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:	Bridgwater House
Centre ID:	OSV-0008421
Provider Name:	Cromey Ltd
Location of Centre:	Co. Tipperary
Type of Inspection:	Unannounced
Date of Inspection:	16/02/2026 and 17/02/2026
Inspection ID:	MON-IPAS-1138

Context

International Protection Accommodation Service (IPAS) centres, formerly known as direct provision centres, provide accommodation for people seeking international protection in Ireland. The International Protection Accommodation Service (IPAS) is a government office responsible for the provision of accommodation centres. In June 2025, this responsibility transferred from the Department of Children, Equality, Disability, Integration and Youth, to the Department of Justice, Home Affairs and Migration.

Direct provision 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

About the Service

Bridgewater Accommodation Centre is located in Carrick on Suir, Co. Tipperary. The centre is situated in a busy rural town, in close proximity to bus and rail links and shops and restaurants. The main building contains 43 family units and 17 single units. At the time of the inspection, the centre accommodated 173 residents.

The building has kitchen facilities for residents to cook their own meals. There is a large laundry room with washers and dryers in an external building. In addition, there is a reception area, offices and one communal room where residents can receive visitors or socialise together.

The centre is managed by a centre manager who reports to an operations manager. The centre is staffed by an assistant manager, a reception officer, a community liaison officer, reception staff, night porters, maintenance staff and cleaning staff.

The following information outlines some additional data on this centre:

Number of residents on the date of inspection:	173

[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

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)
16/02/2026	11:30hrs–18:30hrs	1	1
17/02/2026	08:15hrs–16.50hrs	1	1

What residents told us and what inspectors observed

From speaking with residents and through observations made during the inspection, the inspectors found that the local staff team endeavoured to support residents to experience a good quality of life while living in the centre. Overall, residents, were satisfied with the support they received from the staff team and the standard of the accommodation. However, there were aspects of the governance, risk management and safeguarding systems required significant improvement, to assure the service provider that a consistently good-quality service was being provided to all residents.

The inspection took place over two days. During this time, the inspectors spoke with 14 adults and eight children living in the centre and met other residents as they were going about their days. In addition, resident questionnaires were completed by 13 adults. The inspectors met with the centre manager, deputy manager, reception staff and a night porter. The inspectors also met with the quality and compliance manager, the reception officer, and spoke with the operations manager as part of the inspection process.

Bridgwater House was located in County Tipperary and provided accommodation for up to 211 people, the majority of whom were families. At the time of inspection there were 173 people living in the accommodation centre, including 84 children. In total there were 43 family units and a further 17 single rooms. All of the families had an ensuite or a dedicated bathroom, while some of the single residents shared bathrooms. While the centre's primary function was to provide accommodation to people seeking international protection, 15 (9%) of the residents had received refugee or subsidiary protection status.

The centre comprised one main building with four floors. The ground floor contained offices, a social room, communal kitchens and some resident accommodation. The remaining three floors contained resident accommodation and further kitchen facilities. The reception area of the centre had a reception desk where residents could seek support from staff on a 24/7 basis. The inspectors observed residents accessing support from staff members throughout the inspection and friendly interactions between staff members and residents.

On a walk around the centre, the inspectors observed that the grounds of the centre were well maintained and had pleasant areas for residents to relax. Young children had access to a playground and a sensory garden, and there were seating areas for parents to use while they supervised young children. There were outdoor spaces to the front and back of the building for children to play, but these spaces were also used for car parking. The centre's procedure for resident parking onsite had changed recently and some residents were unhappy with the new arrangements. The exterior of the centre needed

some attention as there was algae growth on the walls and areas where paint had chipped off.

The inspectors found that while general cleaning and maintenance work was carried out, some areas of the building were in need of attention. The inspectors observed cobwebs, stains on paintwork and chipped paint in communal spaces and hallways. There were some kitchen cabinet doors which were loose and worn, and a large crack in the render on a wall in one corridor, for example.

Residents, for the most part, were satisfied with the accommodation provided. Families were accommodated together and single residents enjoyed the privacy of having their own room. However, due to the configuration of the accommodation, there was some overcrowding including parents who shared their room with their children and also siblings over 10 years of opposite genders who shared sleeping accommodation. While there was no private living space, residents had facilities to dine in their room and access to a fridge and basic items such as a kettle and microwave which supported family life. One resident told the inspectors that they have "privacy in the room, can't complain, living in Bridgewater is perfect" while another commented that "life is good here". One resident showed the inspectors a small table which they used to dine and complete homework and said "it's not good as have to sit bent over all the time". There were maintenance issues observed by inspectors in some bedrooms including a leak from a shower, mould in one bathroom and chipped paintwork.

Residents cooked for themselves and had access to a total of seven small communal kitchens spread across the four floors of the centre. Residents were happy to have facilities to cook for themselves despite challenges from time-to-time regarding the cleanliness of the kitchens. Residents had the necessary equipment to prepare and cook their meals but there were no extractor fans or access to boiling water in some kitchens.

Residents bought their groceries and non-food items from the service provider's food store using an online application. Residents were, for the most part, satisfied with this arrangement but some did highlight that the food received was, at times, past its expiry date, not fresh or they found the frozen goods were spoiled when they cooked them.

Storage facilities for residents varied. While most residents were satisfied with the storage for their belongings, there were challenges for some residents who said they did not have sufficient storage for their dried, chilled and frozen goods. Limited freezer space posed a particular challenge for some residents as fresh meet was only delivered to the centre once per week. The inspectors observed one family unit where groceries were stored in a bathroom due to space limitations.

The centre was located in the centre of town which facilitated residents accessing a range of amenities, support services and employment within walking distance. Residents were appreciative of the opportunities they were offered through the 'friends of the centre' group which facilitated many social, recreational and cultural activities for adults and children.

Despite this, facilities for residents within the centre, including children were limited. There was one communal space for adults and children to socialise, meet with their visitors and to study. The children's playroom was closed due to renovation works and there was no appropriate space for teenagers to meet. The communal room was busy during the inspection with teenagers completing their homework and socialising together and at other times, adult residents having conversations with staff members.

Residents were satisfied with the support they received from the staff team. Residents told the inspectors that staff members were "helpful" and "friendly". Some residents told the inspectors about positive experiences where staff had helped them with their difficulties and said staff members listen to their needs and overall helped to resolve any difficulties without delay. One resident named specific staff members who "help me every day, when I have questions, by phone or email". Residents said they felt safe living at the centre.

The inspectors spoke with eight children or teenagers and their feedback was mixed. While some feedback included "life is great", "it's a big place and a big room", others commented on limited play areas. One teenager said they have no silent place to study, and accessed the local library while another said they chose to study in their family unit as the communal room was "too busy and distracting". When asked about life in the centre, one teenage told the inspectors that it "can be boring" and another said "it can be lonely" as they can only bring friends to the communal room. Another child said that they did not have a space to play and would like a place to play soccer and cycle bicycles.

In addition to speaking with residents about their experiences, the inspectors received 13 completed questionnaires from adult residents. The questionnaires asked for feedback on a number of areas including safeguarding and protection; feedback and complaints; residents' rights; staff supports and accommodation. All of the residents who responded to the questionnaire said staff members were kind, respectful and helpful. Twelve of the 13 respondents said they felt safe living in the centre. Nine of the 13 residents reported that they could talk to staff if they were unhappy or worried about something, and six indicated that they were asked for their views and opinions on the centre. Finally, seven of the 13 residents who responded said they had a space to meet with visitors in private.

The observations of the inspectors and views of residents outlined in this section are generally reflective of the overall findings of the report. The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This was the third inspection of Bridgewater House and it was carried out to assess compliance with the national standards. This inspection found that while the service provider was actively endeavouring to enhance their governance systems, the effectiveness of these were impacted due to limited recording, communication and monitoring of the day-to-day practices in the centre. Multiple risks were identified on this inspection which demonstrated that further action was needed in areas such as governance, oversight, risk management and safeguarding.

The service provider had not implemented the necessary governance and oversight systems to ensure they were in compliance with the national standards and, as a consequence, did not fully meet them. While the service provider had developed various policies, procedures and templates to support the staff team in their roles, there was limited oversight, on the part of the service provider, which meant they could not be assured that the standards and regulations were implemented in practice. As a result, for example, statutory notifications required by the regulations had not been submitted to HIQA. Some child protection concerns had not been responded to nor reported in line with the requirements of *Children First: National Guidance for the Protection and Welfare of Children* (2017). In addition, the service provider had not developed a policy in relation to the management of allegations against staff members and this had a direct implication on how they were managed, when such situations arose. HIQA issued an urgent compliance plan to seek assurances from the service provider due to risks identified in relation to safeguarding, food safety and fire safety risks. Assurances were subsequently submitted by the service provider which included the necessary control measures being put in place to mitigate these risks.

The centre was managed by a centre manager who reported to an operations manager, who in turn reported to the director of the service. The centre manager was supported in their role by a relief centre manager and a quality and compliance manager who was a member of the senior management team and supported the team in the development of systems to ensure the delivery of a good quality service in line with the standards.

There were clear lines of accountability and authority but the reporting systems were not effective to ensure adequate oversight and governance of the centre. There were limited records to demonstrate how the service provider was assured of the quality and safety of the service provided. Senior management meetings had taken place previously but they had not occurred in the five months prior to the inspection, nor had the centre manager received formal supervision since September 2025. A daily

reporting tool was developed to report on key areas to the senior management team but they were not being utilised as intended. For example, the inspectors identified concerns, risks, incidents and complaints that had not been reported. Senior managers were reliant on informal communications for briefings on the centre and were unaware of the extent of challenges and risks within the centre.

Monitoring and oversight systems were developed but deemed ineffective due to poor record keeping and reporting within the centre. While the management team advised they routinely carried out visual checks of residents' rooms and communal spaces, these were not recorded. There was no system in place to manage, monitor or track concerns, incidents or complaints, despite sufficient guidance and templates available to support them in this area. In addition, inaccurate recording on the centre's residents' register had not been identified which meant that the management team was unaware when residents, including children, were absent from the centre. While some audits were carried out at a senior management level, they were confined to the risk register, incident management system and supervision and had not yet focused on the day-to-day operations and practices within the centre.

Record keeping practices were underdeveloped and unsatisfactory. This inspection found that the service provider's policies with regard to the recording of incidents, concerns and complaints, for example, had not been adhered to and instead the staff team used a communication tool to highlight when there were risks identified in the centre. Furthermore, not all staff members recorded details of their interventions with residents, and at times there were delays reporting concerns or risks to the management team. The systems of reporting employed in the centre were inadequate and created unnecessary risk for residents, staff and the service provider.

Communication systems also required improvement. The local reporting arrangements was mainly through verbal communication and through a communications diary. There were no formal team meetings or minutes of handover meetings to evidence how the staff team shared experiences, collectively debriefed or discussed practice within the centre.

An annual review of the service was completed in 2025 but this required further development. While the annual review clearly outlined areas of good practice and areas in which improvements were required, they had not been reflected on the centre's quality improvement plan. Residents participated in this review though engaging in a residents' survey but the response rate was low, which had been identified by the service provider as an area for improvement. The annual review was a good starting point but it did not consider a comprehensive assessment or reflection on all aspects of the service, to ensure it met the requirements of the national standards.

Systems to consult with residents were established but inconsistent. Residents had opportunities to meet with staff members informally on a day-today basis in communal areas. The management team had formed a residents' committee but meetings were not consistently scheduled. The most recent meeting took place in October 2025, and it was not evident that resident feedback was actioned or included in the centre's quality improvement plan. Similarly outcomes from a residents' survey which took place prior to the last inspection had not been reflected in the centre's improvements plans.

The complaints management system was ineffective. There was a comprehensive policy to guide the management of complaints. The staff and management team endeavoured to resolve complaints as they arose but they had not recorded the complaints received on a centre complaints log. This meant that the service provider was not aware of the frequency or types of complaints made about the service. The action taken to resolve complaints was not consistency recorded and there was no evidence that complaints were investigated to identify potential learnings.

The risk management system required further improvements. There was a risk management policy as well as a detailed risk register which outlined risks within the centre, including resident risks. However, while control measures were identified to minimise risks, they were not consistently implemented in practice. For example, control measures to reduce fire safety risks, such as, the completion of fire drills, were not routinely carried out. Similarly monitoring of accommodation and storage, for example, was not completed. The inspectors identified risks which had not been assessed, such as lone working and food safety risks. Furthermore, processes to review risks were described as informal and not recorded resulting in limited opportunities for the staff team to engage in risk management related discussions.

The systems in place to manage the risk of fire were not robust. The staff team had appropriate training in fire safety and while residents received an induction on fire safety, upon arrival to the centre, not all residents had engaged in a fire drill. The frequency of fire drills was not in line with the centre's policy and the most recent fire drill carried out in July 2025 had not been reviewed to identify learnings, to improve resident participation or to reduce evacuation times. There was a lack of response to the fire alarm being activated during the inspection and faults identified on a fire alarm panel had not been responded to. The inspectors issued an urgent compliance plan in response to these risk and a satisfactory response was returned.

In summary, while there was a well-intended staff and management team, the reporting, oversight mechanisms and risk reporting systems in the centre could not assure the provider that a consistently safe and quality service was being provided to residents.

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 were ineffective governance arrangements in place in this centre which resulted in limited oversight on the part of the service provider of the quality and safety of the services provided to residents. While the service provider had developed new systems and processes to enhance their compliance, they were not monitored or reviewed to ensure they were implemented in practice. As a result, there were deficits across many themes of the national standards including significant risks which related to fire safety, food safety and safeguarding. HIQA issued an urgent compliance plan to the service provider to request assurances that these risks were addressed. Following the inspection, several statutory notifications were retrospectively submitted to HIQA, which had not been previously been referred, in line with required time frames.

Judgment: Not 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.

There were limited systems in place to maintain oversight of the service and as a result the senior management team was unaware of several concerns and risks identified during this inspection. While there was a clearly defined reporting structure in place, the governance arrangements in place were ineffective. Formal senior management meetings had not occurred in recent months and while the service provider relied on a daily reporting mechanism for updates on the centre, there was no follow-up despite the absence of escalations on risks and concerns.

While the staff team was well-intended and responsive to residents' needs, records of their interactions were minimal and they had not followed the service provider's policies or tools to support them in the management of incidents, safeguarding concerns and complaints, for example.

Monitoring and oversight of the centre and day-to-day practices were informal and as there were no team meetings, important aspects of service provision and practice were not consistently discussed or reviewed.

Judgment: Not 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 developed an auditing programme which had evaluated some aspects of the service but local audits of day-to-day practice and systems had not been carried out to assure the provider that the service delivered was safe and effective.

While an annual review of the quality of care and experience of the residents was completed, the quality of this was impacted by limited oversight and monitoring of the service delivered. There were methods in place for residents to give feedback on the centre; however, these were informal and not consistently recorded.

Judgment: Partially Compliant

Standard 2.1

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

Recruitment practices were in line with the centre's policy and all staff had Garda Síochána (Irish police) vetting. Staff who required an international police check had obtained these documents and they were available on the corresponding staff files. The induction of new staff was not documented and discussions regarding newly recruited staff members performance and probation were informal and not recorded.

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 team reported that they were well supported in their role and the majority of the team had received formal supervision on a quarterly basis. In addition, an annual appraisal was completed for staff members. The centre manager had not received supervision in line with the requirements of the national standards as only one supervision session took place in the six months preceding the inspection.

Judgment: Partially Compliant

Standard 2.4

Continuous training is provided to staff to improve the service provided for all children and adults living in the centre.

A comprehensive training programme was in place to ensure all training needs were met. Training in child and adult safeguarding was provided to all staff. Training required by the national standards was provided to all key staff working with residents in the centre. Further training was planned shortly after the inspection for specific members of the team to act as a designated liaison persons.

Judgment: Compliant

Standard 3.1

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

The risk management system was not fully effective to ensure risks within the service were identified, addressed, managed and escalated in a timely way. While there was a detailed policy and a risk register in place, there was a lack of oversight of the process and risk escalations internally were not evident. The management team had not ensured that risks were appropriately reviewed to ensure controls measures listed were implemented in practice and when new risks emerged, they were not assessed in a timely way. For example, food safety risks, which were identified on a previous inspection, had not been assessed and additional risks associated with incidents, such as aggressive behaviour towards staff members had also not been assessed.

Records of fire drills did not provide assurance that all residents could be evacuated in the event of a fire. The frequency of fire drills was not in line with the centre's policy and as a result not all residents had engaged in a fire drill. There was a lack of response to the activation of the fire alarm during the course of the inspection and faults identified on a fire alarm panel had not been responded to. HIQA issued an urgent compliance plan and satisfactory response was returned.

Judgment: Not Compliant

Quality and Safety

Residents in this centre had access to good supports from a committed and dedicated staff team and for the most part, felt happy living in this centre. The centre was centrally located and residents had access to a wide range of amenities and services in the locality. Despite this, residents did not have access to sufficient communal facilities which was particularly impactful considering there were cases of overcrowding within the centre. The service provider's policies on safeguarding were not implemented in practice which meant that some safeguarding concerns were not adequately managed or addressed in a timely manner.

The allocation of accommodation was guided by a room allocation policy. The service provider received limited information about residents before they arrived to the centre but the management team considered residents' needs, when known, while allocating accommodation. They also facilitated residents to change rooms when this was requested or required to meet their needs; however, there was no log to keep a record of these requests, or to demonstrate how they were prioritised.

The standard of the accommodation was adequate but there was some overcrowding evident as this centre was not designed with the intention of accommodating families. The sleeping arrangements for some families were not in line with the requirements of the Housing Act 1966, as there were some families where parents were required to share bedrooms with their children. In other cases, siblings of opposite gender who were aged 10 years and over shared the same bedroom while some teenagers over the age of 15 slept in bunk beds. The management team were aware of these findings but not had adequately assessed the associated risks.

On a walk around the building, the inspectors found that there were areas of the centre that required a cleaning and maintenance. There were multiple systems in place to record maintenance related issues and therefore it was difficult for the centre manager to maintain oversight of the system. Cleaning schedules had not been developed, nor were checks completed of the general upkeep of the centre.

Residents were provided with self-catering facilities but food safety risks were identified following delivery of groceries to the centre. This inspection found that there were occasions when chilled and frozen goods were left for long periods at room temperature, following delivery to the centre by the service provider which posed a food safety risk. Inspectors issued an urgent compliance plan to ensure there were appropriate measures for storing perishable food items and a satisfactory response was returned.

The system in place to ensure the rights of residents were promoted and protected required review. There were some examples of good practice whereby residents' rights were promoted. There was access to information about rights, local support and services and significant work was carried out to integrate residents in to the local community. However, despite these good practices, there were some disparities in the application of rules in the centre which impacted some residents negatively. For example, there was no clear guidance for staff or residents in relation to the availability of onsite car parking and as a result there were inequities in how it was applied. In addition, the decision making process to provide funding to some residents for various reasons, including, access to overnight accommodation outside of the centre, was not documented. As outlined previously, the service provider could not be assured that the rights and diversity of each resident were promoted and respected as complaints, concerns and incidents were not recorded, managed and reported in line with centre policy.

Safeguarding practices in the centre were not effective to ensure residents were consistently safe and protected while living in the centre. There were detailed policies and guidance for the staff team in relation to the safeguarding of both adults and children but there were not consistently implemented in practice. Additionally, there was no policy for the management of allegations against centre staff. While the staff team had the appropriate training, the inspectors found multiple safeguarding concerns including child protection and welfare concerns and an allegation against staff members, which had not been appropriately responded to, managed, risk assessed and or reported in line with national and local policy.

There was no centralised system to maintain oversight of safeguarding concerns. As noted previously, record keeping practices and communication among the team was suboptimal and there was no system to track, manage or have oversight of concerns which arose. While there was a designated liaison person (DLP) and a deputy DLP, the roles had not been adapted in line with the requirements of national policy. On occasions, there was a delayed or inadequate response from the DLP to staff queries and there were several occasions when the DLP was not contacted when a safeguarding concern arose.

Following the inspection, the inspectors issued an urgent compliance plan seeking assurances that a comprehensive review of records was completed by the service provider. The inspectors requested that actions and procedures be put in place to ensure that the appropriate management and reporting of concerns. A comprehensive response was returned to confirm that referrals to statutory agencies were completed, where required.

The management and oversight of incidents which occurred in the centre required improvement. The service provider had introduced a comprehensive recording system

and ensured training was provided to the staff team but this had not led to an improvement in the management and oversight of incidents. This inspection found that incidents were recorded, for the most part, sporadically in a communication book and as a result, were not thoroughly managed, risk assessed or escalated, if required. There were no processes in place to maintain oversight of incidents, or to ensure they were routinely discussed, reviewed and trended to derive learning or instigate changes to practice.

The service provider had employed an appropriately qualified and committed reception officer who endeavoured to assess and meet the needs of residents living in the centre. There was a policy and procedure manual in place to identify, communicate and address special reception needs to guide practice. Residents engaged in an initial vulnerability assessment upon arrival to the centre and if special reception needs were identified, they were logged on a resident risk register which allowed the reception officer and management team to maintain oversight of the needs of residents in the centre. To further enhance the assessment process a new template was rolled out, to aid a consistent approach to record keeping.

The reception officer worked across two centres and this posed a challenge to ensuring residents and staff had regular access to the reception officer. Residents were updated on the reception officer's availability but the service provider had not considered the resources required to assess and meet the needs of the residents in the centre. The reception officer was supported in their role by another staff member but at times there was some ambiguity regarding roles and responsibilities and delayed reporting of concerns or resident needs to the reception officer. While all staff members were well-intended, their roles and responsibilities needed to be clarified to ensure both the staff team and residents were clear on who the principal point of contact was in relation to special reception needs. Despite this, residents were well supported and referred to the support services they required in line with their needs.

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.

The service provider had a room allocation policy and endeavoured to allocate accommodation in a fair and transparent manner but this was a challenge as the centre was not designed to provide accommodation for families. Families were provided with one or more bedrooms, depending on the size of their family but they had no private living space. The management team ensured that room changes were facilitated when possible but resident requests to change rooms were not formally recorded.

Judgment: Partially Compliant

Standard 4.4

The privacy and dignity of family units is protected and promoted in accommodation centres. Children and their care-givers are provided with child friendly accommodation which respects and promotes family life and is informed by the best interests of the child.

The privacy and dignity of the family unit was not fully promoted or protected in the accommodation centre. The sleeping arrangements for some families did not promote their rights, as parents shared bedrooms with their children and in other cases siblings of opposite gender who were aged 10 years and over were sharing the same bedroom, due to the limiting configuration of some of the accommodation provided in the centre. While the service provider was aware of these deficits, the risk assessments required review to ensure they adequately outlined the risks and considered the most appropriate control measures.

Judgment: Substantially Compliant

Standard 4.5

The accommodation centre has adequate and accessible facilities, including dedicated child-friendly, play and recreation facilities.

Residents were encouraged to socialise and access amenities and recreational activities in the community which were offered through the 'friends of the centre' group. In addition, gym and swimming passes were provided to some residents. However, there were limited facilities available for adults and children in the centre. The children's playroom was closed due to renovation works and plans to provide an adequate space for older children and teenagers had not progressed. While there was one communal space containing books, board games and one computer for all residents to access, this was not sufficient considering the number of residents living in the centre.

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.

All school age children living in the centre had an educational placement and a homework club was available locally. The staff team provided supports to parents to source educational placements, bus transport and necessary equipment for school. Due to the type of accommodation at this centre it was not possible for some children and young people to study in their rooms and there was no dedicated space within the centre to facilitate these residents. There was one computer available in the centre and clarity was required within the staff team as to whether children could access this to support them with their school work, if required.

Judgment: Partially Compliant

Standard 4.7

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

The service provider did not have the appropriate schedules in place to ensure the centre was clean and well-maintained throughout. The inspectors identified cleaning and maintenance issues that required attention which had not been identified or resolved through the systems in place at the time of the inspection.

Residents had access to appropriate laundry facilities.

Judgment: Partially Compliant

Standard 4.9

The service provider makes available sufficient and appropriate non-food items and products to ensure personal hygiene, comfort, dignity, health and wellbeing.

The provider ensured residents had additional points to buy non-food items and products for personal hygiene, comfort and dignity. The provider had also ensured residents were provided with two sets of towels and bedlinen on arrival.

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 but not all residents had sufficient food storage facilities to store their food including refrigerated and dried goods. Procedures were not in place to ensure the consistent safe storage of chilled and frozen goods upon delivery to the centre by the provider. The inspectors were advised of occasions when chilled and frozen goods remained stored at room temperature following their delivery to the centre for long periods of time.

Judgment: Not Compliant

Standard 5.2

The service provider commits to meeting the catering needs and autonomy of residents which includes access to a varied diet that respects their cultural, religious, dietary, nutritional and medical requirements.

Residents bought their groceries from the service provider's online food ordering system. The orders were delivered to the centre from the provider's offsite shop.

Judgment: Compliant

Standard 6.1

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

The staff team strove to ensure that the rights and diversity of residents were respected, safeguarded and promoted by the staff team but further work was required in this area. Residents had sufficient information about their rights and they had informal opportunities to meet with the staff and management team but systems to consult with residents regarding their experiences of living in the centre were limited and insufficient. There was some disparity in how decisions were made in relation to, for example, flexibility regarding residents using the car park and the provision of funding to supports resident needs. There were no records to outline the rationale for how decisions were made to ensure equity and consistency. As noted previously, the recording, reporting and management of complaints could not assure the provider that residents' rights were upheld.

Judgment: Partially Compliant

Standard 7.1 The service provider supports and facilitates residents to develop and maintain personal and family relationships.
Visitors were welcomed to the centre and there was a communal space for residents to meet their friends. However, private spaces for residents to meet with their visitors were limited. This had not been risk assessed, particularly in light of the competing demands for private meeting space due to the large number of residents living in the centre and need for certain staff, such as the reception officer, who also required this space.
Judgment: Partially Compliant
Standard 7.2 The service provider ensures that public services, healthcare, education, community supports and leisure activities are accessible to residents, including children and young people, and where necessary through the provision of a dedicated and adequate transport.
Residents were well integrated into the local community. The staff team had developed strong links with community organisations and residents had information about community supports, education, employment and social groups. There was an active 'friends of the centre' group that ensured residents had access to a variety of activities such as dance classes for children, knitting classes and in addition, trips and fun cultural events were arranged periodically.
Judgment: Compliant
Standard 8.1 The service provider protects residents from abuse and neglect and promotes their safety and welfare.
The service provider had an appropriate adult safeguarding policy in place. However, there was no policy to guide the management of allegations against staff members. Not all safeguarding concerns were identified, managed and notified or referred to relevant agencies in line with legislative requirements or national policy including adult safeguarding concerns and allegations against staff members. As a result, HIQA issued an urgent compliance place to seek assurances that all concerns and associate risks were addressed and managed appropriately.

Judgment: Not 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.

A number of child protection or welfare concerns had not been identified, managed or reported to Tusla in line with Children First. While these were submitted following the inspection at the request of the inspectors, there was a lack of understanding within the staff team as to what constituted a concern and therefore a delay or absence of required reporting. Staff members were not alerted to incidents where single parents did not have their children present and as a result had not documented absences of children from the centre. There was no system to maintain oversight of communications with the DLP, Tusla or concerns for children living in the centre.

Judgment: Not 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.

A procedure had been developed by the service provider in relation to managing and reviewing incidents but this was not applied in practice. There were several incidents identified on this inspection which had not been recorded as an incident and therefore not subjected to the standard procedure of review, escalation and reporting to relevant authorities, as required.

Judgment: Not 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.

There were examples of good practice in the centre where the staff team supported residents in relation to their health and wellbeing and ensured residents had access to health or social care services. Funding was provided to help some residents to access mental health supports and therapy.

Judgment: 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.

For the most part, the provider was not made aware of any special reception needs in advance of an admission to the centre. Despite this, the staff team endeavoured to provide the required support, accommodation and assistance to residents when they became aware of their needs.

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 developed a reception officer policy to identify, communicate and address existing and emerging special reception needs. Residents had their needs assessed and residents were referred to support services as required, in line with their needs.

Judgment: Compliant

Standard 10.4

The service provider makes available a dedicated Reception Officer, who is suitably trained to support all residents' especially those people with special reception needs both inside the accommodation centre and with outside agencies.

While a suitably qualified reception officer was employed to provide support to residents in the centre, the reception officer also worked in another centre. The arrangements in relation to the availability of the reception officer to both staff and residents was not informed by any assessment of need. The reception officer was supported in their role by another staff member but their responsibilities were not clearly specified in terms of their capacity, responsibilities and reporting arrangements. The reception officer was part of the senior management team.

Judgment: Partially 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	Not Compliant
Standard 1.2	Not Compliant
Standard 1.4	Partially Compliant
Theme 2: Responsive Workforce	
Standard 2.1	Substantially Compliant
Standard 2.3	Partially Compliant
Standard 2.4	Compliant
Theme 3: Contingency Planning and Emergency Preparedness	
Standard 3.1	Not Compliant
Dimension: Quality and Safety	
Theme 4: Accommodation	
Standard 4.1	Partially Compliant
Standard 4.4	Substantially Compliant
Standard 4.5	Partially Compliant
Standard 4.6	Partially Compliant
Standard 4.7	Partially Compliant
Standard 4.9	Compliant
Theme 5: Food, Catering and Cooking Facilities	

Standard 5.1	Not Compliant
Standard 5.2	Compliant
Theme 6: Person Centred Care and Support	
Standard 6.1	Partially Compliant
Theme 7: Individual, Family and Community Life	
Standard 7.1	Partially Compliant
Standard 7.2	Compliant
Theme 8: Safeguarding and Protection	
Standard 8.1	Not Compliant
Standard 8.2	Not Compliant
Standard 8.3	Not Compliant
Theme 9: Health, Wellbeing and Development	
Standard 9.1	Compliant
Theme 10: Identification, Assessment and Response to Special Needs	
Standard 10.1	Compliant
Standard 10.3	Compliant
Standard 10.4	Partially Compliant

Compliance Plan for Bridgewater Hotel

Inspection ID: MON-IPAS-1138

Date of inspection: 16 and 17 February 2026

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	Not Compliant

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

There is a robust and comprehensive risk management framework in place across all areas of the national standards. However, going forward the centre manager and staff are to strictly adhere to the company's policies and procedures. For instance, the company's safeguarding, complaints, incidents, fire safety and risk management policies and procedures are to be strictly adhered to and implemented in practice. The company incident/complaint form is to be completed, reported and submitted to Senior Management Team in real time, and reported to the appropriate external bodies where it is deemed necessary and within the specified 3 day timeframe.

Additional monitoring measures to ensure governance and oversight include the following:

Personal Safeguarding meetings take place between the Quality Manager and the Centre manager weekly and fortnightly audits of centre records will be completed until SMT is assured all company's' policies and procedures are strictly adhered to.

The centre manager is to complete and submit monthly incident and complaints logs to SMT and Safeguarding and Child Protection tracking record systems to ensure there is sufficient SMT oversight and governance of the centre.

The Quality Manager will review/audit all incidents and complaints on the day of occurrence or within a 3 day timeframe at a maximum.

Daily handover records have been introduced. Daily handovers will be reviewed by SMT on a daily basis to ensure there are appropriate oversight arrangements in place to monitor safeguarding of residents.

Finally, staff meetings are now in place on a monthly basis to ensure there is a formal record on the important aspects of service provision and practice discussed or reviewed between centre staff.

Prior to inspection, DLP training was scheduled for key staff in the centre. The staff completed the training as scheduled on the 25.2.26. Refresher training in Safeguarding, incidents, complaints and adhering to company's policies and procedures was completed with all staff in March 2026.

All staff fire safety and evacuation drill training was up to date at time of inspection. The last fire safety training was completed in April 2025. Notwithstanding this, both staff and residents received fire safety and evacuation drill training again by external Fire Safety Company on the 20th of Feb 2026.

Staff are trained to take the appropriate actions and responses to a fire alarm activation/fault. In light of the poor response to the fire alarm activation on the day of inspection a new template is now in use for the recording of all fire drills/ evacuations and the frequency has been increased from twice to four times a year. All residents are informed and offered fire training by the external Fire Safety Company and some residents attended training on the 20th of Feb 2026. Residents are also offered and encouraged to also complete Fire warden training.

New residents receive a fire safety and evacuation induction on arrival to the centre by the centre manager which is recorded and held on file until new residents have the opportunity to engage in the next in house fire drill and scheduled training by the external Fire Safety Company. There is an annual maintenance contract in place and the fire panel is serviced on a quarterly basis. Any fault with the fire panel is promptly reported and addressed by the fire panel company.

The food hall system provides the facility for residents to choose the date and time of their food deliveries. We continue to encourage residents to collect their food order at the agreed and scheduled time frames. In the event the resident cannot collect the food at the agreed time of delivery the resident will be requested to nominate a person to collect and store their food on their behalf. Any uncollected chilled/frozen goods will be stored appropriately by staff until the resident is able to collect. Going forward, there will be additional quality checks implemented. Residents will be required to check and sign off their food orders with a designated staff member to ensure the quality of the food is to the resident's satisfaction. This will also be utilised as another method of

formal engagement with residents. If any issues, concerns or suggestions emerge they will be recorded and actioned by the centre.

1.2	Not Compliant

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

There is a robust and comprehensive risk management framework in place across all areas of the National Standards. However, going forward the centre manager and staff are to strictly adhere to the company's policies and procedures. All incidents and complaints are to be reported in line with the company's adult and child safeguarding, complaints, incidents, and risk management policy and procedures. The company incident/complaint form is to be completed, reported and submitted to Senior Management Team in real time, and reported to the appropriate external bodies where it is deemed necessary and within the specified 3 day timeframe.

Both senior management meetings and formal supervisions will take place four times a year, on a quarterly basis with the centre manager. Since the recent inspection additional measures have been put in place to ensure the centre's comprehensive risk management framework and associated policies and procedures are adhered to at local level.

1.4	Partially Compliant

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

Resident surveys are a scheduled annual audit. In 2025, the annual resident survey was completed and actioned and the 2026 survey is scheduled for later this year. Resident committees were commenced in 2025 and will be scheduled on a quarterly basis in 2026. There is a resident suggestion box for residents to provide their formal feedback along with the resident surveys and the committees.

Resident feedback will be further monitored and tracked through the Quality Improvement Plan 2026 to ensure residents' feedback is taken into consideration and actioned where it is possible to do so. Finally, it is important to note that the center manager operates an open door policy and informal engagement takes place daily between staff and residents.

There is also an easily accessible 24 hour helpline available to residents to utilize at any time.

The Annual Review is comprehensive and reflects the Quality Improvement Plan for 2025 and discusses the Quality Improvement Plan for 2026. All areas improved and noted for improvement are discussed and the review is structured by the National Standards.

Going forward, all areas for noted for improvement derived from audits, surveys or committees will be reflected in the Quality Improvement Plan 2026.

2.3	Partially Compliant

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

Both senior management meetings and formal supervisions will take place four times a year on a quarterly basis with the centre manager.

3.1	Not Compliant

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

There is a robust and comprehensive risk management framework in place across all areas of the National Standards. However, going forward the centre manager and staff are to strictly adhere to all of the company's policies and procedures. For example, the risk management policy and standard operating procedures require the timely identification, assessment, action and management of any potential or identified risk in a timely manner, and (the escalation of the risk- where deemed necessary as per risk management policy and procedure). Additional measures are now in place to ensure all risks are promptly identified, assessed, actioned, managed and escalated in a timely manner and to ensure the comprehensive risk management framework is implemented in practice include the following:

- Personal Safeguarding meetings take place between the Quality Manager and he Centre manager weekly and fortnightly audits of centre records will be completed until SMT is assured all company's' policies and procedures are strictly adhered to.
- The company incident/complaint form is to be completed, reported and submitted to SMT in real time, and reported to the appropriate external bodies where it is deemed necessary.

The centre manager is to complete and submit monthly incident and complaints logs to SMT and Safeguarding and Child Protection tracking record systems to ensure there is sufficient SMT oversight and governance of the centre.

There is a trends audit and analysis of incidents, complaints and safeguarding incidents completed on an annual basis. Going forward, these records will be monitored as follows:

(1) Weekly via safeguarding meeting, (2) monthly via the incidents, complaints and safeguarding logs quality and (3) centre manager meetings and monthly staff meeting.

- The Quality Manager will review/audit all incidents and complaints on the day of occurrence or within a 3 day timeframe at a maximum.
- Daily handover records have been introduced. Daily handovers will be reviewed by SMT on a daily basis to ensure there are appropriate oversight arrangements in place to monitor safeguarding of residents.
- Refresher training in Safeguarding, incidents, complaints and adhering to company's policies and procedures was scheduled in March 2026.

Training to support staff to remain safe while managing or responding to aggressive behaviours directed towards them or others in the workplace is scheduled for April 2026. The risk in regard to aggressive behaviours towards staff members has been assessed, actioned and managed, with the control measures now reflected in the general risk register.

All staff fire safety and evacuation drill training was up to date at time of inspection. The last fire safety training was completed in April 2025. Notwithstanding this, both staff and residents received fire safety and evacuation drill training again by external Fire Safety Company on the 20th of Feb 2026.

Staff are trained to take the appropriate actions and responses to a fire alarm activation/fault. In light of the poor response to the fire alarm activation on the day of inspection a new template is now in use for the recording of all fire drills/ evacuations and the frequency has been increased from twice to four times a year. All residents are informed and offered fire training by the external Fire Safety Company and some residents attended training on the 20th of Feb 2026. Residents are also offered and encouraged to also complete Fire warden training.

New residents' receive a fire safety and evacuation induction on arrival to the centre by the centre manager which is recorded and held on file until new residents have the opportunity to engage in the next in house fire drill and scheduled training by the external

Fire Safety Company. There is an annual maintenance contract in place and the fire panel is serviced on a quarterly basis. Any fault with the fire panel is promptly reported and addressed by the fire panel company.

4.1	Partially Compliant

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

The Accommodation Allocations Policy is fair, transparent and person centered. We aim to meet the accommodation needs of all residents on admission. However, on arrival and in the absence of a prior assessment of resident needs, on occasion some residents may need to be temporarily allocated the available accommodation at the time until more suitable accommodation becomes available. Any family deemed to be in this situation is placed on priority re-allocation waiting list. Such a setting was included in the risk register in general terms on the day of the inspection. Going forward any family pending re-allocation will be placed the resident risk register by name.

During the recent inspection it was noted that some residents sleeping arrangements were not in line with the National Standards. We commenced a full review of all accommodation allocated to residents. The findings of the review identified the vast majority of residents are allocated accommodation in line with the National Standards.

Six families were identified as requiring alternative accommodation. In line with the Accommodation Allocation Policy and the upcoming imminent departures we plan to re-allocate the six identified families to accommodation that meets their needs when the rooms become available. The center manager will formally record all resident requests to transfer rooms going forward.

4.5	Partially Compliant

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

Communal spaces and their use have been reviewed. A playroom will be in place in the coming months.

We will aim to provide a space for teenagers to socialise within the center if we can gather parental support for the initiative.

We continue to encourage all residents including teenagers to integrate into the local community. In respect of teenagers, the center's community liaison officer links and

offers to register all teenagers with organizations such as 'Foroige' that offer an array of events and activities for teenagers within the town only steps away from the center. In addition the community liaison officer organizes many events for residents including teenagers and there is a comprehensive social calendar for the residents of Bridgewater in place through the support of the 'friends of the center'.

Finally, these areas to improve will form part of the Quality Improvement Plan 2026

4.6	Partially Compliant

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

Communal spaces and their use have been reviewed. We will aim to provide a dedicated space with the appropriate facilities for homework/study with a dedicated computer(s) for study and a playroom for residents residing in the center. We envisage the space shall be ready for use in the coming months. These areas to improve will form part of the Quality Improvement Plan 2026.

4.7	Partially Compliant

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

There are two full time housekeepers on seven days a week from 8am to 7pm. The center manager and support manager monitor the cleanliness of the building a minimum three times a day. The maintenance schedule has been reviewed and the maintenance hours have increased.

Maintenance works will be prioritized and the work will be completed over the coming months. The areas required to improve form part of the Quality Improvement Plan 2026.

5.1	Not Compliant

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

The food hall system provides the facility for residents to choose the date and time of their food deliveries. We continue to encourage residents to collect their food order at the agreed and scheduled timeframes. In the event the resident cannot collect the food at the agreed time of delivery the resident will be requested to nominate a person to collect and store their food on their behalf. Any uncollected chilled/frozen goods will be stored appropriately by staff until the resident is able to

collect. Going forward, there will be additional quality cheks implemented. Residets will be required to check and sign off their food orders with a designsted staff member to ensure the quality of the food is the resident's satisfaction. This will also be utilised as another method of formal engagement with residents. If any issues, cncerns or suggestions emerge they will be recorded and actioned by the centre.

6.1	Partially Compliant

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

There is a robust and comprehensive complaints policy in place. However, going forward the centre manager and staff are to strictly adhere to the company's complaints policy and procedures. All complaints are to be reported in line with the company's complaints policy and procedures. The company complaint form is to be completed, reported and submitted

to Senior Management Team in real time, and reported to the appropriate external bodies where it is deemed necessary and within the specified 3 day timeframe.

There will be closer monitoring and auditing of all areas of service provision within the center to ensure the complaints policies and procedures are strictly adhered to and implemented in practice.

It is important to note informal engagement takes part on a daily basis with residents. We engage in formal resident feedback through an annual resident survey and resident committee meetings. Resident surveys are a scheduled annual audit. In 2025, the annual resident survey was completed and actioned and the 2026 survey is scheduled for later this year. Resident committees were commenced in 2025 and will be scheduled on a quarterly basis in 2026. There is a resident suggestion box for residents to provide their formal feedback along with the resident surveys and the committees. The resident committee record provides an action log and an open action log and tracks residents' feedback and suggestions with subsequent actions and progress updates. This will be further monitored and tracked through the Quality Improvement Plan 2026 to ensure residents' feedback is taken into consideration and actioned where it is possible to do so.

A parking policy has been developed and disseminated to both staff and residents to eliminate any potential disparities in regards to parking. All supports defined in the contract between the center and IPAS are provided to residents and upheld by the center. Finally all communications with residents will be recorded in their residents file from this date onwards.

7.1	Partially Compliant

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

We have reviewed the communal spaces available for residents. The meeting/visitors room is now solely designated for residents use.

8.1	Not Compliant

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

There is a robust and comprehensive safeguarding and incident management policy in place. A policy to guide the center on responding to allegations against staff members is now in place. However, going forward the centre manager and staff are to strictly adhere to the company's safeguarding, responding to allegations against staff members, risk management and incident management policies. All incidents and allegations are to be reported in line with the company's safeguarding, risk management, responding to allegations against staff members and incident management policies and procedures. The company incident/complaint form is to be completed, reported and submitted to SMT in real time, and reported to the appropriate external bodies where it is deemed necessary and within the specified 3 day timeframe.

Prior to inspection, DLP training was scheduled for key staff in the centre. The staff completed the training as scheduled on the 25.2.26. Refresher training in Safeguarding, incidents, complaints and adhering to company's policies and procedures was completed with all staff in March 2026.

Additional measures now in place to ensure all safeguarding concerns and allegations against staff members are promptly identified, managed, notified and referred to relevant agencies include the following:

- Personal Safeguarding meetings take place between the Quality Manager and he Centre manager weekly and fortnightly audits of centre records will be completed until SMT is assured all company's' policies and procedures are strictly adhered to.

- The company incident/complaint form is to be completed, reported and submitted to SMT in real time, and reported to the appropriate external bodies where it is deemed necessary.

The centre manager is to complete and submit monthly incident and complaints logs to SMT and Safeguarding and Child Protection tracking record systems to ensure there is sufficient SMT oversight and governance of the centre.

There is a trends audit and analysis of incidents, complaints and safeguarding incidents completed on an annual basis. Going forward, these records will be monitored as follows:

Weekly via safeguarding meeting, (2) monthly via the incidents, complaints and safeguarding logs quality and (3) centre manager meetings and monthly staff meeting.

- The Quality Manager will review/audit all incidents and complaints on the day of occurrence or within a 3 day timeframe at a maximum.
- Daily handover records have been introduced. Daily handovers will be reviewed by SMT on a daily basis to ensure there are appropriate oversight arrangements in place to monitor safeguarding of residents.

8.2	Not Compliant

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

There is a robust and comprehensive risk management framework in place across all areas of the national standards. However, going forward the centre manager and staff are to strictly adhere to the company's child protection policies and procedures. All child protection or welfare concerns are to be reported in line with the company's safeguarding, child protection, complaints, incidents, incident management, responding to staff allegations policies.

All staff complete and have up to date training in Children First: National Guidance for the protection and welfare of children (2017).

Prior to inspection, DLP training was scheduled for key staff in the centre. The staff completed the training as scheduled on the 25.2.26. Refresher training in Safeguarding, incidents, complaints and adhering to company's policies and procedures was completed with all staff in March 2026.

Additional measures now in place to ensure all safeguarding concerns and allegations against staff members are promptly identified, managed, notified and referred to relevant agencies include the following:

- Personal Safeguarding meetings take place between the Quality Manager and he Centre manager weekly and fortnightly audits of centre records will be completed until SMT is assured all company's' policies and procedures are strictly adhered to.

- The company incident/complaint form is to be completed, reported and submitted to SMT in real time, and reported to the appropriate external bodies where it is deemed necessary and within the specified 3 day timeframe.

The centre manager is to complete and submit monthly incident and complaints logs to SMT and Safeguarding and Child Protection tracking record systems to ensure there is sufficient SMT oversight and governance of the centre.

There is a trends audit and analysis of incidents, complaints and safeguarding incidents completed on an annual basis. Going forward, these records will be monitored as follows:

Weekly via safeguarding meeting, (2) monthly via the incidents, complaints and safeguarding logs quality and (3) centre manager meetings and monthly staff meeting.

- The Quality Manager will review/audit all incidents and complaints on the day of occurrence or within a 3 day timeframe at a maximum.

- Daily handover records have been introduced. Daily handovers will be reviewed by SMT on a daily basis to ensure there are appropriate oversight arrangements in place to monitor safeguarding of residents.

8.3	Not Compliant

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

There is a robust and comprehensive risk management framework in place across all areas of the national standards. However, going forward the centre manager and staff are to strictly adhere to the company's incident management and safeguarding policies and procedures. All incidents and any safeguarding concerns are to be reported in line with the company's incident management and safeguarding policies and procedures. The company incident form is to be completed, reported and submitted to SMT in real time, and reported to the appropriate external bodies where it is deemed necessary and within the specified 3 day timeframe.

Prior to inspection, DLP training was scheduled for key staff in the centre. The staff completed the training as scheduled on the 25.2.26. Refresher training in Safeguarding, incidents, complaints and adhering to company's policies and procedures was completed with all staff in March 2026.

Additional measures now in place to ensure all incidents and safeguarding concerns are promptly identified, managed, notified and referred to relevant agencies include the following:

➢Personal Safeguarding meetings take place between the Quality Manager and he Centre manager weekly and fortnightly audits of centre records will be completed until SMT is assured all company's' policies and procedures are strictly adhered to.

➢The company incident form is to be completed, reported and submitted to SMT in real time, and reported to the appropriate external bodies where it is deemed necessary and within the specified 3 day timeframe.

The centre manager is to complete and submit monthly incident logs to SMT and Safeguarding and Child Protection tracking record systems to ensure there is sufficient SMT oversight and governance of the centre.

There is a trends audit and analysis of incidents and safeguarding incidents completed on an annual basis. Going forward, these records will be monitored as follows:

Weekly via safeguarding meeting, (2) monthly via the incidents, complaints and safeguarding logs quality and (3) centre manager meetings and monthly staff meeting

➢ The Quality Manager will review/audit all incidents on the day of occurrence or within a 3 day timeframe at a maximum.

➢Daily handover records have been introduced. Daily handovers will be reviewed by SMT on a daily basis to ensure there are appropriate oversight arrangements in place to monitor incidents and any safeguarding concerns to ensure the safeguarding of all residents.

10.4	Partially Compliant

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

The Reception Officer Manual Policy is a comprehensive policy with a detailed standard operating procedure to help support and guide them in their role. It clearly outlines the reporting structure and the Reception Officer's line manager as the center manager. Equally, it provides detailed guidance on their responsibilities and capacity within their role of reception officer. However, going forward the policy is to be strictly adhered to. For example, since the recent HIQA inspection a review and action plan addressed each member's capacity, responsibility and reporting arrangements In this respect, both the reception officer role and the community liaison officer role were clearly defined in conjunction with their job descriptions. Both roles are now clearly defined to ensure clarity and promote good communication across the staff team

The Reception officer hours have been increased significantly over a short period of time and the Reception Officer is allocated 3 full days a week in the center and has the support of the community liaison officer 3 days a week.

Finally, any resident can reach the reception officer four days a week. The reception officer is 3 full days in Bridgewater and has the option to work an additional fourth day if the need arises.

The center manager and staff are on duty 24/7 and are always there to support residents. There is an emergency helpline residents can contact anytime. Equally we have introduced vulnerability assessments to provide additional support to both the reception officer and (residents if they wish to engage in the process). However, we implement our existing SOP which risk assesses residents' vulnerabilities with associated interventions in (1) resident (special reception needs) risk assessment, (2) resident (special reception needs risk register), and (3) resident support plans.

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 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.	Not Compliant	Red	30/04/2026
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.	Not Compliant	Red	30/04/2026
Standard 1.4	The service provider monitors and reviews the	Partially Compliant	Orange	19/02/2026

	quality of care and experience of children and adults living in the centre and this is improved on an ongoing basis.			
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.	Partially Compliant	Orange	19/02/2026
Standard 3.1	The service provider will carry out a regular risk analysis of the service and develop a risk register.	Not Compliant	Red	30/04/2026
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	19/02/2026
Standard 4.5	The accommodation centre has adequate and accessible facilities, including dedicated child-friendly, play and recreation facilities.	Partially Compliant	Orange	19/02/2026
Standard 4.6	The service provider makes available, in the accommodation centre, adequate and dedicated facilities and materials to support	Partially Compliant	Orange	01/09/2026

	the educational development of each child and young person.			
Standard 4.7	The service provider commits to providing an environment which is clean and respects, and promotes the independence of residents in relation to laundry and cleaning.	Partially Compliant	Orange	30/04/2026
Standard 5.1	Food preparation and dining facilities meet the needs of residents, support family life and are appropriately equipped and maintained.	Not Compliant	Red	30/04/2026
Standard 6.1	The rights and diversity of each resident are respected, safeguarded and promoted.	Partially Compliant	Orange	31/03/2026
Standard 7.1	The service provider supports and facilitates residents to develop and maintain personal and family relationships.	Partially Compliant	Orange	31/03/2026
Standard 8.1	The service provider protects residents from abuse and neglect and promotes their safety and welfare.	Not Compliant	Red	30/04/2026
Standard 8.2	The service provider takes all reasonable steps to protect each child from abuse and neglect and children's safety	Not Compliant	Red	30/04/2026

	and welfare is promoted.			
Standard 8.3	The service provider manages and reviews adverse events and incidents in a timely manner and outcomes inform practice at all levels.	Not Compliant	Red	30/03/2026
Standard 10.4	The service provider makes available a dedicated Reception Officer, who is suitably trained to support all residents' especially those people with special reception needs both inside the accommodation centre and with outside agencies.	Partially Compliant	Orange	19/02/2026