Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of a Children's Residential Centre

Name of provider	The Child and Family Agency
Tusla Region	South West
Type of inspection	Unannounced
Dates of inspection	03 – 04 February 2026 09 February 2026
Centre ID	OSV-0009006
Fieldwork ID	MON-0049437

About the centre

The following information has been submitted by the centre and describes the service they provide.

Our aim is to provide a residential setting wherein children/young people live, are cared for, supported and valued.

Our objective is to provide a high standard of care and support in accordance with evidence based best practice, in a manner that ensures each child's safety and wellbeing and enables them to access the supports and interventions necessary to address the circumstances of their admission to the unit. This is achieved through a supportive, nurturing and holistic living environment that promotes wellbeing, safety, rights, education and community involvement.

The centre provides medium or long term residential care to young people in a multi occupancy setting who require therapeutic interventions to address vulnerabilities and behaviours of concern. The centre works in conjunction with other professionals and has access to a psychologist.

The staff team encourage positive attachments and build relationships to provide a therapeutic environment for young people in order that they can learn new skills to live successfully in the community.

A safety planning and risk management model is an integral element of the programme.

A young person is eligible for this service where they have been identified by TUSLA as in need of care and protection.

The following information outlines some additional data of this centre.

Number of children on the date of inspection	03

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings and information received since the last inspection.

As part of our inspection, where possible, we:

- Speak with children and the people who visit them to find out their experience of the service
- Talk to staff and management to find out how they plan, deliver and monitor the care and support services that are provided to children who live in the centre
- Observe practice and daily life to see if it reflects what people tell us.
- Review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarize our inspection findings and to describe how well a service is doing, we group and report on the standards and related regulations under two dimensions:

1. **Capacity and capability of the service**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. **Quality and safety of the service**

This section describes the care and support children receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all standards and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:			
Date	**Times of inspection**	**Inspector**	**Role**
03 February 2026	09:15hrs to 17:30hrs	Lorraine O'Reilly	Lead Inspector
04 February 2026	09:00hrs to 18:30hrs	Lorraine O'Reilly	Lead Inspector
09 February 2026 (remote interview)	14:15hrs to 16:00hrs	Lorraine O'Reilly	Lead Inspector

What children told us and what inspectors observed

This was an unannounced inspection of a children's residential centre carried out to assess the centre's compliance with a number of National Standards for Children's Residential Centres, 2018. Due to concerns that arose upon arrival to the centre, the focus of this inspection changed to a risk based inspection. This was the second inspection of this centre since it opened as a newly renovated two-storey building in 2025. At the time of this inspection there were three children living in the centre with capacity for four children in total.

During this inspection, there were immediate risks to the safety, health and welfare of children living in the centre. An urgent compliance plan was issued on the first day of the inspection requesting that the provider outline how they would address these risk issues. This response and a subsequent second response did not provide adequate assurances that the risks outlined would be addressed. Following this, a cautionary meeting took place to discuss the concerns which required clear actions by senior management to monitor the risks and ensure the effectiveness of actions. The senior management team provided further updates with regard to the significant amount of work required within the centre and that this would be extended to ensure standards would be met.

There was regular illicit substance use occurring in the centre and on the grounds of the centre by some of the children residing there. Children had openly discussed this issue with staff, both from their experience of engaging in illicit substance use in the centre and also from the perspective of being exposed to it. Despite staff and management being aware of this and ensuring this was clearly documented, it was not being addressed in line with national policies and legislation. This was an active concern during the inspection.

Upon arrival at the centre, staff showed the inspector to a room which they said was used for meetings. Upon entering the room, there was a distinct smell. Staff also noticed this and opened a window to allow fresh air to circulate. A subsequent review of records from the week prior to the inspection indicated there was a strong smell of an illegal substance in the centre.

The back garden area could be seen from this room. The garden had substantial space and had sports equipment. There was a large green area, a shed and a slabbed pathway external to the back doorways. There were two outdoor chairs and a small outdoor table located in a covered area within close proximity to one of the back doors adjacent to the kitchen area.

There were several cigarette ends visible which were left on the pathway area close to where the chairs were located and also along the grass perimeter. There were more left by the drain which was also located close to the outdoor furniture.

Children were offered the opportunity to meet with the inspector and were informed by staff that the inspection was occurring. The inspector interacted with two of the three residents during this inspection. Children said that they liked living there and said staff were doing 'a good job'. Children spoke about the location of the centre and that staff were available to take them out when they wanted to go out. All children residing there were aware of the illicit substance use. They were aware of where this occurred and could smell a substance within the centre. This was noted in children's records and they spoke to staff about this.

Staff voiced concern about children using illicit substances within the centre and told the inspector that they had sought guidance from their management team about how to address this. They told the inspector that although this issue was discussed repeatedly, a clear action plan and expectations of what should be done were absent. For example, some staff would report and record information while others did not. This was also the practice of managers within the centre. Both managers worked in the centre on a full-time basis and although being aware of the illicit substance use over an extended period, the approach of zero-tolerance was not implemented.

While efforts were made to contact external professionals, the inspector did not get to speak with them as part of this inspection.

From what the inspector observed in the centre, through interactions with children and staff and a review of records, it was clear that the house was well-maintained, children engaged with staff and for the most part were comfortable there. Children spent time with staff and asked for things that they wanted such as items for school and money when leaving the centre. They also engaged in general conversation with staff.

The centre was bright with natural light through the rooms and hallway. The centre had two sitting rooms. The rooms were large and spacious with plenty of space for young people to spend time alone or with friends and family. The premises was clean and decorated in a child-friendly manner with pictures and paintings. There was plenty of age-appropriate activities available for young people.

The house was suitable to meet the requirements of the children residing there. The kitchen area was open plan with a dining table and an adjoining large sunroom. The kitchen area was bright and welcoming. Fridges and cupboards were filled with food and there was a dining table area where children and staff were seen together at meal times. Children had their own routines and did not all eat together for meals. For example, one child may have been at school or another was spending time outside of the centre. When they ate was dependent on their individual programmes for each day. There was a utility room next to the kitchen which opened out to the back garden area. The ground floor also had an accessible shower room and toilet, two offices and a meeting room with large doors which also led out to the back garden area. The first floor comprises of four en-suite bedrooms and a staff office.

The grounds consisted of a lawn area, front and back of the house, with a gravel drive and ample parking. Close circuit television cameras (CCTV) were in use to the front of the house for security purposes, which children were aware of and it did not intrude on their privacy.

Staff and centre management acknowledged the significant concern of illicit substance use during the inspection which had remained unaddressed and managed ineffectively. While committed to wanting to address this risk, there appeared to be lack of decision making at a governance level and ineffective oversight to ensure the risk was appropriately managed, as well as poor risk management and governance in general.

Due to the seriousness of this risk and the lack of managerial response to address this significant issue, there was an immediate escalation of these concerns on the first day of the inspection. This will be discussed in the other sections of this report.

Capacity and capability

This was the second inspection of this residential centre which opened in February 2025. This was an unannounced inspection, and significant concerns arose during the inspection which meant that this changed from a safeguarding inspection to a risk-based inspection. The main focus was the lack of effective management of active illicit substance use by children in the centre and the impact of this for all children living there.

Governance required strengthening to support centre staff to effectively safeguard children in their care. While staff were aware of their role, there were unclear lines of accountability and oversight of responsibilities from senior management. The risks identified was escalated to the regional manager to provide urgent assurances that actions would be taken to come into compliance with two of the national standards and legislation. These were escalated at the time of the inspection due to the significant risk they posed to children's safety and well-being while in the care of Tusla.

Of the five national standards for children's residential centres assessed:

- five were judged as not compliant.

Management had failed to ensure a safe living environment for children in the full-time care of Tusla through being aware of and allowing illicit substance use to continue in the centre on a regular basis. This exposed children to risk which should have been managed more effectively. The lack of management oversight, action and failure to risk manage in an effective way had an impact on the safety, health and welfare of children living in the centre.

Management failed to effectively implement national policies, procedures and legislation within the residential centre. For example, not all incidents were identified, managed and reported in a timely manner. Incidents which were recorded as significant events led to relevant people being notified of them such as social workers, guardians and others involved in care planning for the children. Management reviews of incidents did not mean changes to practice to improve the lives of children residing in the centre.

External oversight of incidents was limited given the sporadic identification of incidents, under-reporting of substance misuse and a limited number of those reported were determined as a priority for review. Identified child protection concerns as well as violence and aggression were two areas which were reviewed. Due to this limited reporting of incidents, learning from reviews was limited. All safeguarding concerns, given they were not reported as such by centre management, were not overseen externally or by senior management of the residential centre.

All staff were aware of their responsibilities as mandated persons under *Children First: National Guidance for the Protection and Welfare of Children (2017)*. They were knowledgeable about the clear mechanisms in place to ensure child protection concerns were reported as required. While staff and management demonstrated this awareness, not all staff reported concerns or incidents when they occurred within the centre. This was due to the failure to recognise the

regular illicit substance use within the centre as a safeguarding concern. For example, the smell of cannabis was recorded on daily logs but not recorded as a concern for children's safety or welfare. These incidents were not reported by staff as significant event notifications. Training in relation to safeguarding was completed as part of the safe recruitment process in place.

Safe recruitment and selection policies and procedures were followed which demonstrated the national processes and practices were in place to recruit suitable people to work within the centre. While this was positive, ongoing safety processes and oversight of concerns which may not meet the threshold for intervention by Tusla's social work department required improvement. For example, behaviours impacted on resident's well-being in their daily lives may not reach the threshold of abuse, they may give cause for concern due to the impact of being exposed to activities such as smoking, the lack of boundaries in place and the uncertainty in terms of managing behaviours within the centre.

The possibility of safeguarding concerns arising from a lack of professional competencies had not been assessed by management at the time of the inspection. Supervision was not occurring in line with national policy and this meant that any concerns about staff performance were not recorded or addressed by management. Supervision as a means to ensure safe practice, support staff and provide oversight required significant improvement.

Standard 3.3
Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.

The provider had policies and procedures for the notification, management and review of all incidents that helped to safeguard children. This did not result in all incidents being effectively identified, reported, recorded and managed in line with Tusla's own policies. The focus of this inspection was based on the presenting risk of illicit substance use occurring within the centre. The provider's failure to effectively manage this risk did not promote children's safety and wellbeing within the centre.

When incidents were identified and recorded as significant events, they were notified to the children's social workers and other relevant parties. From the sample of records reviewed, these were done in a timely way and the date, time and oversight of the management team within the centre was recorded.

From a review of the centre's log of significant event notifications, there were records of 44 incidents reported during the five months prior to the inspection. Episodes of missing in care were not a significant risk factor from the information recorded and reported by staff and management. Some children for whom there were ongoing risks identified had extended periods of free time and children were not being adequately supported to address these in a way which would promote their health and safety.

Not all incidents of staff recording the smell of cannabis within in the centre or the impact on the residents for each time this happened was recorded and acted upon. This meant that it was unclear to the staff team what should be reported as a significant event and what actions were required when this occurred.

Eight incidents were recorded as relating to drug or alcohol use. Records indicated staff sought guidance about how to manage the presenting risks. From the sample reviewed during the inspection, reported incidents were responded to when there was clear guidance and support by management. For example, for one incident on-call management support informed staff about contacting An Garda Síochána and another incident led to the completion room searches. However, as outlined, not all incidents were reported.

Incidents identified and recorded by the staff were subject to discussion for learnings at the external significant event notification review group (SENRG). Incidents reviewed related to areas such as violence and aggression and other safeguarding issues. From the sample reviewed by the inspector covering the time period, those reviewed did not relate to the illicit substance abuse within the centre. This meant that the impact of the illicit substance use was potentially not known by management external to the centre and therefore was not subject to review to improve practice and ultimately enhance the daily lives of children residing in the centre. The SENRG often asked for the status of child protection and welfare reports as part of their feedback on incidents and this remained outstanding at the time of the inspection.

Audits were requested as part of the documentation review during this inspection. None relating to safeguarding were provided. Of the audits reviewed, they related to direct work, restrictive practices and significant event notifications. Direct work involved staff meeting with a young person to discuss the use of an illegal substance. While this was positive to see, the audit found that this was not signed by staff or the young person and it did not identify any follow up actions. The two incidents reviewed for the audit involving restrictive practices for the month prior to the inspection did not relate to illicit substance use. This meant that children

continued to use illicit substances, with staff and management being aware of this, yet audits did not identify these issues.

There was no evidence of any learning from audits or reviews undertaken, nor any improvements to practice being discussed and implemented by the team. All staff including management acknowledged that communication required improvement and while discussions were noted to have taken place, they lacked effective decision making to demonstrate any service improvement.

There was a failure in the service's responsibility to adequately identify, manage and review risks. This meant that there was ineffective safety measures to address the risk of children engaging in illicit substance use within the centre while in the care of Tusla. Despite an approach of zero tolerance being spoken about and recorded, it continued to occur despite the recording of the risk and several team and management discussions. For these reasons, the centre was assessed as not compliant with this standard.

Judgment: Not compliant

Standard 5.1

The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the welfare of each child.

Regulation 5:

Care practices and operational policies

The provider failed to ensure that the residential centre performed its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the welfare of each child. Monitoring and oversight of the centre's management systems and processes required development to ensure accountability in providing a child-centred, safe and effective service.

As clearly stated in the national policies for Tusla's mainstream children's residential centres, the use of illicit drugs, alcohol, smoking, e-cigarettes and vaping are strictly prohibited. Residential care is a smoke-free environment. While staff had been provided with the policies to review at the time of the inspection, they had not been collectively reviewed as a team and they were not implemented in practice by management and staff.

While staff demonstrated an understanding of legislative requirements, policies and standards as well as being aware of their safeguarding responsibilities, this

was not reflected in the day-to-day practice within the centre. Management had not ensured that the centre was compliant in fulfilling its obligations to maintain the safety and well-being of children living there and it did not implement available mechanisms and resources effectively to adequately perform its functions.

Supervision was of poor quality and required significant improvement. A meeting in October 2025 noted that assurances had been provided by centre management to the deputy regional manager that supervision had been occurring within the centre. During this inspection, a review of supervision records showed very poor record-keeping, a lack of systems for filing and storage and no clear record of any discussions and decisions which occurred about children. The records also failed to capture any concerns by staff, management and any actions which were required to be implemented.

It was clear during the inspection that children smoking within the house was happening on a regular basis. This was documented through various records and of significant concern was the activation of fire alarms due to children smoking in their bedrooms. While documented in the fire log records that the alarm had been set off twice in one week due to the smell of smoke/vaping/cannabis from children's bedrooms, children also refused to leave the property when the alarm was activated. Furthermore, when the smell of cannabis was detected within the house and on the grounds, this did consistently lead to personal or room searches being conducted.

Restrictive measures while they should be short and only used when required, they are a safeguarding measure. They were rarely used in relation to preventing or reducing illicit drug use within the residential centre. Measures such as searches were rare and were not documented in the restrictive practice log.

Collective risk assessments did not effectively consider the mix of children in the centre as part of the admissions process. Children placed in the centre have their individual needs assessed prior to admission as well as looking at any impact on children already living in the centre. These were completed to identify any supports which children may require to best promote their safety and well-being. For example, social care staff should support children to cease using drugs, smoking or vaping and follow any recommendations made for the children's care needs. Some aspects of this work included health information, individual work with children and referral to specialist services if required. This is outlined in Tusla's national policies and compliance with this was assessed under this standard to protect and promote children's welfare. During the inspection, risk assessments prior to admission clearly indicated the presenting risk issues for children. Illicit

substance use was an identified risk factor. The service failed in its function to provide all residents with a safe environment by not effectively managing this risk within the residential centre and this was also an exclusion criteria in the centre's statement of purpose and function given the specific support needs for children.

Efforts were made by the team to engage children in individual work to discuss their safety needs and well-being. Staff completed individual work with children and this covered various topics such as hopes for the future, the impact of drugs and alcohol and staying safe online. While these discussions assisted and supported children, what the team were advising children and what was being allowed to occur within the residential centre were in contrast with one another. For example, having discussions with children about the impact of illicit substance use while children continued engaging in this behaviour within the centre.

All relevant parties were aware of and involved with care planning for children living in the centre. There were external professionals such as a psychologist who provided guidance to the team in supporting children with their individual needs. There were copies of children's care plans on their files, some of which required updating. For example, one child-in-care review occurred prior to the child moving into the current residential centre and the care plan from this review was completed after the child moved into the centre. From review, it appeared children's care needs as outlined in their care plans were not being met or addressed. Children's educational needs or an alternative programme to engage children during the day was absent for some children as well as promoting life skills, supporting relationships and encouraging new opportunities; all of which are included in the residential centre's information booklet for children.

Children were provided with opportunities to engage in individual work as well as avail of supports with external services should they agree to do so. Sometimes children declined the opportunity to engage with external services when this was offered to them. There were missed opportunities by the centre staff and management in terms of how they could assist and support children to manage issues in their daily lives. Some children spent several hours outside of the centre on a daily basis and were not engaged in structured activities during this time. Significant periods of time spent outside the centre on a daily basis did not provide children with the opportunities to develop their skills to work towards living independently.

Judgment: Not compliant

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

The governance and management systems were ineffective in promoting safe care practices. Nationally, safe recruitment practices were in place. There was a lack of supervision within the centre which meant that staff were not adequately supervised to both ensure a safe service and receive support and direction in fulfilling their roles. While there were management structures in place within the centre, staff did not have clear lines of responsibility, accountability or a shared knowledge of the systems which were required to ensure the delivery of effective care and support for all children living in the centre.

Safe recruitment and selection practices were found to be in line with national policy and procedures. Five staff files were reviewed as part of the inspection process and all had the required checks completed. Following on from these steps of safe recruitment, safe retention mechanisms were required within the centre. For example, staff being adequately supported to fulfil their roles in line with national policies and procedures.

Supervision had not been established within the centre to provide all staff with sufficient support and guidance in managing risk. The inspector reviewed the supervision records of eight staff members and none were in line with policy requirements. This meant that staff were not consistently provided with the opportunity to discuss practice and receive formal support from managers. It also meant that challenges remained unaddressed and actions required were not discussed, recorded and tracked to promote better outcomes for children residing in the centre.

All supervision records were not available for review when requested by the inspector such as those of the deputy social care manager and social care manager. The storage of records was ad-hoc, recording of information was poor and there was limited information available to demonstrate how supervision could provide management with effective oversight of the quality of care being provided to children. Overall, supervision was an oversight mechanism which required significant improvement to be effective in managing risk while also supporting staff.

The social care managers had the appropriate experience required for their roles. While managers were accessible to staff, clear guidance to promote shared

responsibility and accountability throughout the team was lacking. This was caused by poor communication, lack of enhanced management support for a newly-established team, effective reporting mechanisms and lack of good quality supervision for all staff.

The centre had adequate staffing levels to cater for the needs of the child at the time of the inspection. However, management and staff spoke about the ongoing challenges with staffing and the centre were relying on agency staff to fill rosters. This demonstrated further the importance for all staff to be led well by management in terms of consistency of care and expectations when working with children living in the centre.

National policies, procedures, protocols and guidance across significant areas of practice directly related to the provision of safe and effective care to children in residential care had recently been updated. These had been made available to staff at the time of the inspection.

Communication systems in place included; daily handovers, team meetings and management meetings and these aimed to ensure safe, child-centred and individualised care for the children. The management team had identified improvements were required to daily handovers as information was being missed. The inspector reviewed team meeting minutes which showed that while areas of practice were discussed, including safeguarding, discussions did not result in changes to practice within the centre. For example, the same concern voiced by staff about a child's use of cannabis upon their admission to the residential centre was repeated throughout the five months prior to the inspection.

The social care manager reported to a deputy regional manager, who in turn, reported to a regional manager for children's residential services in the Tusla North Cork/ South Tipperary region. When the social care manager was out on leave, the deputy social care manager took on this responsibility.

Senior management meetings had taken place since the centre opened, attended by the deputy regional manager, social care manager and deputy social care manager. A review of these minutes from October 2025 noted key areas for improvements. These included recording systems, areas of practice which required strengthening across the management and staff team and supervision. These remained issues to be addressed at the time of this inspection.

Social care leader meetings had been established in the residential centre. While these discussed various topics such as the care of young people, health and safety

and rosters, they lacked effective action to address areas of concern. The minutes recommended that supervision be scheduled, typed up and sent to the supervisee. This remained outstanding at the time of this inspection.

The social care manager and deputy manager had the responsibility to maintain oversight of all the centre's registers, such as complaints, child protection, restrictive practices, risk and significant events. Inspectors found that these registers required updating and also required verification of the information being recorded. For example; consultation and direct work with the child was not completed in the majority of events reviewed, there was inaccurate recording in the centre logs and tracking of documents noted on logs was not reflective of what staff told the inspector.

A national risk assessment framework was in place which supported staff and managers to identify, manage and regularly review safeguarding risks and concerns. Staff demonstrated appropriate knowledge and understanding of the risk management policy and how this underpinned their day-to-day tasks and the care they provided in order to keep the child safe. The social care manager held responsibility for a risk register. Risk registers are a record of risks that impact on the service's ability to deliver on its objectives and the measures to be put in place to mitigate against these risks.

The risk register in the residential centre was not regularly reviewed and updated to reflect new risks and changes to existing risks. For example, illicit substance use in the centre was not on the risk register. At the time of the inspection, there were three risks on the register relating to staffing, information technology and the risk to safety due to violence and aggression which was listed twice. This risk register had been updated six weeks prior to the inspection when all three children were living in the centre.

Significant improvements were required to ensure that all national policies and guidance intended to guide staff in the provision of an effective service were fully implemented within the centre. Governance and management oversight required improvement such as establishing good effective supervision practice and its oversight, and having effective risk management systems in place which were dynamic and responsive to the needs of all children living in the centre. There were gaps in the management of risk which meant that appropriate assessments, review and monitoring of risk were not in place. In addition, centre records such as supervision and team meetings required development to ensure accountability for decisions made. For this reason, this standard is judged as not compliant.

Judgment: Not compliant

Standard 5.3
The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The statement of purpose required reviewed and evaluation as part of the residential centre's governance arrangements, in order to provide assurance that services were being delivered in line with the statement of purpose. The statement of purpose for the residential centre was not reflective of the service being provided by the residential centre. The aims and objectives did not accurately reflect the findings of the inspection. For example, while previously the aim was to a provide placement for one young person, this had changed and the statement of purpose had not be updated to reflect this. The centre opened in February 2025 and was located in a newly renovated premises that could accommodate up to four children. In addition, the residential centre was not conducive to promoting wellbeing, safety, rights, education and community involvement.

The statement of purpose also noted that a safety planning and risk management model was an integral part of the programme. With this in mind, some children may not have their needs met in the most suitable way within the centre and this meant there was exclusion criteria for admissions. These were listed in the statement of purpose and function document. Exclusion criteria noted in the statement of purpose included substance misuse. This was not reflective of the daily lives of some of the children residing in the centre at the time of the inspection.

The children's version of the statement of purpose included brief sentences about daily life, the model of care and a description of the centre with photographs included. It lacked a description of the staff working there and information about maintaining safety of children placed in the centre.

The statement of purpose had been developed prior to the admission of more than one child. The residential centre was not operating in line with its own statement of purpose and function with regard to admissions to the centre. For these reasons, this standard was assessed as not compliant.

Judgment: Not compliant

Quality and safety

Overall, improvement was required to ensure that the service was child-centred and children living in the centre received good quality, safe care. The centre ensured staff were trained to report safeguarding concerns in line with *Children First: National Guidance for the Protection and Welfare of Children (2017)*. Staff were aware of their responsibility to keep children safe yet concerns identified during the inspection had not been reported or managed effectively.

While children received care and support in the centre to meet their basic requirements, this was impacted upon by risks which had continued to be managed ineffectively by the management of the centre. On the day of the inspection an issue was identified with children engaging in illicit substance use in the centre and all residents were exposed to this.

The quality and safety of the service was linked directly to the governance of the centre. There were gaps identified, which staff and the management team had an awareness of. This required addressing to promote children's best interests and to reach compliance with this standard.

Standard 3.1

Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

Not all children were safeguarded when in the residential centre and their care was welfare was not always protected and promoted. Some but not all child protection and welfare concerns were reported in line with the requirements of Children First (2017). For example, the illicit substance misuse previously discussed had not been identified as a concern which warranted reporting to Tusla through its national portal. Other instances such as disclosures of abuse and online safety concerns had been reported as required.

Staff in the centre were aware of and had completed training in Children First (2017) as required. Staff had received additional safeguarding training such as child sexual exploitation to ensure they were aware of and alert to signs of safeguarding risks.

There were concerns about the quality and effectiveness of the assessment of risk and safeguarding for children. Due to the mix of young people placed, there were safeguarding concerns about exposure to risk taking behaviours, their sense of

safety and predictability and their emotional and physical development, whilst in the centre. While there were agreed safety measures to mitigate risk such as increased supervision of children when they were together, these safety measures were not fully effective in reducing the impact of living in the centre as they did not fully mitigate against the exposure to incidents. The cumulative impact of risk impacting on the safeguarding of children had not been considered and it was not recorded in the centre management and oversight documents such as the child protection and welfare register.

There was a child protection and welfare register held in the centre. There were six child protection and welfare reports made in the six months prior to the inspection. Recording and reporting systems in place were poor at the time of the inspection. For example, one child protection and welfare report on the log did not record the date the report was made and therefore it was not clear if this was timely. In addition, while the log indicated that a copy was placed on children's records, staff indicated that these were not kept on children's files. This showed that the maintenance of records was poor and key information could be missing from children's files such as information relating to disclosures of abuse and potential risks depending on the information reported by children.

There was lack of structure and clarity of governance mechanisms which were aimed to ensure accountability and safe practice. Clarity was sought but not provided in relation to the recording in both the child protection and welfare log and the significant event notification log. From those reviewed during the inspection, incidents recorded on the significant event notifications did not match with the child protection and welfare reports made. This demonstrated lack of managerial oversight and review of the registers as well as potentially missed child protection and welfare referrals which should have been made to safeguard children.

There was a policy on protected disclosure which was available in the staff office. Staff were aware of the procedures should they choose to report concerns about practice in the centre.

Staff were trained in Children First (2017) and were aware of their role as mandated reporters. Some safety measures taken on an ad-hoc basis by the staff team to reduce the risk to residents were not fully effective. Management systems and oversight required significant improvement to ensure children were safeguarded from abuse and neglect such as the reporting and recording of incidents and the storage of information. Ultimately, not all children were safeguarded when in the centre and their care and welfare was not always

protected and promoted. For this reason, this standard was deemed not compliant.
Judgment: Not compliant

Appendix 1 - Full list of standards considered under each dimension	
Standard Title	**Judgment**
Capacity and capability	
Standard 3.3: Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.	Not compliant
Standard 5.1: The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the welfare of each child.	Not compliant
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.	Not compliant
Standard 5.3: The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.	Not compliant
Quality and safety	
Standard 3.1: Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.	Not compliant

Compliance Plan

This Compliance Plan has been completed by the Provider and the Authority has not made any amendments to the returned Compliance Plan.

Compliance Plan ID:	MON-0049437
Provider's response to Inspection Report No:	MON-0049437
Centre Type:	Children's Residential Centre
Service Area:	South West
Date of inspection:	03-04 February 2026 & 09 February 2026
Date of response:	13th April 2026

Introduction and instruction

This document sets out the standards where it has been assessed that the provider is not compliant with the National Standards for Children's Residential Centres 2018.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which Standard(s) the provider must take action on to comply.

Section 2 is the list of all standards where it has been assessed the provider is not compliant. Each standard is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider has not complied with a standard and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk rated red

(high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the standard in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that standard, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Capacity and Capability: Leadership, Governance and Management	
Standard : 3.3	**Judgment: Not compliant**
Outline how you are going to come into compliance with Standard 3.3: Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice**.** • To ensure that all incidents are identified, reported, recorded and managed in line with policy, centre management will review and sign all daily logs and attend staff handover meetings when in the centre. Where incidents are identified as requiring reporting, this will be completed with appropriate management oversight. Significant Event Notifications (SEN's) and child protection concerns have been included as standing agenda items at team meetings for review and learning with the team. Substance misuse reporting guidance is to be discussed at supervision with all team members to assist staff understand and improve practice for reporting incidents/concerns. Centre management will review these records to ensure compliance Action due: 17th April 2026 • A professionals meeting was held on 17th February 2025 with stakeholders for all young people in the centre. Alterations to the free time plans for some residents was agreed in line with their individual plans. A further meeting will be held with relevant social work team to review the amendments made. Action due: 17th April 2026 • The updated policies on substance misuse and restrictive practices were reviewed at team meeting dated 26th February 2026. These policies are required reading by all staff with a sign-off sheet attached acknowledging understanding of the content. Upon review of the sign-off sheet on 11th March 2026 the deputy regional manager identified further action was required and a plan was implemented where	

each staff member will be met by centre management to remind them of the requirement and assist them where necessary to ensure they undertake the necessary action.
Action due: 31st March 2026

- Commencing at the team meeting on 11th February 2026 all current risk assessments pertaining to substance misuse in the centre and placement support plans were reviewed. In line with the provider assurance report submitted on 26th February 2026, all relevant risk assessments and placements support plans remain standing agenda items for team meetings. The minutes of these meetings will be reviewed by the deputy regional manager for a three-month period for additional oversight of compliance. Following a three-month review, this will then be incorporated into routine governance by the Deputy Regional Manager with Centre Management. The updated risk assessments provide clear direction and guidance to staff on the management of direct observations of substance misuse, but also where drug paraphernalia is found or suspected substance misuse has occurred but is not directly observed. To assist staff, gain a clearer understanding of risk management, a team input will be delivered by the deputy regional manager and QRSI on the 29th of April 2026.
  Action Due: 29th April 2026

- Following receipt of significant event notification review group (SENRG) meetings minutes, a copy will be provided to the team through individual email. The minutes will feature at the team meeting monthly for additional learnings with the team. At present one social care leader has attended significant event notification review group (SENRG) meetings and there are plans for additional social care leaders to attend where availability arises. Social care leaders in the centre will be required to assist management in oversight of significant event notifications (SEN's) prior to submission to improve quality and standards, attending the regional SENRG will assist them improve their competence and ability to undertake this task. The regional office as part of SENRG minutes will issue data collation graphs to the centre each month to assist the centre to identify and review incident trends.
  Action due: 27th March 2026
- In addition to the National Audit, there are additional audits in place for the service to complete including supervision audit, medication audit and health and safety walkthrough. The centre is currently undertaking scheduled audits under a nationally agreed audit tool. The format incorporates a clear framework for completion along with action plan tracker to identify and monitor necessary improvements required in maintaining compliance legislation, policy and standards within the centre. The deputy regional manager assigned to the service will discuss the Audits completed as part of governance meetings on a quarterly basis, commencing April 2025.
  Action Due 16th April 2026

- Centre Management will conduct a review of young people's files since their admission. Any identified deficits in safeguarding or underreporting of incidents pertaining to substance misuse will be retrospectively submitted to bring the service into compliance in this regard. Management will discuss their findings with staff at team meeting and this discussion will be recorded in meeting minutes. To improve practice going forward, case managers for each young person will be

required to review logs and files monthly where feedback will feature at scheduled social care leader meetings.
Action due: 24th April 2026

- The service has introduced two new registers, one for each individual young person and the other for centre management governance. These registers will assist management in collating information and identifying trends within specific areas that will further improve practice and ensure compliance. Each area of the young person's individual registers requires management oversight sign off, to improve management governance of key areas for each resident. This register was introduced and effective from 1st January 2026, replacing all previous registers. This will be reviewed by the Deputy Regional Manager to ensure implementation and compliance with this new system.
Action due: 29th April 2026

Proposed timescale: **29th April 2026**	**Person responsible:** **Social Care Manager,** **Deputy Regional Manager** **QRSI**

Capacity and Capability: Leadership, Governance and Management	
Standard : 5.1	**Judgment: Not compliant**

Outline how you are going to come into compliance with Standard 5.1:

The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

In line with the reviewed national suite of policies referenced above and the requirement for staff to adhere to policy, the substance misuse policy clearly identifies the centre as being a smoke free environment. Direct work has been identified as necessary with the residents on this topic and is to be completed as part of keywork to be undertaken with the young people by 25th March 2026.

All new staff joining the service will be required to read and adhere to the guidance on this policy as part of their induction to ensure they also understand the standard expected. This will be documented through the induction and probation process.

Action due 31st March 2026

- Incorporated into individual risk assessments for each young person regarding substance misuse is the risk of fire alarm tampering, there are mitigations in place for the monitoring and inspection of these alarms. The centre has a schedule of fire drills in place which are recorded in the fire register. Each young person has been met by centre management and the expectation of participating in fire drills reiterated to them. Where it is noted that young people regularly refuse to participate in fire drills, centre management will meet the young person in the company of their allocated social worker to collaboratively outline centre expectations regarding fire safety. As a result of non-engagement with fire drills this will be noted in the young people's Personal Emergency Evacuation Plan (PEEP) and efforts will remain ongoing to engage them in fire safety measures.

- To provide a robust and consistent approach to substance misuse and prevalence in the centre, there are clear measures detailed in the risk assessments for young people. Restrictive practices which are undertaken to assist staff deter and reduce the incidents of illicit drug use in the centre are recorded in the young person restrictive practise registers. The registers are reviewed and are to be signed off by management on a weekly basis as part of improved oversight in the centre. Action due 27th March 2026

- Although the collective risk assessment for some of the residents identified various risk factors, due consideration and appropriate mitigations were not fully explored as part of the admission process for their admission to the centre. For future admissions the centre management will ensure that they will more robustly consider the milieu of risks, current residents and mitigations that can support placements and this will be supported as required by the regional office.

- The centres statement of purpose and function will be reviewed by the centre manager and deputy regional manager to ensure it appropriately reflects the service provided to young people availing of the service
  Action due: 31 March 2026

- Substance misuse risks and agreed safeguarding measures will be consistently communicated through daily handovers, shift planning and team meetings, with the intention of safeguarding all young people placed in the service. Centre Management attends these meetings to ensure governance and adherence to decisions made. The Children's Residential Services (CRS) policies on substance misuse and restrictive practice were reviewed with the team at a meeting on 11th February 2026 to ensure a clear understanding on practice. The policies are required reading for all staff with a sign off sheet attached acknowledging understanding of the content. Upon review of the sign-off sheet on 11th March 2026 the deputy regional manager identified further action was required and a plan was implemented where each staff member will be met by centre management to remind them of the requirement and assist them where necessary to ensure they undertake the necessary action.
  Action due: 31st March 2026

- Commencing at the team meeting on 11th February 2026 all current risk assessments and Placement Support Plan's (PSP's) will be reviewed at each team meeting and centre management will ensure this is a standing item on the agenda.

- All staff in the centre are up to date with all elements of Children's First training and are aware of their role as mandated person's. Child Protection and Safeguarding concerns are discussed under the agenda item of risk in each team meeting however to ensure a more enhanced focus on Child Protection and Safeguarding, this will now be a standalone agenda item which will commence at the next team meeting on the 11th of February 2026. Centre Manager completed an input on Child Protection and Safeguarding at the team meeting on the 11th of February 2026. Child protection and safeguarding are a standing item for team meetings, with content detailed within the meeting minutes.

- Staff will receive regular supervision in the centre going forward and can use this forum to discuss any queries or concerns they may have regarding safeguarding concerns and the operational policies and procedures in the centre.

- The centre manager conducted a supervision Audit on 20th February 2026, identifying several areas of deficit, this was reviewed by the deputy regional manager and centre management. The matter will feature as part of governance meetings with the centre manager and be incorporated into their own supervision records. Areas of improvement and increased governance by centre management relating to supervision in the service will be detailed in the centre's service improvement plan. The deputy regional manager assigned to the service will discuss the Audits completed as part of governance meetings on a quarterly basis, commencing April 2025.

- All Significant Event Notifications (SEN's) involving substance misuse will be reviewed by the centre management and documented on a Manager Review and Response record and discussed with the team. All relevant risk assessments and Placement Support Plans will be updated to reflect the incident and risk. The Deputy Regional Manager receives and reviews all Significant Event Notifications and will review the Manager review and response record for each incident of substance misuse to ensure good oversight of risk and incident management.

- Child Protection and Welfare Report Forms (CPWRF) are completed in the centre when a safeguarding concern arises. Centre Management ensure that when a CPWRF is submitted and an appropriate response is received in a timely manner. The escalation process will be implemented should a response not be received within the appropriate timeframe. Centre Management have daily oversight of the daily journals and Significant Event Notifications for the centre and ensure that any child protection concerns are reported in line with Children's First legislation. The centre has a child protection register which details any child protection concerns that have been submitted for the centre. The centre manager has oversight of this register which is also intermittently reviewed by the Deputy Regional Manager assigned to the centre.

- All Significant Event Notifications (SEN's) which involve a child protection concern, are reviewed by the Significant Event Notification Review Group (SENRG) and require a follow up in relation to the status of the concern. Individual registers for each young person were implemented from 01st January 2026. The deputy regional manager will review these registers with the centre manager as part of governance meetings.

- Personal Emergency Evacuation Plans (PEEP's) for all young people who engage in substance misuse have been updated to reflect the risk that they may require additional support in the event of an emergency evacuation should they be under the influence of illegal substances. PEEP's were updated on 04th Feb 2026. This document is to be completed monthly as part of placement support plan updates. Centre management will be required to review and sign off on each updated PEEP. These documents will be reviewed by deputy regional manager during governance meetings for increased oversight.

- Due to incidents of young people smoking in the house, health and safety risks relating to fire have been updated to reflect this risk. A fire drill was conducted on the 5th of February 2026. Fire drills for all young people were completed on 11th February 2026; Fire drills will take place as per agreed standards for the centre. The centre manager will review the fire register to ensure all young people engage in the process, where difficulties arise, the matter will be discussed with the young person and their social worker. The young person's PEEP will also be updated to reflect non-engagement with fire drills. Tusla Health and safety department along with centre management, reviewed risk assessments pertaining to the ongoing Health and safety measures for the centre. This review was completed on 16th February 2026

- The forums of both internal management meetings with Social Care Leaders and external governance meetings with the Deputy Regional Manager will be used to discuss and examine risk and ensure clear understanding of managing risk including regular review, reporting issues of concern and escalation thresholds. The Regional Crisis Management guidance document and incident management policy will be used to inform best practice. The QRSI Officer completed an input on the 28th of January 2026 at the centre's team meeting on the incident management policy.

- A weekly meeting with the Deputy Regional Manager and centre management was scheduled for an initial four-week period to ensure actions were being implemented and to ensure follow-through with any additional actions arising from professionals meetings. This will now be extended to 12 weeks to support oversight of actions to meet compliance.

- Weekly meetings continue to take place with centre management and the deputy regional manager. Minutes are completed and available on request. Initially these meetings were planned for four weeks with a review, however it has been noted by the deputy regional manager that these will need to be continued due to the ongoing dynamic and scale of work to be undertaken by management and staff in the centre. The deputy regional manager will be visiting the centre twice weekly up to and including the week of 23rd March 2026 in addition to the above weekly meetings, to review progress and offer support to staff and management in addressing the deficits. These in-person visits will be conducted through a combination of announced and unannounced visits. This period of on-site governance, support and weekly meetings will be extended further to be reviewed again on 20th April 2026.

• The deputy regional manager reviews the digital files and logs for the young people on a regular basis. They also receive all SEN's and meeting minutes. Observations and recommendations noted upon review will be fed back to centre management and the team where appropriate for discussion at team meetings. The centre manager will conduct an audit on the centre as part of the national audit tool. This audit will be overseen and reviewed monthly by deputy regional manager, where the findings will feature as part of governance meetings. • These meeting forums will examine the need for additional therapeutic input for the young people and the team from CRS Psychology, or the model of care consultant. An input from the Violence Harassment and Aggression (VHA) Lead in CRS did take place on the 13th of February 2026 to support staff in the management of incidents involving VHA. The model of care consultant is currently coordinating dates with the centre management to provide team inputs for the centre and this will be finalized by 27th March 2026. CRS psychologist assigned to the centre has confirmed team inputs throughout 2026, the first of these commenced on 11th March 2026. Input for the team by external professionals is being sourced by the deputy social care manager. The Deputy regional manager will seek regular updates on this training need as part of the weekly meetings being undertaken with centre management.	
Proposed timescale: **31st March 2026**	**Person responsible:** **Social Care Manager** **Deputy Regional Manager**

Standard : 5.2	**Judgment: Not compliant**
Outline how you are going to come into compliance with 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. • To assist improve standards in providing supervision to staff in the centre, supervision will feature in the centres service improvement plan for 2026. There are clear steps to be undertaken including the monitoring of scheduled supervision dates for staff by management, a requirement for centre manager to undertake quarterly audits for practice improvement, support in fulfilling their roles as well as quality review. There will also be changes to the storage of supervision records, so they are more accessible for review going forward. Although the centre has a reliance on agency staff to fill various gaps through leave and recruitment challenges, the centre has consistent agency staff in use, offering both familiarity and continuity of care to the residents. Agency staff working in the centre, will receive supervision in line with policy, compliance in this regard will be overseen in line with the service improvement plan for supervision for the centre, this will be overseen by the assigned deputy regional manager. Social care leaders who have not completed supervision training will be enrolled into courses throughout 2026 which will assist them in undertaking the task. The next scheduled course is due to conclude 17th June 2026.	

Action Due 17th June 2026

- To assist in ensuring that all incidents are identified, reported, recorded and managed in line with policy, centre management will review and sign all daily logs and attend staff handover meetings when in the centre. The Minutes from team meetings will continue to be issued to staff as required reading with weekly management oversight. Staff will be required to sign off on team meeting minutes to evidence they have read and understand them. All placement support plans and risk assessments are now a standing agenda item for team meetings, where alterations in content will be required. This will assist in strengthening communication on key areas of practice while also providing an additional signpost to staff on reviewed documentation. The changes in procedure will be communicated to staff at team meeting dated 25th March 2026.
  Action due: 25th April 2026

- Difficulties in communication between centre management and the staff team have been an issue within the centre that has required intervention by the regional office. This has involved supporting the management and staff team to improve systems of operation and more efficient use of forums such as handover, staff meetings and supervision to improve communication and practice.

- Staff in the centre have received additional training/team inputs to support them in their practices from VHA lead, CRS psychology and EAP. The supports will remain ongoing. There is a schedule of dates throughout 2026 for CRS psychology and the centres model of care consultant to support the team. Review of all support needs in this area will take place on 26th March during the management governance meeting. Going forward this will remain an agenda item for regional office and centre management review.
  Action Due 26th March 2026

- To improve the efficiency of the daily handover and improve communication between staff, centre management will be present at handover meetings held during the working week. This commenced on 11th February 2026, the system appears to have improved communication, it is due to be reviewed by deputy regional manager and the team at team meeting scheduled 06th May 2026
  Action Due: 06th May 2026

- Senior management continue to work with centre management around all identified areas of service improvement. An agreed plan for weekly onsite visits to the centre have been reviewed with regional manager and agreed to continue for another four-week period. Progress made will be reviewed on 21st April 2026 to assess if additional supports are required or continued onsite presence of assigned deputy regional manager is necessary. Where progress has sufficiently been identified, the plan identified to inspectors in the provider assurance report for reduction in onsite presence of senior management will commence.
  Action Due 21st April 2026

- The regional QRSI will review the centres risk register with the assigned deputy regional manager to ensure all identified risks are up to date and accurate for the centre. A more robust review of risk registers for the centre will feature in centre

management and deputy regional manager governance meetings, this will include the register being brought to these meetings for verification of timely risk reviews. Action due: 29th March 2026. • The annual review of the service for 2025 was submitted by the centre manager on 13th February 2026, in addition to identified areas of service improvement based on the report Safeguarding will feature on the centres service improvement plan. The areas of improvement identified include staff awareness of safeguarding identification, reporting and review by the centre. A specific plan for improvement in this area is to be completed by centre manager and reviewed with assigned deputy regional manager on 21st April 2026.	
Proposed timescale: **17th June 2026**	**Person responsible:** **Social Care Manager** **Deputy Regional Manager** **QRSI**

Standard : 5.3	**Judgment: Not compliant**
Outline how you are going to come into compliance with Standard 5.3: The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided. • The statement of purpose and function for the centre will be reviewed by the deputy regional manager to ensure it appropriately reflects the service provided to young people availing of the service. The statement of purpose and function will have clear aims and objective identified so that the wellbeing of all young people residing in the centre. Although the presenting profile of some young people may put them beyond the scope of the service, including substance misuse, such presentations do not automatically preclude these young people from availing of placement in this service. However acknowledgment is accepted going forward, all prospective young people will undergo a more robust collective risk assessment prior to admission to ensure the service can meet the safeguarding and care needs of all residents while staying in the parameters of the statement of purpose and function. More consideration will also be given to the risk management strategy implemented as a result of risks identified within the Collective Risk Assessment (CRA) process ensuring risks are adequately mitigated against. Action due: 10th April 2026	
Proposed timescale: **10th April 2026**	**Person responsible:** **Deputy Regional Manager**

Quality and Safety: Safe Care and Support	
Standard : 3.1	**Judgment: Not compliant**

Outline how you are going to come into compliance with Standard 3.1: Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

- To provide assurances that all safeguarding incidents have been identified, reported, recorded and managed in line with policy, centre management will review and sign all daily logs for the residents. Where incidents are identified as requiring reporting, this will be completed with appropriate management oversight.
  Action due: 04th April 2026

- Following the review of all incidents, each young person's child protection file will be reviewed by the deputy regional manager to ensure all information is accurate, where deficits or errors are identified, these will be amended and overseen to completion by the deputy regional manager, the updated files will be maintained in secure file in the centre which will be added to young person's main file upon discharge from the service. In addition to compulsory training which staff undertake on Child protection, A team input will be provided to staff in the centre to ensure they are assured in how to complete child protection report forms and the submission process.
  Action Due:08th May 2026

- The deputy regional manager will assist centre management in implementing a clear and understandable filing system in the centre, to ensure that all information is available in the centre or signposted to information can be located. To ensure management in the centre maintain appropriate registers and files in the service, these will be reviewed by assigned deputy regional manager regularly.
  Action Due: 02nd May 2026

- Each young person's placement support plan was reviewed and updated to explicitly address substance misuse including identified risks, triggers and responses to the behavior should this occur. To provide absolute clarity for staff these responses have included the behavioral, medical and safeguarding approaches to be used including restrictive practices such as room searches. The identified risk of peer to peer exposure to this behavior in the centre has been outlined including protective and preventative measures. The views of all young people have been clearly documented. These updates to the placement support plans were clearly communicated to all team members through email and at the team meeting on the 11th of February 2026.

- All placement support plans have been identified as required reading for all staff with sign-off sheet attached. Upon review of the sign-off sheet the deputy regional manager identified further action was required and a plan was implemented where

each staff member will be met by centre management to remind them of the requirement and assist them where necessary to ensure they undertake the necessary action. The deputy regional manager will oversee this action to completion.
Action due: 3rd April 2026

- Individual risk assessments relating to substance misuse or exposure to substance misuse were reviewed and strengthened to ensure they are specific to the young person and clear actions to be undertaken should the risk occur. There are clear step-by-step instructions identified for staff to adhere to should either substance misuse be suspected or confirmed in the centre, the centre vehicles or on the individual young person. Risk assessments will document the young person's view of the risk. All risk assessments have been clearly communicated to all team members through email and at the team meeting on the 11th of February 2026 and emailed to all relevant professionals for their input. All risk assessments have been identified as required reading for all staff with sign-off sheet attached. Upon review of the sign-off sheet the deputy regional manager identified further action was required and a plan was implemented where each staff member will be met by centre management to remind them of the requirement and assist them where necessary to ensure they undertake the necessary action. The deputy regional manager will oversee this action to completion.
  Action due: 3rd April 2026

- The substance misuse risk assessments have been reviewed at team meetings weekly since the inspection, this was verified by deputy regional manager through meeting minutes oversight and attendance at team meeting on 25th February 2026.
  Staff will be required to sign both the updated Placement Support Plans and individual risk assessments to ensure they are aware of the procedures to follow in the event of risk occurring.

- Structured individual keyworking will be undertaken with each young person on substance misuse. Sessions will focus on risk awareness, coping strategies and decision making in addition to risk awareness, safety, boundaries and wellbeing. Centre Management will have monthly oversight and digital sign off on these sessions to ensure they are occurring consistently.

- Each Keyworking team has been informed of the requirements to undertake individual keyworking with the residents of the centre. The centre manager is due to review the records of these keywork sessions on 9th April 2026 to ensure keyworking on the topic has taken place. This will be an ongoing topic for discussion with young people while substance misuse remains at high risk in the centre, management will review each keywork record monthly.

- Additionally, the centre manager met with each of the young people on the 10th of February 2026 to clarify house rules, expectations and the importance and rights of all young people to have a safe living space. These sessions were documented and maintained on the young people's files.

• A professionals meeting took place with social workers, and team leaders for all young people, centre management and deputy regional manager on the 17th of February 2026. Minutes of the meeting are available on request and maintained in the centre. • External supports in relation to substance misuse has been offered for young people who engage in substance misuse in the centre, however engagement has been minimal or refused. Following on from the professionals meeting held on 17th February 2026, Re-referral has been submitted by social work for specialized therapeutic support for young people. If the referral process does not progress in a timely manner the matter is to be formally escalated to deputy regional manager. The referrals will be discussed at weekly meeting between centre management and deputy regional manager.Action due: 9th April 2026. • External advocacy support services visited the centre in June 2025 however they have not visited since two of the residents moved in. An advocacy service have been contacted and confirmed the allocation of the cases to a worker and will schedule a visit to the centre in the coming weeks. Young people are reminded of their rights to make a complaint. The complaint procedure is also part of the admission process in the centre where new residents are informed of the procedure for making a complaint. This information is also given to each new resident in their welcome pack to the centre. The young person's meeting on Monday the 9th of February 2026 will feature the complaints procedure as an agenda item where young people will be again reminded of the procedure.

Proposed timescale: **08th May 2026**	**Person responsible:** **Social Care Manager,** **Deputy Regional Manager**

Section 2:

Standards to be complied with

The provider must consider the details and risk rating of the following standards when completing the compliance plan in section 1. Where a standard has been risk rated red (high risk) the inspector has set out the date by which the provider must comply. Where a standard has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The provider has failed to comply with the following standards(s).

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
3.3	Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.	**Not compliant**	**Orange**	29 April 2026
5.1	The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.	**Not compliant**	**Red**	31 March 2026
5.2	The registered provider ensures that the residential centre has effective leadership, governance and management	**Not compliant**	**Orange**	17 June 2026

	arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.			
5.3	The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.	**Not compliant**	**Orange**	10 April 2026
3.1	Each child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.	**Not compliant**	**Red**	08 May 2026

Published by the Health Information and Quality Authority (HIQA).

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