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:	St Patrick's Centre
Centre ID:	OSV-000 8451
Provider Name:	Tattonward Limited
Location of Centre:	Co. Monaghan
Type of Inspection:	Unannounced
Date of Inspection:	21/05/2024
Inspection ID:	MON-IPAS-1036

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

St Patrick's Accommodation Centre is located on an 18-acre site, formerly agricultural land, on the outskirts of Monaghan town. The centre had a recorded capacity of 380 people. At the time of inspection, it accommodated 354 residents. The centre provides accommodation to families, single males, and females. In addition to living quarters, the centre comprised administration offices, a large dining room, communal kitchens, multi-function rooms, and seven outdoor playgrounds, and green areas.

The centre had a dedicated bus service contracted to a private operator for residents to travel to Monaghan town to access services such as schools, health centres, and shops.

The centre is staffed by a management team, administrative staff, security, maintenance, and catering staff.

The premises are privately owned, and Tattonward Limited provide the service on a contractual basis on behalf of the Department of Children, Equality, Disability, Integration and Youth.

The following information outlines some additional data on this centre:

Number of residents on the date of inspection:	354

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	Lead Inspector(s)	Support Inspector(s)
21/05/2024	09:30 – 16:45	1	1

What residents told us and what inspectors observed

From conversations with residents, a review of documentation, and observations made during the inspection, the inspectors found that the service provided a generally positive living environment for the residents. This inspection found substantial improvements, driven by a fundamental shift in service delivery, which was informed by the findings from HIQA's previous inspection in January 2024. The provider had assumed control over a pest infestation in the centre, and had developed policies and implemented other actions outlined in their compliance plan to address findings from the previous inspection. However, some policies needed to be developed further and to be embedded into practice, and some actions remained outstanding. For example, there was no updated Garda vetting and international police clearances for some staff members. Overall, improvements were required in relation to safe recruitment practices, record-keeping, safeguarding, risk management, as well as in enhancing internal systems for oversight and monitoring.

This was an unannounced inspection of this centre, which took place over one day. The inspection was carried out to monitor the implementation of the compliance plan submitted by the service provider to HIQA, following an inspection carried out in January 2024 (MON-IPAS-1003), which found significant levels of non-compliances.

During this inspection, the inspectors spoke and engaged with eight residents. In addition, the inspectors spoke with the service provider representative and the centre manager. The centre catered for families, couples, single females, and single males, and there were 354 residents at the time of the inspection. On arrival at the centre, the inspectors were met by the centre manager and office administrator and brought to a common room for an initial introduction meeting.

On a walk around the accommodation centre, inspectors observed that the physical structures of the centre were in good condition. There were no significant changes to the physical environment of the centre since the time of the previous inspection. The common areas and toilet facilities were found to be very clean throughout and cleaning schedules were on display in bathrooms. Fire safety equipment was visible throughout the buildings, and fire evacuation routes and exits were clearly marked.

The centre provided both self-catering and fully catered facilities for residents. There were seven shared kitchens spaces in the centre and were available to residents 24 hours each day. However, the kitchens were all locked at the time of the inspection, and the centre manager explained that this was to prevent children from entering and playing in the kitchens. This meant that residents had to collect keys from the reception office whenever they needed to access a kitchen. There was a main dining hall which served food to residents with vulnerabilities and those unable to cook for themselves.

Inspectors observed one of the residents' kitchens in the main building. The kitchen contained microwaves but did not have the glass plates or the turntables inside. There were three freezers and two fridges. One of the freezers required cleaning. Unlike the other freezers, it was not locked, and inspectors observed that it was obsolete, empty, and had stagnant water at the bottom. The centre manager told the inspectors that these freezers and fridges belonged to residents and that they were responsible for having them cleaned and maintained. This is discussed later in this report. Inspectors also observed pest traps located in several areas of the kitchen, which were empty.

Information was displayed on notice boards on child safety practices, routine room inspections, invitations to join the residents' committee, house rules, and centre bus timetables in the reception area. There was also information for various support services and external agencies. For example, there was information available on advocacy services, supports around domestic violence and human trafficking. The details of the designated liaison persons in the centre were displayed, however, posters on child and adult safeguarding were confined to one area close to main offices. The centre manager explained that the rationale for this was that these posters were tampered with in the past. This is also discussed later in this report.

Inspectors observed residents going about their daily routines. One resident who engaged with the inspectors was preparing their bicycle to travel to the town centre. Inspectors observed children accompanied by an adult playing on swings in a well-kept playground in the middle of the centre. The playground contained sufficient outdoor play equipment and was colourful and well-maintained. The centre grounds provided ample space for children to play and opportunities for walks and recreation. The inspectors observed courteous and respectful interactions between residents and staff members throughout the inspection. Overall, there was a calm and relaxed atmosphere within the centre at the time of inspection.

Over the course of the inspection, inspectors met with eight residents, and two completed questionnaires were returned. During the previous inspection, inspectors found that there was a pest infestation in the centre. Consequently, the service provider was required to take immediate action to address this issue. Residents who met with inspectors said that there were significant improvements in this regard. Inspectors revisited residents where pests had been observed during the previous inspection and found that their living quarters were clear of pests. These residents told inspectors that weekly checks for pests were being conducted and they were happy about this. While pest infestation had not been completely eliminated in the centre, the inspectors found that the provider had taken appropriate measures, and the health and wellbeing of residents, specifically children, was much improved as a result.

Residents confirmed that they now had lockable storage facilities in their rooms. While residents were generally complimentary of the services received in the centre, some were not satisfied that they had to buy their own freezers to store food, and that the residents' kitchens were very far from their living quarters. While residents who completed questionnaires felt safe in the centre, one said that they would like to see improvements in levels of support from the staff team, and that they were not aware of the complaints procedure.

Over-crowding remained a concern in some rooms in the centre, and the centre manager gave an example of where this was the case. Although this was escalated externally, alternative accommodation was not provided to the family concerned at the time of inspection.

In summary, by closely observing daily life and interactions within the centre and engaging with its residents, inspectors found that overall, the centre was a supportive environment for the residents. The provider had taken appropriate steps to take control of a pest infestation and the residents benefited from these actions. While overcrowding persisted in some rooms in the centre, residents who engaged in this inspection said that they felt safe and were generally happy with the service they received. The observations of the inspectors and the views of residents presented in this section of the report reflect the overall findings of the inspection.

The following two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impacted the quality and safety of the service delivered.

Capacity and capability

This was an unannounced inspection to monitor the implementation of the actions the provider said they would take in response to findings of a previous inspection in January 2024 (MON-IPAS-1003).

This current inspection found that the provider had implemented some actions from the compliance plan to address the governance and management arrangements in the service. Some of these actions were at the initial stages of being embedded into practice. While improvements were found, more was required in areas such as the oversight arrangements, risk management systems, safe recruitment of staff, staff supervision and record-keeping. Additionally, the process for reviewing and learning from incidents required further development.

The service provider had committed to complete 27 actions in their compliance plan by May 2024. At the time of the inspection, 17 were completed, four were on schedule, and six were overdue. The inspectors found that while these actions helped clarify the strategic direction of the service, policy development was at a basic level, and some policies were yet to be developed and or embedded into practice.

The service had developed a suite of policies and procedures, but not all the required policies were in place. For example, there were no written policy and procedures to help identify and respond to special reception needs and vulnerabilities of residents. This action was overdue the 30 April 2024 deadline specified in the provider's compliance plan.

The inspectors found that systems of oversight and accountability in the service required improvement. Staff meetings had begun, with two held since the previous inspection and while the minutes of these meetings showed a range of items were discussed, there were no discussions on areas such as performance against the national standards and national policy. This was a missed opportunity for staff to be participate in discussions around the governance of the service and the various changes that were being implemented in the centre. Furthermore, there was no formal management communication system for decision-making. Meetings between the provider and centre manager were not documented. Additionally, there were no job descriptions in staff files. Together, these deficits resulted in reduced transparency in decision-making, unclear expectations of staff members and low levels of accountability for individual and collective responsibilities.

Notwithstanding, there was a fundamental shift in relation to recording systems, particularly for documenting interactions with residents. The service had developed a centralised system to record key information relating to the residents. This was

recorded in a daily journal and included issues such as incidents, complaints, child safeguarding issues and interactions with residents. While inspectors found that this daily journal supported the team to share relevant information, it did not ensure appropriate management oversight and the trending of information that could lead to changes in practice.

An effective quality assurance system was not yet in place, but progress had been made in developing a policy to monitor the quality of care provided to residents. The policy included various data collection methods, such as resident feedback through meetings, suggestion boxes, audits, surveys and periodic reviews. While some of these measures were pending implementation, resident meetings had begun, with two held and documented since the last inspection. The meetings indicated the provider's efforts to address residents' evolving needs and improve the quality and safety of the service. However, auditing and quality improvement plans were yet to be progressed.

There was an absence of formal supervision arrangements for staff members, which would ensure ongoing accountability for staff practice and provide an opportunity for staff development. While the supervision policies were in place, supervision was yet to be rolled out to the wider staff team and the management team had not yet received supervision training. Inspectors reviewed the supervision policy and found that it did not outline the frequency of supervision meetings, and there were no arrangements for the supervision of the centre manager. Coupled with the lack of job descriptions and effective oversight systems, this meant that the provider could not be fully assured of the quality and safety of the service on an ongoing basis. A staff appraisal policy was in place but was also yet to be implemented.

Similar to the previous inspection, the provider did not ensure safe and effective recruitment practices in this centre. Staffing records showed that four staff members did not have updated Garda Vetting, and two lacked international police checks for the periods of their residence outside Ireland. While the centre had developed a recruitment policy, which included Garda vetting procedures, this deficit highlighted a disconnection between policy and practice in the centre. In addition, the Garda vetting procedure did not include assessments to manage positive disclosures should they arise.

There was an improvement in staff training. All staff including contracted staff had completed Children's First training. A training needs analysis was completed to identify gaps in training, however, this required improvement to include review timeframes and refresher training details. Where there were deficits in training, the provider had implemented a schedule of training for staff and a plan was devised for staff to complete a number of courses which included; adult safeguarding, person-centred care and risk assessments.

The provider had made significant efforts to review the risk management arrangements in the centre, however, this remained a new process needing further integration. A comprehensive risk register was developed and included resident welfare risks, including risks identified on inspection. However, this could be improved by maintaining the risk register as a live system, incorporating processes such as oversight arrangements, review timeframes, risk ownership, and escalation procedures. While risks were managed proactively by the staff team, with appropriate escalation, there was no overarching risk management policy guiding risk identification, assessment and management within the service.

There was good progress in the development of the centre's contingency plan. This was a comprehensive plan, demonstrating good continuity planning for emergencies, covering alternative accommodation, evacuation procedures, and shortages in electricity, gas, water, and food supply. Additionally, comprehensive fire safety arrangements were also in place, with residents participating in scheduled fire drills.

In summary, there were improvements made in the centre since the last inspection and more were required. While some actions were taken in line with the provider's compliance plan, others had yet to be taken or were in progress for full implementation. The inspectors found that provider's governance arrangements were not yet adequate to ensure that all aspects of the service provided were appropriate to meet residents' needs and were effectively monitored. Substantial improvement to the centre's governance and management arrangements, staff supervision, record-keeping, recruitment and risk management systems was required to ensure a consistently safe and effective good quality service was being provided.

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.

There was an improved awareness and knowledge of the full extent of the provider's responsibilities as set out in the National Standards. Although there were still high-levels of non-compliances, significant strides had been made in developing some policies and procedures. However, in some areas the service had not achieved some of their targets as per their compliance plan. For example, there was no reception officer policy and no written procedures on the identification, communication and addressing of existing and emerging special reception needs.

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 there were improved governance arrangements in place, the effectiveness of this structure was compromised by an absence of recorded communication systems between staff. There were better records relating to residents but management systems required improvement to ensure there was appropriate and effective governance and oversight of all aspects of service provision. There were no formal monitoring and reporting systems to ensure the service provider was aware of all risks, incidents and safeguarding concerns. There were also no job descriptions on staff files reviewed.

Judgment: Partially 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.

The service provider had not yet implemented systems for the oversight and monitoring of the quality of care and experience of adults living in the centre. A policy to monitor the quality of care provided to residents had been developed and residents' meetings had commenced in the centre. However, the process for reviewing and learning from incidents that occurred in the centre required further development. Audits of the quality of the service were planned but had yet to be developed.

Judgment: Substantially Compliant

Standard 2.1

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

The provider had failed to ensure that recruitment practices in this centre were safe and effective. There were no updated Garda vetting for four members of staff and no international police clearances for two staff members.

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.
While staff supervision and appraisals policies were developed, staff members were not yet in receipt of regular formal supervision from the centre managers as required by the national standards. However, the centre was found to be on schedule to meet targets and the service had provided a deadline of June 2024 to develop supervision policy and commence supervision.
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.
All staff including contracted staff had completed Children's First training. The service provider had completed a training needs analysis to identify gaps in training. Where there were deficits in training, the provider had implemented a schedule of training for staff and a plan devised for staff to complete a number of courses which included; adult safeguarding, person-centred care and risk assessments.
Judgment: Compliant
Standard 3.1 The service provider will carry out a regular risk analysis of the service and develop a risk register.
While a risk register was in place, there was no overarching risk management policy to guide the staff team in the identification, assessment and management of risk. Inspectors found that considerable work was required to develop and implement an effective risk management system. There was a lack of ownership of the identified risks and some known risks were not on the register. The arrangements for reviewing the risk register had not fully been decided upon. There was, however, a comprehensive plan and evidence of good emergency continuity planning for emergencies.
Judgment: Partially Compliant

Quality and Safety

Overall, the inspectors found that while the physical environment of the centre had remained unchanged since the previous inspection, some improvements had been made across most standards reviewed. Further actions were required to ensure residents consistently received a safe and quality service. Inspectors identified areas for improvement such as maintenance, safeguarding, learning from incidents, and supports to residents with special reception needs. While there were some governance systems that required further development, it was found that residents were generally receiving a good and supportive service.

A room allocation policy had been developed, accompanied by a requirement for new residents to voluntarily provide information which would inform the allocation of accommodation. An escalation policy was also in place to ensure people were suitably placed at the time of admission and on an ongoing basis, particularly where their needs became more apparent. Given the number of residents in the centre, the inspectors found that there was a need for a policy on access to common rooms and routine room checks to promote transparency, privacy, and fairness.

In response to the previous inspection findings, the provider had made improvements to promote each resident's right to privacy and safety. For example, residents engaged with confirmed that they now had lockable drawers to store their personal belongings.

The service provider had clear maintenance arrangements and regularly completed room and building checks. A cleaning register and cleaning schedules were kept in bathrooms and common rooms. However, improvements were needed in some areas. For example, inspectors observed an unlocked, and old freezer with stagnant water at the bottom on the day of the inspection. Despite regular accommodation checks, this issue had not been dealt with.

In line with the urgent compliance plan issued following the previous HIQA inspection in January 2024, a pest control plan was in place in the centre. From a review of documents, observations and talking with residents, inspectors found that the centre had assumed control over the pest infestation in the centre. A pest control company attended the centre twice a week to review control measures. Inspectors observed pest traps in place throughout the centre. Residents who engaged with the inspectors explained that the issue of pests in the centre was significantly improved. Inspectors were assured that the provider had taken appropriate measures to address this issue in both the immediate and longer-term.

While the physical structure of the centre was reasonably good, the centre manager acknowledged that overcrowding remained in some circumstances, and that some residents and children with significant health needs lived in unsuitable accommodation. There were 354 residents in the centre compared to 338 residents during the previous inspection. While there were external pressures associated with the provision of accommodation, the provider did not assess risks associated with overcrowding in the centre. The provider had committed in their compliance plan to ensuring that risks assessments would be completed in situations where the safety of residents may be compromised but this had not happened in this example.

Inspectors reviewed the safeguarding arrangements in the centre, and while some progress was noted, improvements were required to strengthen the safeguarding processes. There was evidence that all staff, including contracted staff, had received training in child protection. There was a designated liaison person, and their details were displayed on notice boards in several languages. However, the role of the designated liaison person (DLP) was not reflected in some cases reviewed. For example, inspectors found incidents where there was no DLP available due to staff leave, and records showed that staff members sought guidance directly from the Child and Family Agency (TUSLA) on issues that a designated liaison person would typically have dealt with. There was one DLP for the centre. The designated liaison person was trained in 2015. The provider acknowledged this deficit and had identified the need for refresher training for the designated liaison officer prior to this inspection.

An adult safeguarding statement had been developed and there was a plan to provide on-site training to all staff. However, inspectors found that both adult and child safeguarding polices were not publicly displayed as required by national policy. Inspectors observed that these were displayed on a notice board in the reception area which had restrictive access for residents, and not on various other notice boards in the centre-which would make them accessible to all residents. In addition, as highlighted previously, there was no system in place to assess risks to individual residents where they were identified. For example, the centre manager had self-identified risks related to children with complex behaviours, however, corresponding risk assessments had not been completed.

There was good progress in developing a centralised log of incidents. This was accompanied by a locally developed incident management policy, which required management to activate an emergency response plan to deal with the matter before escalation. However, as mentioned previously, a tracker for incidents was needed to enable learning from such events.

In line with the findings of the previous inspection, the inspectors found that, generally, the special reception needs of residents were identified and responded to. However, no formal arrangements or policies were in place to guide this process. The implementation of this action was beyond the deadline set by the service provider in their compliance plan. The service provider told inspectors that they remained in the process of recruiting a reception officer, and this had not changed since the last inspection. A reception officer policy and manual had yet to be developed. A vulnerability assessment questionnaire was developed, and one assessment was completed to date. Vulnerability assessments were no longer being carried out prior to residents arriving at the centre.

In summary, this inspection found that residents felt safe in the centre and, for the most part, had their basic needs met. The staff team endeavoured to provide as good a service as possible within the resources available. Significant improvements were found in relation to pest control and a room allocation and adult safeguarding policies were in place. While it was evident that the provider had implemented most of the actions in their compliance plan, some remained outstanding. In line with findings from the previous inspection, albeit with some improvements, this meant that the service was not yet at a stage where the provider could not be assured that a safe and quality service was delivered to residents.

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.

A policy had been developed to ensure that room allocations were based on a clear, fair and transparent criteria. In addition, an escalation policy was in place to ensure effective and prompt liaison with the DCEDIY where there were concerns about meeting people's needs.

Judgment: Compliant

Standard 4.3

The privacy, dignity and safety of each resident is protected and promoted in accommodation centres. The physical environment promotes the safety, health and wellbeing of residents.

The centre had assumed control over pest infestation in the centre. Plans were in place to monitor and review the presence of pests in the centre. While the problem had not been eliminated, residents expressed satisfaction on the plans and progress made to date. However, overcrowding still persisted in the centre and the service had not completed risk assessments on this matter as required by their policy.

Judgment: Partially 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.

A plan was in place to convert one common room into a homework room, however, no arrangements had been made to properly furnish it and make the necessary adjustments for it to be suitable for children. At the time of the inspection, there was no adult/parent supervision rota for the homework club established as per the compliance plan.

Judgment: Substantially Compliant

Standard 8.1

The service provider protects residents from abuse and neglect and promotes their safety and welfare.

An adult safeguarding policy had been developed, and a plan was in place for staff members to attend training in adult safeguarding in line with the requirements of national policy. However, in line previous findings and as per centre policy, there was an absence of risk assessments or safeguarding plans in place for dealing with situations where the safety of residents may be compromised.

Judgment: Substantially Compliant

Standard 8.2

The service provider takes all reasonable steps to protect each child from abuse and neglect and children's safety and welfare is promoted.

All staff, included contracted staff had completed child protection training. While a designated liaison person was in place, their role was not reflected in some cases reviewed. Inspectors found that staff were contacting Tusla and DCEDIY for issues that would have easily been dealt with by a designated liaison person. Refresher training for the designated liaison person was required but the provider had self-identified this gap prior to the inspection

Judgment: Substantially 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.

While there was central logging of events and incidents, there were no arrangements in place to learn from these incidents and events as part of continual quality improvement.

Judgment: Partially Compliant

Standard 10.1

The service provider ensures that any special reception needs notified to them by the Department of Justice and Equality are incorporated into the provision of accommodation and associated services for the resident.

In the event that the provider was notified of any special reception needs, it was found that they strove to meet them. For the most part, the provider was not made aware of any special reception needs in advance of resident admissions.

Judgment: Compliant

Standard 10.3

The service provider has an established policy to identify, communicate and address existing and emerging special reception needs.

The provider had not developed a policy to guide staff on how to identify and address existing and emerging special reception needs, as required by the standards.

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.
In line with previous findings, the service provider had not ensured that a reception officer with the required qualifications was employed in the centre.
Judgment: Not Compliant

Appendix 1 – Summary table of standards considered in this report

This inspection was carried out to assess compliance with the *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 1.4	Substantially Compliant
Theme 2: Responsive Workforce	
Standard 2.1	Not Compliant
Standard 2.3	Substantially Compliant
Standard 2.4	Compliant
Theme 3: Contingency Planning and Emergency Preparedness	
Standard 3.1	Partially Compliant
Dimension: Quality and Safety	
Theme 4: Accommodation	
Standard 4.1	Compliant
Standard 4.3	Partially Compliant
Standard 4.6	Substantially Compliant
Theme 8: Safeguarding and Protection	
Standard 8.1	Substantially Compliant
Standard 8.2	Substantially Compliant
Standard 8.3	Partially Compliant

Theme 10: Identification, Assessment and Response to Special Needs	
Standard 10.1	Compliant
Standard 10.3	Not Compliant
Standard 10.4	Not Compliant

Compliance Plan for St Patrick's Centre

Inspection ID: MON-IPAS-1036

Date of inspection: 21 May 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:

1) St Patrick's has engaged with a specialist external organisation with a focus on health and social care quality, resident safety, and regulatory compliance. This external organisation will provide training and support to the Provider, Center Manager, and the broader team to ensure a comprehensive understanding of the legal and policy frameworks that govern service operations. This shall include relevant legislation, national policies, and standards. Support provided by the specialist organisation shall incorporate but shall not limited to:

- Education and training
- Review of current governance arrangements and structures
- Development, Review, Approval, Dissemination and Communication of key processes in line with the relevant Legislation, National Policy, and National Standards
- Implementation of a structured Audit Management process including the identification and monitoring of Quality Improvement Plans.
- Continuous Improvement.

This support will be provided over a 12-month period.

2) St. Patrick's shall regularly evaluate the service against relevant standards and regulations through the development and Implementation of a structured Audit Management Process.

1.2	Partially Compliant

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

1) St Patrick's shall review current governance arrangements and structures and establish a clear governance structure to ensure accountability and oversight of the support provided to residents. Residents and staff shall be made aware of the governance structures to ensure a clear understanding of roles and responsibilities.

2) A clearly defined team and committee structure shall be developed and implemented. This shall include:

- Management Team.
- Centre Team.
- Residents Committee/Forum.

Terms of reference shall be developed for each of these teams, which include aims and objectives, roles, frequency and required membership.

Agenda Templates for each team shall be developed to ensure key topics of discussed and reviewed.

3) A yearly meeting schedule for all teams and committees shall be developed. Lessons learned will be formally provided to staff through ongoing communication and scheduled team meetings.

4) St Patrick's shall ensure roles and responsibilities are detailed within all staff job descriptions including the management team. The job descriptions shall identify the purpose, scope, duties, responsibilities and reporting relationships in line with the National Standards.

5) St. Patrick's shall develop a risk management framework/policy to identify, assess, and manage risks, and maintain an updated risk register.

6) A review of St. Patrick's Risk Register shall be completed to identify and mitigate risks with regard to Corporate Services, Service Provision and Health and Safety. Specific risks and hazards relating to residents shall be detailed within the reviewed risk registers.

7) St. Patrick's shall establish a system to identify and record complaints and incidents, ensuring residents are informed about the processes and protected against retaliation. This shall include the development of policies, procedures and supporting forms. A record of complaints and incidents shall be maintained in a central register. The Management Team are committed to ensuring that when required, investigations are dealt with in an appropriate and timely manner to ensure that complainants and/or incidents are appropriately managed and monitored.

8) Implement a continuous quality improvement program that includes regular internal audits and resident feedback to systematically identify and address areas for enhancement.

1.4	Substantially Compliant

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

1) St. Patrick's shall develop a Quality Improvement Plan that identifies SMART actions from Incidents, complaints, audits etc. Learnings will be identified, and Actions appropriately allocated to key team members for review and include close out of actions and ongoing monitoring.

2) An internal audit schedule in line with the requirements of the National Standards shall be developed and implemented. External support will be provided in the identification of areas for improvement.

3) To ensure a culture of continually striving to improve the centre's services, the agendas for all Teams and Committees (detailed in Standard 1.2, action 2) shall incorporate Quality Improvement Strategies as an agenda item.

4) Resident consultation and feedback mechanisms shall be reviewed and implemented. These shall include but are not limited to:

- Residents Committee Meetings
- Resident access to report complaints in a structured manner
- Resident feedback surveys Resident suggestion boxes.

An annual survey for all residents (adults and children) on their experience of living in St. Patrick's. Review and discuss findings with Resident's Committee. Identify Learnings and Actions.

2.1	Not Compliant

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

1) St. Patrick's shall develop and implement a Recruitment, Selection and Appointment Policy and Procedure which shall incorporate but is not limited to:

- Garda vetting requirements and review as per National Standards

- Process to ensure adherence to National Standards
- The management of garda vetting
- The management of risks identified from the outcome of the garda vetting process.

- Staff file requirements in line with the National Standards

2) Staff files shall be reviewed and those requiring Garda Vetting shall have the vetting completed.

3) A Staff File Checklist shall be developed to support compliance with National Standards and Internal Policy.

4) Staff file audit has commenced. Gaps identified will be actioned immediately by the Centre Manager, which include but are not limited to, garda vetting, employment references, contracts, and job descriptions.

2.3	Substantially Compliant

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

1) St. Patrick's shall develop and implement a Staff Supervision, Development, Performance and Appraisal Policy and Procedure. This shall incorporate a performance appraisal system detailing the processes to review and document the skills and competencies of each staff member on an ongoing basis

2) As per Standard 1.2, Action 1, staff and management reporting lines shall be defined to indicate clear supervision accountabilities.

3) An Appraisal Form, incorporating probationary reviews, shall be developed to support compliance with National Standards and internal policies.

3.1	Partially Compliant

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

1) As per Standard 1.2, Actions 5 and 6.

St. Patrick's shall develop a risk management framework to identify, assess, and manage risks, and maintain an updated risk register.

A review of St. Patrick's Risk Register shall be completed to identify and mitigate risks with regard to Corporate Services, Service Provision and Health and Safety. Specific risks and hazards relating to residents shall be detailed within the reviewed risk registers.

A review of the Risk Register shall be a standard Agenda Item for the Management Team Meetings

2) St. Patrick's shall ensure that the Risk Register incorporates:

- The identification of allocated owners to risks

- Clear Control Measures to manage risks

3) St. Patrick's shall ensure that staff carry out reflective learning following an incident, and risk assessments are reviewed and updated accordingly to encourage a culture of shared learning amongst the team.

4.3	Partially Compliant

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

1)A review of overcrowding risks shall be completed and documented on the Risk Register. Control measures and actions shall be implemented.

4.6	Substantially Compliant

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

1) A plan to maintain and furnish the identified homework room shall be developed and implemented

2) A Supervision rota shall be developed for the homework club.

8.1	Substantially Compliant

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

1) As per Standard 1.2, Action 6 the risks associated with Adult and Child Safeguarding shall be analysed and added to the Risk Register.

8.2	Substantially Compliant

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

1)Safeguarding shall be a standard agenda item for the Centre Team Meetings to continuously communicate safeguarding process and awareness of the DLP.

2) Details of the DLP shall be displayed in a range of languages throughout the centre.

8.3	Partially Compliant

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

1) St. Patrick's shall develop and implement a Management of Incidents Policy and Procedure incorporating processes to learn from events.

2) Lessons learned shall be formally provided to staff through ongoing communication and scheduled team meetings.

3) As per Standard 1.2, Action 6, the risks identified from incidents shall be analysed and added to the Risk Register.

10.3	Not Compliant

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

1) St. Patrick's shall develop and implement a Special Reception Needs Policy and Procedure to identify and respond to existing and emerging special reception needs and vulnerabilities of residents. This shall include detailed requirements for the assessment of needs and vulnerabilities.

2) A record of individual resident's special reception need requirements shall be maintained as received, notified and or identified.

10.4	Not Compliant

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

1) The Centre Managers Job Description shall be updated to include the roles and responsibilities of a Reception Manager when required.

2) The Centre Manager shall receive Reception Officer training over 2 days. This shall be an interim measure while recruiting for an Assistant Manager with the required qualifications.

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	27/08/2024
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	06/09/2024
Standard 2.1	There are safe and effective recruitment	Not Compliant	Red	28/06/2024

	practices in place for staff and management.			
Standard 3.1	The service provider will carry out a regular risk analysis of the service and develop a risk register.	Partially Compliant	Orange	06/09/2024
Standard 4.3	The privacy, dignity and safety of each resident is protected and promoted in accommodation centres. The physical environment promotes the safety, health and wellbeing of residents.	Partially Compliant	Orange	06/09/2024

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	06/09/2024
Standard 10.3	The service provider has an established policy to identify, communicate and address existing and emerging special reception needs.	Not Compliant	Red	31/07/2024
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.	Not Compliant	Red	31/07/2024