



An Ghníomhaireacht um
Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 212

Year: 2025

Inspection Report

Year:	2025
Name of Organisation:	Teach Nua Care Services
Registered Capacity:	Two young people
Type of Inspection:	Unannounced themed inspection
Date of inspection:	1st, 2nd & 6th October 2025
Registration Status:	Registered 22nd December 2025 to 22nd December 2028
Inspection Team:	Ciara Nangle Janice Ryan
Date Report Issued:	31st December 2025

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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 22nd December 2022. At the time of this inspection the centre was in its first registration and was in year three of the cycle. The centre was registered without attached conditions from the 22nd December 2022 to the 22nd December 2025.

The centre was registered to provide dual occupancy placements to young people aged between 13 to 17 years on admission, providing a family orientated therapeutic model of care. This was to be accomplished through the RAP model of Care (Response Abilities Pathways) which provides strength- based strategies for young people. The centre had previously been registered as single occupancy centre and had increased their capacity in February 2025 for a specific purpose. There were two young people living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.2
6: Responsive Workforce	6.3

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

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

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 18th November 2025. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 2nd December 2025. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 212 without attached conditions from the 22nd December 2025 to 22nd December 2028 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

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.

It was evident from how staff and management spoke about the young people, their placements and the care they provided, that a strengths-based approach to the provision of care was utilised. However, staff and management were not clear on the model of care, how this differed from the framework for the management of behaviour that challenged, or the policies and procedures in place that guided practice.

Staff had been trained in a framework for the management of behaviour. Records on file indicated that this training was up to date for all but three staff. A small number of staff had not completed all mandatory training however for the majority this was up to date and included Children's First eLearning and medication management training. The centre had a mechanism in place for tracking staff's training needs, and plans were made to provide training required in a timely manner. Specific training in relation to the young people's presenting needs had not been completed. The centre was in the process of sourcing some specific training for the team in relation to one young person. One young person presented with complex needs and had multiple additional needs diagnosed. While the centre had access to a psychotherapist employed by the agency, they did not have support from an identified specialist service to support or guide them in providing care for this young person. The social worker confirmed in interview that this support was now in place and would be engaging with the centre.

The suite of documents in place to guide the management of behaviour was not always clear or accurate, at times it was inconsistent, with various documents containing contradictory information. It did not always accurately describe all presenting needs of the young people and did not clearly describe how to manage behaviour that challenged. Some guidance documents were overly detailed with lengthy and outdated information contained within, while others, did not contain the

relevant information which would support the team in the positive management of behaviour.

In interview with staff and management it was evident that they had a good understanding of the young people, their needs and their behaviours however this was not reflected within the documentation which did not support a consistent approach to the provision of care for the two young people. A review of all the guidance documents is required to ensure they contain only relevant and up to date information. The documents should be clear in the guidance to the team, to support the provision of consistent behaviour management and to ensure that the team have all the required information to meet the needs of the young people.

Outside of the behaviour management documentation, the team's practice was also guided by the risk management framework. The centre had a significant number of open risk assessments, and within interview the team regularly referenced the use of risk assessments to support and guide practice. However, given the number of open risk assessments and the contents within some of these, there appeared to be an over reliance on these, and at times, risk assessments were being completed unnecessarily. There did not appear to be clarity amongst the management and team on the risk assessment policy and its implementation in use. Review of this is required to ensure that it is only being used in line with policy to support the team and young people.

Both young people had placement plans in place, however the goals within these were broad ranging and did not detail specific work to be completed with the young people to achieve the goals set out. A review of the plans would be beneficial in supporting both the young people and the team to work towards achievable goals with clear plans of action to achieve these.

Regular key working was occurring with the young people. At times, this was focused on supporting them to understand their behaviour and the impact of this however more work in this area could be beneficial. For one young person, some of the challenging behaviours they were engaging with in the community was not consistently recorded across their documentation and work around these behaviours was not being completed. The other young person had complex needs which impacted on their ability to engage in effective key working. As noted previously there was no specialist service engaged with the young person and as such it was difficult to determine if key working was likely to be an effective way of supporting the young person to understand their behaviour and the impact of this on themselves and others.

Both young people met with inspectors as part of this inspection. Both presented well and positive engagement with the team was observed by inspectors. One young person spoke positively about the team, indicating the activities they liked to engage with and the specific team members they liked to work with. The other young person noted that they liked the placement but provided little other detail. Both had their own bedroom which was decorated with personal items.

Social workers for both young people reported positively on the placements provided by the service. They advised that the needs of the young people were being met to a high standard, that there was regular and effective communication with the centre and that all information was shared within a timely manner. For one young person who had been resident for an extended period their social worker advised that the centre had supported them in progressing and reaching their potential. For the other young person, the social worker was satisfied with the measures in place and work being done to support the young person in preparing for aftercare.

There was a newly appointed manager within the organisation who had responsibility for direct management of the centre manager and for auditing the service. They reported to the operations manager. Their role and job description had not been fully formulated at the time of this inspection; however it was anticipated that the role would allow for more effective governance and oversight within the centre.

The completion of audits was the responsibility of the operations manager, who was also one of the registered providers. Audits had not been completed within the centre for the first 12 weeks of the year due to unexpected leave, however since then they had recommenced and audits had been completed under various themes and standards aligned to the National Standards for Residential Care, 2018 (HIQA). These audits included a narrative of findings and an action plan to ensure compliance. No audit under theme three had been completed this year. Deficits in practice documentation regarding management of behaviour had not been identified by the operations manager and there was minimal evidence of their oversight of young people's records to facilitate the monitoring of the provision of positive behaviour support for the young people.

Governance meetings between the centre manager and operations manager occurred at a minimum of monthly, and within these meetings significant events that had occurred were discussed and reviewed to support oversight in the management of behaviour that challenged. Also, significant event review group meetings occurred

monthly and within these the management of behaviour was reviewed and analysis completed for the tracking of any patterns or trends. Feedback from these was provided to the team during team meetings.

The centre had a number of restrictive practices in place, including restricted access to certain areas at all times and a locked front door. In interview staff were not clear on what a restrictive practice was or the centre’s policy in relation to same. There was a risk assessment in place regarding the locks on doors however it did not provide sufficient detail or rationale for the practice remaining in place for an extended period of time. In interview staff and management struggled to clearly identify the risk which necessitated these practices, particularly the locked front door was not clear, and it appeared that it had remained in place due to historical risks rather than current identified risks. It had also not been reviewed in line with the admission of the second young person with detailed consideration being given to their needs and the impact the restriction had on them.

Inspectors found that other restrictive practices were in place however they did not all have an associated risk assessment e.g. removal of cutlery. The centre manager advised that they had recently identified that some of the restrictions may not have been required, specifically the locked front door, and had requested the social workers views on this. However, when no response was received after a period of two weeks no follow up had been completed. The centre manager and registered provider committed to an immediate review of the restrictive practices in place to ensure that they are in line with the requirements of the National Standards for Children’s Residential Care, 2018 (HIQA). Prior to this draft report being issued, this review had been completed and was confirmed by the allocated social workers for both young people.

Compliance with Regulation	
Regulation met	Regulation 5 Regulation 16
Regulation not met	None Identified

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

Actions required

- The registered provider must ensure all restrictive practices that are in place are in line with the National Standards for Children’s Residential Centres, 2018 (HIQA).
- The registered provider must review all practice guidance documents in relation to the provision of care for the young people to ensure they contain clear and relevant information which is effective to support and guide the team’s practice.
- The registered provider must review the risk management framework in place and ensure that the team understand its application in practice and that all open risk assessments are aligned to it.

Regulation 6: Person in Charge

Regulation 7: Staffing

Theme 6: Responsive Workforce

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

As detailed in the previous section, staff were not clear on the centre’s operational policies and procedures. Staff could outline their day-to-day responsibilities, however struggled to articulate what their role and responsibilities were outside of the day-to-day tasks they completed. Further development of the team in this regard is required, to ensure that they are clear on their professional responsibilities associated with their role.

While staff were supported to use their professional judgement in planning shifts, they appeared to be a reliant on management to make decisions and guide practice. When staff were making a decision on shift, they utilised the risk management framework to assess all possible risks, rather than relying on their professional judgement when appropriate as set out in the centres policy. This was resulting in a significant number of open risk assessments which was not supporting the professional development and decision making within the team.

When specific risks to staff safety were identified these were risk assessed, and management plans put in place. However, risk assessments were not updated when new information was known, e.g. exposure to behaviour that challenges, this risk

assessment had not been updated to reflect the increase in significant events and challenges within the centre when the occupancy had increased. As noted earlier in this report, review and development of the risk management framework is required for all areas of risk.

Staff reported being supported to engage with training should they wish to, and inspectors noted training being referenced within supervision however this tended to be focused on the completion of mandatory training. There was no collective process for reflective practice, however within debriefs and handover there was some level of reflection included. Supervision notes were brief, so it was hard to ascertain the level of reflective practice occurring in this forum.

Handovers were in place daily and attended by staff and management. Shifts were planned within handover with tasks clearly assigned to each staff member. From a sample of shift evaluations reviewed, the team reported working well together. In interviews this was also reflected with the team speaking positively about working in the centre and the support they received from colleagues and management, particularly when experiencing challenges.

The team was relatively new and as such experience levels of the team were lower. This had been identified within management meetings and a plan to move some more experienced team members into the service was implemented to support the development of the team.

Team meetings were occurring monthly, and attendance was mandatory. Records maintained were brief and at times contained repeated information from the previous month. However, there was evidence of discussion around staff accountability, the young people, issues such as maintenance and significant events. Due to the brevity of the records, it was at times hard to determine where learning from events or practice was being identified and where this was then incorporated into practice guidance documents.

Supervision was not always occurring in line with policy and there had been some gaps, although in recent months improvement was noted. Records maintained of supervision were brief. They were signed by both the supervisor and supervisee. However, due to the brevity of the records it was hard to ascertain the quality of discussion that occurred on various topics and if staff were being supported to develop professionally. For some, it was their first role as a social care worker, and it was not evident from the records how they were being supported. For one staff

member they were completing duties outside of their job description and there was no reference to this within supervision or any additional supports being provided to them as a result. The registered provider must ensure that staff only work in the capacity they are employed to.

As several of the staff team were relatively new, they had not yet received annual appraisals. One staff member was due an appraisal in the coming weeks and had previously had their probation review. For two other members of the team, appraisals in the form of professional development plans had occurred and actions identified for the upcoming year.

Staff reported feeling supported by management and the registered provider in their role, they named that external counselling support from the organisation’s psychotherapist could be provided if required and that they received a high level of day-to-day support. Within relevant staff records it was evident that there was a focus within the organisation on supporting the team in relation to the impact of the work.

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

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

Actions required

- The registered provider must ensure that the team understand their roles and responsibilities and only work in the capacity they are employed to.
- The registered provider must ensure that all staff and management have completed training and have good working knowledge of the centre’s policies and procedures, model of care and all mandatory trainings.
- The registered provider must ensure that records maintained of team meetings and supervision contain enough detail to reflect the discussions had and decisions made particularly in relation to care provision to the young people or changes to practice.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	<p>The registered provider must ensure all restrictive practices that are in place in the centre are in line with the National Standards for Children’s Residential Centres, 2018 (HIQA).</p> <p>The registered provider must review all practice guidance documents in relation to the provision of care for the young people to ensure they contain clear and relevant information which is effective to support and guide the team’s practice</p>	<p>Restrictive practices have been reviewed.</p> <p>The access restriction of the front door has been removed in consultation with the Social Work Department. Key working on safe care practices was required prior to completion.</p> <p>Guidance Documents were reviewed in full. Placement plan template has been reviewed to ensure clear plans: Goals, Tasks, Timeframe, Person Responsible and Review of Goals and Further Action.</p> <p>ICSP/IAMP: Updated to include additional information to describe the behaviours of young people in different stages of escalation</p>	<p>Restrictive Practices are reviewed monthly.</p> <p>Evaluation of the risk will be of focus and restrictive practice removed as soon as safe to do so.</p> <p>Continue to review Restrictive Practices within Governance Meetings and in consultation with Social Work Department. Line Manager and Operations Manager will audit risk assessments each quarter in addition to monthly oversight.</p> <p>All practice documents are reviewed monthly by case managers. Deputy and Social Care Manager to review and give oversight. Line Manager will support to give advice and support and another layer of governance to ensure positive care planning.</p>

	<p>The registered provider must review the risk management framework in place and ensure that the team understand its application in practice and that all open risk assessments are aligned to it.</p>	<p>for all staff to understand. Clear relevant direction within IAMP/ICSP/Practice guidelines and young person’s weekly plan to support the staff in caring for the young people.</p> <p>All practice guidance documents have been reviewed and cross referenced to ensure clear and relevant information to direct and support the staff team.</p> <p>Young people’s Risk assessments are reviewed by the Social Care Manager and Line Manager. All risk assessments have been evaluated and closed if risk is deemed inactive. Management have condensed where applicable and categorised risks for clear direction for staff. Completed by 30.11.2025.</p> <p>Social Care Manager will review our risk management framework with each staff in supervision. Timeframe for completion; 18.12.2025.</p>	<p>Risk Assessments are reviewed monthly. These will be audited by Social Care Manager and reported to Line Manager. Line Manager and Operations Manager will complete Spot Check Audits to ensure compliance. Teach Nua will train staff in the Risk Management Framework and review the risk assessment policy with staff within Team Meetings.</p>
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		Training will be scheduled in Risk assessments/risk management framework and restrictive practices. Timeframe for completion: January/February 2026	
6	<p>The registered provider must ensure that the team understand their roles and responsibilities and only work in the capacity they are employed to.</p> <p>The registered provider must ensure that all staff and management have completed training and have good working knowledge of the centre's policies and procedures, model of care and all mandatory trainings.</p>	<p>Social Care Manager will ensure to review staff's Professional Development Plans and their level of experience and the tasks they are undertaking. SCM will encourage growth and give opportunities to learn that are within their role. Timeframe: 01.11.2025</p> <p>Line Manager has completed a new training schedule for 2026 for onboarding staff and current staff. Management completed in house training on model of care, Our therapeutic processes and day to day application of therapeutic processes on the 22.09.2025. Further training will be scheduled in the new year on the RAP model of care, professional report writing, risk assessments and restrictive practices. Policy and Procedures are reviewed at each</p>	<p>Staff duties will be reviewed at each Governance meeting monthly. Staff development is discussed within Weekly Quality Assurance meetings between Social Care Manager, Line Manager and Operations Manager. Through training and mentoring staff will learn the application of their roles and responsibilities.</p> <p>Training scheduled for 2026 on all mandatory training, inclusive of inhouse training on RAP Model of Care, complaints, risk assessments, restrictive practices, safeguarding and child protection and professional report writing. Annual schedule for policy review is implemented with discussion of policies throughout the year and an online learning platform during staff meetings. Policy review is part of the 3 day induction</p>

	<p>The registered provider must ensure that records maintained of team meetings and supervision contain enough detail to reflect the discussions had and decisions made particularly in relation to care provision to the young people or changes to practice.</p>	<p>team meeting. An annual schedule is completed with policies outlined and an online learning platform.</p> <p>Supervision procedures have been reviewed. Supervisees are responsible for recording clear agenda's and pre-recording the form in preparation for supervision. Supervisors will add agenda items, context and further actions/decisions. This will be completed from November 2025's supervision dates. This aims to reflect on staffs' performance, learning and decision making, giving rationale behind decisions and discussions of how decisions were made.</p> <p>Social Care Manager and Line Manager will ensure minutes of meetings are detailed to reflect discussions and decisions made.</p> <p>Timeframe for commencement: 01.11.2025</p>	<p>and additional mentoring and policy review will be integrated into practice.</p> <p>Management will ensure minutes of meetings and minutes of supervision are in depth, detailed, clear discussions and decisions recorded. Supervision will be audited quarterly by Line Manager and Operation's Manager.</p> <p>Social Care Manager has responsibility to ensure all records are recorded and reviewed. Staff support and supervision is discussed at the weekly Quality Assurance meetings and the Monthly Governance Meetings. A focus on clear, open and transparent discussions recorded to reflect the care of the young people and further actions required.</p>
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