An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 306

Year: 2026

Inspection Report

Year:	**2026**
Name of Organisation:	**Victoria Healthcare Organisation Ltd**
Registered Capacity:	**One young person**
Type of Inspection:	**Announced**
Date of inspection:	**20th and 21st of January 2026**
Registration Status:	**Registered from the 30th of May 2025 to the 30th of May 2028**
Inspection Team:	**Eileen Woods** **Catherine Hanly**
Date Report Issued:	**15th of July 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 30th of May 2025. At the time of this inspection the centre was in its first registration and was in year one of the cycle.

The centre was registered as a single occupancy service, for young people thirteen to seventeen years old. Its stated aims were to provide care and support to promote the wellbeing and health of a young person, taking the young person's preferences into account. The placement could be on a respite or a longer term basis. The centre was operating under a special emergency arrangement (SEA) model for referrals. There was one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspectors examined the following themes and standards:

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

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young person, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 20th of February 2026. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 13th of March 2026. This was deemed to not be satisfactory and the inspection service requested clarifications and evidence to support the CAPA commitments. The inspection service received evidence on the 16th, 24th and 30th of March 2026 of initial actions taken. Further evidence was requested by the ACIMS of actions undertaken and this was received on the 8th of June 2026 and demonstrated continued engagement by the registered proprietor in implementing development and improvements.

Whist there was a regulatory noncompliance identified during this inspection the findings of this report and assessment of the submitted CAPAs and subsequent evidence submitted 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: 306 without attached conditions from the 30th of May 2025 to the 30th of May 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.

Inspectors found that the young person in placement did not have a full copy of their statutory care plan on file, a copy of minutes had been shared with the centre some time after the care plan meeting which took place in October 2025. The care plan meeting took place within one month of their admission. The centre created its own care plan document following the child in care review meeting and utilised this and a previous care plan as a guide for their care delivery for this young person. There was evidence that the senior management team, the manager and staff had an unclear understanding of the roles and status between the statutory planning by Tusla and their own planning within the centre and what the roles and responsibilities were for all parties involved.

Initial steps were being taken in ensuring robust understanding for the various roles and plan types, this had commenced with the team in late December 2025 and January 2026 following inspections completed in their sister centres in November and December 2025. During interview the team members displayed some emerging understanding of care and placement planning. It remains an area of development for the company. The centres self-titled care plan document had been replaced by a placement plan format and this was developed and implemented in November 2025. The inspectors found that the young person had been well consulted with for this plan. The young person told inspectors in written feedback that they were happy in this placement and were listened to by the team.

The centre did not have a copy of the updated care plan as stated above and did not have a copy on file of the aftercare plan. There had been an aftercare plan created and a child in care review had been held. The social worker cited some recent issues with the Tusla digital systems and agreed to follow up to ensure that the centre had all the necessary plans and documents required to support the young person in their final three months in care.

The placement plan on file was formatted to support planning for key working. The content created required attention. Inspectors found that preparation for leaving care, diet and substance misuse were underrepresented. The young person had two key workers allocated and both spent one to one time with them. The first month of key working records were found by inspectors to be purposeful and clearly planned. Key work was also planned for on the behaviour management plan but this was not co-ordinated as yet fully to the placement plan and required review to be paced, focused and achievable. As the placement had progressed, the structure around key working had decreased in focus and variety. There were monthly team meetings during which there was discussion of the young persons plan but these records lacked detail, and inspectors did not see records of additional key work planning. The provision of structured supervision had recently commenced so there were overall limited opportunities to convene as a team and plan. More regular meetings geared to key work and planning are recommended.

The centres placement plan policy currently advises a review every twelve weeks and referenced a placement plan approach that the team had not been trained in. Inspectors found that this policy and the related procedures must be reviewed to assist the team development in placement planning. Inspectors found also that there must be diversification in key work topics and tasks to represent the age and stage of a young persons needs. That they must focus on independent living skills and on providing positive dietary options and role modelling day to day.

The young person had a long term allocated social worker that they saw regularly and communicated well with, they had a wraparound team of professionals from aftercare, youth justice, probation and education services that focused on core emotional and practical support and planning. The social worker informed inspectors that they were happy with the work of the team and the location of the centre and that it met the young persons needs well at this time, being closer to family and community.

Both the centre manager and the social worker agreed that they communicated well and collaborated with the young person in all plans. The centres contract status as a special emergency arrangement defined significant aspects of the task allocation and distribution with the social worker and allied professionals taking the lead role. Inspectors found evidence that the centre was developing a more detailed approach to their own role for young people within this. Inspectors found that as part of this development that the overall standard and organisation of record keeping and report writing required attention across the team. Whilst some staff had more experience in

record keeping not all shared the same standard and internal report writing training is recommended.

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 centre manager and staff team must ensure that effective placement planning procedures are implemented to ensure that young people's health, well-being and overall needs are appropriately planned for and that progress can be tracked and documented.
- The centre manager and the director of care must clarify and support the team in the ongoing awareness of care and placement planning roles and responsibilities.
- The director of care must ensure that the organisations placement planning policy is reviewed and is accurate, with regular placement plan review schedules identified as part of the policy.
- The centre manager must ensure that all staff receive training and development in report writing and recording.

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.

An updated management of challenging behaviour policy was introduced at a team meeting on the 5th of November 2025. In that meeting and the following meeting in

December the team meeting minutes recorded that behaviour management planning, positive reinforcement and person-centred planning was discussed. The minutes taken were limited and staff interviews established that more discussion and development is required to bring the intended goals in behaviour management to realisation. The team consistently referred to a calm environment and giving space followed by calling the Gardai should behaviours escalate despite their policy and own behaviour management plans making commitments to interventions, role modelling and de-escalation techniques. There was a clear need for staff to be supported to define day to day interventions to build coping skills as defined from responses during an outburst. The team completed refresher training in a recognised model of behaviour management in January 2026.

Inspectors found that the staff team and management had positive practices in consulting with the young person and had shared aims they wished to achieve in person centred care. These goals must be continually supported and reinforced through ongoing training and skills development, input from young persons and from professionals.

There was a behaviour management plan on file, this was a large document with time and attention paid to identifying areas of need and developing intervention plans to respond to these, each was informed by an accompanying risk assessment. Inspectors found while the content was well written that the scale and scope, inclusive of multiple key working commitments, would be a challenge to implement and were not known by staff. The manager and staff alongside the key workers must prioritise areas, implement a response, review it promptly and link it to actual keywork that was completed or can be completed. The team must be resourced appropriately in doing so through regular meetings, guidance and evaluation of plans to ensure that they are implemented and suited to the needs of a young person.

There had not been a dedicated audit of positive approaches to behaviour management, and this must be completed as part of compliance with this standard. Feedback must be given to staff to support learning and expansion of effective interventions and how they can build on this with future young people.

There was communication between the centre and the social worker related to any significant incidents and missing child from care/MCFC episodes. There was no internal review of significant events notifications/SENs and MCFC episodes and inspectors recommend that the centre manager start to include such a process in line with patterns or types of incidents. The centre management must also ensure that the

printer has regular ink cartridge replacements as some of the photos for the MCFC forms were faded and hard to see. The centre did not have a system of recording returns from MCFC and should implement same to ensure that they are recording a young persons physical and personal presentation and any comments or observations about their well being and whereabouts.

The team had been completing a process called life space interview, LSI, that they believed was required by Tusla but was not part of their training model. Inspectors recommended that they focus on recording the return and presentation and seek to engage the young person in a process that the team have trained in.

The centre manager had liaised with the social worker to put a safety plan in place around a regular visitor to the centre. Inspectors found that the team did not have key information that would be helpful to fully safeguarding the situation but that they were careful to implement the safety plan they had. The plan on file that inspectors reviewed required additional detail to name the specific number of visits, days and times as well as length of these visits.

There was a policy and procedure in place for restrictive practice and there were good templates in place for this practice. When asked about examples of that might constitute a restrictive practice the team knew those identified to date. Inspectors found that the young persons room was searched daily and this was recorded, these checks were not for health and safety purposes but a search for any items that should not be present in the centre. Inspectors found that there was no examination or consideration of this as a restrictive practice. The centre manager must ensure that such practices are reviewed for purpose, taking the known information into account. This should be recorded as a restrictive practice and implemented when concerns exist and evidence supports that it is required.

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 proprietor must ensure that there are regular audits of the positive approach to behaviour management and that feedback is given to staff to promote learning.
- The centre manager and staff team must ensure that key working identified within the behaviour management plans is paced and proportionate and reflected on the placement plans.
- The registered proprietor and centre manager must ensure that there are systems in place for the review of significant event notifications and missing child from care incidents. There must be feedback with the staff to ensure that any learning and actions are integrated into planning.
- The centre manager and director of care must review what constitutes a restrictive practice versus a justified safety measure and the evidence there is to support these decisions.

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.

This is the third inspection by the alternative care inspection and monitoring service (ACIMS) since November of 2025 within this company. There had been two draft

reports issued to date and these addressed governance mechanisms and policy development in detail. The senior management meeting minutes from November and December 2025 addressed the flow of information and feedback emerging from the successive inspections. Inspectors found on this occasion that the centre manager and director of care had discussed some but not the full outcomes.

There were arrangements in place for funding per placement through Tusla. The centre staff knew the structure of the company and the personnel at every level, they were familiar with their director of care who visited the centre regularly. The centre manager and director worked well together and had yet to establish a recorded mechanism for governance reporting and accountability to sit alongside their regular calls, visits and supervision. The provision of supervision at every level had been recently introduced, prior to that was a six monthly performance review process. Supervision was therefore a new process for all and in the early stages of development. The centre manager had recently been supported by the company to complete a level six qualification in professional supervision and was commencing a structured approach to supervision with the staff. This was in the initial stages.

Inspectors found that the centre manager was qualified and consistent in their approach to date within the pre-existing structures. The centre had been in operation since 2022 as a special emergency arrangement (SEA) and they had been in position as centre manager since 2023. They were well regarded by the team and the social worker. Inspectors found that the centre manager was not evidencing their governance and oversight effectively. The centre manager must more robustly evidence oversight, commentary and critical review of the work completed at the centre in order to further enhance theirs and the teams development. Inspectors found that the centre manager and their team leader were not aware of the full extent of the responsibilities within their roles. They were not clear on the responsibilities related to child protection, specifically being a designated liaison person (DLP) or being a mandated person. The centre manager and director must agree a system of formal governance and oversight to ensure that there is accountability and to assess the safety and quality of care being provided in the service. This must include a review of the current auditing system which required ongoing development based on inspection review, the format was poorly structured.

Inspectors requested that the centre manager and the person identified to provide cover in their absence complete training in the role of DLP and that all staff complete the Tusla module on the role of mandated person. These had not been completed by any of the team or management to date. The centre manager and director of care took

action to direct staff to the training and to book DLP training for the centre manager. There were no records of any team member or line management being registered on the relevant portal for the reporting of child protection concerns or mandated reporting. These matters and upskilling of the team must be prioritised.

The team must be provided with a programme of focused training in policy, procedure, practice, roles and the national standards. Some work had commenced in these areas but now must be undertaken as a programme informed by inspection feedback and CAPA commitments. There must be awareness of mandated person legal responsibilities and a system of promotion of professional understanding of recording, tracking and reports of concerns. A system of delegation of duties was displayed at the centre and the social care leader had briefly acted up for the centre manager. The delegation of duties and the designated responsibilities in the centre managers absence must now take account of the areas identified in this report.

There was a centre risk register in place and this was guided by a recently introduced matrix to assist the centre manager in assessing risks and devising responses. This was still being embedded in practice and the risk register was found by inspectors to require review. The centre manager had sought to identify risks for example in staffing but without the requisite knowledge of registration requirements and of ACIMS notices related to same and other relevant areas. Therefore, it was not possible for them to adequately risk assess and to identify controls as they were not aware of and did not account for the actual gaps and risks. The same applied to training and knowledge gaps on the team, such as those in roles in child protection and reporting. The centre risk register must be fully reviewed and updated to accurately rate the risk areas.

The key workers and the centre manager had created risk assessments to inform the identified areas of behaviour management, and these showed evidence of a good capacity to plan appropriately when all information has been shared and reviewed together.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must implement a formal governance reporting system taking account of its purpose and function.
- The registered proprietor must ensure that the auditing system is adapted to assess the safety and quality of care provided in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA).
- The centre manager and director of care must provide training to centre staff on the revised policies and procedures document to guide and promote best care practices.
- The centre manager must review the centre risk register taking account of all guidance received on regulatory notices, national policy and regulations, as well as statutory responsibilities.
- The centre manager and their team leader must be trained in the role of designated liaison person and agree delegated roles and responsibilities within this for practice at the centre. All staff must know how to make a report of a child protection nature.
- The centre manager and the director of care must ensure that there is a clear managerial delegation structure is in place.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

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

The staffing list provided for this inspection contained the names of six qualified staff with double cover being provided through the deployment of staff members qualified to Level 5 Healthcare Assistant (HCA) grade. A review of rosters showed that this had been the case in the preceding three months of rosters. The director of services has stated that this has been in place since the registration of the centre with the HCA grades as relief staff. The letter accompanying registration emphasised the responsibility to inform the ACIMS where qualified staff levels drop and the mitigations in place. The ACIMS had not been contacted when qualified staffing levels had decreased. The centre was registered with a team of eight qualified staff. An immediate action notice was issued to the registered proprietors on the 27th of January 2026 outlining the noncompliance and requesting a response by the 30th of January 2026. The CEO subsequently returned, on the 30th, a list of eight qualified staff to support the centre whilst recruitment remains ongoing. They wished to also highlight the skills and abilities of the HCA staff and confirmed the names of those HCA staff who had applied to CORU for recognition as social care workers.

Upon further examination of the rosters and staffing lists it was found that one staff was on long term leave, one had moved internally and another two had left the company. Existing staff worked on a double cover for twelve hour shifts, with a waking night shift coming on duty and a person sleeping over unless required to be awake due to incidents. There was a team consisting of a qualified and an unqualified staff member typically with a centre manager present Monday to Friday office hours. On the staffing rosters it was found that some staff were accommodated with thirty six hour shifts due to their travel circumstances. There was no record of the centre manager or line management tracking or risk assessing this for compliance with the Organisation of Working Time Act, 1997. These actions must now be completed and reflected in the centre risk register. This was outlined in the immediate action notice issued to the registered proprietor and they responded with a risk assessment and a governance plan. Inspectors also found that staff shifts began and ended at the same time with no specific allocation for a handover process, this must be included in rostering going forward.

Inspectors found the staff interviewed and interacted with during the inspection were an engaged group who were interested in their work with the young person and previous young people. This view was echoed by the young person and by the social worker. They had been a largely consistent group who told inspectors that they have worked harmoniously with each other and supported the young person.

There were formalised procedures for on-call arrangements at evenings and weekends. The centre had recently introduced an on-call folder to inform staff of the details of who was providing on call support and to log on call events.

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

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must ensure that they continue to recruit and staff the centre in compliance with the 'Staffing Levels and Qualifications for Registration Children's Residential Centres' (Part VIII, Child Care Act 1991) Guidance ACIMS August 2025.
- The centre manager must ensure that they risk rate and review the arrangements in place for the total hours worked per person and to include rest periods.
- The centre manager must ensure that the roster takes account of an appropriate time for staff handover. The records maintained should reflect this and those in attendance.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The centre manager and staff team must ensure that effective placement planning procedures are implemented to ensure that young people's health, well-being and overall needs are appropriately planned for and that progress can be tracked and documented.	The centre manager conducted individual placement plan briefings with all staff members, aligned with the reviewed care and placement planning policy. These briefings commenced on 16/02/26 and were completed on 25/02/26. Key working sessions were held with the young person on 24/01/26 to discuss placement plan goals. Placement planning was also addressed during staff meetings held on 27/01/26 and 27/02/26. Placement planning has now been established as a standing agenda item for all staff meetings. The placement plan was shared with and discussed alongside the social worker on 11/02/26 and 27/02/26. Additionally, the centre manager developed a monthly placement plan progress tracking form. The February progress tracker was completed on	The director of services (DoS) will ensure that the centre manager conducts placement planning reviews at a minimum of once every three months. The quality assurance officer (QAO) will audit the placement plans and associated placement plan tracking documentation as part of the quarterly inspection process.

		02/03/26.	
	The centre manager and the director of care must clarify and support the team in the ongoing awareness of care and placement planning roles and responsibilities.	The centre manager conducted individual placement plan briefings with staff members in the centre, in line with the reviewed care and placement planning policy, with a particular emphasis on roles and responsibilities. These briefings commenced on 16/02/26 and were completed on 25/02/26. In addition, the centre manager discusses staff roles and responsibilities during supervision sessions, which commenced on 13/02/26.	The quality assurance officer will assess staff awareness of their roles and responsibilities in relation to placement planning as part of the quarterly audit process.
	The director of care must ensure that the organisations placement planning policy is reviewed and is accurate, with regular placement plan review schedules identified as part of the policy.	The Director of Services completed the review of the care & placement planning policy on 02/02/26.	The CEO will ensure that the policy is reviewed every two years, or sooner if required due to operational needs or legislative changes.
	The centre manager must ensure that all staff receive training and development in report writing and recording	The centre manager is delivering in person training for staff to enhance the quality of report writing, which commenced on 13/02/26.	The DOS will review daily records and other documentation during routine visits. The QAO will audit records for compliance with regulations as part of the audit.

3	The registered proprietor must ensure that there are regular audits of the positive approach to behaviour management and that feedback is given to staff to promote learning.	The centre manager has included discussions on SEN as a standing agenda item in staff meetings, effective from 27/02/26. Beginning 06/03/26, the Centre Manager will report on SEN matters in her weekly centre report to senior management. The centre manager ensured that the key working sessions outlined in the behaviour management plan were completed and appropriately reflected in the placement plan. This was completed on 03/03/26.	The QAO will conduct a behaviour management audit of the centre on a quarterly basis. The CEO will review and discuss the audit findings with the staff team during a team meeting.
	The centre manager and staff team must ensure that key working identified within the behaviour management plans is paced and proportionate and reflected on the placement plans.	The centre manager conducts daily reviews of SENs and provides corresponding commentary. Any immediate actions identified during these reviews are communicated to staff for prompt implementation. The centre manager also reviews SENs with the team during scheduled team meetings and discusses them with the social worker as part of ongoing collaborative planning.	The Director of Services (DoS) will ensure alignment between the behaviour management plan, key working sessions, and the placement plan during the monthly centre review.

	The registered proprietor and centre manager must ensure that there are systems in place for the review of significant event notifications and missing child from care incidents. There must be feedback with the staff to ensure that any learning and actions are integrated into planning. The centre manager and director of care must review what constitutes a restrictive practice and the evidence there is to support these decisions.	The centre manager and the DoS have reviewed the restrictive practice log, with all supporting evidence maintained on file. This review was completed on 22/01/26. The restrictive practice log was subsequently reviewed and approved by the social worker on 27/02/26. The centre manager discusses the restrictive practice log during monthly staff meetings to ensure ongoing	The DoS conducts monthly reviews of SENs and provides feedback to the centre manager and senior management. The QAO will carry out a quarterly behaviour management audit of the centre. The CEO will review and discuss the audit findings with the staff team during a team meeting. The CEO will ensure that SENs are formally reviewed during monthly senior management meetings. The CEO will ensure that the restrictive practice log is reviewed monthly during senior management meetings.
5	The registered proprietor must implement a formal governance reporting system taking account of its purpose and function.	Effective 06/03/26, the centre manager will submit a weekly centre report to the director of services (DoS). The DoS will provide a monthly report on the centre to the CEO and senior management. Additionally, the centre manager attends monthly senior management meetings to present updates and reports on the	The CEO will regularly review all reports and provide feedback to the centre. The CEO will also compile a six-monthly appraisal of each centre based on the submitted reports. The DoS will conduct supervision of the centre manager at least once every three months.

		centre's operations.	
	The registered proprietor must ensure that the auditing system is adapted to assess the safety and quality of care provided in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA).	The QAO has developed a new audit format for the centre, aligned with the HIQA National Standards for Children's Residential Centres, 2018. This format will be used for quarterly audits and was finalised on 26/02/26.	The CEO has approved the new audit tool, which the QAO has now implemented. The CEO will ensure that the template is regularly reviewed to maintain alignment with national standards and regulatory requirements.
	The centre manager and director of care must provide training to centre staff on the revised policies and procedures document to guide and promote best care practices.	The centre manager and the DoS commenced training for staff on all revised policies beginning 27/01/26. In addition, the centre manager has initiated ongoing training for staff on the HIQA National Standards for Children's Residential Centres.	Effective April 2026, the CEO will ensure that policy reviews are included as a standing agenda item in the monthly senior management meetings.
	The centre manager must review the centre risk register taking account of all guidance received on regulatory notices, national policy and regulations, as well as statutory responsibilities.	The centre manager has reviewed the risk register, incorporating all relevant guidance on regulatory requirements, national policies, and statutory responsibilities. This review was completed on 26/01/26.	The DoS will conduct a review of the risk register on a quarterly basis.

	The centre manager and their team leader must be trained in the role of designated liaison person and agree delegated roles and responsibilities within this for practice at the centre. All staff must know how to make a report of a child protection nature.	Both the centre manager and the team leader completed the uncertificated DLP training on the Tusla Portal on 20/01/26 and are scheduled to attend the full training with a training provider on 23/03/26 and 26/05/26, respectively. All staff have completed their mandated person training. The centre manager conducted one-to-one debriefing sessions with staff from 20/01/26 to 16/02/26, emphasising their roles and responsibilities in identifying and reporting child protection concerns via the Tusla portal. The procedure for reporting Child Protection and Welfare Reports (CPWR) was further discussed during the staff meeting on 27/02/26. The child protection and safeguarding policy were updated on 26/01/26 and reviewed with staff at the meeting on 27/02/26.	The DoS will ensure that the centre manager and team leader remain current with their Designated Liaison Person (DLP) refresher training. The centre manager will ensure that all staff maintain up-to-date mandated person refresher training. The DLP will review all reported child protection concerns and communicate the findings to the DoS.
	The centre manager and the director of care must ensure that there is a clear managerial delegation structure is in place.	During the staff team meeting on 05/11/25, the DoS and centre manager clarified the managerial delegation structure, outlining staff roles and	Senior management will consistently convey any updates or modifications to the managerial delegation framework to ensure ongoing governance continuity. The

		responsibilities. A new delegation log template was implemented in January 2026, records delegated tasks, expected completion timeframes, and actual completion dates.	DoS will assess the delegation framework during the monthly review and consult with the centre manager regarding any recommended adjustments.
6	The registered proprietor must ensure that they continue to recruit and staff the centre in compliance with the 'Staffing Levels and Qualifications for Registration Children's Residential Centres' (Part VIII, Child Care Act 1991) Guidance ACIMS August 2025.	The organisation is actively recruiting additional qualified staff, with several candidates currently undergoing assessment through the Tusla Central Compliance Unit. Existing qualified staff have been reassigned within the team to ensure that staffing levels are appropriately maintained.	The CEO continuously authorises recruitment drives to align staffing levels with organisational needs.
	The centre manager must ensure that they risk rate and review the arrangements in place for the total hours worked per person and to include rest periods.	The centre manager will monitor staff schedules to ensure weekly hours do not exceed 48. The DoS and centre manager engaged the team during the staff meeting of the 27/02/26 to clarify and reinforce the working hour expectations.	The CEO will review rosters to ensure staff do not exceed 48 working hours per week. Any overtime will be authorised by the DoS, who will also ensure staff have adequate rest and that schedules are balanced in subsequent weeks.
	The centre manager must ensure that the roster takes account of an appropriate time for staff handover. The records maintained should reflect	The centre manager will incorporate handover periods into both shift schedules, running from 7:45–8:00 am and 7:45–8:00 pm, commencing	The DoS will ensure that handover periods are consistently reflected in all staff rosters. The centre manager will supervise the execution of the handover process to

	this and those in attendance.	09/03/26. These handover arrangements were discussed with the staff team at the meeting on 27/02/26 and in effect from 09/03/26 onward.	ensure compliance.