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:	Johnston Marina
Centre ID:	OSV-0008438
Provider Name:	Onsite Facilities Limited
Location of Centre:	Co. Kerry
Type of Inspection:	Unannounced
Date of Inspection:	30/09/2024
Inspection ID:	MON-IPAS-1057

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

Johnston Marina is an accommodation centre located on the outskirts of the town of Tralee, Co. Kerry. The centre contains 34 bedrooms, all of which have their own bathroom facilities. At the time of the inspection, Johnston Marina accommodated 76 residents, of which 56 were adults and 20 were children. The centre accommodates families and single females.

The centre provides a fully catered service to residents, where meals are eaten within a communal dining room. In addition, there is a large reception area, a laundry room, a family play room, a multi-purpose room and a small gym area. The multi-purpose room is used as a study, recreation, storage and religious practice space. The centre also has an outdoor play area. The centre is close to local amenities including doctors, play grounds, schools, shops and the local transport system.

The building is owned by the State and the service is privately operated on a contractual basis by Onsite Facilities Management Ltd. The centre is managed by two centre managers who report to the managing director of the company. Both centre managers are directors of the company also. The centre has a team of general support staff including kitchen, laundry, cleaning and reception staff members.

The following information outlines some additional data on this centre:

Number of residents on the date of inspection:	76

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)
30/09/2024	09:50hrs – 20:00hrs	1	1

What residents told us and what inspectors observed

From speaking to residents and through observations made during the inspection, the inspectors found that residents were supported by the staff team to live independent lives. The majority of residents felt safe and happy living in the centre, but improvements were required to areas such as incident and risk management, auditing, resident consultation and safeguarding practices to ensure a consistently good quality service was being provided

This was an unannounced inspection which took place over the course of one day. During this time, the inspectors spoke with 13 adults and four children, and an additional six adults completed HIQA's resident questionnaire. The inspectors also spoke with the service provider, one of the centre managers, the reception officer and members of the general staff team.

Johnston Marina provided accommodation to families and single females with a maximum of three single adults per room. During a walk around the centre, the inspectors observed that the communal areas were clean and well maintained. There were information boards displayed in the reception area and in the multi-purpose room which had information regarding local services and activities. The staff were pleasant and interacted in a respectful manner with residents. There was a new playground available to children to the rear of the building, and picnic benches were also available for residents to relax in the outdoor area. Residents were able to move freely through the centre, and could access the multi-purpose rooms as required.

The inspectors observed several bedrooms, and found that those bedrooms provided to single female residents had ample space. However, the rooms provided to families did not facilitate the parents and children to have separate bedrooms or living space. Bedrooms were appropriately furnished though storage space for personal belongings was limited. While additional open shelving areas had been created in the small multipurpose room, the inspectors observed that this was primarily used to store car seats for children. Residents were also facilitated to store some of their personal belongings and larger items in the open area above the gym, where the service provider also stored beds, cots and mattresses belonging to the centre. The inspectors found that this area was cluttered and disorganised, which created a challenge for residents to be able to identify their own property.

The inspectors observed that dining hall and kitchen facilities were clean and bright. This was a fully catered service, and there was adequate seating for residents and there were appropriate high chairs available for children. While residents did not have access to cooking facilities, they were provided with basic food supplies and kitchen equipment

to prepare snacks for themselves and their family. These included bread, cereal, fruit, milk, tea and coffee. Residents also had access to a toaster, a microwave, a sandwich maker and a panini press. Communal refrigerators were available in the dining room so residents could store their own food and also meals that they had collected from the catered facilities. During the walk around the centre, families told the inspectors that if they were facilitated to have access to basic cooking facilities in their own rooms, it would have a positive impact on their lives. For example, one family shared that they would really like to have had a toaster in their room, rather than having to bring all of the children to the dining area if one of the family members needed something to eat.

Generally, residents who spoke with the inspectors or completed the questionnaire said they were happy with the food and meals provided in the centre. One resident told the inspectors that the "food is good", however another resident commented that residents "don't have a choice with the food". The inspectors observed that residents could ask to have meals held for them if they were not present in the centre, and this was facilitated by the staff members. However, the inspectors observed that meals including salad and meat dishes prepared by the kitchen staff had been left out on the tables in the dining area for residents for a prolonged period of time. This was brought to the attention of the centre manager and the service provider as it posed a potential food safety risk for residents.

The majority of residents who spoke with the inspectors or completed the questionnaires said that they felt safe living in the centre. One resident explained that "life is good and I feel safe living here". Residents felt respected and said they would speak to the reception desk staff or the two centre managers if they had any issues or concerns. However, a small number of residents told the inspectors that did not feel listened to. These residents said that they did not feel safe living in the centre due to other residents arguing and fighting. They were not aware of the complaints policy for the centre, or who they could speak to regarding their concerns. In addition, the majority of residents who spoke with the inspectors were not aware of who the reception officer was for the centre or the support that they could offer residents.

While the accommodation was generally well maintained, the inspectors observed that a window in a second floor bedroom had a broken hinge, while there had been a water leak in a second room that needed attention. These concerns were brought to the attention of the service provider during the inspection.

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

Capacity and capability

This inspection was carried out to assess compliance with the standards, and to monitor the provider's progress with the compliance plan submitted in response to the inspection MON_IPAS_1007 carried out in February 2024. The service provider demonstrated limited progress made in relation to completing the actions identified in the previous compliance plan. The inspection found that governance, incident and risk management and child protection systems were not as effective as they could be. Improvements in these systems were required to ensure the safety of residents and compliance with the national standards.

The service provider and management team had a limited knowledge of their responsibilities as outlined in the relevant legislation, regulations, national policies and standards. Of the 26 actions identified by the service provider, three had been fully completed, 16 were in progress while the remaining seven had not been fully addressed or progressed since the previous inspection. For example, the service provider had not provided training for the management and staff team to develop their understanding of the requirements of the national standards. There was no system in place for the service provider to review their level of compliance with the national standards, or to ensure that the services provided were consistently safe or effective.

The management and governance arrangements in place for the centre were not fully effective. The roles and responsibilities of the management team were not clearly defined. There were two named centre managers in place who had the same job description with no clear differentiation between their roles or areas of responsibility. Staff members were required to report issues to the service provider and the two named centre managers as they arose, which created confusion at times. There was a lack of clarity on who held the post of centre manager. Ultimately, this did not promote accountability for the operations of the centre on a day to day basis. While this was identified as a finding in the previous inspection, the service provider had not taken actions to address this.

Systems to ensure appropriate oversight and communication were not very effective. Staff meetings had commenced on a quarterly basis. The inspectors found that while issues such as menu choices and the supervision of children were discussed, topics including risk management, complaints and incidents had not been included as standing items on the agenda. In addition, while the inspectors were told that monthly managers meetings took place, there were no minutes held of these meetings. This

limited the service provider's ability to ensure that actions agreed were completed, and did not provide appropriate oversight of the service.

There were improvements evident in the system to hear and manage complaints made by residents. Verbal and written complaints were maintained on a log where the actions taken and the person responsible were recorded. While complaints were followed up in a timely manner, there was limited evidence of management oversight or input into the decisions made or follow up actions recorded on the complaints log. Similar to the previous inspection, there was little evidence that the outcome of the complaint was shared with the complainants, or whether they were satisfied with the outcome. Some residents who spoke with the inspectors were not aware of the complaints policy for the centre. This process required further development to ensure appropriate management oversight and communication with residents.

The service provider had not implemented effective systems to monitor and review the quality of care provided to residents living in the centre. Despite the service provider committing to completing internal audits covering all areas of operations since March 2024, these audits had not commenced. The inspectors found evidence that audits were completed in relation to accommodation and room checks, and that they were waiting to commence a new software package that would provide increased oversight of the service. As there was no timeframe for the implementation of this software package, interim arrangements were required to keep a check on the quality of the service.

Consultation with residents had improved in the centre. A resident's committee had been established and meetings took place in response to emerging issues as opposed to being part of routine practice in the centre. There was evidence that feedback from residents had led to improvements in the services provided at the centre. For example, additional food preparation equipment had been provided following feedback from residents. A suggestion box was provided for residents but this was located at the rear of the reception desk which meant that residents could not report anonymously. While improvements were evident, there was a need to take this a step further and regularise scheduled meetings with the residents which would encourage a culture of participation and involvement from the residents' perspective.

The inspectors found limited improvement in the area of risk management. The service provider had updated the risk register for the centre. However, the risk management system continued to be ineffective. Similar to the previous inspection, the actions identified by the service provider to mitigate against risk had not been consistently implemented, and it did not reflect all risks known to the centre managers. For example, risks relating to positive disclosures returned during the Garda vetting process, residents' health needs and risks relating to child protection

and welfare concerns had not been included. While the service provider had a detailed plan in place to ensure the continuity of the service in the event of a fire, similar procedures had not been developed to ensure the continuity of the service in the event of other unforeseen circumstances such as flooding, for example. Fire drills were being carried out in a timely manner, and fire safety training was completed by all staff, which was a positive finding.

The recruitment practices in the centre were not sufficiently safe or effective. During the previous inspection, there were deficits identified in relation to Garda Síochána (police) vetting, international police checks and staff files. Despite assurances having been provided that Garda vetting had been renewed where required, the inspectors found that Garda vetting was out of date for two staff members, one of whom was a named designated liaison person for the centre. A review of the staff rosters and personnel files found that three members of staff who had been rostered as working in the centre in the weeks prior to the inspection were awaiting their Garda vetting, and the international police checks required for all three were only available on one staff member's file. Records showed that Garda vetting application forms had been completed and disclosures were awaited for these three staff members. Garda vetting was available for external support staff who provided services to residents living in the centre.

Not all staff had engaged in a performance appraisal and staff were not appropriately supervised. The inspectors found that a performance appraisal system had been introduced. While the service provider had provided assurances that appraisals would be completed for each staff member by July 2024, the inspectors found that appraisals were not completed for three staff members at the time of the inspection. A supervision policy had been developed, but staff supervision had not commenced. There was an improvement in the documentation held on personnel files, which included specific job descriptions for specific roles. However, the service provider had not taken action to address the absence of references on file for long-term staff members.

There was no plan in place to ensure that staff had completed the mandatory training as set out in the national standards. The service provider had developed a training matrix and plan. This plan needed to be expanded as it did not include all core training identified in the national standards to ensure this training was updated for all staff. A review of these documents found that they provided limited oversight of the training needs for staff, and staff had not received the training they required to effectively carry out their roles.

A review of the residents' charter found that, despite this being identified as a deficit during the previous inspection, the charter did not contain the information required by

the national standards. The residents' charter was not available in different languages but where needed it could be translated into different languages.

Standard 1.1

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

The lack of a timely response to the findings of the previous inspection, and the absence of a system to review compliance with national policy and standards impacted the service provider's ability to be assured as to the quality and safety of the service provided to residents. There were mixed levels of compliance with the national standards identified throughout this inspection and some areas required urgent action to be taken by the provider to ensure a safe living environment was provided to residents.

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.

The management and governance arrangements in place for the centre were not effective. There was no clear differentiation between the roles or areas of responsibility for both centre managers, and at times, there was a lack of clarity on who held the post of centre manager.

While improvements had been made to the complaints process for the centre, there was limited management oversight or input into the decisions made or follow up actions recorded on the complaints log, including whether the outcome of the complaint was shared with the complainants, or if they were satisfied with the outcome. Some residents were not aware of the complaints policy for the centre.

The frequency of residents' committee meetings and the location of the suggestion box needed to be reviewed to ensure that a culture of participation and involvement was maintained at the centre.

Judgment: Partially Compliant

Standard 1.3

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

Despite this being identified as a deficit during the previous inspection, the residents' charter did not contain the information required by the national standards. The service provider said that the residents' charter could be translated into different languages if required.

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.

There was an absence of effective systems to monitor and review the quality of care provided to residents living in the centre. Internal audits in relation to the operation of the service had not commenced, and there were no arrangements in place to review the quality of the service, compliance with the national standards or to develop a quality improvement plan for the centre. Residents' feedback regarding areas of service provision had been considered by the service provider.

Risk management, complaints and incidents had not been included as standing items on the quarterly team meeting agenda. The absence of regular management meetings or minutes impacted the service provider's ability to ensure that actions agreed were completed, and limited their ability to have appropriate oversight of the service.

Judgment: Partially Compliant

Standard 2.1

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

The recruitment practices in the centre were not safe or effective. Garda vetting was out of date for two staff members, one of whom was a named designated liaison person for the centre. Three members of staff who had been rostered as working in the centre in the weeks prior to the inspection were awaiting their Garda vetting, and two of these staff did not have the international police checks required.

Judgment: Not Compliant

Standard 2.3

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

While a performance appraisal system had been introduced, appraisals were not available for three staff members at the time of the inspection. A supervision policy had been developed, however supervision meetings had not commenced for staff members. The service provider had not taken action to address the absence of references on file for long term staff members.

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.

Staff members had not completed the mandatory training as set out in the national standards, and there was no clear plan in pace to ensure these trainings were scheduled. The training matrix and training plan provided limited oversight of the training needs for staff.

Judgment: Partially Compliant

Standard 3.1

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

While an updated risk register was available for the centre, the risk management system was not effective. The actions identified to mitigate against risk had not been consistently implemented, and it did not reflect all risks known to the centre. Procedures

to ensure the continuity of the service in the event of unforeseen circumstances such as flooding, for example had not been developed.

Judgment: Partially Compliant

Quality and Safety

Residents living in this centre were provided with good quality accommodation. The staff team endeavoured to be person-centred in their approach, however, improvements were required to ensure the needs of residents' were appropriately assessed and relevant supports were in place. In addition, the child protection practices in the centre required improvement to ensure that all designated liaison officers had the relevant training, and that the staff members were aware of the procedures to follow should a child protection or welfare concern emerge.

The centre was found to be well maintained and in good condition. Residents were generally satisfied with their accommodation, and rooms were equipped with adequate furniture. The service provider said that they were in the process of purchasing new furniture for residents' accommodation which would provide some additional storage. During the inspection the inspectors observed a bedroom window with a broken hinge, and a water leak in another bedroom which were brought to the attention of the service provider. Monthly room checks were completed, and maintenance issues were addressed accordingly.

Where possible, accommodation in the centre was allocated based on the needs and best interests of residents. The service provider had developed an allocation policy that outlined the objectives of the room allocation process. The policy noted that the manger or reception officer may conduct an assessment to understand the specific needs of residents regarding room allocation, however, there was no evidence that these assessments had occurred. Requests to move room were recorded on the daily log and facilitated where possible. However, there was no evidence of management oversight of these requests. The room allocation policy would be enhanced by including the process whereby residents could request a change of room.

The privacy and dignity of families was impacted by the accommodation that was made available to them in the centre. Adjoining rooms were provided to families when they became available, though they were limited in number. Families living in the centre continued to be placed together, and all bedrooms had ensuite facilities. Due to the configuration of the building, parents and children were required to share the

same bedroom. Families did not have access to private living space. While there were two communal rooms available, the smaller of these rooms was also used for multiple purposes including the storage of strollers and car seats for children. They offered limited privacy to families, and both rooms were also monitored by closed-circuit television (CCTV). In addition, access to the smaller communal room was through the larger playroom, again limiting the privacy afforded to the families using the larger communal room.

Residents were not facilitated to independently complete their own laundry. There were laundry facilities available in the centre, however staff members were assigned to complete the laundry for each resident. Some residents who spoke with the inspectors said that they would have preferred to be able to complete their own laundry. At the time of the inspection, three of the tumble dryers available were not working. The senior management team told the inspectors that they were due to be repaired and replaced where necessary.

Following the previous inspection, the service provider was required to consult with residents regarding the laundry and transport facilities available in the centre. The inspectors found that there was no evidence that this consultation had taken place. In addition, a review of the non-food items provided to residents was required to ensure that practice in the centre was in line with the requirements of the national standards. For example, while some toiletries were being provided to residents free of charge, nappies were not being provided on an ongoing basis to residents who required them.

While there were sufficient security measures in place in the centre, all staff members including those who worked in the centre as security, had not been provided with the training relevant to managing conflict. This was important training for the staff team as records showed that there had been incidents of resident to resident aggression. While the security staff members had the necessary licences, only two of the 12 staff members had completed training in conflict resolution, and no staff had completed training in equality, diversity and cultural competency.

The centre provided a fully-catered service, and there were no facilities for residents to prepare or cook meals for themselves or their family in tandem with the catering option available. As this was a state-owned premises, the provision of cooking facilities for residents was out of the hands of the provider, but they had raised it at an appropriate level. The service provider had taken additional steps to provide basic cooking facilities for residents. Additional basic equipment had been made available to residents so they could prepare snacks and sandwiches outside of the scheduled meal times. A review of the menus available found that these had been amended since the previous inspection to ensure they operated on a 28 day cycle. The meal options

included a good selection of culturally appropriate foods. However, the dates recorded on the menus were inaccurate and required updating.

Residents and children were provided with access to activities organised by local services during school holiday periods. Following the previous inspection, the service provider was required to consider contingency planning for periods of high occupancy such as school holidays. The inspectors found that the service provider had worked with, and encouraged local organisations to arrange outings and activities for residents living in the centre over the summer months.

The service provider had developed an appropriate policy to guide staff in the management of adult safeguarding concerns. All staff had completed training in relation to safeguarding vulnerable adults. The general staff team endeavoured to manage incidents and concerns that arose between residents appropriately. For example, where alternative bedrooms were available these were offered to the resident's involved. The inspectors found that there was limited evidence of management oversight of these incidents. Some residents who spoke with the inspectors said they sometimes felt unsafe living in the centre due to the fighting and aggression between other residents. While incidents were reported appropriately and in line with national policy, the service provider had not reviewed the incidents which occurred in the centre to identify trends and implement appropriate supports and control measures to prevent the re-occurrence of such incidents.

Child protection and welfare practices in the centre were not fully effective. The service provider had a child protection policy and a child safeguarding statement in place. However, the inspectors found that one incident of a child welfare nature had not been reported to the Child and Family Agency (Tusla). Furthermore, steps were not taken by centre staff to ensure the immediate safety of the children involved. The service provider was issued with an urgent action for assurance that relevant referrals were made to Tusla, and to enhance the safeguarding arrangements in the centre. Practices in the centre were not in line with the requirements of the child protection policy in place, or *Children First: National Guidance for the Protection and Welfare of Children (2017)*. National policy in relation to childminding arrangements were not implemented in the centre. The Garda vetting and Children First 2017 training for one of the designated liaison person's was out of date. Practice in the centre indicated that the staff and management team had a limited understanding and awareness of their roles and responsibilities in protecting children from abuse and ensuring their safety and welfare was promoted.

There was no system in place to review adverse events and incidents, including those of an adult safeguarding or child protection nature. This limited the service provider's ability to maintain oversight, or to ensure that learnings from such incidents were

reviewed and shared across the staff team. There was no evidence that safeguarding related issues and concerns were reviewed or discussed at a management level. Records related to incidents such as aggression between residents were fractured. They were recorded in two separate sets of records, one maintained by security staff and the other by centre's day staff. Furthermore, where incidents reached the threshold for reporting to the DCEDIY in line with policy, at times these incidents were only recorded in incident reports and were not reflected elsewhere. This was a complex recording system which did not support managerial oversight or monitoring for trends and learning. In addition, the risk register for the centre noted that a root cause analysis would be completed following incidents and learning from incidents would be documented to be discussed at monthly managers meetings. The inspectors found that these actions had not been completed by the service provider.

There was a suitably qualified reception officer employed to provide support to residents in the centre, but the additional posts they held across other centres limited their availability to the residents and therefore their effectiveness. Following the previous inspection, the service provider committed to employing additional reception officers to provide appropriate cover to the centre, however, this action had not been completed. While inspectors understood that the current reception officer was available in the centre a minimum of two days per week, in practice, the reception officer was available in the centre one morning per week. The current arrangements in relation to the availability of the reception officer was not informed by any assessment of need.

Similar to the previous inspection of the centre, additional training had not been provided to the staff members to support them to identify and respond to the emerging or identified special reception needs of residents. While the reception officer had completed a specific training course relevant to the needs of residents, their limited availability in the centre and the lack of training provided to staff impacted their ability to adequately assess and address residents' needs. A review of centre records showed there was no written plans in place to guide staff on their interventions with residents with special reception needs. There was also an absence of staff wellbeing initiatives, or debrief support sessions following incidents.

The inspectors found that although there was a comprehensive policy in place regarding the assessment and management of special reception needs, this policy had not been implemented in practice. There was no written manual in place to guide the work of the reception officer. While a small number of residents had been identified as having special reception needs, there were limited records maintained of the supports or services provided. There was no system in place to ensure that the residents with special reception needs were regularly monitored in conjunction with the reception officer.

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 room allocation policy required review to ensure that practice was in line with the requirements of the policy in place. While requests to move or change rooms were managed in a timely manner, the system in place to record these requests or the decision making process needed to be reviewed.

Judgment: Substantially 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 families was impacted by the accommodation that was made available to them in the centre, as parents and children were required to share the same bedroom. The two communal rooms available in the centre offered limited privacy to families, and both rooms were also monitored by CCTV.

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.

Residents were not facilitated to independently complete their own laundry. At the time of the inspection, three of the tumble dryers available were not working. There was no evidence of consultation having taken place with residents to ensure that practice in the centre addressed the needs of the residents.

Judgment: Partially Compliant

Standard 4.8

The service provider has in place security measures which are sufficient, proportionate and appropriate. The measures ensure the right to privacy and dignity of residents is protected.

Residents did not have access to rooms without CCTV where they could meet with visitors, support services or the reception officer for the centre. Security and general staff members had not been provided with the training relevant to their roles, including cultural sensitivity, equality and diversity training. There was limited evidence of management oversight, risk assessments or actions identified to mitigate against incidents of physical aggression and fighting taking place between residents.

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.

A review of the non-food items provided to residents, including nappies was required to ensure that practice in the centre was in line with the requirements of the national standards.

Judgment: Substantially Compliant

Standard 5.1

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

There were no facilities for residents to prepare or cook meals for themselves or their family in tandem with the catering option available. As this was a State owned premises, the service provider had escalated this issue appropriately. Communal food storage facilities were available to residents. The procedure for storing meals for residents who were not present in the centre at meal times required review to ensure risks relating to food safety were identified and addressed.

Judgment: Substantially 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.
Menus available in the centre had been updated to operate on a 28 day cycle, though the dates recorded on the menus were inaccurate. Residents had access to a large, welcoming dining area. Drinking water was freely available.
Judgment: Substantially Compliant
Standard 7.1 The service provider supports and facilitates residents to develop and maintain personal and family relationships.
Residents had access to activities organised by local services, and visitors were welcomed to the communal areas of the centre.
Judgment: Compliant
Standard 7.2 The service provider ensures that public services, healthcare, education, community supports and leisure activities are accessible to residents, including children and young people, and where necessary through the provision of a dedicated and adequate transport.
While the centre was located on the outskirts of the town, consultation with residents regarding transport facilities available in the centre had not taken place.
Judgment: Substantially Compliant
Standard 8.1 The service provider protects residents from abuse and neglect and promotes their safety and welfare.
There was appropriate policy to guide staff in the management of adult safeguarding concerns. All staff had completed training in relation to safeguarding vulnerable adults. Some residents said they felt unsafe living in the centre due to the fighting and

aggression between other residents. While incidents were reported appropriately, these incidents had not been risk assessed or reviewed to identify trends and implement appropriate supports and control measures, where necessary.

There was limited storage available for the residents' personal belongings.

Judgment: Partially 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.

Child protection and welfare practices in the centre were not effective. While a child protection policy and a child safeguarding statement were available, not all incidents of a child protection nature had been reported to Tusla. Practices in the centre were not in line with the requirements of the child protection policy in place, or *Children First: National Guidance for the Protection and Welfare of Children (2017)*. The service provider was not aware of the need to implement a system to ensure they were aware of child minding arrangements between residents. The Garda vetting and Children First 2017 training for one of the designated liaison person's was out of date. The staff and management team had a limited understanding and awareness of their roles and responsibilities in protecting children from abuse and ensuring their safety and welfare was promoted.

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.

There was no system in place to review adverse events and incidents, including those of an adult safeguarding or child protection nature. Learnings from such incidents had not been identified or shared across the staff team. The system to record and maintain appropriate management oversight of incidents and adverse events in the centre was not effective. The actions identified in the risk register for the centre regarding the review and management of incidents and adverse events had not been completed by the service provider.

Judgment: Not Compliant

Standard 10.2 All staff are enabled to identify and respond to emerging and identified needs for residents.
Additional training had not been provided to the staff members to support them to identify and respond to the emerging or identified special reception needs of residents. There was no system in place to ensure that best practices were shared or communicated across the staff team. There was an absence of staff wellbeing initiatives, or debrief support sessions following incidents.
Judgment: Not Compliant
Standard 10.3 The service provider has an established policy to identify, communicate and address existing and emerging special reception needs.
While there was a comprehensive policy in place regarding the assessment and management of special reception needs, this policy had not been implemented in practice. There were limited records maintained regarding residents with special reception needs, and there no system in place to ensure that the residents with special reception needs were regularly monitored in conjunction with the reception officer.
Judgment: Partially 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 current arrangements in relation to the availability of the reception officer was not informed by any assessment of need. A manual to guide the work of the reception officer had not been developed.
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	Partially Compliant
Standard 1.3	Partially Compliant
Standard 1.4	Partially Compliant
Theme 2: Responsive Workforce	
Standard 2.1	Not Compliant
Standard 2.3	Partially Compliant
Standard 2.4	Partially Compliant
Theme 3: Contingency Planning and Emergency Preparedness	
Standard 3.1	Partially Compliant
Dimension: Quality and Safety	
Theme 4: Accommodation	
Standard 4.1	Substantially Compliant
Standard 4.4	Partially Compliant
Standard 4.7	Partially Compliant
Standard 4.8	Partially Compliant
Standard 4.9	Substantially Compliant

Theme 5: Food, Catering and Cooking Facilities	
Standard 5.1	Substantially Compliant
Standard 5.2	Substantially Compliant
Theme 7: Individual, Family and Community Life	
Standard 7.1	Compliant
Standard 7.2	Substantially Compliant
Theme 8: Safeguarding and Protection	
Standard 8.1	Partially Compliant
Standard 8.2	Not Compliant
Standard 8.3	Not Compliant
Theme 10: Identification, Assessment and Response to Special Needs	
Standard 10.2	Not Compliant
Standard 10.3	Partially Compliant
Standard 10.4	Partially Compliant

Compliance Plan for Johnston Marina

Inspection ID: MON-IPAS-1057

Date of inspection: 30 September 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	Not Compliant
Outline how you are going to come into compliance with this standard: Specific: We have established a structured compliance review system that aligns with national policies and standards, focusing on areas identified as non-compliant during the recent inspection. Measurable: Our goal is to achieve full compliance with national standards in all identified areas within the next twelve months. We will track and document improvements monthly to measure progress. Achievable & Realistic: We have assigned a dedicated team to address urgent issues immediately and develop a timeline for implementing corrective actions for all identified areas. Time-Bound: All urgent actions have been completed and we aim to have full compliance within twelve months, with regular progress reviews and adjustments as necessary.	
1.2	Partially Compliant
Outline how you are going to come into compliance with this standard: Specific: We have implemented a clear governance structure that distinctly defines the roles and responsibilities of each center manager to ensure consistent leadership and	

accountability. We will also revise the complaints management process to ensure that all decisions, follow-up actions, and outcomes are reviewed by management, communicated to complainants, and tracked for satisfaction.

Measurable: By the end of the next quarter, we aim to have documented role descriptions and established a formal complaints oversight process. All complaints will be reviewed within five working days, and feedback will be provided to each complainant.

Achievable & Realistic: We will accomplish this by assigning a project lead to oversee the role differentiation process and by training all management staff on the updated complaints policy. Additionally, we will ensure that residents are informed of the complaints policy through printed and verbal reminders.

Time-Bound: The new role definitions and complaints process will be in place within three months. We will also review and adjust the frequency of residents' committee meetings and move the suggestion box to a more accessible location within the next month to foster greater resident involvement.

1.3	Partially Compliant

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

Specific: We have updated the residents' charter to ensure it meets all requirements set out by the national standards. This has included revising the charter to include any missing information and ensuring translations are available in relevant languages as needed.

Measurable: Our target is to have a fully compliant residents' charter, aligned with national standards. Translations in the primary languages of our residents are now available at reception.

Achievable & Realistic: A team has reviewed the current charter, identified missing information, and made necessary revisions.

Time-Bound: The updated charter has been completed. There will be periodic reviews to ensure continued relevance and accessibility.

1.4	Partially Compliant

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

Specific: We will implement a structured quality assurance system that includes monthly internal audits, quarterly reviews of service quality, and compliance with national standards. A quality improvement plan (QIP) will be developed and updated regularly, and resident feedback will be incorporated into improvement actions.

Measurable: Our goal is to complete the first internal audit within 30 days, with ongoing monthly audits and a quarterly QIP review. All management meetings will document actions taken, with a 100% follow-through on agreed actions.

Achievable & Realistic: We will designate a quality coordinator to oversee internal audits and QIP development, while all managers will be trained on quality assurance practices. Agendas for team meetings will now include risk management, complaints, and incidents as standard items.

Time-Bound: The first audit will be conducted within one month, and quarterly quality reviews and team meetings (with standardised agendas) will begin immediately. The QIP will be completed and in effect within two months, with updates provided quarterly.

2.1	Not Compliant

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

Specific: We will implement strict recruitment protocols to ensure that all staff have up-to-date Garda vetting and international police checks (where applicable) before starting work in the center. This includes reviewing all current staff files to confirm compliance with vetting requirements

Measurable: We have completed a vetting compliance review for all staff, ensuring that 100% of staff have completed Garda vetting and, if necessary, international police checks.

Achievable & Realistic: We have assigned a dedicated HR/Training coordinator to oversee this compliance check and have established a tracking system to ensure that vetting is current and required documents are collected for all new hires before they begin work.

Time-Bound: The vetting compliance review for all current staff has been completed.

2.3	Partially Compliant

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

Specific: We will ensure that all staff have completed performance appraisals and that supervision meetings are conducted regularly. We will also review all employee files to confirm that references are on file, including for long-term staff.

Measurable: Our target is to complete the missing appraisals and initiate supervision meetings for all staff members within the next 30 days. Additionally, 100% of long-term staff files will be reviewed, and any missing references will be obtained within 45 days.

Achievable & Realistic: We will assign a designated supervisor to complete outstanding appraisals and initiate regular supervision meetings for all staff members.

Time-Bound: All outstanding appraisals and the first round of supervision meetings will be completed within 30 days. The review of staff files for missing references will be completed within 45 days, with any necessary references obtained promptly.

2.4	Partially Compliant

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

Specific: We will establish a comprehensive training plan to ensure all staff complete mandatory training as required by national standards. This includes updating the training matrix to provide clear oversight of training needs, due dates, and completed courses for each staff member.

Measurable: Our goal is to achieve 100% compliance with mandatory training within the next six months. We will track monthly progress, ensuring that at least 33% of required trainings are completed by staff each month.

Achievable & Realistic: We will designate a training coordinator to oversee the scheduling and tracking of mandatory courses, and partner with a training provider to ensure all courses are available. Additionally, staff members will be notified of required trainings in advance to facilitate timely completion.

Time-Bound: We will have the updated training matrix and full training schedule in place within two weeks. The target is for all staff to be fully compliant with mandatory training within six months, with monthly reviews to monitor progress.

3.1	Partially Compliant

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

Specific: We will revise the risk management system to ensure that all known risks are accurately recorded in the risk register and that mitigation actions are implemented consistently. Additionally, we will develop and document emergency procedures to ensure continuity of service during unforeseen events, such as flooding.

Measurable: Our target is to update the risk register with comprehensive risk entries and mitigation actions for all known risks within the next 90 days. We will conduct monthly audits to ensure that 100% of mitigation actions are actively implemented.

Achievable & Realistic: A risk management team will be assigned to review and update the risk register and to develop emergency procedures.

Time-Bound: The risk register updates and new emergency procedures will be completed within 90 days. Monthly audits to confirm compliance with risk mitigation actions will begin immediately, ensuring that the system remains effective going forward.

4.4	Partially Compliant

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

Specific: We will implement measures to improve the privacy and dignity of families staying in the center. This will include revising communal room arrangements to enhance privacy. Additionally, we will review the CCTV placement in communal areas to ensure privacy standards are met.

Measurable: Our goal is to create a more private and respectful accommodation environment within the next six months.

Achievable & Realistic: We will work with a facilities team to assess feasible options for communal room modifications. Feedback from residents will be gathered to ensure changes meet their needs.

Time-Bound: Privacy improvements, including communal room adjustments, will be completed within six months, with a review of resident feedback afterward to assess the effectiveness of these changes.

4.7	Partially Compliant

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

Specific: All dryers are now repaired. We will also engage in consultation with residents to ensure that laundry facilities and practices meet their needs.

Measurable: We will conduct a survey or hold a meeting with residents within the next 30 days to gather their input on laundry facilities and practices.

Achievable & Realistic: A team will be responsible for organising the consultation with residents and implementing any needed changes based on their feedback.

Time-Bound: The consultation with residents will be completed within 30 days. Any necessary changes to laundry practices will be implemented immediately following the consultation.

4.8	Partially Compliant

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

Specific: We will provide residents with access to private, CCTV-free spaces for meetings with visitors, support services, and the reception officer. We will also ensure that all security and general staff receive training on cultural sensitivity, equality, and diversity, and we will implement robust risk assessments to address incidents of physical aggression among residents.

Measurable: Our goal is to establish at least one private, CCTV-free meeting room within the next six. All security and general staff will complete the required training within the next two months, and risk assessments for physical aggression will be conducted and updated monthly.

Achievable & Realistic: A team will be designated to oversee the creation of private spaces for residents, and the training coordinator will ensure all staff are scheduled for relevant training sessions. A risk management team will be responsible for conducting and reviewing risk assessments for incidents of aggression.

Time-Bound: The private meeting room will be established within 30 days, with ongoing training for security and general staff to be completed within two months. Risk assessments will be conducted monthly, with appropriate mitigation actions identified and implemented within 30 days of each assessment.

8.1	Partially Compliant

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

Specific: We will review and enhance the current risk assessment processes for incidents of aggression and fighting between residents to identify trends, implement control measures, and provide necessary support. We will also address the limited storage space for residents' personal belongings by evaluating options for additional storage solutions.

Measurable: Our goal is to complete risk assessments and trend reviews for all reported incidents of aggression within 60 days. Additionally, we will increase the storage capacity for residents' personal belongings by providing additional storage units.

Achievable & Realistic: A team will be designated to review and assess incidents of aggression, with clear action plans to mitigate future occurrences. The facilities team will explore options for increasing storage space, such as additional cabinets or storage rooms, to ensure all residents have sufficient space for their belongings.

Time-Bound: Risk assessments for all incidents of aggression will be completed within 60 days, and new storage solutions will be implemented within six months, with ongoing reviews to assess the effectiveness of the changes.

8.2	Not Compliant

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

Specific: We have implemented a clear and effective child protection system that aligns with the Child Protection Policy and Children First: National Guidance for the Protection and Welfare of Children (2017). This includes ensuring that all incidents of a child protection nature are reported to Tusla, updated Garda vetting and Children First training for all relevant staff, and a system to track child minding arrangements between residents has been implemented in conjunction with the residents

Measurable: Our goal is to ensure 100% compliance with child protection reporting requirements, including the immediate reporting of all child protection incidents to Tusla. All designated liaison persons have now updated Garda vetting and Children First training, and a system for tracking child minding arrangements has been implemented

Achievable & Realistic: The training coordinator will ensure all relevant staff and management complete their training, and an audit will be conducted to ensure all child minding arrangements are appropriately tracked.

Time-Bound: All required training and Garda vetting updates have been completed .The child minding tracking system has been implemented, and ongoing monitoring will be conducted to ensure all child protection practices are consistently followed

8.3	Not Compliant

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

Specific: We have implemented a system to review and analyse all adverse events and incidents, including those related to adult safeguarding and child protection. This system will ensure that learnings are identified, shared across the staff team, and incorporated into practice. Additionally, we will improve the management oversight of incidents by updating the risk register and ensuring that identified actions are completed.

Measurable: Our target is to establish a formal incident review system within 30 days and ensure that 100% of adverse events are reviewed and analysed within 48 hours of occurrence. We will also ensure that 100% of actions identified in the risk register are completed within the next 60 days.

Achievable & Realistic: A designated incident review team will be created to oversee the analysis and sharing of learnings from adverse events. The risk management team will be tasked with ensuring all actions from the risk register are tracked and completed. Staff will receive training on the new review system.

Time-Bound: The incident review system will be in place within 60 days, with all adverse events reviewed within 48 hours. The risk register actions will be completed within 60 days, with ongoing quarterly reviews to ensure the system's effectiveness.

10.2	Not Compliant

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

Specific: We will provide targeted training for staff to help them identify and respond to the emerging and identified special needs of residents. We will establish a system

for sharing best practices among staff, including regular debrief sessions after incidents to support staff health and resilience.

Measurable: Staff will complete additional training on resident needs within 30 days. Monthly team meetings will include a dedicated session to share best practices, and at least one debrief session will be scheduled within 24 hours following each significant incident.

Achievable & Realistic: We will work with training providers to offer relevant courses for staff. A team member will facilitate monthly best practice sessions, and a training coordinator will organise debrief sessions.

Time-Bound: The additional training will be completed within 90 days, with monthly best practices sessions starting immediately. Debrief sessions will be offered after each incident to ensure timely support for staff.

10.3	Partially Compliant

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

This compliance plan response from the provider did not adequately assure the Health Information and Quality Authority that the actions will result in compliance with the standards

10.4	Partially Compliant

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

This compliance plan response from the provider did not adequately assure the Health Information and Quality Authority that the actions will result in compliance with the standards

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.	Not Compliant	Red	29/11/2024
Standard 1.2	The service provider has effective leadership, governance arrangements and management arrangements in place and staff are clearly accountable for areas within the service.	Partially Compliant	Orange	30/03/2025
Standard 1.3	There is a residents' charter which accurately and	Partially Compliant	Orange	01/11/2024

	clearly describes the services available to children and adults living in the centre, including how and where the services are provided.			
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.	Partially Compliant	Orange	31/01/2024
Standard 2.1	There are safe and effective recruitment practices in place for staff and management.	Not Compliant	Red	29/11/2024
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	23/12/2024
Standard 2.4	Continuous training is provided to staff to improve the service provided for all children and adults living in the centre.	Partially Compliant	Orange	08/05/2025
Standard 3.1	The service provider will carry out a regular risk analysis of the service and develop a risk register.	Partially Compliant	Orange	07/03/2025
Standard 4.4	The privacy and dignity of family units is protected and promoted in	Partially Compliant	Orange	09/05/2025

	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.			
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	04/12/2024
Standard 4.8	The service provider has in place security measures which are sufficient, proportionate and appropriate. The measures ensure the right to privacy and dignity of residents is protected.	Partially Compliant	Orange	04/12/2024
Standard 8.1	The service provider protects residents from abuse and neglect and promotes their safety and welfare.	Partially Compliant	Orange	07/02/2025
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.	Not Compliant	Red	29/11/2024

Standard 8.3	The service provider manages and reviews adverse events and incidents in a timely manner and outcomes inform practice at all levels.	Not Compliant	Red	29/11/2024
Standard 10.2	All staff are enabled to identify and respond to emerging and identified needs for residents.	Not Compliant	Red	29/11/2024
Standard 10.3	The service provider has an established policy to identify, communicate and address existing and emerging special reception needs.	Partially Compliant	Orange	08/05/2025
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	08/05/2025