An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 316

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Odyssey Social Care**
Registered Capacity:	**Four Young People**
Type of Inspection:	**Announced**
Date of inspection:	**16th and 17th February 2026**
Registration Status:	**Registered from 25th July 2025 to 25th July 2028**
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Date Report Issued:	**13/05/2026**

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1. Information about the inspection process

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

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

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

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

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

National Standards Framework



1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 25th July 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 to provide multiple occupancy care, for up to four young people who required medium to long term placements and who ranged in age from eight to sixteen years on admission. It aimed to provide child-centred, supportive, care in a safe and open environment based on their ability to manage needs and presenting behaviours. There was a focus on education, social and psychological development. The organisation had adopted an evidenced based, recognised model of care for children who had experienced trauma. It was intended to be flexible and responsive to individual needs of young children. There was a sibling group of three children 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 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 26th of 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 centre manager returned the report with a CAPA on the 9th of April 2026. A regulatory compliance meeting was held with the provider on 22nd April 2026 as non-compliance with Regulation 7: staffing of the Child Care (Standards in Children's Residential Centres) Regulations, 1996 had been identified at the time of the inspection. However, the CAPA was deemed to have satisfactorily addressed the non-compliance, and the centre was deemed compliant with Regulation 7 at the time of the final report.

The findings of this report and assessment of the submitted CAPA deem the centre to be operating 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: 316 without attached conditions from the 5th of July 2025 to the 5th of July 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.

This was the first inspection of this centre since commencement of operations when the three children were placed in October 2025. There was evidence that information was provided to the team prior to children's admission to facilitate identification of supports required and plan to assess and manage risk.

Two of the young people were aged under 13 years and as such monthly child in care review meetings should have been taking place in line with the National Policy and Procedure for the Placement of Children aged 12 years and under in the care of the Child and Family Agency, 2025. This was not evident upon review of care records at the time of inspection. Review meetings were requested by the recently appointed acting manager and were now scheduled for the child who remained under 12 years. There was evidence of frequent strategy meetings for all young people. While statutory child in care reviews took place for all children six weeks after their admission, no care plans were received by the centre until the week prior to this inspection in February 2026.

The organisation operated a specific model of care that had a system for the development and review of placement plans with a focus on specific domains such as, being active and healthy, safe and nurtured, developing life skills and achieving full potential, amongst others. Progress, or lack of, was intended to be assessed through measurable outcomes.

Inspectors found that this centre had a particularly high staff turnover and significant deficits since opening. This is discussed in greater detail under standard 6.1. A significant number of the team had not received training in all six modules of the model of care. Dates were not yet scheduled for this training due to staffing pressures and recruitment of new staff at the time of inspection. Placement planning was a key component of realising the model of care in practice.

Overall inspectors found that the implementation of this placement planning framework and model of care programme was in the early stages of development in this centre. Managers interviewed during the inspection acknowledged that due to staffing pressures and skills deficits attributed to deficits in training, they had retained responsibility for developing placement plans. From review of care and centre records, staff interviews, and speaking with relevant professionals it was evident that placement planning required improvement. A quarterly consultation with the consultant with oversight for the model of care to support placement planning and full implementation of the system had not taken place. While care staff interviewed named key pieces of work planned with children, there was a lack of clarity around the process of placement planning and who was responsible for specific tasks. Inspectors recommend further training and guidance from the consultant who developed the model is sourced to support its implementation in this centre.

While it is acknowledged that it was still early days in the children's placement and the transition was a difficult period for all, there was limited evidence of key working across all care records reviewed. Notwithstanding this, inspectors found that there was a strong emphasis on building trusting relationships with the children, and this was observed during the two-day visit to the home. Inspectors took the opportunities to play, meet and interact with all children and shared meals with some. They were proud to show inspectors around the house and while all said they would prefer to live at home with family, they said it was a 'nice place to live', and 'fairly good'. They named the same two or three people that they could talk to if they had good news or if they were upset.

Inspectors found many examples of how a parent was consulted and actively involved in the care of the children. Their wishes were considered and they received regular check ins and updates. The children described how this parent came to visit them in the house and cooked and cared for them when there. They also had opportunities to meet this parent and a sibling in the community. They had opportunities to have their voices heard when discussing meal planning, activities, chores and how to support them with school or education preferences. These meetings also often involved the parent where possible.

The social worker confirmed they received copies of all planning documents.
The inspectors found that some identified external supports and specialist services were not yet in place in line with care plans. Strategy meetings were held and funding was approved to source required supports when appointments became available.

While care plans were delayed, there was evidence that there was regular communication with the social work department and the court appointed guardian ad litem in support of planning for the children.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 2.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that all staff are trained and familiar with the model of care, have support with its implementation, and that placement planning is aligned to the model and implemented in practice.
- The registered provider must ensure that the direction and guidance of professionals and specialists involved in planning for young people is implemented in full and monitored with effective oversight.

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 organisation had a suite of policies to support care staff to manage children's behaviour. These included managing challenging behaviour, promoting positive behaviour, and policies in respect of managing risk or absences from the centre. The model of care in place was intended to support young people through an identified framework and therapeutic alliances; however, not all staff were trained in the model and oversight of the delivery of model in practice was not evident either internally within the organisation or through support of the external consultant.

All staff were trained in a recognised behaviour management model during their induction and refresher training was completed as required. Inspectors recommend that the centre management should consider a family focused version of this training which may be more appropriate given the ages of some of the children being cared for. Staff training was monitored and tracked on a staff training database. Notwithstanding policies and this training, the behaviours of some of the young people presented a significant challenge and there were high numbers of significant events in the first three months following the children's admission to the centre.

Inspectors found deficits in the overall management of behaviour. This view was shared by the allocated social worker, appointed guardian ad litem and by other professionals such as school staff and An Garda Síochána, who had expressed verbal and written concerns to centre management and the social work department. There were a number of contributory factors identified by inspectors. There was a high level of staff turnover since the centre opened, and only three of the team presented upon application for registration remained on the team at the time of this inspection. The organisation had faced challenges in recruiting and retaining staff for this centre and the current team was relatively inexperienced in residential care. Scheduled training was frequently unable to take place due to staff shortages and on occasion staff did not present for training. Internal and external managers concurred with these findings and were making efforts to take remedial action. Details in respect of impact of staffing deficits are further discussed under standard 6.1 of this report. There was also a change in manager of the centre since it opened four months ago. At the time of this inspection an experienced deputy manager from another centre was acting up temporarily to the position of person in charge until a full-time manager was appointed.

The framework of behaviour management in the centre involved the development of Individual Crisis Support Plans (ICSPs), Individual Absence Management Plans (IAMPs), routine support plans, risk assessments and behaviour support plans (BSPs), if required. Inspectors found that due to identified skills deficits and insufficient staff, that the centre manager or deputy managers drew up these plans rather than the staff team. Risk management was not well understood. The ratio of staff to young people and high levels of supervision identified as being required, was below that indicated in these plans so they could not be implemented in practice. Additionally, care staff interviewed were not familiar with the identified interventions in these plans and often they were not implemented in practice. During one recent incident, a staff member was left alone to manage violent and aggressive behaviour contrary to written plans communicated to and signed off by all. Inspectors found

that initial review of this incident by internal and external managers was inadequate. A subsequent review was provided at the request of inspectors that set out identified actions and appropriate follow up.

There was limited evidence of follow up work or creative interventions with the young children to help them to understand their feelings and learn new coping strategies. Incidents over a certain threshold were subject to analysis through significant event review meetings. While there was some evidence of review of triggers and contributory factors, the analysis did not benchmark interventions against written plans or clearly specify what practice changes or management interventions were required. For example, one review determined that staff 'should not rely on public intervention' rather than a thorough consideration of the impact of depleted resources (staffing) and specific actions required to ensure safety.

Despite high levels of significant events for two children, only one had a written behaviour support plan (BSP) that was devised in consultation with the behaviour support analyst who had attended team meetings and visited the centre to meet the young person and observe behaviour. The significant events in the centre were primarily between two children and usually escalated quickly. The reason for the delay in development of a BSP for the other child was not clear although the risk register indicated that they were completed for both young people. The relevant people must ensure that this child's plan is completed, and robust guidance and support is provided to the care team as a matter of priority.

For the BSP that was drawn up and communicated to the team, care staff interviewed were not able to specify advised interventions, were not familiar with resources and reading material suggested by the specialist, and implementation of recommended interventions such as a sensory corner and nature-based activities were not evident. Additionally, resources suggested by a school to support attendance for another young person were not communicated to the staff team. While care staff interviewed were able to understand the cause of children's frustration and challenging behaviour, it was clear that training, skills development and professional supervision was key to developing their confidence and responses.

There was evidence in recent weeks of more coordinated and collaborative planning to address identified deficits. Inspectors found that following review of incidents, strategy meetings with social workers and feedback from managers that an over reliance on the Gardai to support management of behaviour was decreasing.

There was evidence that the young people had developed trusting relationships with a small group of core people and this was beginning to have a positive impact. There was evidence that significant events had reduced month on month. Joint strategy meetings were taking place with relevant professionals, and it was hoped that once there was a full stable staff team this improvement would continue. The centre was registered to accommodate four children however the regional manager confirmed that no further admissions would take place at this time.

The social work team leader who was the allocated worker for the majority of the children's time in the centre spoke with inspectors. They acknowledged that it was a difficult transition into care for these children and that there was a period of time when staffing problems and communication difficulties contributed to the capacity of the team to manage presenting behaviours effectively. They indicated that following various strategy meetings and enhanced communication, planning had improved, the manager and team were committed to supporting the children and significant events and incidents had greatly reduced. They felt that if the centre had a full consistent staff team and manager, training and support they would develop skills and confidence and have an increased capacity to meet the identified needs of the children.

Over the course of the two days in their home inspectors observed the care team responding to the children's individual needs and interacting with them in a warm and caring manner. One older young person confirmed to inspectors that while they sometimes became involved when their siblings became escalated, they were not expected to intervene.

The centre had a small number of restrictive practices in place to ensure safety which were risk assessed and subject to regular review. The social work department was made aware of any restrictive practices in place.

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 robust review of serious incidents with evidence of timely actions relating to any findings.
- The registered provider must ensure that behaviour support plans are drawn up and implemented according to children's needs and organisational policy.

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.

While there was no policy in respect of governance, all staff interviewed were clear about the lines of authority and accountability within the company. Notwithstanding this, there were significant staffing deficits since the centre opened in October 2025. At the time of inspection, the management team comprised of a temporary acting social care manager, one full time deputy manager, and a second deputy manager who was due to move to another position within the organisation when staffing stabilised. The remainder of the team consisted of one social care leader, three social care workers and one residential care worker. The team was supplemented by two staff temporarily deployed from a sister house within the organisation. There was one management vacancy and five staff vacancies with recruitment underway.

If a full team is achieved, the internal management structure would be appropriate to the size and statement of purpose for the centre. At the time of inspection, the acting manager (redeployed from another centre) was expected to remain until April 2026 at which time a new manager who had accepted the position would be in post and there would be a comprehensive handover with both overlapping for a time. It must be highlighted that this will be the third change of manager the children have experienced since they moved in in October 2025.

The acting manager was supported by two deputy managers, one of who was moving to take up a managers post for a new centre opening within the organisation. There were two social care leader posts, one of which was vacant at the time of inspection. The acting social care manager reported to a regional manager who held responsibility of this and two other centres in the region currently (with a fourth opening soon). The regional manager normally visited the centre monthly, however due to the high levels of significant events and staff and management changes they had a greater presence in this centre.

The regional manager confirmed that there was a service level agreement (SLA) in place with Tusla, scheduled meetings took place and there were pathways for the communication of all key information.

The post of quality assurance auditor was held for a short time in 2025, but this person left their post in the weeks prior to inspection, and the position was vacant with recruitment ongoing for a replacement. This person had completed an audit of the centre on January 6th, 2026. This was based on their assessments of compliance with the national standards for residential care, 2018, HIQA. Actions requiring attention such as those related to placement planning, key working, care plans and training were ongoing at the time of inspection.

The responsibility for policy and procedure review was held by the head of residential care services and the CEO of the company, and the last review took place in October 2024. Inspectors were informed in previous inspections in 2025 that a company-wide policy review had commenced with the involvement of the previous quality assurance person. This task was assigned to a replacement person to ensure this work continued and it remained underway at the time of this inspection. Inspectors were provided with evidence of the scheduled plan for the policy review in 2026.

The internal communication structure set out meetings that individuals at different layers of management were expected to attend to fulfil their role (such as supervision,

strategy meetings, significant event reviews and auditing). There was evidence that policies were discussed at team meetings however, there were some knowledge deficits during interviews with team members even among those with some management responsibilities.

The inspectors found that since the appointment of the acting centre manager there was evidence of increased oversight of centre's practices and recording systems. Staff interviewed stated that this person was supportive and accessible to them. They felt that this manager and the regional manager have now acknowledged that the centre had experienced a period of uncertainty and instability and it had been a challenging time. They had found it difficult but understood that efforts were underway to fully resource the centre. There was evidence that the manager made comments on some centre records to evidence oversight and that they provided guidance and direction. They had yet to commence supervision with the team.
The acting centre manager maintained a delegation log in place that evidenced tasks assigned to the deputy managers. There were arrangements in place if the centre manager took leave one of the deputy managers undertook this role.

There was evidence of governance systems in place such as the weekly meetings between centre managers and the regional manager, service governance reports, the regional managers operational reports, managers meetings, risk registers, a delegation log and auditing by the quality assurance auditor. The regional manager had completed reviews of complaints, staffing and child protection. From review of these records inspectors found that some required actions remained outstanding at the time of inspection such as a full stable team, training needs and implementation of behaviour support plans. Additionally, a complaint about staff members who were speaking in their native language in front of children remained open despite an acknowledgement that this should not have happened.

A review of team meeting records evidenced that they were generally well attended and that the regional manager attended on occasion. There was evidence of reflection on the findings of the quality assurance audit, discussions and updates in respect of risk and plans for key working and individual work with children-In recent times there was evidence that the manager and regional manager was trying to support the team to develop a more cohesive and consistent approach and there were plans in place to track and monitor key working more effectively and improve governance and oversight. Team meetings took place on a monthly basis and consideration should be given to increasing the frequency of meetings until levels of skills and staff development and confidence increase.

Inspectors found that the current provision of on call support was not sustainable given the staff numbers, skills deficits and high levels of risk and frequent incidents to date. The centre manager was expected to provide support from 8am each Monday to 8am each Saturday with the remainder covered by a roster across the region. The regional manager accepted this was excessive and stated it would be reviewed.

Inspectors found that there were deficits in respect of the management of risk including a lack of evidence that risk was properly categorised, aligned to the company risk matrix or reviewed to assess requirements for ongoing mitigation measures. Additionally, as described above, the manager and regional manager acknowledged that the staff team required extra supports to build confidence and competence in respect of risk management. Following inspections across the wider organisation in 2025, actions were required to improve the risk management framework and staffs' awareness and understanding of the identification, assessment and management of risk. The regional manager outlined the current status of this work and provided evidence that it was almost at completion and a plan to train staff was imminent.

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 the timely implementation of actions arising from internal audits or inspection processes.

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.

As previously outlined, there were significant and ongoing staffing deficits since the centre opened due to resignations, one staff transfer and a significant level of sick leave. Of the original list of ten staff members presented at the point of registration, only three remained (one deputy manager and two social care workers). From a review of centre rosters from October 2025 to February 2026 inspectors found that 42 different people had covered shifts in the centre, which was particularly concerning given the young age of the children and the difficult transition into care. As mentioned previously, issues related to staffing were raised by social workers, a court appointed guardian ad litem, school personnel and an Garda Síochána. These issues were responded to in writing and through strategy meetings with commitment to address known deficits. Notwithstanding this, commitments made subsequent to an Alternative Care Inspection and Monitoring Service (ACIMS) risk response review, following a risk escalation, were not yet realised and this standard was not met.

While there was evidence that recruitment was ongoing and staffing was discussed at various management forums the centre remained understaffed at the time of inspection. To date, staff from other centres were used to cover the rota, the managers covered on occasion and where all options were exhausted agency staff were used. There were occasions staff worked additional shifts and on at least 12 occasions back-to-back shifts were worked. There was evidence that this was entered on to the risk register, monitored and avoided where possible.

As previously stated, inspectors found that depleted staffing resources had impacted on capacity to implement the model of care and model of behaviour management. It also negatively impacted the capacity to build trusting relationships with children and on staff morale and wellbeing. The children who spoke with inspectors all stated that they had two or three people that they liked and trusted however all agreed that a lot of different people had worked with them. One stated it was 'confusing' and another explained that there was 'no point getting to know some people'.

It was determined to meet the needs of children and fulfil the statement of purpose, that three staff per day were required in the centre. In the four months that the centre was operational there were at least 36 occasions where only two staff were available to provide care for the three children. As a result, the mitigation and control measures identified on the child safeguarding statement, risk assessments, safety plans and the risk register could not be implemented to ensure safe and effective care.

In interview with inspectors, the regional manager accepted that the team had been through a period of crisis and were under immense pressure due to staffing shortfalls, changes in management and the level of risk. They informed inspectors that they had implemented temporary redeployments of care staff to this centre, that recruitment was ongoing and that a manager and five new care staff were offered posts prior to inspection. They acknowledged when questioned by inspectors that more people leaving, and six others commencing had the potential to create further instability. They stated they understood this would need to be carefully managed so as not to create unintended consequences of increased significant events and more staff turnover.

Some exit interviews were undertaken with staff who left the service and there was evidence that while uptake was low that the issues arising were discussed at senior management level. Management should consider ways to increase uptake of exit interviews to inform service improvements based on possible trends and patterns arising.

By the time of the inspection, despite ongoing staffing deficits, with temporary redeployment the centre had sufficient staff numbers to provide the required 1:1 staff/child ratio each day as required. There were three staff on duty during the day and two staff in the centre overnight although, on at least four occasions, a staff member did not work the entire duration of the shift and came in late or left early. Senior managers must make sure this does not happen. The centre manager stated that they planned the roster as far as possible in advance to try to ensure there was a balance of experienced to inexperienced staff on each shift. There was only one recently appointed social care team leader with limited experience and knowledge of residential care on the team, and it was not feasible to have a team leader on each day.

The inspectors recommend that at recruitment stage for middle managers that skills and experience are better considered to ensure sufficient day to day support for the team to facilitate learning and skills development.

There was one dedicated relief staff member available to cover all types of leave and they were studying and only available at weekends so this must be strengthened.

Compliance with regulations	
Regulation met	**Regulation 6**
Regulation not met	**Regulation 7**

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 6.1**

Actions required

- The registered provider must ensure that there are sufficient numbers of fulltime (and relief staff) with the necessary qualifications, skills, competencies, appropriate to their role, to provide care and support to children. The agreed child to staff ratio must be adhered to at all times.

4. Corrective Actions and Preventive Actions (CAPA)

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre must ensure that all staff are trained and familiar with the model of care, have support with its implementation, and that placement planning is aligned to the model and implemented in practice.	A structured model of care implementation plan will be embedded within the centre, including mandatory training for all new and existing staff, with attendance tracked and monitored by management to ensure full compliance. The centre manager will complete monthly audits of staff understanding and application of the model of care in practice, including direct observation, staff supervision, and review of daily logs and key working sessions. Placement plans and behaviour support plans (BSPs) will be formally reviewed on a 6-weekly basis, with clear evidence that	The clinical support (ICS) team will provide ongoing oversight through attendance at team meetings, case reviews, and the continued operation of the ICS drop-in hub, ensuring staff have consistent access to specialist guidance and support. ICS have shared schedule with organisation, since January 2026 with dates of attendance. Invites for drop in hub will be sent on an ongoing basis directly to each team member in organisation. A standing agenda item will be introduced at all team meetings to review the model of care and its application to current placements, ensuring it remains central to daily practice and decision-making. This

		they are aligned to the model of care and fully implemented in practice. Any gaps identified will result in immediate action plans for staff.	will commence within the organisation in May 2026. The regional manager and the centre manager will complete quarterly governance reviews to ensure that specialist recommendations are implemented in full, with clear accountability and escalation pathways where actions are not completed. Commencement date for this is May 2026. Staff supervision will include a specific focus on the model of care and BSP implementation, ensuring individual accountability and continuous professional development. This will be communicated in weekly link in meetings in April 2026 to centre managers and deputy managers.
	The registered provider must ensure that the direction and guidance of specialists involved in planning for young people	Review of current cases • The organisation will conduct an urgent audit of all young people's	The organisation will continue to utilise a tracking system of specialist involvement, this is working well, this will be improved

	is implemented in full and monitored with effective oversight.	care plans to identify where specialist recommendations (e.g. Psychology, CAMHs, speech & language, occupational therapy) have been made. This will occur in April 2026	for oversight from June 2026 with update centre policies to include: • A clear process for receiving, recording, and implementing specialist guidance • Defined timeframes for action • Escalation procedures if actions are delayed The organisation will review policy & procedure by June 2026 The organisation will strengthened governance & oversight to include monthly ICS/regional manager meetings per region to review specialist support

3	The registered provider must ensure robust review of serious incidents with evidence of timely actions relating to any findings.	All serious significant events (SENs) will be reviewed in line with the organisation's risk management policy, with clearly defined timeframes for initial review, action planning, and closure. Compliance with these timeframes will be monitored by the centre manager and regional manager. This is now in place, however action plans and follow up require improvement. A standardised SEN review process will continue to be implemented, ensuring that each incident includes a clear analysis of contributing factors, identified learning, and specific, measurable actions. This is in place however further work required to ensure process is filtering down to social workers. Ongoing learning from incidents will be embedded into practice through weekly team meetings and organisational forums,	The centre and regional managers, from May 2026 will complete monthly oversight reviews of all SENs, ensuring that actions are implemented in a timely manner and that there are no delays in progressing outcomes. From May 2026 action plans arising from SENs will be tracked with assigned responsibilities and deadlines. The centre manager and regional manager will complete formal sign-off only when all actions are evidenced as complete.

		ensuring that trends, patterns, and risks are consistently communicated and addressed across the service. Implemented and in place.	
	The registered provider must ensure that behaviour support plans are drawn up and implemented according to children's needs and organisational policy.	All young people will be assessed on admission (or following any significant change in presentation) to determine whether a Behaviour Support Plan (BSP) is required. Where indicated, BSPs will be developed within defined policy timeframes and not delayed. Any existing gaps (including previously delayed BSPs) will be prioritised and completed immediately.	Behaviour support plans (BSPs) will be developed, reviewed, and updated in line with assessed need and organisational policy, with formal 6-weekly reviews and immediate updates following any significant incident or change in presentation, this will follow policy review and commence in July 2026.
		Daily oversight mechanisms will be strengthened, with centre managers/deputy managers reviewing logs to ensure BSP strategies are consistently applied and escalating any gaps in implementation without delay. Immediate implementation.	Behaviour Support Plans (BSPs) will be developed, reviewed, and updated strictly in line with assessed need and organisational policy. Not all young people require BSPs; however, where a need is identified, timely development is mandatory. Formal 6-weekly reviews will

		From May 2026, staff supervision will include a specific focus on incident learning and BSP implementation, ensuring accountability at an individual staff level and reinforcing best practice approaches.	take place, with immediate updates following any significant incident or change in presentation. This will follow policy review and commence in July 2026. Weekly childcare meetings involving centre managers, regional managers, and the director of operations will include a standing agenda item on BSP status (required, in development, or completed). Template has been updated. Any delay in BSP development beyond policy timeframes will be escalated to the director of operations without delay. The ICS team will maintain active involvement through referrals, attendance at team meetings, and regular house visits, ensuring that BSPs are both appropriate and effectively implemented in practice. Regional manager and ICS team will continue to hold monthly meetings to

			review and prioritise the needs of specific young people, with clear timeframes agreed for BSP development, recognising the need for quality and informed planning. From June 2026, unannounced audits and spot checks by the centre and regional management will be conducted to ensure consistency between recorded incidents, action plans, and actual practice on the ground.
5	The registered provider must ensure the timely implementation of actions arising from internal audits or inspection processes.	The organisation from June 2026, will maintain a standardised audit action tracking system will be implemented across the organisation, with all actions assigned clear owners, deadlines, and status updates to ensure transparency and accountability. The two-week timeframe for action plan closure will be formally monitored by the regional manager, with mid-point check-ins (weekly) to track progress and address	Where actions cannot be completed within the agreed timeframe, a documented rationale and revised deadline will be required, with escalation to senior management where delays are not justified. Pre-closure review meetings, from July 2026, will be held involving the centre manager, and regional manager to ensure all actions are fully implemented and evidenced prior to formal sign-off.

		any barriers to completion.	The regional manager, from June 2026 will complete monthly governance oversight reviews of all open audit actions across centres to ensure there is no drift and that timelines are consistently met. Learning from audits and inspections will be embedded through team meetings and supervision, ensuring that recurring issues are addressed proactively and inform ongoing practice improvements. A system of spot checks and follow-up audits will be conducted to ensure that actions marked as complete are sustained in practice
6	The registered provider must ensure that there are sufficient numbers of fulltime (and relief staff) with the necessary qualifications, skills, competencies, appropriate to their role, to provide care and support to children. The agreed child to staff ratio must be adhered to at all times.	With immediate effect, a daily staffing compliance system will be embedded in the centre and organisation with the centre manager completing and reviewing staffing levels against required ratios each day, ensuring immediate escalation where deficits are identified. From 30th March, weekly roster planning	The organisation currently maintains a live staffing matrix, tracking staff qualifications, experience, and competencies to ensure all shifts are appropriately staffed in line with the needs of the young people. Recruitment oversight will be strengthened

		and review meetings will take place between the centre manager and regional manager to ensure staffing levels are planned, with contingency arrangements in place to maintain agreed child-to-staff ratios at all times. The centre currently has five pending staff, which are working their way through on boarding process. The centre will complete a in house training plan for these new staff members which will be led by regional manager and training department.	through ongoing weekly recruitment meetings involving regional managers and the recruitment team, ensuring priority vacancies are progressed without delay and aligned to centre-specific needs. These commenced February 2026 and to date are proving effective. A structured onboarding and induction programme is in place for all new staff, including mandatory training, shadow shifts, and competency sign-off, led by the regional manager and training department to ensure staff are fully prepared for their roles. A relief panel will continue to be actively maintained and monitored, ensuring access to trained and familiar staff to cover annual leave, sick leave, and unplanned absences without impacting ratios. The regional manager will complete monthly staffing audits, reviewing rota

			compliance, use of relief staff, and adherence to required ratios, with immediate action taken where gaps are identified, this is a currently a key performance indicator in place in the organisation. Staff supervision and performance management will include ongoing assessment of staff competency, ensuring that all staff are appropriately skilled and supported to meet the needs of the young people, in place but will be more focused on from May 2026 with a strong emphasis on development and skillset. Escalation protocols to the director of operations will be in place where staffing levels fall below required ratios, including immediate notification and implementation of contingency measures to maintain safety and compliance. The director of operations started role in January 2026, and this

			measure is established since then.