An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 071

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Smyly Trust**
Registered Capacity:	**Four young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**25th & 26th of November 2025**
Registration Status:	**Registered from the 30th of April 2023 to the 30th of April 2026**
Inspection Team:	**Mark McGuire** **Eileen Woods**
Date Report Issued:	**11th of February 2026**

Contents

1. Information about the inspection process

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

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

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

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

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

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in 2002. At the time of this inspection the centre was in its eighth registration and was in year three of the cycle. The centre was registered without attached conditions from 30th April 2023 to the 30th of April 2026.

The centre is registered to provide medium to long-term, multi-occupancy care for up to four young people, aged thirteen to seventeen upon admission. The model of care follows a therapeutic community approach aimed at meeting the emotional and developmental needs of the young people within a supportive and stable environment. This model is based on five core principles: attachment, containment, communication, citizenship, and reflection. Goals are pursued through a combination of individual work, group work, and family involvement. At the time of inspection, four young people were residing in the centre.

1.2 Methodology

The inspectors examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
3: Safe Care and Support	3.2

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. Two out of the four young people completed questionnaires as part of the inspection process. 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 29th of December 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 director of services returned the report with a CAPA on the 12th of January 2025. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report 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: 071 without attached conditions from the 30th of April 2023 to the 30th of April 2026 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 17: Records

Theme 2: Effective Care and Support

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

Inspectors found that, while the centre is large and provides sufficient space to accommodate the number of young people residing there, repairs and maintenance continue to be an area requiring improvement. The centre had experienced periods of difficulty and had undertaken notable repair works – particularly in relation to fire doors – however, several outstanding maintenance issues remained unresolved since the previous inspection in December 2024. A comprehensive review of the premises, conducted with a fresh perspective, is now required to identify and address all outstanding repairs and maintenance without further delay.

Additionally, the system for tracking and monitoring premises-related issues through health and safety checks was not found to be robust enough. The current arrangements did not adequately capture, prioritise, or escalate all areas requiring attention. Inspectors saw multiple examples during a walk-through of the centre, including: extension leads creating trip hazards in office areas, holes in walls, fire doors not closing automatically, extension leads buried under clothing in a young persons room, exposed wiring in ceiling lights, and general health and safety concerns in a young persons room which will be elaborated on further in this report.

The director of services provided a schedule of works post inspection; however not all elements identified during the inspection were added to this and an updated schedule of works that includes all outstanding items must be completed with outstanding maintenance items identified and appropriate timelines for completion outlined.

The maintenance log was not being utilised effectively. Required fields were not being completed by the centre manager, including entry and completion dates. The absence of accurate records reduces transparency and impeded appropriate oversight. Where

maintenance is not completed within expected timeframes, timely escalation by centre to senior management was not occurring as required.

While the staff carry out a number of duties and checks in relation to fire safety and health and safety, inspectors found some gaps in practice with this regard in the fire logbook. For example, records of fire drills were not entered into the relevant section, nor do they include sufficient detail regarding staff and young people who participated or did not participate. Although daily and weekly checks were taking place, gaps were noted in these records and as mentioned previously, fire doors were not closing correctly despite the fire logbook recording no issues with this regard. Retraining for centre management and the designated health and safety representative is required to ensure fire safety duties are fulfilled to an acceptable standard. Inspectors also found that fire extinguishers did not correspond with the current floor plans of the premises; this must be reviewed to ensure extinguisher locations remain appropriate given changes to the layout of the centre that have occurred over time. The centre manager confirmed to inspectors that the issue relating to fire doors was actioned and completed immediately post inspection and that a review of extinguisher locations had been scheduled with a suitably qualified person.

Inspectors reviewed a training matrix and found that the majority of the team had received core training in matters relating to fire safety and health and safety. However, given presenting safety concerns, ligature training and training on responding to suicidal ideation and self-harming is required. A training plan for 2026 was also provided which outlined planned dates for refresher training across the service.

Although the centre has a sufficient number of bathrooms, some repair work along with outstanding decorative works remain incomplete from the December 2024 inspection. Inspectors also observed that the centre vehicle had minor body damage requiring repair, although tax, insurance and NCT were in order. The centres health and safety statement was due for review in July 2025 and while the director of services confirmed a review had taken place in August 2025, the updated health and safety statement was not found in the centre files.

As noted earlier in this report, there was sufficient space for young people and they all had large bedrooms which they could decorate as they chose, with inspectors seeing how some young people had put up posters they liked and other items to personalise their space. Photographs were also seen in communal spaces, which

helped to create a homely feel. One young person highlighted through their inspection questionnaire that they could help to decorate the house and that they found the house to be warm and comfortable.

However, inspectors identified one young person's bedroom as a significant health and safety concern. The young person also did not have adequate storage facilities for their belongings. The social work team lead for the allocated young person named that they too had raised the issue of adequate storage being required, and this must be addressed without further delay by the centre manager. Inspectors were informed of a therapeutic intervention which led to limited intervention by the team in this young persons room so that it remained their safe sanctuary. However, inspectors found that this approach was preventing staff from addressing health and safety concerns. While the basis of the therapeutic rationale was understood, this approach was found to be unworkable during the inspection as the room presented with immediate health and safety risks. Regardless of therapeutic input, staff must intervene where hazards exist to ensure young people's welfare is prioritised.

Of further concern for inspectors, was that staff reported during interviews as part of the inspection, that the room had been deemed clean and chore money given without any verification. The social work department representative for this young person was also found to be unaware of the scale of this issue during interview as part of the inspection. While they hold their own responsibilities for oversight during visits, the centre team and management must ensure that the severity of concerns is communicated promptly and accurately in future. The therapeutic rationale had been developed in 2024 by the services previous therapeutic consultant and required update and review given the presenting health and safety concerns. The services new therapeutic consultant must be accurately informed of the scale and severity of this issue so that they can appropriately respond and guide the team on this matter.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 2.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The registered proprietor must carry out a full premises audit to identify all outstanding maintenance and decorative works and ensure these are completed without delay.
- The centre manager must review and enhance the health and safety monitoring and check system in place to ensure hazards and works are identified, recorded, prioritised and escalated appropriately. This includes ensuring the maintenance log is used effectively by the care team.
- The centre manager must ensure that significant issues affecting young peoples safety and wellbeing are communicated appropriately to the placing social work department.
- The centre manager must ensure that all young people have adequate storage in their rooms and that appropriate measures are taken to routinely review and address health and safety concerns in bedrooms.

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.

Inspectors found that, while there was a wide range of policies in place to support the centre's approach to positive behaviour management, the team's understanding and

application of these policies required improvement. Refresher training in key policies is required for all staff to ensure consistency of practice. The centre had a clearly defined model of care based on the principles of a therapeutic community that helped young people to learn, grow and develop in placement. They also used and had a policy in place on a recognised behaviour management model.

Training in the recognised behaviour management model was not found to be in date for all of the care team. There were some gaps also in the team's training on their model of care. The director of service made inspectors aware that there were internal trainers for both of these areas and that a schedule is in place to address gaps in behaviour management and the model of care training in the coming months.

The care team had access to multiple documents to guide their response to behaviours, including individual crisis support plans (ICSPs), risk assessment, safety plans, and absence management plans (AMPs). However, the quality of these documents required improvement. The AMP was completed using an outdated HSE template. While centre and senior management noted that risk assessments and safety plans were in place with social work input, more work could be done for concerns regarding absences with inspectors finding that improvement was required to ensure they were adequately linked. In several cases rating, context, and control measures lacked accuracy, clarity and sufficient detail to instruct staff on how best to respond to these behaviours.

Inspectors saw evidence of work undertaken to explore underlying causes of behaviours and to support young people to reflect following incidents. However, the quality of this work was inconsistent across care records. Significant event notifications (SENs) were generally well documented and notified to relevant parties. However, the practice of storing child protection and welfare report forms (CPWRFs) with SENs was inappropriate, as CPWRFs need to be stored confidentially on the care record. Inspectors also saw some commentary on SENs that did not align to the therapeutic community model, with language that demonstrated frustration or blame towards young people. This was noted to the director of service who informed inspectors they concurred with this observation and had made similar observations themself. Staff must always adhere to the therapeutic and positive behaviour support model, particularly during periods of heightened behaviours.

Inspectors found clear evidence of group dynamic issues, confirmed both through the SEN register and interviews with staff and representatives from the social work department. Despite this, there was no evidence of a recent group impact risk

assessment taking place at multi-disciplinary level. Given the significant behaviours of concern identified – including threats to the premises, and direct impact of young people on one another – a group impact risk assessment at multi-disciplinary level needed to be prioritised. A social worker interviewed by inspectors noted that the young person who was allocated to them had been negatively impacted by another resident throughout their placement. While there were some periods of progress seen with this regard, based on recent incidents they had concerns this matter had again escalated to a level that is having a significant impact on this young person, and this requires urgent review. Notably, this issue was prevalent at the previous inspection in 2024 and despite attempts by the care team to manage this impact, inspectors found that it was no longer solely a mismatch between the assessed needs of the young people. Despite significant efforts by the care team, inspectors have found that the centres overall response has not been effective in preventing the significant impact of one young person on another and this required further immediate multi-disciplinary review. A social worker for one of the young people stated that a group impact strategy meeting had been scheduled by the director of services following inspectors visit. The director of service confirmed this post inspection and provided evidence of updated risk assessments and safety plans also. A clear framework for measuring the effectiveness of this plan over a specified time-period was also requested to ensure the high impact risk is monitored, reviewed and responded to as appropriate.

While inspectors found young people were linked with appropriate external supports where required, the teams understanding of recommendations arising from these services was limited. Information shared by specialist clinicians was not consistently seen in plans for young people. Inspectors noted historic guidance on care records, such as guidance from a therapeutic consultant from 2024 that had not been reviewed and did not reflect current presentations and concerns as referenced in Standard 2.3 of this report. One social worker also noted that there had been confusion with the care team regarding the starting of medication for one young person to help them with a condition affecting their behaviour, leading to their treatment not starting when it should have. While the care team have since met with the social work department and addressed this matter, agreed interventions must be implemented without delay by the centre manager and care team.

Although several audits had taken place within the service, none focused specifically on behaviour management. The services management team must ensure that audits are better targeted on behaviour management given the centre's current challenges and in accordance with National Standards.

The restrictive practice log was amended and improved since the last inspection and now included relevant fields. However, the daily repetition of restrictive practice continues to be recorded, resulting in unnecessary duplication. Restrictive practices should be recorded with clear start and end dates rather than repeated daily entries for ongoing practices. In one questionnaire completed, a young person indicated that they cannot access the kitchen when they wish and that they do not always feel safe in the centre. While inspectors found evidence contrary to this perception with regards to kitchen access, their feedback requires review to ensure their voice is heard and their concerns clarified with appropriate responses then provided.

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	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Standard 3.2**

Actions required

- The centre manager must review the policies guiding the approach to positive behaviour support with the care team.
- The centre manager must review and enhance the quality of behaviour management documents, including ICSP's, risk assessments, AMPs and safety plans, to ensure they are clearly linked and accurately rated to reflect young people's behaviours of concern.
- The centre manager must ensure that updated group impact risk assessments are carried out at multi-disciplinary level when group dynamic issues present.
- The registered proprietor must ensure that targeted audits on the approach to positive behaviour support are carried out routinely.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	The registered proprietor must carry out a full premises audit to identify all outstanding maintenance and decorative works and ensure these are completed without delay.	The Director of Services will carry out a full audit of the premises on the 8th of January 2026. The Director will be accompanied by the centre manager and maintenance. It will identify all works that are needed. A schedule of works will be developed immediately with agreed timelines.	The Director of Services will audit the premises annually. A policy on the escalation of H&S issues will become operational and discussed at every H&S meeting. This will be actioned in the first quarter of 2026
	The centre manager must review and enhance the health and safety monitoring and check system in place to ensure hazards and works are identified, recorded, prioritised and escalated appropriately. This includes ensuring the maintenance log is used effectively by the care team.	The centre manager has strengthened the health and safety checks so that any hazards or required works are clearly identified, logged, prioritised and, where necessary, escalated for timely action. This will be actioned with immediate effect The deputy manager will support the centre manager with oversight of the maintenance log to ensure it is being used effectively by the care team.	Centre management and the care team will complete the modules on health & safety through the Health & Safety Authority. This will create a combined responsibility to any health and safety issues in the centre. The Director of Service will oversee and monitor the impact of the training and ensure the maintenance log is effectively used during their regular site visits.

	The centre manager must ensure that significant issues affecting young people's safety and wellbeing are communicated appropriately to the placing social work department. The centre manager must ensure that all young people have adequate storage in their rooms and that appropriate measures are taken to routinely review and address health and safety concerns in bedrooms.	The centre manager will ensure that all significant issues affecting young people's safety and wellbeing are communicated appropriately to the placing social work department. This will be done by phone calls or emails. A record of the conversation will be filled in the young person's file or communication log. This will be actioned immediately. The centre manager will ensure that each young person has sufficient, appropriate and secure storage in their bedroom (for example wardrobes, drawers and lockable space) so they can store clothing and personal belongings. This has been completed in December 2025. In addition, the centres policy on Homely Environment has been sent by the centre manager to all of the care team in January 2026.	The Director of Services sends out a questionnaire to placing social workers requesting feedback on the quality of the service. This should highlight any issues in communication. This data is analysed to improve the quality of the services. The director of services will ensure appropriate communication when reviewing issues effecting young people as part of their live review of significant events. The director of services is kept informed of deficits in storage, feedback from room checks and the timeframes for addressing same through health and safety meetings and/or staff meetings. Any issues will be promptly addressed by the director of services.
3	The centre manager must review the policies guiding the approach to positive behaviour support with the care team.	The centre manager will review the policies that guide positive behaviour support with the care team to ensure they are up to date, trauma-informed approach,	As an additional measure the director of services has sourced train the trainer training for the centres deputy manager which will be actioned in January 2026 to

		and in line with national standards. This has been actioned for completion by February 2026.	ensure there is a person onsite for delivering training to the team on the policies. The deputy manager will subsequently continue to lead out on the policies and approaches to positive behaviour. This will also be included in staff Induction Programmes. The Director of Service will provide support and guidance to the deputy manager as this role develops.
	The centre manager must review and enhance the quality of behaviour management documents, including ICSP's, risk assessments, AMPs and safety plans, to ensure they are clearly linked and accurately rated to reflect young people's behaviours of concern.	The centre manager will review and improve the quality of behaviour management documents, including ICSPs, Risk Assessments, AMPs and Safety Plans, so they are clearly linked, consistent with each other and grounded in functional assessment. This will be actioned from the 1st of February 2026.	The director of services will assess the quality of the behaviour management documents on a monthly basis through monthly observation and/or audits.
	The centre manager must ensure that updated group impact risk assessments are carried out at multi-disciplinary level when group dynamic issues present.	The centre manager will ensure that group impact risk assessments are updated at multidisciplinary level whenever group dynamic issues arise, and that they reflect the interaction between young people's	The Director of Services will provide oversight and guidance when group dynamics issues present though their attendance at the MDT meetings. In addition, when these issues arise the risk

		needs and risks. MDT meetings with the social work departments took place in December 2025 and again in January 2026 with further meetings scheduled to ensure group dynamic issues are robustly assessed by the MDT.	register will be updated.
	The registered proprietor must ensure that targeted audits on the approach to positive behaviour support are carried out routinely.	The Director of Services will ensure that targeted audits on the approach to positive behaviour support are completed routinely, in line with regulatory expectations for safe care and support. An audit has been arranged for the 22nd of February 2026 with this regard.	The Director of Services will if needed get an external person to support the targeted approaches to positive behaviour support.