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:	Emmet Lodge
Centre ID:	OSV-0008566
Provider Name:	Coolebridge Limited
Location of Centre:	Co. Dublin
Type of Inspection:	Unannounced
Date of Inspection:	03/12/2024
Inspection ID:	MON-IPAS-1070

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

Emmet Lodge is located in Dublin's south inner city. The centre provides accommodation to people seeking international protection and has a capacity of 15 people. At the time of inspection, it was accommodating 14 single males.

The centre is a three storey mid-terraced apartment building, and spans over a ground floor, first floor and basement levels. The accommodation comprises an entrance hall, residents' bedrooms, staff offices, and open plan kitchen and dining areas.

The centre is located on a busy street and provides access to a range of public transport services. The centre is located close to a wide variety of amenities and outdoor leisure facilities, including the Phoenix Park, the Grand Canal, and the Memorial Gardens.

The buildings are privately owned and the service are privately provided by Coolebridge Limited on a contractual basis on behalf of the Department of Children, Equality, Disability, Integration and Youth (DCEDIY).

The following information outlines some additional data on this centre:

Number of residents on the date of inspection:	14

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)
03/12/2024	10:00hrs–16:50hrs	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 safe and positive living environment for residents. This inspection found some improvements had been made since the previous inspection of the centre in February 2024. However, some systems and procedures needed to be developed further, and some actions that were commited to by the service provider in response to the previous inspection of the centre remained outstanding. For instance, there was no Garda vetting for one staff member, and there were no policies in place to guide staff members in identifying, communicating and addressing special reception needs. Overall, improvements were required in relation to safe recruitment practices, record-keeping, 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 the course of 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 February 2024 (MON-IPAS-1008), which found significant levels of non-compliance with the national standards.

During this inspection, the inspectors spoke and engaged with five residents, and three residents completed the questionnaires provided. In addition, the inspectors spoke with the regional manager, centre manager, reception officer and a social care worker. On arrival at the centre, the inspectors were met by a social care worker and brought to a common room for an initial introduction meeting.

On a walk around the accommodation centre, the inspectors observed that the physical structure of the centre was 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. Fire safety equipment was visible throughout the buildings, and fire evacuation routes and exits were clearly marked.

The accommodation centre was located in Dublin City within walking distance of many local amenities and services, including local and national transport links. The centre had capacity to accommodate up to 15 single male residents across seven en-suite bedrooms with a maximum occupancy of two people in a room, and one single room which had access to a bathroom across the corridor. At the time of inspection, there were 14 residents accommodated in the centre.

The centre comprised a three-storey building, including a basement area, with an entrance accessed via a busy street. The building comprised an open plan dining area adjoining the communal kitchen, reception area, and residents' bedrooms. In addition, a small multi-purpose room was available in the centre for residents to meet visitors in private, and this space was also used for prayers and study. Wi-Fi coverage extended throughout the centre.

There was access from the basement floor to the rear patio area which also had laneway access with a monitored gate. Laundry facilities, which included two washing machines and two dryers, were in an enclosure located in the rear patio area. A free parking space for residents was available in the laneway at the back of the centre.

The centre provided self-catering facilities for residents to prepare and cook their meals. Residents used a voucher system to buy food from a local supermarket. A kitchen was available until midnight for residents to prepare food and snacks. The kitchen was well equipped with an adequate number of cookers, fridges, freezers, kettles, toasters, and microwaves. The dining area had tables and chairs, appropriate for the number of residents in the centre. There were shared fridges and sufficient storage facilities in the kitchen and dining areas where residents could store dry foods. The inspectors observed residents using these facilities during the course of the inspection and those who engaged with the inspectors were complimentary of the kitchen and dining facilities in the centre.

The inspectors found that there was a homely, relaxed and warm atmosphere in the centre at the time of the inspection. The inspectors observed staff providing information and informal support to some residents over the course of the inspection. The inspectors observed staff interacting respectfully and kindly with residents, who appeared comfortable and communicated easily with them.

Upon being invited by residents, the inspectors observed some bedrooms. The service provider had endeavoured to make the living environment comfortable for residents. For example, in the case of one bedroom without an en-suite bathroom, private bathroom facilities had been made available nearby. While most residents shared bedrooms, each resident had a lockable chest of drawers and wardrobe to store their personal belongings and clothes. The provider had made additional storage facilities available to residents in the dining and communal areas to store their dry food and other belongings, which limited the amount of additional items residents had to keep in their bedrooms. Residents told the inspectors they were happy with their bedrooms.

Residents who spoke with the inspectors said that they were happy with the facilities and services provided, and that they felt safe living in the centre. They also said that the centre manager and staff were approachable and that they felt comfortable raising any concerns with them. Some of the residents expressed appreciation for the practical support provided by staff members, in terms of facilitating access to local services and supports. However, one resident informed the inspectors that there had been no manager present in the centre for some time and that the kitchen was occasionally left unclean and untidy.

In addition to speaking with residents about their experiences, there were four questionnaires completed and submitted.. There was mostly positive feedback provided in the completed questionnaires, with the residents indicating that they felt respected and adequately protected while living in the centre. However, one respondent stated that they did not have access to relevant centre policies and procedures, while another felt the centre was not a dignified environment.

In summary, careful observation of everyday activities and interactions within the centre, coupled with active engagement with the residents, made it clear that the centre provided a positive environment where residents had access to supportive staff and managers. Interactions with residents were marked by warmth, respect, and a focus on individual needs. The observations of the inspectors and the residents' views presented in this section of the report reflect the overall findings of the inspection.

The next two sections of the report present the inspection findings in relation to governance and management of the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor the implementation of actions outlined in the provider's compliance plan which they submitted to HIQA in response to the findings of the previous inspection of the centre which was completed in February 2024 (MON-IPAS-1008).

The inspectors found that the service provider had taken action to address the deficits relating to the governance and management of the service and a positive shift had taken place in the culture of the centre. While improvements were found, additional development was required in areas such as the oversight arrangements, risk management systems, safe recruitment of staff, and staff supervision.

This inspection found that the provider had implemented some actions from the compliance plan, and some of these actions were at the initial stages of being embedded into practice. There also remained several actions from their compliance plan which were outstanding, some of which were overdue, due to lack of capacity of the service to complete them all in a timely manner. For example, there were no reception officer manual and a policy to identify and respond to residents with special reception needs was not in place.

The management team in the centre had experienced significant changes since the last inspection. The centre manager had recently been recruited and was responsible for this and another centre, a walking distance away. The reception officer, in the role for a few months, oversaw this and three other centres. Both reported to a regional manager, appointed two months after the last inspection. A compliance officer position had been created, with the new officer starting during the week of the inspection. The lack of stability and consistency of the management team had an impact on the ability of the service provider to implement several actions in their compliance plan, and also residents' familiarity and sense of security.

Notwithstanding these changes, staff members were clear on their roles and areas of responsibility. The inspectors observed a culture of respect, kindness, and a person-centred approach among the management and staff teams. In addition to the managers mentioned above, a team of four social care workers and one relief worker worked across two centres which were located in close proximity to each other, with the roster ensuring a social care worker was always available for day and night shifts. A formal on-call system ensured management availability after hours and during the weekend.

While oversight and accountability systems in the service had improved, further development was required. Governance meetings, involving the directors and centre

managers, and staff meetings at the centre level, were held every two weeks to address risks, complaints, incidents, and policy development. In addition, separate senior management meetings were also held and these focussed on maintenance and corporate issues. These meetings were minuted and actions clearly set out. While these meetings enhanced oversight, other areas of practice required improvement. A handover log was completed and this helped facilitate information sharing between shifts but it lacked sufficient detail and management oversight to ensure follow-up on issues. For example, a substance misuse incident was noted in the log but was not tracked or addressed, highlighting deficiencies in recording and oversight that undermined the safe and effective delivery of services to residents.

While an effective quality assurance framework was not yet in place, progress had been made in developing systems and mechanisms to monitor the quality of care provided to residents. This included one-to-one consultations with residents, suggestion boxes, audits, and the development of a quality improvement plan. Despite this, resident meetings were yet to commence, and audits were yet to be completed in some areas of practice. While a quality improvement plan was in place, it was limited to addressing deficits identified in the compliance plan. The provider was required to adopt a broader approach to include all of the national standards.

Similar to the previous inspection, the provider did not ensure safe and effective recruitment practices in this centre. For example, Garda vetting was not available for one member of staff at the time of the inspection, although there was evidence the application had been submitted. The provider had self-identified vulnerable residents in the centre and as a result Garda vetting for staff was required. Three staff members did not have references contrary to the centre's recruitment policy. While the lack of Garda vetting had been risk assessed, this deficit highlighted a disconnection between policy and practice in the centre. In addition, the recruitment policy did not include processes to manage positive Garda vetting disclosures should they arise.

The service provider had implemented a supervision policy, but discontinuity in the management team hindered the ability of the provider to offer consistent supervision to staff members. Two staff members were overdue supervision, and no supervision records were provided for one other team member. Performance appraisals for all staff were also overdue. The lack of regular supervision compromised staff support and accountability, leaving the provider unable to ensure an effective and safe service.

The risk management system had improved since the last inspection but still required further development. A risk management policy was in place, and as highlighted previously, risks were discussed at a range of meetings ensuring escalation where required. However, several current risks, such as resident conflicts and substance

misuse, had not been identified and included in the risk register. This gap weakened the effectiveness of the risk management system in guiding strategic decision making to improve the overall quality of the service and the oversight of the service provider. While ccontingency plans were in place, plans for addressing staff shortages were lacking. Fire safety measures were in place, and fire drills were conducted in a timely manner.

In summary, while improvements were made since the last inspection, further action was required. Some actions outlined in the compliance plan were completed, but others were still pending or in progress. The inspectors found that the provider's governance arrangements were inadequate for effectively monitoring and meeting the needs of residents. Substantial improvements were required in governance and management, staff supervision, record keeping, recruitment and risk management to ensure a consistently safe and high quality service.

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 service provider's responsibilities as set out in the national standards. Although there were areas of non-compliance identified, significant strides had been made in developing some policies and procedures and some of these were in the early stages of implementation. However, in some areas the service provider had not completed actions as outlined in 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 staffing changes, limited oversight and recording practices. Staff meetings were regularly held and enhanced records relating to residents had been developed but governance and 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.

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 impelemented systems to seek feedback from residents, and these had informed practices in the centre. However, audits in all areas of practice had not been completed and the quality improvement plan needed to be more comprehensive.

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. Garda vetting was not completed for one staff member and there were no references in place for some others. While there was evidence of vetting application on file and completed risk assessments, the vetting disclosures were not in place at the time of the inspection.

Judgment: Not Compliant

Standard 2.2

Staff have the required competencies to manage and deliver person-centred, effective and safe services to children and adults living in the centre.

The centre was appropriately resourced to meet the needs of residents availing of its services at the time of the inspection. A formal on call system was in place to ensure management availability after hours and during weekends. However, the discontinuity of staffing in the months preceding the inspection had impacted the ability of the service to ensure a safe and effective service.

Judgment: Substantially 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.

The staff and management teams reported that they were well supported in their roles, however, there was no consistent supervision provided for staff members or centre managers. In addition, a formal performance appraisal system was not in in place for staff members at the time of the inspection.

Judgment: Partially Compliant

Standard 3.1

The service provider will carry out a regular risk analysis of the service and develop a risk register.

There was a risk management policy in place that clearly outlined how risk was managed in the centre but improvements were required. The risk management policy was complemented by a risk register and corresponding risk assessments. However, the risk register was not comprehensive in nature and the provider had not identified and assessed all potential risks which existed in the service. While the service provider had a detailed plan in place to ensure the continuity of the service in the event of a fire and other emergencies, similar procedures had not been developed for other unforeseen circumstances such as staff shortages, for example.

Judgment: Partially Compliant

Quality and Safety

Overall, the inspectors found that while the physical environment of the centre had remained unchanged since the last inspection, some improvements had been made across most standards reviewed. In the time since the previous inspection, significant progress had been made to establish a culture where residents' rights were respected and promoted. However, further actions were required to ensure residents consistently received a safe and quality service. The inspectors identified areas for improvement such as room allocation, 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.

Similar to the previous inspection, there was no policy or procedure to guide the provider on the allocation of accommodation to residents at the time of admission and on an ongoing basis. The lack of a policy to guide staff practice in this area resulted in failures to manage situations of conflict between residents over room sharing in the centre, and instead escalating these matters to a government department.

The inspectors found that the centre was clean and well-maintained throughout, enabling all residents to have a good quality of life. The physical structure of the centre was in good condition, and the common areas were homely. The inspectors found that residents' rooms were in a good state of repair and sufficiently furnished, and adequate storage facilities were observed in most of the rooms. 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. Residents who engaged with this inspection were happy with the centre and the facilities it provided.

Residents' rights were respected and promoted in the centre. All staff had completed training on promoting and protecting human rights and this had impacted positively on how they supported and engaged with residents. Residents had opportunities to engage with the staff team through an anonymous suggestions box, and in individual consultation meetings regularly held in the centre. There was evidence available to demonstrate that the staff team advocated for residents when required and were supported to exercise their rights to access information and entitlements. Some of the information displayed on notice boards in the centre had been translated into languages that residents could understand.

It was noted that residents were provided with information about local services including healthcare, education and leisure activities. While most residents managed their personal health and wellbeing needs independently, the management team

ensured that residents were referred to local support services when required. The reception officer completed needs assessments to identify the support and welfare requirements of each resident, and ensured their support was informed by their individual circumstances and expressed wishes.

While safeguarding practices in the centre had improved, the service provider needed to ensure that safeguarding policies were implemented in practice. While there were no active safeguarding issues at the time of the inspection, the inspectors found that previous concerns in relation to interpersonal conflicts between residents were escalated to a government department without attempts to manage them in the centre. Combined with the fact that some staff did not have updated Garda vetting meant that there were latent risks in the service in relation to the safeguarding of adults. However, residents met with reported feeling safe, protected and comfortable reporting any concerns they had to the management team.

While there was a system in place to record incidents and accidents which had occurred in the centre, not all incidents were appropriately recorded or followed up on. The inspectors reviewed handover logs and identified incidents relating to substance misuse and significant illnesses which were not followed up on nor risk assessed. As highlighted previously, the recording systems in use meant that it was difficult for the management team to have thorough oversight or to track the number of incidents, or welfare concerns, or to trend the information which could lead to improvements in practice.

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. While a reception officer with extensive training, relevant experience and competencies was in place, a reception officer manual and policy to identify, communicate and address the needs of residents with special reception needs were yet to be developed. The lack of training and policy to guide staff practice meant that the needs of residents with special reception needs were not fully addressed and monitored.

In summary, the management and staff teams in Emmet Lodge had, in the time since the previous inspection, taken considerable action to improve the quality and safety of the service they provided to residents. While there remained some actions to be taken on the part of the service provider; particularly in oversight and monitoring systems, risk management, safeguarding and learning from incidents; it was clear to the inspectors that the management and staff teams had the skills and drive to ensure these actions were taken to further improve the service being provided.

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.

While there was some evidence that efforts were made to ensure accommodation was allocated in a way that considered and met residents' known needs, the service provider had not ensured that there was a fair and transparent approach to the allocation of rooms to residents. A centre specific allocation policy was required to direct the allocation of accommodation to ensure a transparent approach was taken and adequate records were maintained.

Judgment: Partially 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 inspectors found that residents' right to privacy and dignity was promoted and protected. Additional storage had been provided for residents to store their personal belongings and food. Residents were provided with a chest of drawers and wardrobes for their clothers and personal belongings. There was also storage facilities provided for dry food in the kitchen and dining areas.

Judgment: Compliant

Standard 5.1

Food preparation and dining facilities meet the needs of residents, support family life and are appropriately equipped and maintained.

The centre provided self-catering facilities for residents which were in good working condition. There was a communal kitchen in the centre and the food preparation facilities were adequate for the number of residents in the centre. The kitchen and dining areas were clean at the time of the inspection. Residents used a voucher system to buy groceries from a local supermarket. Residents were complimentary of the kitchen and dining facilities available in the centre.

Judgment: Compliant

Standard 6.1

The rights and diversity of each resident are respected, safeguarded and promoted.

The general welfare of and rights of residents were promoted and protected. Feedback procedures were in place and utilized to improve service delivery. Residents were encouraged to be independent while receiving necessary support. The right to access information was supported and residents exercised their right to choose their own daily activities and what food they prepared. Staff members had completed human rights training and this had influenced the way they supported residents in the centre.

Judgment: Compliant

Standard 7.3

The service provider supports and facilitates residents, including children and young people, to integrate and engage with the wider community, including through engagement with other agencies.

The provider was ensuring that residents had access to information about local services and facilities in the community. It was found that the centre manager and staff team were supporting residents to avail of resources in the local area and providing information about their rights and entitlements. It was evident that the centre had strong working relationships with support groups and services in the area. There were notice boards throughout the centre that provided up-to-date information about a range of support services.

Judgment: Compliant

Standard 8.1

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

While an adult safeguarding statement and policy were in place, some of the latent risks in the service had not been appropriately managed in the centre. Incidents around interpersonal conflicts between residents were routinely esclatated to a government department instead of attempting to resolve them in the centre in the first instance. This coupled with the fact that some staff did not have updated Garda vetting meant that there were latent risks in the service in relation to the safeguarding of adults.

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.

There was a system in place to report, track and notify all incidents and serious events in the centre. Staff meetings provided spaces for management and staff team to learn from these incidents and events as part of continual quality improvement to enable effective learning and reduce the likelihood of reoccurrences. However, there was limited recording of incidents or safeguarding concerns and some risks in the centre had not been identified and assessed.

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 inspectors found that arrangements in the centre ensured that each resident received the necessary support to meet their individual needs. The staff team provided support that was person-centred and they promoted the health and wellbeing of residents. The service provider had appropriate links with community health and social care services and provided information or referrals, when appropriate, to services to meet a resident's health or social care needs. The centre manager ensured that where suitable supports could not be provided in the centre, that residents were assisted to avail of support from external services.

Judgment: Compliant

Standard 10.2 All staff are enabled to identify and respond to emerging and identified needs for residents.
The reception officer carried out a needs assessment on admission to the centre, with the consent and agreement of residents. These assessments were used to inform the supports provided to residents. However, there was no specialised training or support provided to staff in the centre to identify and respond to special reception needs and vulnerabilities of residents.
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 provider had not developed a policy to guide staff members on how to identify and address existing and emerging special reception needs, as required by the national standards. While the service provider had implemented a system to complete needs assessments on newly arrived residents, if they consented, this was not sufficient to assess or determine the needs of residents with special reception needs.
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.
The provider had ensured that a reception officer with appropriate qualifications and experience was in place.
Judgment: 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 2.2	Substantially Compliant
Standard 2.3	Partially Compliant
Theme 3: Contingency Planning and Emergency Preparedness	
Standard 3.1	Partially Compliant
Dimension: Quality and Safety	
Theme 4: Accommodation	
Standard 4.1	Partially Compliant
Standard 4.3	Compliant
Theme 5: Food, Catering and Cooking Facilities	
Standard 5.1	Compliant
Theme 6: Person Centred Care and Support	
Standard 6.1	Compliant
Theme 7: Individual, Family and Community Life	

Standard 7.3	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	Compliant
Theme 10: Identification, Assessment and Response to Special Needs	
Standard 10.2	Partially Compliant
Standard 10.3	Not Compliant
Standard 10.4	Compliant

Compliance Plan for: Emmet Lodge

Inspection ID: MON-IPAS-1070

Date of inspection: 03 December 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: There was a Needs assessment policy at the time of inspection, and we were guided that this needed to be further developed. The senior management team and Reception Officer will review the current policy and ensure it covers procedures on the identification, communication and addressing of existing and emerging special reception needs. To be completed by 31.01.2025	
1.2	Partially Compliant
Outline how you are going to come into compliance with this standard: At the time of inspection, the centre had undergone some staffing and management changes, and this has now stabilised with the recruitment of a new dedicated centre manager. The manager will continue to formally report to governance meeting every second week on all risks as per the resident and centre risk tracker. The manager reviews all centre trackers each week for consistency. The manager will continue to review the quality of team meeting minutes, handover and all practice related documents. This will be further enhanced by the compliance officer external audits. To be reviewed Fortnightly and completed by 31.03.2025	

2.1	Not Compliant

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

Coolebridge will continue to seek Garda vetting through the channels available to us to ensure staff are vetted and processed as per time frames of the IPAS vetting bureau. Completion 28.02.2025

All references that were missing at the time of inspection are now on file or have been sought – expected completion 28.02.2025

2.3	Partially Compliant

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

A regular, formal and recorded supervision process has been implemented for staff and centre managers as required by the national standards. A formal performance appraisal system is in place for all staff members. As this was only implemented and running off the anniversary dates of staff joining the company appraisals are scheduled for those dates. All probation are set at 6 months and scheduled accordingly. This is monitored in the governance meetings under the staff personnel tracker. All staff have up to date personnel files and all management have implemented the formal process of support and supervision. In addition to this a formal probation and annual appraisal system is in place and actively underway.

Completion as per probation and annual appraisal scheduled dates

3.1	Partially Compliant

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

The risk management trackers will allow for live updating, monitoring and tracking of risk. The centre manager will escalate as needed and the Senior management team and Reception Officer will review along with the centre managers all risks for appropriate risk management actions. In relation to organisational risk, we have an organisational risk matrix where issues that could potentially impact services are discussed, documented and reviewed with senior management team on a monthly basis, this includes potential service disruption and staffing shortages. We have a robust Relief staff team and where this falls through we have two agencies enlisted for managing any staffing shortages should these arise. We also have a regular recruitment campaign running on various recruitment sites. As a preventative measure

we operate annual leave trackers, rolling rosters and training planners to ensure staffing provision at all times possible.

Reviewed fortnightly in governance meeting and monthly within SMT. Expected completion 31.03.2025

4.1	Not Compliant

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

We have developed a room allocation policy. This policy and procedure aim to provide a framework for the fair and transparent allocation of rooms for residents of Coolebridge. The procedures outlined take into account the guidance and requirements provided by the governing bodies, the International Protection Accommodation Service (IPAS), and HIQA. Complete by 14.01.2025

8.1	Partially Compliant

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

The new centre manager will review all current risks safeguarding concerns and incidents and ensure that all are accounted for documented correctly and actioned. All risk and incidents are recorded on the centre trackers and discussed in the fortnightly Governance meeting.

Expected completion 28.02.2025

8.3	Partially Compliant

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

The new centre manager will review all current risks safeguarding concerns and incidents and ensure that all are accounted for documented correctly and actioned. All risk and incidents are recorded on the centre trackers and discussed in the fortnightly Governance meeting.

Expected completion 28.02.2025

10.2	Partially Compliant

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

We have developed a full training plan for all staff that is to commence early 2025 which consists of both in house and external training covering topics on:

- Child Protection
- First Aid Responder
- Fire Safety and Manual Handling
- Trauma Informed Training
- Substance misuse
- Active Listening
- Defusing and Debriefing for managers and Team Leads
- TCI
- Professional Practice and Boundaries
- Trafficking and DSGBV (domestic, sexual, and gender-based violence
- Children First online
- ASIST
- Safe talk
- Vulnerable adults
- Support planning and management
- Supervision and disciplinary process

As per annual training planner. Expected completion 31.12.2025

10.3	Not Compliant

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

At the time of inspection, we had a Reception Officer policy that covered needs assessing and upon further discussion and guidance from the inspectors were advised that this needed further reviewing. We have reviewed same and developed an Exceptional needs policy inclusive of roles and responsibilities that supports the guidance on determining the needs of residents with special reception needs.
In addition to this, we identified the need to train staff in understanding the issues that our residents face and have developed a full training plan for all staff that is to commence early 2025 which consists of both in house and external training covering topics on:

- Child Protection
- Trauma Informed Training
- Substance misuse
- Active Listening
- Defusing and Debriefing for managers and Team Leads

- TCI
- Professional Practice and Boundaries
- Trafficking and DSGBV (domestic, sexual, and gender-based violence
- ASIST
- Safe talk
- Vulnerable adults
- Support planning and management

Training will be completed over the course of 2025 and as per annual training planner.
Completion date for needs assessment policy review 28.02.2025

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	31/01/2025
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	31/03/2025

Standard 2.1	There are safe and effective recruitment practices in place for staff and management.	Not Compliant	Red	28/02/2025
Standard 2.3	Staff have the required competencies to manage and deliver person-centred, effective and safe services to children and adults living in the centre.	Partially Compliant	Orange	31/01/2025
Standard 3.1	The service provider will carry out a regular risk analysis of the service and develop a risk register.	Partially Compliant	Orange	31/03/2025
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.	Partially Compliant	Orange	31/01/2025
Standard 8.1	The service provider protects residents from abuse and neglect and promotes their safety and welfare.	Partially Compliant	Orange	28/02/2025
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	28/02/2025

Standard 10.2	All staff are enabled to identify and respond to emerging and identified needs for residents.	Partially Compliant	Orange	31/12/2025
Standard 10.3	The service provider has an established policy to identify, communicate and address existing and emerging special reception needs.	Not Compliant	Red	28/02/2025