An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 002

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Solis SMC**
Registered Capacity:	**Three young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**10th and 11th February 2025**
Registration Status:	**05th December 2023 to 05th December 2026**
Inspection Team:	**Linda Mc Guinness** **Sinead Tierney**
Date Report Issued:	**8th April 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 05th of December 2014. At the time of this inspection the centre was in its fourth registration and was in year two of the cycle. The centre was registered without attached conditions from the 05th of December 2023 to the 05th of December 2026.

The centre was registered to provide emergency accommodation to three young people aged between 12 and 17 years. The centre operated three categories of placements. Firstly, for young people whose care placement had broken down and they required an emergency bridging placement for a period of seven days, this could be extended to fourteen days where an onward placement was being sought. Secondly, an emergency placement for up to twenty-one days for young people who may be able return to their previous, or alternative living arrangement supported with a tailored home care package. Thirdly, emergency placements referred through the Tusla social work out-of-hours service. The relevant social work department was then notified, and an alternative placement must be secured within the next working day. The relationship approach model of care was based on Erik K. Laursen's Seven Habits of Reclaiming Relationships. The model is based on the understanding that caring relationships are key to the development of resilience. There were two young people living in the centre at the time of the inspection. The centre was granted a derogation to accommodate one of the young people as they were aged under twelve years on admission which was outside the stated statement of purpose.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.5
2: Effective Care and Support	2.5
5: Leadership Governance and Management	5.4
6: Responsive Workforce	6.3

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 6th March 2025. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 19th March 2025. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 002 with/without attached conditions from 05th of December 2023 to the 05th of December 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 9: Access Arrangements
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.5 Each child develops and maintains positive attachments and links with family, the community and other significant people in their lives.

The centres statement of purpose, children's rights policies and contact with family policy highlighted the importance of young people maintaining regular and meaningful contact with families where possible. Policies also aimed to ensure that family members were included in planning. During interviews with inspectors, the social care manager and care team described how they supported young people's contact with their families. Inspectors found that there was no up to date written information to give to families and social workers describing the centre and its operation. Additionally, the young people's information leaflets should be reviewed to ensure that they are up to date and are written in plain English using child friendly language.

Inspectors found that statutory child in care review meetings took place as required, although the centre was waiting on the provision of a care plan for one young person. Records of meetings and regular communication between the team and the allocated social worker evidenced arranging and supporting family contact and this was built into placement plans where relevant. One social worker who spoke with inspectors stated that they were working closely with a parent and the team with the aim of increasing family contact at the young person's request. They commended the manager and care team for ensuring that this young person maintained positive links with friends and key people in their community of origin despite it being a considerable distance from the centre.

The parent of one young person who was involved in their care had attended their child in care review meeting and received regular updates on their progress from the allocated social worker. The team described how young people were supported to celebrate birthdays and other special occasions with family members. They were facilitated to buy presents and cards for their loved ones if they wished.

Inspectors found that despite some staffing pressures throughout 2024 there was always sufficient people available to facilitate family contact. Sibling contacts were managed and supported wherever possible. Additionally, the team supported the development of a relationship with an extended family member in a planned way in consultation the social work department.

There was evidence that an audit of the centre had highlighted that improvements were required in respect of records of family contacts, and this was actioned in a timely manner. At the time of inspection relevant communication and all contacts with family was appropriately maintained on young people's care records.

The statement of purpose stated that centre operated an individualised activity-based programme and young people's interests were ascertained at admission and their hobbies and interests were maintained if possible. There was varying degrees of young people's engagement with the activities on offer at the time of inspection and it was difficult for inspectors to see the implementation of the relationship-based model of care in practice.

During inspection one young person met with inspectors and while they wanted to live closer to their family of origin, they did confirm that the team encouraged them to be involved in activities inside and outside the centre even when they chose not to participate. The young person often chose to spend significant periods of time in their room and the team found it was taking longer to build relationships. The team must continue to liaise with social worker to ensure that healthy sleep habits, excessive phone/ online activity and building relationship with the young person is built into placement planning and remains a priority. Inspectors found that individual work relating to internet safety had not yet taken place with one young person and recommend that a meeting takes place with the social worker to plan jointly about any potential negative impact in line with centre policy.

There was evidence that when young people celebrated a birthday the occasion was marked with a cake, card and gifts.

The second young person met briefly with one inspector following inspection and while their ability to provide direct feedback on their experience was limited, they provided feedback on key areas through individual work with a member of the care team. No concerns arose about the quality-of-care provision.

While the centre did not provide young people with access to WIFI, young people with phones had access to the internet through their data plan. They also had access to television in communal areas, DVD players, and gaming consoles.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 9** **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 1.5**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that up to date written information about the centre and its operation is accessible and available for families, young people and professionals.

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

Theme 2: Effective Care and Support

Standard 2.5 Each child experiences integrated care which is coordinated effectively within and between services.

The centre had a policy relating to working in partnership with supervising social workers. Social workers confirmed to inspectors that in general there was good communication and that the centre was responsive. One social worker acknowledged that the young person was finding the separation from family and community difficult but that the team were making efforts to try to establish relationships with them.

A second social worker commended the team for the regular updates, strategy meetings and efforts to provide consistency and stability for the young person. The team were working on issues identified for action in monthly child in care reviews.

Communication with social workers was recorded on young people's care records. The team made every effort to ensure that young people were referred for specialist supports or supported to remain with services they were already engaged with.

At the time of inspection, the system to receive feedback from social workers, families, and relevant professionals was not evident from review of centre records or management meetings.

Given the specific purpose and function of the centre, the team often only received information about young people when they moved into the centre and there was normally no capacity to facilitate a phased transition into the house. There were policies relating to admissions and discharges from the centre. Five young people had been admitted and discharged from the centre in 2024. The shortest placement was three weeks (in line with the statement of purpose) and the longest was seven months. Due to resource issues, there were frequently difficulties securing move on placements for young people however, inspectors found that most had moved on within a three-month time frame.

The centre had policies and mechanisms to receive feedback from the young people on what it was like for them living in the centre. However, inspectors found that this information was not collated in a way that was available and accessible to identify positive practices or track trends/patterns and inform service improvements. The written feedback was returned to Tusla and archived a short time after young people left the centre. Analysis of the information was not evident in management or team meetings. Additionally, the complaints policy was not being implemented in practice so young people's verbal and written feedback was not being effectively captured through this process as intended. This is further discussed under standard 5.4.
In line with policy and with social work approval, arrangements were in place for the transfer of files following discharges from the centre.

Young people were encouraged and supported to attend and participate in their child in care reviews and have their opinions and voices heard. Oftentimes, the notice period for move to a suitable long-term placement was quite short, however the team worked in consultation with the young person and relevant professionals to devise and implement a thoughtful transition plan. Young people were provided with information/photos about their new placement and where possible a visit or meeting the new team was facilitated.

While it was policy to conduct end of placement reviews following a young person's discharge inspectors found the information was not recorded or collated to evidence how it affirmed what was working well or informed any required service improvements.
Learning from audits of the centre was discussed at team meetings however the detail was not recorded meaning that those not present could not easily access the information if they missed a meeting.

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 2.5**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered provider must ensure that policies in respect of feedback from young people, professionals and families are reviewed and implemented. There must be evidence that information from these processes is recorded, analysed and collated to inform any required service improvements.

Regulation 5: Care Practice s and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

Inspectors found that significant improvements were required in systems of governance and oversight to review the quality and safety of care in the centre. Procedures relating to governance in the centre were not being implemented in line with organisation policy. This inspection found several areas for improvement in the

centre that should have been highlighted through a robust system of governance. These included deficits in implementation of policies and procedures, training deficits, delays with required maintenance and upkeep of the centre, oversight of records and the implementation of the models of care and behaviour management. Improvements were also required in oversight of adherence to Children First, National Guidance for the Protection and Welfare of Children, 2017 that was highlighted in the 2023 inspection of this centre.

The centre manager was supported by an acting deputy social care manager. Both were present in the centre on a daily basis and the team members interviewed stated that they provided support to them in their day-to-day work and through supervision. The centre managers read the young people's daily logs, significant event notifications and other records generated by the care team.
The centre manager reported to a service manager who was in post approximately one year at the time of inspection. The service manager was confident the centre manager had good organisation and leadership skills and was satisfied that they managed the centre well. One aspect of the governance system in place was that the service manager and the service director monitored the quality of care through receipt of monthly governance reports from the centre manager. This was a quantitative report on aspects of operations such as staffing numbers, supervision sessions, training, and the numbers of significant events. Inspectors did not find evidence of oversight or quality assurance of the information by the service manager or the director of service.

Based on review of centre and care records inspectors found that some recorded interventions and the language in records was not always child friendly. It was inspectors assessment that effective oversight of the records in the centre could have created discussions and follow up relating to some care practices and child centred language across records but there was limited evidence of this.

The service manager in interview indicated that they made regular visits to the centre, (up to twice monthly) and that they periodically attended team meetings and provided supervision to the centre manager. Inspectors found limited evidence of this in practice in that there was only evidence of one attendance at team meetings, six reports of visits to the centre and seven supervision records in 2024.

There was a system in place whereby the service manager for this centre conducted audits of centres managed by another service manager in the organisation and there was a reciprocal arrangement in place where that person was to provide audits of this

centre. These audits were to benchmark and assess the safety and quality of care in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA). In the year prior to the inspection only one such audit took place which focused on three of the 29 standards. There was an associated action plan and some evidence that the learning was communicated to the team although the detail was not recorded to facilitate effective communication to any care staff not present.

The registered provider must review the systems of governance in place and ensure that there is a clear plan in place to assess the quality of care in line with the relevant regulations and national standards.

There was evidence that when young people were admitted they were made aware of the centre complaints process and given information on their rights at the initial admissions meeting. The process in place was not suitable for very young children and must be revised to ensure that it is delivered in a child friendly manner and revisited with them to assess that they fully understand the information.
The written information they were provided with relating to complaints informed them of Empowering People in Care (EPIC) the children's advocacy service and the Ombudsman for Children but did not include information on Tusla's "Tell Us" feedback and complaints procedure. While there was evidence that young people who previously lived in the centre were supported to use the process, inspectors recommend that this information is included in updates to young people's information leaflets.

Inspectors found from inspection interviews and from a review of the centre's complaint register that there was only one complaint recorded in 2024. This was not in line with centre policy which indicated that all types complaints or dissatisfactions would be recorded, managed, and entered onto the centre register. Inspectors were informed in interviews that verbal complaints and dissatisfactions or grievances were dealt with informally and only recorded on young people's daily logs. Inspectors were not satisfied that information in relation to feedback or complaints from young people was being recorded, monitored, and analysed. There was a lack of evidence across minutes from team meetings, management meetings and in supervision records that complaints were regularly discussed and reviewed. Oversight and auditing of the centre by service managers did not highlight this as an issue that required attention.

The centre management must ensure that the centre is more proactive in ensuring any feedback/dissatisfaction whether verbal or written from young people is managed as per organisation policy to inform and promote service improvements.

Inspectors were informed that an annual review of compliance with the centre's objectives had not taken place for the year prior to inspection but senior management recently agreed that the social care manager would complete this process. When this was explored it transpired that the incorrect national standards were incorporated onto the proposed template. Further, the annual review could not effectively assess compliance with centre objectives as there was a lack of initial auditing by external managers to identify required actions and areas for improvement.

The inspectors recommend that senior management re- assess how they annually review compliance with the centres objectives and that timely action is taken to promote improvements in systems and care practice to achieve better outcomes for young people.

Compliance with regulations	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None identified**

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

Actions required

- The registered provider must review the systems of governance in place and ensure that there is a clear plan to assess the quality of care against the relevant regulations and national standards.
- The registered provider must ensure that the centre adheres to organisation policy in respect of the recording, management, and analysis of complaints to promote service improvement.
- The registered provider must ensure that they review how they annually assess compliance with the centres objectives and ensure that timely action is

taken to promote improvements in systems and care practice to achieve better outcomes for young people.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

The centre had policies in respect of induction, training, supervision and appraisals. Inspectors found management and the care team interviewed were clear on aspects of their roles and responsibilities, but some improvements were required particularly in respect of implementation of the model of care and some centre policies.

There were clear lines of authority and accountability within the organisation and care team members interviewed by inspectors were familiar with the external management structure.

The centre manager was in post since March 2024 and was appropriately qualified for the role. Inspectors viewed nine personnel files. Role specific job descriptions were on five of the records. There was no evidence that the newly appointed acting deputy had a job description specific to this post. An organisational and centre specific induction was evident on the personnel records of recently appointed team members. There was evidence that their roles and responsibilities were reviewed with them during induction and probation processes. Support was also available for newer team members through shadowing, social care leader support and accessibility of the managers, although more frequent supervision set out in policy was not being implemented in practice. Longer standing team members were confident in their practice and were not reliant on managers to make decisions.

While there were staffing difficulties during 2024, at the time of inspection the team consisted of a manager, deputy, three social care leaders and six social care workers providing consistency and stability for the young people.

The centre had been through a difficult period with high levels of challenging behaviour and staffing challenges. There was evidence that the team was provided with a team building exercise after a period when morale was low.
However, inspectors found that exploration of the reasons behind this could be more evident across team supervision records and team and management meetings.

Centre policy stated there would be monthly team meetings and from a review of records inspectors found that ten meetings took place across 2024. There was evidence of regularly reviewing centre policies and that the social care manager discussed accountability with the care team. Notwithstanding this, inspectors found that there were some recurring issues such as poor communication at handover meeting and signing of centre records and there was limited evidence of follow up to ensure changes in practice. Inspectors found there was a heavy focus on tasks and recommend that there is a greater emphasis on reflective practice, skills development, risk management and review of complaints for example.
The inspector who attended the handover meeting concurs that there could be improvements to the handover process as some key information was not communicated and shift planning was limited.

Inspectors found that there was a lack of evidence of an embedded culture of learning and development. While there was a focus on knowledge of policies at team meetings, as discussed previously, the systems in place to ensure they were implemented in practice were not active or effective at the time of inspection. Learning from Tusla inspections across other centres was discussed however, it was not possible to see how learning from audits or significant event review group meetings across the organisation were communicated to share best practice.

The inspectors reviewed a sample of staff supervision files and found that improvements were required to ensure it was being implemented in line with policy and providing effective support and development to the care team in their roles. Appointed supervisors received training and, staff in interview described how some of the functions of supervision took place in their scheduled sessions. There were however large gaps where supervision did not take place. Training was reviewed during supervision however there were significant gaps in training of some team

members at the time of inspection. Review or auditing of supervision records was not evident.

There was evidence on supervision records that the manager highlighted self-care and also provided feedback to team members on their work and held people accountable for completion of specific tasks. Sessions could be improved by a more robust focus on care practice, relationship building as well as the focus on tasks. While key working was discussed in supervision, the care team would benefit from feedback in supervision relating to the quality of interactions with young people and how the model of care is implemented in practice.

There were seven supervision records available to evidence supervision of the centre manager across 2024. These records showed that there were discussions on communication of policies, national standards, staffing difficulties, some individual staff development, risk management and collaborative working. Some improvements were required to support the manager with implementation of the model of care, compliance with national standards and follow up to auditing of the service. There was no evident focus on training and development needs of the manager.

Inspectors found that some personnel files did not hold an up-to-date supervision contract agreement that set out the process and the expectations. The records of some sessions were maintained on file however they were not signed by both parties as required in line with policy.

During inspection interviews there was a lack of clarity from the manager and staff members about the range of supports available to them to manage any negative impact of working in the centre. Some described how managers would recognise if they needed support and debriefing following a difficult incident. However, there was limited evidence of this and those provided related only to formal debriefing in line with the model of behaviour management where their interventions were also analysed. Inspectors could not assess if staff were provided with additional supports if they suffered verbal abuse, racial abuse or were stressed in their work. Those interviewed were not able to signpost the psychological supports that the organisation made available to them.

Centre policies set out a number of measures in place to minimise potential risks to staff safety such as, training, risk management and availability of on-call support. However as mentioned previously there were training deficits and inspectors did not find risk assessments relating to this issue.

Organisation policies set out a system for the annual appraisal of the practice and performance of staff and managers and to identify areas of support required. This was not in operation at the time of inspection.

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

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

Actions required

- The registered provider must ensure that the handover and team meetings are reviewed by external managers and that they support the implementation of centre policies, the model of care and effective planning for young people.
- The registered provider must ensure following the review of governance in the centre, that there is evidence a culture of learning and development is in place and implemented in practice.
- The registered provider must ensure that all supervision and individual annual appraisals are implemented in line with policy and subject to oversight and review.
- The registered provider must ensure that all staff are fully aware of the range of supports available to them.

3. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The registered provider must ensure that up to date written information about the centre and its operation is accessible and available for families, young people and professionals.	The centre manager will immediately review and update all written information regarding the centre's purpose, services, and operations to ensure it is accurate, current, and readily accessible. The updated information will be made available in both physical and digital formats to ensure easy access for families, young people, and professionals. As part of this action, new brochures are currently being devised and are in the process of being printed to clearly reflect the centre's mission, services, and operational details. These brochures will be distributed to social workers, families, and young people to ensure they have access to the most up-to-date information about the centre's purpose and operations.	All relevant documents, including the new brochures that outline the centre's services and purpose, will be reviewed for accuracy and updated as necessary. Any outdated documents will be removed and replaced. The updated written information, including the newly printed brochures, will be made available in printed form at key locations within the centre. Social workers, families, and young people will be provided with a copy of the updated brochures also. Families, young people, and professionals will be informed of the availability of the updated information via email and during face-to-face interactions. The centre manager will be responsible for ensuring that all information remains up to date and accessible.

2	The registered provider must ensure that policies in respect of feedback from young people, professionals and families are reviewed and implemented. There must be evidence that information from these processes is recorded, analysed and collated to inform any required service improvements.	The registered provider will immediately review and update the current policies regarding feedback collection from young people, professionals, and families to ensure they are clear, effective, and aligned with best practices. The updated policies will outline clear procedures for gathering, recording, analysing, and collating feedback to inform service improvements. The provider will ensure that there is documented evidence that feedback from young people, professionals, and families is consistently recorded, analysed, and collated. This evidence will be stored in a central feedback database. A system for reviewing this will be devised and will likely form part of the monthly governance report. To achieve this, the centre manager will oversee the feedback collection process. The centre manager will discuss this at the team meeting to ensure all feedback is accurately documented and analysed.	The centre manager and service manager to monitor and update the policies as needed, ensuring they remain relevant and effective. The centre manager is responsible for overseeing the collection, recording, analysis, and reporting of feedback from young people, professionals, and families. This ensures that the feedback process is consistent, organised, and integrated into the service improvement cycle. The centre manager will also ensure that any issues or gaps in the feedback process are promptly addressed. The Centre manager will ensure all staff are aware of the feedback collection process, including how to encourage participation, record feedback accurately, and analyse data effectively. This will ensure that everyone involved in the feedback process understands their role and responsibilities. This will also be discussed in supervision sessions and also be contained on team meeting agenda.

		The feedback will be used to inform necessary adjustments to the service delivery, ensuring that it remains responsive to the needs of young people. The review and update of the feedback policies will be completed within 2 weeks from the date of this report. The updated policies will be implemented following this, ensuring the new processes are followed. Feedback will be collected as outlined from the current young people in situ. Ongoing feedback collection and analysis will continue on thereafter.	Staff team will be informed of any changes or updates to the feedback policies and procedures in team meeting where it will be discussed and explained to ensure understanding. It will also be discussed further in supervision sessions with staff. The centre manager will ensure that the analysis of feedback is a regular agenda item in team meetings and management meetings. This will ensure that the feedback collected is consistently used to inform decision-making and service adjustments. The centre manager will review feedback received and create an action plan based on feedback analysis and track the progress of improvements over time. This will guarantee that feedback leads to tangible outcomes and improvements in service delivery. A feedback register will commence in the centre where all feedback and corresponding actions are recorded and

			monitored, ensuring that no feedback is overlooked, and that trends and patterns are easily identifiable. The service manager will oversee and monitor the effectiveness of the feedback process and ensure that service improvements are being made based on feedback. Evidence of this will be available in supervision minutes with the person in charge and relevant governance visit minutes. Clear evidence of such work will be essential. The centre manager and deputy centre manager will carry out regular audits of the feedback process to verify that the system is functioning as intended and that feedback is being properly recorded, analysed, and used to inform service improvements.
5	The registered provider must review the systems of governance in place and ensure that there is a clear plan to assess the quality of care against the	The registered provider will immediately review the current systems of governance to ensure there is a comprehensive and clear plan in place for assessing the quality	The registered provider will ensure the schedule of internal audits is followed to assess the effectiveness of the governance system and the quality of care. These

	relevant regulations and national standards.	of care against the relevant regulations and national standards. To achieve this, the provider will engage the centre management including the service manager and the quality assurance team, in the review and development of the governance plan. The service manager will ensure that quarterly internal audits are carried out on the centre to ensure that the service remains compliant with relevant regulations and national standards, and that the quality of care provided is continuously monitored and improved. The review of the current governance systems and development of the clear plan will be completed on April 4th. This will involve a refinement of current processes with a focus on clear evidence of oversight.	audits will identify any potential gaps or areas of improvement and help ensure that the care provided continues to meet the necessary standards. The findings of quality audits, and the outcomes of governance reviews with staff and at management meetings will create transparency and basis for learning. The service manager will ensure that the outcomes of governance reviews and quality assessments are acted upon quickly and effectively, with clear documentation of any improvements made and their impact on care delivery.
	The registered provider must ensure that the centre adheres to organisation policy in respect of the recording, management, and analysis of	The registered provider will immediately review and ensure adherence to the organisation's policy regarding the recording, management, and analysis of	The centre manager will ensure going forward that all complaints, including informal and grievances are followed up and also all follow ups and outcomes are

	complaints to promote service improvement.	complaints. This will include ensuring all complaints are documented accurately, handled in line with the policy, and analysed for patterns or trends that can inform service improvements. This will ensure informal complaints are addressed and responded to. A clear tracking system for complaints that ensures all complaints are recorded, processed within the defined timeframes, and analysed. The analysis of complaints will be discussed in team meetings and management meetings to ensure that the information is being used to promote service improvements. The complaints policy will be revised at the team meeting with the staff team to ensure understanding and compliance. This will also be revised on an individual level with each staff member in their supervision to ensure they understand the policy and the necessary steps for managing complaints and analysing them for service improvements. The review of the complaints policy and	clearly evidenced attached to the compliant form, to ensure there is clarity of same on file at all times. This will also be reviewed by service manager and quality auditor on a regular basis to ensure compliance through audits and centre checks. All staff to have training completing on complaints and are familiar with the complaints policy and procedures. A tracking system will be established to ensure that all complaints are logged, processed, and audited by the SCLs, PIC and DPIC regularly. Audits will be conducted to review the complaint handling process and identify any trends that may require attention.

		procedures will be completed by April 18th. The updated tracking and management system for complaints will be implemented within 1 week of the policy and procedures being updated. Complaints will remain as a regular agenda item in the team meeting and management meeting. The service manager will schedule a review to ensure that the complaints system is functioning effectively and is being used to drive service improvements.	
	The registered provider must ensure that they review how they annually assess compliance with the centres objectives and ensure that timely action is taken to promote improvements in systems and care practice to achieve better outcomes for young people.	The registered provider will review and enhance the process for the annual assessment of compliance with the centre's objectives. An updated assessment framework that clearly defines how compliance with the centre's objectives will be evaluated. Additionally, an action plan will be developed for addressing identified gaps, with measurable targets for improvement and timelines for completion.	An annual review tool to be devised by the Service manager. The Centre manager to use this tool to create an Action Report and act on the recommendations. Scheduled audits to be carried out to assess progress and identify any areas requiring improvement before the annual assessment. The centre manager will take timely corrective actions as needed. Additionally, The centre manager will complete a self-audit tool bi-monthly to

		Service manager to conduct the annual assessments. The PIC will work alongside service manager to ensure they can effectively implement improvements based on the findings. A clear and effective process for assessing compliance will help the organisation stay aligned with its objectives and regulatory requirements. The review and update of the annual assessment process will be completed on 25Th March 2025. The first annual assessment using the updated framework will be conducted in April. An action plan with specific improvement goals will be developed and implemented within 2 weeks of annual assessment being circulated.	ensure the centre remains in line with national standards for children's residential centre (2018) and relevant legislation.
6	The registered provider must ensure that the handover and team meetings are reviewed by external managers and that they support the implementation of	Service manager to review handovers and team meetings to assess whether they align with the centre's policies, the model of care, and effective planning for young	Service managers will evidence more clearly the review of handovers and team meetings to ensure alignment with the centre's policies, model of care, and

	centre policies, the model of care and effective planning for young people.	people. The service manager will communicate their observations, recommendations, and any actions taken to support the implementation of the centre's policies and care model to the PIC. All staff will also be informed about the importance of implementing centre policies, the model of care and effective planning for young people. Service manager oversight will help ensure accountability, improve care delivery, and contribute to achieving better outcomes for young people. The service manager and PIC will ensure learning from audits, significant event reviews, and Tusla inspections is effectively communicated and applied in practice, and evident in Team Meeting minutes, supervision minutes and other relevant reports.	effective planning for young people. Additionally, the provider will establish a feedback mechanism where recommendations from service managers are discussed and incorporated into ongoing team planning.
	The registered provider must ensure following the review of governance in the centre, that there is evidence a	The service manager and centre manager will ensure all learning from audits, inspections, and significant event reviews	The registered provider will ensure key learnings from all audits, inspections, and significant event reviews are consistently

	culture of learning and development is in place and implemented in practice.	are shared in depth in team meetings and supervision and acted upon. There will be evidence of monthly team meetings discussing key learning points, and the integration of these insights into practice. By ensuring that learning from audits, inspections, and significant event reviews is consistently applied, the centre will improve care quality, meet regulatory requirements, and enhance outcomes for young people. Monthly team meetings will continue to regularly include SEN review section where SENs will be reviewed and learning outcomes discussed.	applied across all aspects of care delivery. Audits of the centre will review the learning process, staff trainings are up to date, and engagement of staff in team meetings with detailed minutes for all staff to benefit from shared learning. The service manager will ensure that the oversight of the integration of learning into everyday practice and supporting staff development through learning is more clearly evident in governance visit minutes.
	The registered provider must ensure that all supervision and individual annual appraisals are implemented in line with policy and subject to oversight and review.	Supervision sessions will be consistently implemented in line with the policy and that they provide effective support and development for the care team. For all staff including the PIC. The centre manager will ensure that supervision is regularly scheduled using supervision schedule, and that it focuses on both task	Monthly supervision schedule to be enacted. The Service manager will conduct regular checks to ensure there are no missed supervision sessions or annual appraisals and that sessions in general meet the criteria set in the policy. Supervision will be on the agenda of SCL

		completion and care practice. There will be a focus on the relationship building model of care in each session. Additionally, the service manager will review supervision records to ensure compliance and effectiveness. The supervision records will be reviewed monthly by both supervisor and supervisee, ensuring that they focus on care practice, relationship building, and feedback on interactions with young people. Supervision records will audit by the quality auditor, ensuring that supervision sessions are in line with the policy and are addressing all required areas. Annual appraisals for all staff will be scheduled.	meeting to ensure all supervisors understand the importance of focusing on training and development needs, and the model of care implementation during supervision. Quality Auditor ensure all appraisals are completed and supervision sessions are effective, with a focus on both individual development and the quality of care provided. Yearly appraisal schedule to be implemented by the service manager and centre manager.
	The registered provider must ensure that all staff are fully aware of the range of supports available to them.	The registered provider will ensure that all staff are fully aware of the range of supports available to them, particularly in relation to managing the negative impact of their work, such as stress, verbal abuse, racial abuse, and the emotional toll of	The service manager will implement regular staff wellbeing check-ins as part of the supervision process, ensuring that centre manager consistently check in on staff wellbeing and offer support where needed.

		challenging incidents. This includes providing clear guidance on accessing psychological and counselling supports which are currently available. The service manager to review the centres policy and procedures to reflect a comprehensive staff support policy and resource guide detailing the available supports. The Centre manager to communicate the support resources at handovers, team meeting and supervisions to ensure staff are aware of all supports available to them. The staff support policy will be reviewed in April 2025. A discussion was held in February team meeting informing the staff team again of the supports in place and means of accessing same. The staff support counselling service was emailed individually to the staff team and also a copy of steps on how to access this service is printed and on the noticeboard	A memo will be created and signed by staff to ensure that they are aware of and utilising the support resources available when necessary. This will be stored in supervision folders. Monitoring of significant incident reports to take place to ensure that counselling/ psychological support is offered and provided in a timely and appropriate manner when needed or requested by the staff member. Staff team building days, spa days for staff, overnight Christmas parties which all occur, to be clearly evidenced in team meeting minutes.

		in the staff office for ease of access.	