register review has been added to service director and centre manager weekly meetings. Presentation will made available on Data Library for care team,

	framework is implemented. They must ensure continued oversight of risk management to ensure effectiveness. The centre manager must ensure that a written delegation record is kept of when and identify to whom tasks have been delegated and the key decisions made.	 A delegation log has been implemented since 28 October 2025 .	and referenced in induction, by 16 December 2025. Delegation log will be reviewed by centre manager and service director at their weekly meeting.
6	The registered provider must ensure that there are sufficient numbers of staff and relief staff employed in the centre to meet the needs of the young person and the centres statement of purpose.	Since inspection we have added another staff member on 17 November 2025. A further two candidates have been offered relief positions since inspection. We have contacted a second recruitment agency for provision of staff.	Quarterly workforce planning meetings with the centre manager and service director will take place from 1 January 2026 to monitor staff levels and prevent shortages.