Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an Inspection of an International Protection Accommodation Service Centre.

Name of the Centre:	Glenvera Hotel
Centre ID OSV:	OSV-0008431
Provider Name:	Bideau Limited
Location of Centre:	Cork
Type of Inspection:	Announced
Date of Inspection:	05/03/2024 – 06/03/2024
Inspection ID:	MON-IPAS-1015

Context

International Protection Accommodation Service (IPAS) centres, formerly known as direct provision centres, provide accommodation for people seeking international protection in Ireland. This system was set up in 2000 in response to a significant increase in the number of people seeking asylum, and has remained widely criticised on a national[1] and international level[2] since that time. In response, the Irish Government took certain steps to remedy this situation.

In 2015, a working group commissioned by the Government to review the international protection process, including direct provision, published its report (McMahon report). This group recommended developing a set of standards for accommodation services and for an independent inspectorate to carry out inspections against. A standards advisory group was established in 2017 which developed the *National Standards for accommodation offered to people in the protection process* (2019). These national standards were published in 2019 and were approved by the Minister for Children, Equality, Disability, Integration and Youth for implementation in January 2021.

In February 2021, the Department of Children, Equality, Disability, Integration and Youth published a White Paper to End Direct Provision and to establish a new International Protection Support Service[3]. It was intended by Government at that time to end direct provision on phased basis by the end of 2024.

This planned reform was based on average projections of 3,500 international protection applicants arriving into the country annually. However, the unprecedented increase in the number of people seeking international protection in Ireland in 2022 (13,319), and the additional influx of almost 70,000 people fleeing war in the Ukraine, resulted in a revised programme of reform and timeframe for implementation.

It is within the context of an accommodation system which is recognised by Government as not fit for purpose, delayed reform, increased risk in services from overcrowding and a national housing crisis which limits residents' ability to move out of accommodation centres, that HIQA assumed the function of monitoring and inspecting permanent[4] International Protection Accommodation Service centres against national standards on 9 January 2024.

[1] Irish Human Rights and Equality Commission (IHREC); The Office of the Ombudsman; The Ombudsman for Children
[2] United Nations Human Rights Committee; United Nations Committee on the Elimination of All Forms of Racial Discrimination (UNCERD)
[3] Report of the Advisory Group on the Provision of Support including Accommodation to People in the Protection Process, September 2022
[4] European Communities (Reception Conditions) (Amendment) Regulations 2023 provide HIQA with the function of monitoring accommodation centres excluding temporary and emergency accommodation

About the Service

Glenvera is an accommodation centre located in Cork city. The centre has 47 bedrooms, 43 of which have en-suite facilities. At the time of the inspection, the centre provided accommodation to 110 single males. The centre is located within walking distance of local shops, transport links, health and social services.

The centre previously operated as a hotel and is spread across three floors and a basement. Access to the building is gained through a staircase at the front of the building. The building comprises residents' bedrooms, an administration office, a laundry room, a pool room and a large communal area. Residents also have access to a prayer room which is also used as a study room. There is a residents shop on site along with two residents' self-catered kitchens, one of which is due to open at the end of March 2024. There is also a catered kitchen where meals are provided for residents. This is due to close when the second resident self-catered kitchen opens. The centre also has a clinic room which residents use to meet with visitors. Additional storage and a gym area are being built to the rear of the building.

The service is managed by two centre managers who report to a general manager. In addition, there is a general administration manager who is also holding the role of reception officer. The centre has general support staff including a chef, night porters, maintenance and domestic staff.

The following information outlines some additional data on this centre:

Number of residents on the date of inspection:	110

How we inspect

This inspection was carried out to assess compliance with the National Standards for accommodation offered to people in the protection process (2019). To prepare for this inspection, the inspector reviewed all information about the service. This includes any previous inspection findings, information submitted by the provider, provider representative or Centre Manager to HIQA and any unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- talk with staff to find out how they plan, deliver and monitor the services that are provided to residents
- speak with residents to find out their experience of living in the centre
- observe practice to see if it reflects what people tell us and
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service provider is complying with standards, we group and report under two dimensions:

1. Capacity and capability of the service:
This section describes the leadership and management of the service 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 service people receive and if it was of good quality and ensured people were safe. It included information about the supports available for people and the environment which they live.

A full list of all standards that were inspected against at this inspection and the dimension they are reported under can be seen in Appendix 1.

The inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
05/03/2024	11:40 – 18:30	Pauline Clarke	Lead Inspector
05/03/2024	11:40 – 18:30	Cora McCarthy	Support Inspector
06/03/2024	08:15 – 16:00	Pauline Clarke	Lead Inspector
06/03/2024	08:15 – 16:00	Cora McCarthy	Support Inspector

What residents told us and what inspectors observed

From speaking with residents and through the observations made during the course of the inspection, the inspectors found that the service provided a generally positive living environment where residents could enjoy a reasonable quality of life and be active members of their local community. While staff endeavoured to support residents and address their needs, improvements were required across multiple standards to ensure the delivery of a good quality service in the centre. The service provider had, however, commenced a process of self-assessment to identify areas requiring improvement.

The inspection took place over the course of two days. During this time, the inspectors spoke with 32 residents and three residents completed the questionnaire provided. In addition, the inspectors spoke with the cleaning staff, a chef, centre managers, the general administration manager and the service provider's representative.

The accommodation centre was located in Cork city within walking distance of local services and transport links. The centre accommodated 110 male residents across 47 bedrooms. The centre was spread across three floors and a basement. Access to the building was through a staircase at the front of the building, creating a challenge for residents with physical disabilities. The building comprised of 47 bedrooms, of which 44 had en-suite facilities, an administration office, a laundry room, a pool room and a large communal area. Individual shower and toilet facilities were allocated to the residents in the three bedrooms which did not have en-suite facilities available. Four of the residents bedrooms were located in an annex area adjoining to the main building, which were accessed though had a separate entrance. At the time of the inspection, the service provider was renovating a space to the rear of the building to include additional storage and a gym area.

On a walk around the building the inspectors found that communal areas were well furnished and provided a comfortable area for residents to meet and have visitors. There was a large games room which was regularly used by residents and their visitors. Inspectors observed that residents were able to move freely through the building and had a key fob to open the main entrance door. The residents who spoke with inspectors and completed the questionnaires explained that they were happy living in the centre, and felt protected while living there. However, two of the three residents who completed the questionnaires shared that they did not know who the designated officer for vulnerable adult safeguarding was and they did not have access to the adult safeguarding policies for the centre. In addition, while the three residents who completed the residents' questionnaire all agreed that they felt comfortable to make a complaint, only two of the three residents said they had access to the centre's complaints policy.

The inspectors observed pleasant interactions between residents. Residents were talking and laughing as they prepared their meals in the newly opened self-catered kitchen. The residents who spoke with the inspectors stated that they were happy with the kitchen facilities and with the catered meals. Some residents chose to cook their foods in bulk and they stored these in freezers which were available in the kitchen space. As many of the residents were working in the local area, the inspectors also observed that meals cooked in the centre by the chef were held for residents who were working during the day. Residents could also make suggestions to the chef regarding the centre's menu plan.

Due to the proximity of the centre to the city, the centre did not operate a transport service. Residents had access to local services and local volunteer and community services visited the centre on a weekly basis. The inspectors observed these supports and found that residents attended meetings to gather information and advice regarding their individual situations. These services provided information on English language classes and courses available in the area, along with information on financial, educational and social supports.

Generally, residents said that managers were approachable, kind and supportive. Residents explained that Glenvera was a good place to live where they felt respected by staff members who were helpful and provided assistance when needed. However, some residents who spoke with the inspectors and completed the residents' questionnaires felt that services in the centre were not delivered in a person-centred way, and that residents were not always listened to. Two of the three residents who completed the questionnaires said that the management team did not seek to involve or consult with residents on the operation of the centre or on matters which affected them.

During a walk through the service and visits to residents' bedrooms, the inspectors found that bunk beds were used to accommodate residents in multiple rooms. Residents told the inspectors that they had not requested the bunk beds and found them noisy and disruptive, particularly at night time if they need to use the bathroom. The inspectors observed that while the rooms were furnished with wardrobes, lockers and a chest of drawers for each resident, there was limited floor space for residents to move through. The majority of residents who spoke with the inspectors shared that they felt the bedrooms were too small to accommodate the number of residents in each room. Two of the three residents who completed the residents' questionnaire felt the sleeping accommodation in the centre did not provide them with privacy and dignity, and that overall the centre did not provide a dignified environment for the residents living there.

Generally, the centre was clean and well maintained. The inspectors observed that bathrooms were clean. However, burn marks and cigarette ash was evident on carpets in a communal hallway.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This was the first inspection of Glenvera by HIQA. The inspection found that while the service was effectively managed on a day-to-day basis and had a committed management and staff team in place, improvements were required to further develop the governance systems and ensure good oversight and monitoring of the service provided. The inspectors found mixed levels of compliance with national standards due to a limited awareness and understanding on the part of the service provider of the requirements and expectations of legislation, policy and the standards. For example, staff recruitment, risk management, recording systems and communication arrangements were some of the key areas which required improvements and development. While the service provider had begun to put systems and processes in place to address the deficits identified, these processes were in the early stages of development and required further implementation.

The inspectors found that the service provider and centre management team had a limited knowledge and understanding of the national standards, policy and legislation. This impacted their ability to fulfil their required roles and responsibilities. For example, the inspectors found that there had been a delay in a statutory notification being completed, and in a second case the required notification had not been sent to HIQA. This notification was completed when the inspectors brought it to the attention of the management team during the inspection. However, the centre managers and service provider showed a commitment to increasing their knowledge, and developing systems and policies to ensure compliance with the standards and the provision of a safe service. The service provider had recruited an experienced and knowledgeable general administration manager to oversee compliance matters.

The service provider had a clear governance structure in place. The centre was managed a daily basis by two centre managers who worked opposite shifts. This ensured that there was a centre manager on shift seven days per week. The centre managers reported to the general manager for the service. The senior management team comprised of the general manager and the newly-recruited general administration manager, both of whom reported to the two company directors. While staff members and managers had a clear understanding of their roles and the lines of accountability, the inspectors found that there was a limited delegation of tasks and areas of responsibility for the centre managers. However, at the time of the inspection the service provider was further developing the delegation of tasks between staff members.

The inspectors found that the reporting and communication systems in the centre required further development. The service provider had handover books in place for the managers during their day shifts and a separate handover book for each night porter. The inspectors reviewed these logs and found that while activities and requests from

residents were recorded, it was difficult to establish if the individual requests had been followed up on, or if senior management had oversight of these records. In addition, the inspectors found that the managers' handbook had numerous letters belonging to various residents in the centre and staff from another centre held within it. Managers explained that these were letters that were to be given to the residents when they came to the office for their post or with other requests. While the service held appropriate files for residents on a password-protected computer, a system for the management of residents' paper documents needed to be established. The senior management team were available to centre managers outside of their working hours, however, the service provider did not have a formal on-call system in place. The service provider told the inspectors that while they had regular informal discussions and phone calls with the centre managers and staff in the past, at the time of the inspection they were in the process of establishing a monthly team meeting forum.

The inspectors found that the service provider was developing an internal audit system for the centre. The senior management team had completed a self-assessment of the service to review practice and compliance with the national standards. A quality improvement plan and a tracker to monitor progress in relation to the identified actions were also being developed. The general administration manager told the inspectors that monthly reports were going to be prepared for the service directors to monitor the implementation of the quality improvement plan and to ensure that a good quality service was being provided to residents. While the quality improvement plan and tracker clearly identified specific areas requiring action relating to the national standards, and identified the person responsible and the expected timeline for the action to be completed by, this assessment had not identified all areas that required improvement.

The service provider had a system in place to receive and record complaints from residents. The complaints procedure was included in the residents' charter and was also on display in the centre. The service provider had appointed a complaints officer for the centre and the complaints policy for the service was under review. There were no records of any complaints made by residents.

The service provider had a system in place to record and report in incidents that took place within the centre. In addition, the general administration manager was developing an incident learning log and meeting system whereby incidents would be reviewed at incident learning meetings. However, while these systems were under development, the inspectors found that incidents which had occurred in the months preceding the inspection had not been reviewed for learning or analysis of training needs. For example, incidents had not been tracked to ensure staff had the appropriate skills, training and support to manage such situations should they reoccur in the future.

Improvements were required to ensure that a culture of consulting with residents was embedded in practice in the centre. This was an area that the service provider had self-

identified as requiring action when they completed the self-assessment of the service. The general manager and service provider reported that residents meetings were being re-established. Residents told the inspectors that they felt the staff team listened to their issues or requests and managers dealt appropriately with situations where there were disagreements between residents. The service provider had developed a residents' charter and it contained the information required by the national standards. It was available in seven languages and was discussed with residents during their induction meeting at the centre. This ensured that residents had accurate information regarding the services provided to them in the centre.

The risk management framework required further development to ensure that all risks were identified, assessed, monitored and appropriate control measures were in place to provide a safe service. While the service provider had approved and implemented a new risk management policy the week prior to the inspection, the inspectors found that a risk register had not been developed for the centre. The senior management team explained that the risk register was under development. The inspectors found that while some risks relating to individual residents had been assessed and control measures identified, further improvements were required. The inspectors identified additional risks during the inspection including staffing arrangements, contingency planning, and fire risks in communal hallways and in the rooms of residents where alcohol misuse was an identified risk.

The service provider had carried out regular fire drills and consideration had been given to the times these were completed to ensure all residents and staff were aware of fire-evacuation procedures. While the safety statement for the centre identified that staff members working alone was to be avoided where possible, the inspectors found that the night porters were consistently rostered to work alone, which was not in line with the recommendations of the safety statement. The service provider stated that the centre was in the process of recruiting additional staff members to work at night time in the centre in order to reduce situations where staff were working alone. The continuity of the service in the event of an emergency situation and the associated contingency planning had not been considered as a risk by the service provider.

The practices for the recruitment of staff members were not safe or effective. The inspectors found that the Garda Siochána (police) vetting for one staff member was out of date and international police checks had not been completed for staff members who lived overseas for periods of six months or longer. The senior management team explained that all staff who required these checks had made their applications at the time of the inspection. In addition, the inspectors found the Garda vetting or police checks had not been sought for support workers or volunteers providing supports to residents in the centre. The service provider had a system in place to risk assess positive disclosures identified through vetting processes, where applicable.

The inspectors reviewed a sample of personnel files and found that service had an effective performance management and appraisal system in place. The general manager explained that new staff members participated in appraisal meetings during their probationary period while all other staff members received an annual appraisal meeting. These meetings were documented and reviewed the staff members' performance including areas where they required support.

Improvements were required to ensure that personnel files contained the documents required to ensure the safe recruitment of staff members. While personnel files were held securely and included role profiles and contracts for each staff member, the inspectors found that references were not available on some staff files. In addition, the service provider needed to ensure that all staff members received regular, formal supervision to support them to carry out their roles. The centre had developed updated job descriptions for various roles within the centre and were beginning to implement a new recruitment policy. The general manager told the inspectors that the new recruitment policy ensured that references would be sought for all newly recruited staff in the future. A new staff supervision policy had been approved by the service provider prior to the inspection and was also due to be implemented locally.

The inspectors found that while the annual staff appraisals contributed to identifying the learning needs of the staff team, the service provider needed to complete a full review of the training needs of all staff members working in the centre. Addressing these training needs would ensure that the staff team had the required skills and knowledge to support residents living in the centre. The general administration manager reported that specific training deficits had been identified and the service were planning to track and monitor training completed and when refresher training was required through a training matrix. However, there remained deficits in staff training when records were considered in the context of training required by the national standards. All staff were provided with an employee handbook and the service had developed a code of conduct for staff working in the centre.

In summary, the service provider had a limited understanding of their role and responsibilities as set out in the national standards. While the service provider had commenced a process of self-assessment, improvements were required in relation to the governance and oversight systems to ensure that a consistently safe and good quality service was provided to residents. This will be discussed further in the next section of this report.

Standard 1.1

The service provider performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect residents living in the accommodation centre in a manner that promotes their welfare and respects their dignity.

The service provider and centre management team had a limited knowledge and understanding of the national standards, policy and legislation. There had been a delay in a statutory notification being completed, and in a second case the required notification had not been sent to HIQA. While the centre managers and service provider showed a commitment to increasing their knowledge, improvements were required to ensure that the required policies and procedures were in place to guide staff practice and ensure continuity in approach.

Judgment: Partially Compliant

Standard 1.2

The service provider has effective leadership, governance arrangements and management arrangements in place and staff are clearly accountable for areas within the service.

While the service provider had a clear governance structure in place, there was a need for the development and implementation of effective management and oversight systems. The reporting and communication systems in the centre required further development to ensure appropriate management of documentation and oversight by the service provider of incidents, complaints and safeguarding concerns. The development of formal meeting structures and on-call systems were required to ensure that the staff team were appropriately supported in their roles. While the service provider had begun to develop new governance systems, implementation was required to measure their effectiveness.

Judgment: Partially Compliant

Standard 1.3

There is a residents' charter which accurately and clearly describes the services available to children and adults living in the centre, including how and where the services are provided.

The service provider had developed a residents' charter, and it contained the information required by the national standards. It was available in seven languages and was discussed with residents during their induction meeting at the centre.

Judgment: Compliant

Standard 1.4

The service provider monitors and reviews the quality of care and experience of children and adults living in the centre and this is improved on an ongoing basis.

Improvements were required to ensure that a culture of involving and consulting with residents was embedded in practice in the centre. While the service provider was developing systems to review incidents and areas of practice requiring improvement, these processes required further development. Incidents that had taken place in the months preceding the inspection had not been reviewed or tracked to ensure staff had the appropriate skills, training and support to manage such situations.

Judgment: Partially Compliant

Standard 2.1

There are safe and effective recruitment practices in place for staff and management.

The staff recruitment practices in place were not safe or effective and required improvement in relation to the completion of Garda vetting and international police checks. The inspectors found that the Garda vetting for one staff member was out of date and international police checks were not available on staff files, where required. The service provider had not sought Garda vetting or police checks for support workers or volunteers providing supports to residents in the centre.

Judgment: Not Compliant

Standard 2.3

Staff are supported and supervised to carry out their duties to promote and protect the welfare of all children and adults living in the centre.

Improvements were required to ensure that personnel files contained the documents required to ensure the safe recruitment of staff members. References were not available on some staff files. In addition, the service provider needed to ensure that all staff members received regular, formal supervision to support them to carry out their roles. A new recruitment policy had been developed and was being implemented and a new staff supervision policy was awaiting implementation.

Judgment: Substantially Compliant

Standard 2.4 Continuous training is provided to staff to improve the service provided for all children and adults living in the centre.
While actions had been identified by the service provider to address deficits in this area, at the time of the inspection the staff team had not completed the mandatory training required. This resulted in significant training needs for the staff team, particularly in relation to safeguarding, person centred care and conflict resolution.
Judgment: Partially Compliant
Standard 3.1 The service provider will carry out a regular risk analysis of the service and develop a risk register.
The risk management framework required further development to ensure that all risks were identified, assessed, monitored and appropriate control measures were in place to provide a safe service. A risk register had not been developed for the centre. While some risks relating to individual residents had been assessed and control measures identified, further improvements were required. The inspectors identified additional risks during the inspection which had not been identified by the provider. The safety statement for the centre identified that staff working alone was to be avoided where possible, however, this had not been adhered to. The continuity of the service and contingency planning for staffing or an emergency situation had not been addressed in risk assessments reviewed during the inspection.
Judgment: Not Compliant

Quality and Safety

The inspectors found that the staff team were committed to supporting residents to live independent lives while providing the additional supports that some residents needed. While residents informed the inspectors that they felt safe living in Glenvera, improvements were required in relation to the accommodation provided, policy development, recording systems and the safeguarding processes to ensure that a safe and good quality service was provided.

The service provider, where possible, allocated rooms to residents based on their needs. The service provider had developed and approved a new policy for the allocation of rooms, which clearly outlined the relevant factors that were taken into consideration when allocating rooms. This ensured that there were clear and transparent criteria considered when making decisions regarding room allocation. The inspectors found that factors such as family links and health needs were taken into consideration, with residents who had specific health needs being given individual rooms, where possible.

The accommodation provided to residents required improvement. The service provider was using bunk beds to accommodate adult residents in rooms, though residents had not requested these beds. Residents explained that they found the use of bunk beds in the rooms stressful. For example, if a resident needed to use the toilet during the night, the metal frame on the bunk bed creaked which could wake the other residents in the room. The inspectors found that the sleeping accommodation provided to some residents did not promote privacy or dignity. The inspectors found that while the bedrooms were appropriately furnished, there was limited floor space for the residents to move through, which in turn did not provide a good quality living environment. The inspectors found that due to the lack of space and storage in the bedrooms, residents were storing suitcases and large items at a height which created a health and safety risk when trying to get access to these items. The service provider told the inspectors that they were in the process of building additional storage to the rear of the centre where residents could store their belongings.

The inspectors found that the system used to record maintenance issues in the centre required further development. While maintenance issues that required attention were noted, there was no date recorded as to when the issue had arisen, when it was addressed or who it was addressed by.

The service provider made study facilities available for residents. However, this space was also the area that residents could use for religious practice. The use of this room for both study and prayer impacted residents' ability to participate in their respective activity.

During a walk through the centre, the inspectors observed that the hallways and communal areas were generally clean and comfortably furnished. However, the inspectors found evidence of burn marks and cigarette ashes on the carpet in a communal hallway. Residents explained that that communal hallway was not monitored by CCTV and some residents had used it as an unofficial smoking area. While the management team had actively encouraged residents to use the designated smoking areas, this had not been identified as a risk by the centre staff. This was brought to the attention of the general manager and the service provider during the inspection and they agreed to address the situation by writing to residents to remind them of the smoking areas in the buildings. In addition, the service provider planned to install CCTV cameras in the area to monitor and address the situation.

Residents had access to a games room and a large communal area with sofas. Bathrooms and en-suite facilities were clean and well maintained. The inspectors found that while the centre had a cleaning checklist for the relevant staff, this list was not consistently signed off to indicate that the tasks had been completed. Residents had access to seven washing machines and six tumble dryers in the laundry room, and were provided with laundry detergent by the centre managers.

The security measures in place in the centre were not sufficient and needed to be reviewed by the service provider. While residents had access to private spaces which were not monitored by CCTV, improvements were required to ensure that the use of CCTV in the centre was effective. For example, the inspectors found that non-residents had previously had access to a resident's bedroom where there were concerns regarding allegations of illegal drug activity. While the CCTV footage was used to follow up on these concerns, the centre staff had not been aware of these concerns until they were informed by residents. Security personnel were employed directly by the service provider, however, the inspectors found that they had not been provided with the relevant training to support them in their roles.

The service provider had not made available sufficient non-food items for residents. Residents were provided with one set of bedding and towels on arrival to the centre which was not in line with the requirements of the national standards. The management team explained that toiletries including toothpaste, shampoo and shower gel were regularly provided to residents. However, the inspectors found that the residents were unaware of this and told the inspectors that they had not received these provisions. In addition, there was no evidence that residents were consulted with regarding the types or varieties of non-food items provided in the centre.

Food preparation and dining facilities were appropriately equipped and maintained to meet the needs of residents. The service provider was in the process of transitioning from a fully-catered service to a fully self-catered service. At the time of the inspection, the residents had access to one new kitchen area where they could store, prepare and

cook their own meals. A second self-catering kitchen was due to open to residents at the end of March 2024. In the interim period, residents had access to catered meals prepared and cooked by a chef. Residents explained that they were happy with the catering and new kitchen facilities. The inspectors observed that residents who were working had cooked meals set aside for them, while other residents were cooking their meals in bulk and storing them appropriately in the fridges provided. The general manager explained that while the residents' kitchen closed at midnight, there was the option for it to be opened as required by residents.

Residents had access to catered meals that were provided on a rotating 14-day menu. There was also a daily menu available that was based on requests from residents. The inspectors found that there was good variety of meals available which included a variety of meats and vegetables. Residents also had access to a variety of snacks. However, while breakfast was available for four hours from 07:00, lunch was available for 30 minutes from 13:00 and dinner was available for 30 minutes also from 17:45. The general manager explained that with the introduction of the self-catering facilities, these time slots had been sufficient to meet the needs of the resident. The inspectors found that the shop available in the centre was well stocked and was managed by the centre managers. However, when the price of items in the shop was reviewed it was found that the price of some products had been marked up by between 11 cents and €1.22. This was brought to the attention of the centre management team, and the prices were immediately corrected. The centre managers explained that additional culturally-appropriate products requested by the residents were sourced and available in the shop as required. However, there was no evidence available regarding residents being consulted with, or providing feedback in relation to food or catering decisions.

The inspectors found limited evidence that the rights of residents were consistently upheld and promoted. The majority of residents said they felt that staff members were respectful, and helped residents where they could. Some residents explained to inspectors that they did not feel listened to in the centre. While the inspectors observed staff interacting with residents in an appropriate and respectful manner, the lack of clarity regarding individual staff roles, appropriate training and oversight processes impacted the ability of the staff team to appropriately advocate for residents or support residents to exercise their rights. Improvements were required to ensure that the services provided were informed by a rights based and person-centred approach. While the staff members made some efforts to consult with residents, there was no formal system in place whereby residents could provide feedback to the service provider, or be involved in meaningful consultation. In addition, the use bed bunks to accommodate some adults impacted their right to privacy and a dignified living environment.

Residents were supported and facilitated to develop and maintain their personal and family relationships while living in Glenvera. The inspectors found that, where possible,

siblings had been facilitated to share a room. Residents were allowed to bring visitors to the communal areas and to the games room in the centre.

While the service provider had made appropriate training available to staff in relation to child protection, and had a child safeguarding statement and policy, improvements were required to ensure that adult safeguarding concerns were identified, addressed and reported in line with national policy and legislation. No adult safeguarding concerns had been recorded or reported, and residents reported that they felt protected while living in the centre. Four of the staff members had not completed the necessary adult safeguarding training, and none of the staff team had completed training on conflict resolution. The service provider had identified a designated officer and a designated liaison person for the service. However, some of the residents were not aware of who the designated officer was in the centre. At the time of the inspection, an adult safeguarding policy was being developed. While risk assessments had been completed in relation to concerns regarding individual residents, the lack of appropriate policies and training impacted the staff teams' ability to effectively manage these risks.

Improvements were required to ensure that incidents and adverse events were tracked and reviewed on a regular basis to ensure learnings from such events were captured and used to improve the service. While the service provider had policies in place for the management and reporting of incidents, a system to review and learn from such events was under development. The general administration manager explained that an internal incident report template was being developed to identify the issues that had arisen and the supports that were offered. The service was planning to review these reports at regular incident learning meetings to identify areas for service improvement.

The service provider endeavoured to promote the health and wellbeing of residents and links with local services were established and maintained where required. Residents were referred to mental health services where necessary and information about support services was available to residents. The general manager informed the inspectors that the centre had a general practitioner and nurse who visited the centre when new residents arrived or as requested.

While individual files were held on residents, there was limited details recorded regarding the support offered to residents by staff members. The inspectors found that there was no evidence of a substance misuse statement or policy regarding the management of the misuse of substances in the centre. In addition, the inspectors found that where a resident was required to use sharps for the management of a health condition, the removal of full sharps disposal containers needed to be monitored and supported by the staff in the centre.

While staff endeavoured to meet the needs of the residents in the centre in a timely and appropriate manner, the service provider had not ensured that the centre staff team had received the appropriate training to support them to identify and respond to the needs of residents. The inspectors found that support provided to staff took place on an informal basis and the service provider did not have systems in place to support staff or facilitate learning and quality improvement when incidents or accidents had occurred. The senior managers explained that formal team meetings and incident learning meetings were being established to review events that had occurred in the centre, and to share learning across the team.

The service provider did not have a policy, procedure or guidelines in place to identify or address the special reception needs of residents. The general administration manager explained that this policy was being developed. The inspectors were told that while vulnerability assessments had not been completed to date, the senior management team were reviewing this practice with a plan to complete vulnerability assessments going forward where the need was identified. In addition, the service provider needed to develop a recording system to ensure that the special reception needs of residents could be appropriately responded to and monitored. Where the staff team had become aware of special reception needs of residents, arrangements were put in place to support the individual residents to access the necessary services.

The service provider had recruited a general administration manager with the view that they would also hold the role of the reception officer. The inspectors were told that the person recruited would hold the dual role of reception officer and general administration manager for three other centres also. However, inspectors found that this arrangement was not satisfactory. The service provider acknowledged that as this was a new role for the service, a review would be necessary where the recruitment of additional reception officers for the centres may need to be considered. The reception officer had the appropriate qualifications and was part of the senior management team. As the reception officer was new to the post, further development of the role was required to ensure that sufficient training and knowledge was attained to ensure the reception officer became the principal point of contact for residents, staff and management regarding special reception needs.

In summary, while the residents informed the inspectors that Glenvera was a good place to live, this inspection found that there were deficits in the governance and management of the centre which impacted on the quality and safety of the services provided to residents. Risks relating to safeguarding and substance misuse, promoting the human rights of the residents, identifying and responding to special reception needs and vulnerabilities, the lack of consultation with residents, recording and reporting systems all impacted the service provider's ability to have appropriate oversight of the centre, and the quality of care residents were receiving.

Standard 4.1

The service provider, in planning, designing and allocating accommodation within the centre, is informed by the identified needs and best interests of residents, and the best interests of the child.

Where possible, rooms were allocated to residents based on their needs. There was a policy in place which clearly outlined the relevant factors that were taken into consideration when allocating rooms. Factors such as family links and health needs were taken into consideration, with residents who had specific health needs being given individual rooms, where possible.

Judgment: Compliant

Standard 4.2

The service provider makes available accommodation which is homely, accessible and sufficiently furnished.

The service provider was using bunk beds to accommodate adult residents in rooms although residents had not requested these beds. The floor space in bedrooms was limited. The system used to record maintenance issues in the centre required further development so that the timeline from when the issue arose to the date it was completed was recorded and monitored.

Judgment: Not Compliant

Standard 4.6

The service provider makes available, in the accommodation centre, adequate and dedicated facilities and materials to support the educational development of each child and young person.

The service provider made study facilities available for residents. However, this space was also the area that residents could use for religious practice. The use of this room for both study and prayer impacted residents' ability to participate in their respective activity.

Judgment: Substantially Compliant

Standard 4.7

The service provider commits to providing an environment which is clean and respects, and promotes the independence of residents in relation to laundry and cleaning.

Residents had access to washing machines and tumble dryers and communal areas, bathrooms and en-suite facilities were clean and well maintained. Improvements were required to ensure that the cleaning checklist was consistently signed off to indicate that the tasks had been completed with management having oversight of this system.
Judgment: Substantially Compliant
Standard 4.8 The service provider has in place security measures which are sufficient, proportionate and appropriate. The measures ensure the right to privacy and dignity of residents is protected.
The security measures in the centre required improvement to ensure that the use of CCTV in the centre was effective and promoted residents' safety. Security personnel had not been provided with the relevant training to support them in their roles.
Judgment: Partially Compliant
Standard 4.9 The service provider makes available sufficient and appropriate non-food items and products to ensure personal hygiene, comfort, dignity, health and wellbeing.
Residents were not provided with sufficient non-food items such as bedding, linen and toiletries. In addition, there was no engagement or consultation with residents on the types or varieties of non-food provided in the centre.
Judgment: Not Compliant
Standard 5.1 Food preparation and dining facilities meet the needs of residents, support family life and are appropriately equipped and maintained.
Food preparation and dining facilities were appropriately equipped and maintained to meet the needs of residents. The service provider was in the process of transitioning from a fully-catered service to a fully self-catered service at the time of the inspection. Residents explained that they were happy with the catering and new kitchen facilities.
Judgment: Compliant

Standard 5.2 The service provider commits to meeting the catering needs and autonomy of residents which includes access to a varied diet that respects their cultural, religious, dietary, nutritional and medical requirements.
Residents had access to catered meals that were provided on a rotating 14-day menu. There was also a daily menu available that was based on requests from residents. The shop available in the centre was well stocked. While residents could request additional items to be available in the shop and on the daily menus, there was no evidence of consultation with residents in relation to food or catering decisions.
Judgment: Substantially Compliant
Standard 6.1 The rights and diversity of each resident are respected, safeguarded and promoted.
Improvements were required to ensure that the rights of residents were upheld, promoted and considered in relation to the services provided in the centre. The lack of appropriate training for staff members limited their ability to appropriately advocate for and support residents, and ensure that the centre operated from a person-centre approach. The service provider needed to develop a system to meaningfully engage and consult with residents in order to gather their feedback on the services and supports provided in the centre, and how it addressed their needs. In addition, the use of bunk beds in the centre did not ensure that residents had privacy or dignity within their bedroom environment.
Judgment: Partially Compliant
Standard 7.1 The service provider supports and facilitates residents to develop and maintain personal and family relationships.
Residents were supported and facilitated to develop and maintain their personal and family relationships while living in Glenvera. Where possible, siblings had been facilitated to share a room, and residents were allowed to bring visitors to the communal areas and to the games room in the centre.
Judgment: Compliant

Standard 7.2 The service provider ensures that public services, healthcare, education, community supports and leisure activities are accessible to residents, including children and young people, and where necessary through the provision of a dedicated and adequate transport.
The service provider ensured that the residents had access to the necessary public and social services. Residents had access to services and local transports links. A group of local volunteers visited the centre on a weekly basis to provide information, support and advice to residents on issues such as education and training, allowances and help to attend appointments. The centre had a general practitioner and nurse who visited the centre when new residents arrived or as requested.
Judgment: Compliant
Standard 8.1 The service provider protects residents from abuse and neglect and promotes their safety and welfare.
Improvements were required to ensure that adult safeguarding concerns were identified if they arose, addressed and reported in line with national policy and legislation. Four staff members had not completed the necessary adult safeguarding training, and none of the staff team had completed training on conflict resolution. An adult safeguarding policy was required for the centre. The lack of appropriate policies and training impacted the staff teams' ability to effectively manage risks related to residents as they arose.
Judgment: Partially Compliant
Standard 8.3 The service provider manages and reviews adverse events and incidents in a timely manner and outcomes inform practice at all levels.
Improvements were required to ensure that incidents and adverse events were tracked and reviewed on a regular basis to ensure learnings from such events were captured and used to improve the service.
Judgment: Partially Compliant

Standard 9.1 The service provider promotes the health, wellbeing and development of each resident and they offer appropriate, person centred and needs-based support to meet any identified health or social care needs.
The system to record the support and interventions offered to residents needed further development. Given the risks which presented, a substance misuse statement and policy needed to be developed and implemented. A review of the management of sharps in the centre was also required.
Judgment: Partially Compliant
Standard 10.2 All staff are enabled to identify and respond to emerging and identified needs for residents.
The service provider had not ensured that the staff team had received the appropriate training to support them to identify and respond to the needs of residents. While the service provider had plans in place to formalise meetings and incident reviews, at the time of the inspection the support provided to staff took place on an informal basis.
Judgment: Partially Compliant
Standard 10.3 The service provider has an established policy to identify, communicate and address existing and emerging special reception needs.
The service provider did not have a policy, procedure or guidelines in place to identify or address the special reception needs of residents. A recording system was required to ensure that the special reception needs of residents could be appropriately responded to and monitored.
Judgment: Not Compliant
Standard 10.4 The service provider makes available a dedicated Reception Officer, who is suitably trained to support all residents' especially those people with special reception needs both inside the accommodation centre and with outside agencies.

While the service provider had recruited a general administration manager who was also due to hold the role of the reception officer, the inspectors found that the arrangements whereby they were responsible for four accommodation centres was not satisfactory. While the reception officer had the appropriate qualifications and was part of the senior management team, further development of the role was required to ensure that sufficient training and knowledge was attained to enable the reception officer to become the principal point of contact for residents, staff and management.
Judgment: Partially Compliant

Appendix 1 – Summary table of standards considered in this report

This inspection was carried out to assess compliance with National Standards for accommodation offered to people in the protection process. The standards considered on this inspection were:

Standard	Judgment
Dimension: Capacity and Capability	
Theme 1: Governance, Accountability and Leadership	
Standard 1.1	Partially Compliant
Standard 1.2	Partially Compliant
Standard 1.3	Compliant
Standard 1.4	Partially Compliant
Theme 2: Responsive Workforce	
Standard 2.1	Not Compliant
Standard 2.3	Substantially Compliant
Standard 2.4	Partially Compliant
Theme 3: Contingency Planning and Emergency Preparedness	
Standard 3.1	Not Compliant
Dimension: Quality and Safety	
Theme 4: Accommodation	
Standard 4.1	Compliant
Standard 4.2	Not Compliant
Standard 4.6	Substantially Compliant
Standard 4.7	Substantially Compliant
Standard 4.8	Partially Compliant
Standard 4.9	Not Compliant
Theme 5: Food, Catering and Cooking Facilities	

Standard 5.1	Compliant
Standard 5.2	Substantially Compliant
Theme 6: Person Centred Care and Support	
Standard 6.1	Partially Compliant
Theme 7: Individual, Family and Community Life	
Standard 7.1	Compliant
Standard 7.2	Compliant
Theme 8: Safeguarding and Protection	
Standard 8.1	Partially Compliant
Standard 8.3	Partially Compliant
Theme 9: Health, Wellbeing and Development	
Standard 9.1	Partially Compliant
Theme 10: Identification, Assessment and Response to Special Needs	
Standard 10.2	Partially Compliant
Standard 10.3	Not Compliant
Standard 10.4	Partially Compliant

Compliance Plan for Glenvera

Inspection ID: MON-IPAS-1015

Date of inspection: 05/03/2024 – 06/03/2024

Introduction and instruction

This document sets out the standards where it has been assessed that the provider or centre manager are not compliant with the *National Standards for accommodation offered to people in the protection process.*

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which standards the provider or centre manager must take action on to comply. In this section the provider or centre manager must consider the overall standard when responding and not just the individual non compliances as listed section 2.

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

A finding of:

- **Partially compliant**: A judgment of partially compliant means that on the basis of this inspection, the provider or centre manager met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks which could lead to significant risks for people using the service over time if not addressed.

- **Not compliant -** A judgment of not compliant means the provider or centre manager 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 residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply.

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. The response must consider the details and risk rating of each standard set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard	Judgment
1.1	Partially Compliant

Outline how you are going to come into compliance with this standard:

All staff have a copy of the national standards and all relevant legislation and relate them to their daily practices (complete). Through team meetings all staff have been made aware and we have discussed in depth commitment to an increase in knowledge of the statutory notifications, national standards, and legislation and this is now a standing agenda for all team meetings (complete). Oversight from the Group Administration Manager (GAM) and General Manager will provide assurance that all statutory notifications are submitted to the relevant people within the specified timeframes.

All relevant policies and procedures are in place and have been reviewed by the whole team to ensure they are being implemented in practice and are available to guide staff to ensure continuity in their approach (complete).

Training is scheduled for June 2024 by the GAM in relation to The National Standards and policies and procedures to provide all staff across the organisation with an insight and breakdown and provide assurance that consistency for implementation is achieved across the organisation (30/6/24).

Workshops will be introduced in the long term any time changes are implemented in relation to policy and practice to ensure all members of the team are aware of any policy changes as they arise (ongoing).

1.2	Partially Compliant

Outline how you are going to come into compliance with this standard:

There are effective governance and management structures in place and a full time GAM has been appointed as part of the senior management team (complete).

The incident management policy has been implemented and an incident management system is in place and functioning to generate incident learnings to the team to avoid recurrence. Incidents are reported to the manager and GAM for assessment and where necessary risk management controls are assessed and put in place (complete and ongoing).

A complaints policy is in place and procedures are in place for all residents to have the opportunity to make a complaint. A complaints log is maintained (complete and ongoing).

While there are no open safeguarding concerns in the center, a full safeguarding of vulnerable adults' policy specific to the center has been developed that will guide practices should they arise (complete).

Formal meeting structures are in place and minutes are maintained on site (complete and ongoing).

An on call system will be considered as part of the annual review process (30/6/2024).

Supervision of all staff members has commended in Q2 and all staff will receive formal supervision within the quarter (30/6/2024).

All incidents are logged on the organization incident template and monthly incident learning meetings are in place to ensure learning and prevention of reoccurrence (complete and ongoing).

1.4	Partially Compliant

Outline how you are going to come into compliance with this standard:

Incident management policy is in place in the centre (4/3/24).

All incidents are logged on the organization incident template and monthly incident learning meetings are in place to ensure learning and prevention of reoccurrence (complete and ongoing).

2.1	Not Compliant

Outline how you are going to come into compliance with this standard:

One staff member did not have their re-vetting on the date of inspection due to back logs in the vetting system and their vetting has since been returned by An Garda Siochana and the risk assessment has been closed (complete).

International police checks had all been applied for by all relevant staff members on the date of inspection (17/5/24). These applications were made when this became a new requirement, and we were awaiting documentation on the day of the inspection. All international clearance has been completed and received and risk assessment has been closed (complete).

Garda vetting is on file for any support workers engaging with residents in the Centre (complete).

2.4	Partially Compliant

Outline how you are going to come into compliance with this standard:

Training needs analysis undertaken, and a full training plan is in place (complete).

All relevant trainings have been discussed with staff and a time frame has been provided for completion (30/7/2024).

On site trainings have been booked in relation to all areas that have been identified via the standards and that are specifically relevant to the centre (30/7/2024).

3.1	Not Compliant

Outline how you are going to come into compliance with this standard:

A risk management system is in place and being implemented (30/6/24).

A risk register is in place for the service that identifies all relevant risk areas and establishes clear control measures (complete and ongoing).

Recruitment efforts are active, and the GAM and general manager will continue to review work practices, risk management controls and service needs. This will be an ongoing (30/05/24).

A business continuity plan and business contingency plan is under development that will include assessments of risk in relation to staffing and emergency situations should they occur (30/05/2024).

4.2	Not Compliant

Outline how you are going to come into compliance with this standard:

Accommodation and the use of bunk beds will be reviewed as part of the annual review process (31/7/24). Residents with a preference for a single bed are prioritized in line with needs and wishes. This information is now relayed to all residents on admission (complete and ongoing).

A meeting was complete with the managers of the Centre and maintenance persons regarding the sign off for all maintenance records to evidence clear timelines for completion going forward (complete). The maintenance logs are reviewed by the general manager and GAM also (ongoing).

4.8	Partially Compliant

Outline how you are going to come into compliance with this standard:

The current CCTV system was reviewed, and one new camera was put in a space to mitigate risk of smoking in that area (complete).

A staffing review will further mitigate any security risks in relation to maintaining visiting hours and arrangements in the centre (30/5/24).

A full training analysis has taken place and onsite booking in relevant training areas has been sought (30/7/24).

4.9	Not Compliant

Outline how you are going to come into compliance with this standard:

Two sets of linen are now provided to all residents on arrival and all residents are aware and in receipt of all non-food items available (complete and ongoing).

An agenda item for consultation with residents regarding types or varieties of non-food items has been identified for April's resident forum meeting (30/4/24). All non-food items can be requested from the on-duty manager daily should residents require any additional items (complete and ongoing).

6.1	Partially Compliant

Outline how you are going to come into compliance with this standard:

A full training plan has been put in place for all staff to complete relevant training to the role as set out in the standards (30/7/24). This is inclusive of person-centered planning trainings.

Resident questionnaires have been distributed to all residents as part of the annual review process to consult on the service provided. Residents' meetings are in place (complete).

Accommodation and the use of bunk beds are under review as part of the annual review process (31/7/24).

8.1	Partially Compliant

Outline how you are going to come into compliance with this standard:

A Safeguarding of vulnerable adults' policy is in place specific to the service. While there were no open or active adult safeguarding concerns on the date of inspection, this policy will guide staff on all processes to protect the residents and manage risk should it occur in this area (complete).

All staff have safeguarding of vulnerable adult training and certs are available on site (complete).

Conflict resolution training has been identified as a need and on-site training is being sought at present as part of the training plan (31/7/24).

8.3	Partially Compliant

Outline how you are going to come into compliance with this standard:

Incident management policy and procedures have been implemented within the service (complete).

A standing agenda item on team meetings is incident learning where all incidents and adverse events are discussed at least monthly, and this will be maintained to mitigate recurrences and generate learnings from all incidents as they occur (complete and ongoing).

9.1	Partially Compliant

Outline how you are going to come into compliance with this standard:

A substance misuse policy is under development for the Centre (30/06/2024). A policy on the management of sharps is under development for the centre (30/6/2024).

A full review of resident's needs has been undertaken and care plans in conjunction with residents' input are being complete. Care plans identify referral pathways supports and interventions for residents depending on needs (31/7/2024).

10.2	Partially Compliant

Outline how you are going to come into compliance with this standard:

Supervisions will be complete with all staff on a quarterly basis and all staff will receive their first formal supervision within quarter 2 2024. A supervision policy is in place and a supervision template is in place.

A full training plan is in place that identifies all training needs for the service. This will be inclusive of response to special reception needs (31/7/24).

10.3	Not Compliant

Outline how you are going to come into compliance with this standard:

A policy is under development in the Centre regarding the identification and addressing of special reception needs for residents coming into the Centre and those with special reception needs living in the Centre (30/6/2024).

Care plans that are under development will identify pathways to ensure the special reception needs of residents are responded to and supports are put in place to monitor the supports by the reception officer. (31/7/2024).

10.4	Partially Compliant

Outline how you are going to come into compliance with this standard:

The GAM is actively engaging in the role of reception officer at present and has relevant training and qualifications to fulfil this role (complete).

As part of the annual review process the recruitment of an additional reception officer within the services will be considered and reviewed based on the service needs.

Recruitment is currently open within the organization for staff with relevant qualifications for the role of a reception officer across services (31/7/2024).

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 or centre manager has failed to comply with the following standard(s):

Standard Number	Standard Statement	Judgment	Risk rating	Date to be complied with
Standard 1.1	The service provider performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect residents living in the accommodation centre in a manner that promotes their welfare and respects their dignity.	Partially Compliant	Orange	31/07/2024
Standard 1.2	The service provider has effective leadership, governance arrangements and management arrangements in place and staff are clearly accountable for areas within the service.	Partially Compliant	Orange	31/07/2024
Standard 1.4	The service provider monitors and reviews the	Partially Compliant	Orange	31/07/2024

	quality of care and experience of children and adults living in the centre and this is improved on an ongoing basis.			
Standard 2.1	There are safe and effective recruitment practices in place for staff and management.	Not Compliant	Red	17/05/2024
Standard 2.4	Continuous training is provided to staff to improve the service provided for all children and adults living in the centre.	Partially Compliant	Orange	31/07/2024
Standard 3.1	The service provider will carry out a regular risk analysis of the service and develop a risk register.	Not Compliant	Red	26/04/2024
Standard 4.2	The service provider makes available accommodation which is homely, accessible and sufficiently furnished.	Not Compliant	Red	19/04/2024
Standard 4.8	The service provider has in place security measures which are sufficient, proportionate and appropriate. The measures ensure the right to privacy and dignity of residents is protected.	Partially Compliant	Orange	31/07/2024
Standard 4.9	The service provider makes available sufficient	Not Compliant	Red	05/04/2024

	and appropriate non-food items and products to ensure personal hygiene, comfort, dignity, health and wellbeing.			
Standard 6.1	The rights and diversity of each resident are respected, safeguarded and promoted.	Partially Compliant	Orange	31/07/2024
Standard 8.1	The service provider protects residents from abuse and neglect and promotes their safety and welfare.	Partially Compliant	Orange	31/07/2024
Standard 8.3	The service provider manages and reviews adverse events and incidents in a timely manner and outcomes inform practice at all levels.	Partially Compliant	Orange	31/07/2024
Standard 9.1	The service provider promotes the health, wellbeing and development of each resident and they offer appropriate, person centred and needs-based support to meet any identified health or social care needs.	Partially Compliant	Orange	31/07/2024
Standard 10.2	All staff are enabled to identify and respond to emerging and identified needs for residents.	Partially Compliant	Orange	31/07/2024
Standard 10.3	The service provider has an	Not Compliant	Red	19/04/2024

	established policy to identify, communicate and address existing and emerging special reception needs.			
Standard 10.4	The service provider makes available a dedicated Reception Officer, who is suitably trained to support all residents' especially those people with special reception needs both inside the accommodation centre and with outside agencies.	Partially Compliant	Orange	31/07/2024