An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 100

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Ashdale Care Ireland Ltd**
Registered Capacity:	**Three**
Type of Inspection:	**Announced**
Date of inspection:	**5th & 6th November 2020**
Registration Status:	**Registered from 31st January 2021 to 31st January 2024**
Inspection Team:	**Lisa Tobin** **Eileen Woods**
Date Report Issued:	**27th January 2021**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 31st January 2006. At the time of this inspection the centre was in its fifth registration and was in year three of the cycle. The centre was registered without attached conditions from 31st January 2018 to 31st January 2021.

The centre was registered to provide care for three young people of both genders from age eleven to seventeen years on admission. The current age range needs to be altered before reregistration in order to be in line with the other centres within the organisation. The centres stated purpose was to provide high levels of support to young people on a medium to long term basis. The model of care was described as attachment and trauma based with the inclusion of psychology, art psychotherapy, education and an accredited experiential learning provision. It also included the recently implemented CARE framework (children and residential experiences, creating conditions for change).
There were three children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4
6: Responsive Workforce	6.1, 6.2, 6.3, 6.4

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager on the 10th of December 2020 and to the relevant social work departments on the 10th of December 2020. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 6th of January 2021. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 100 without attached conditions from the 31st of January 2021 to the 31st of January 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulations 5 Care Practices and Operational Policies
Regulation 6 (1 and 2) Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.1 The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

The registered proprietor through their director of care and quality, regional management team and therapeutic team had a structure in place dedicated to ensuring good service delivery for children and young people which was in compliance with the requirements of relevant legislation, regulations and National Standards for Children's Residential Centres, 2018 (HIQA). There was a clear management structure in place which was known by the team. The multidisciplinary approach from management, staff and therapeutic teams, along with the model of care enabled the service delivery of effective care to the young people with complex needs.

The director of care and quality met with inspectors and was aware of gaps in the policy. The policy for mandated and non-mandated people needs to be updated to reflect both roles as both are relevant to the organisation. The restrictive practice policy requires review in order to take on board the learning established through the strategy meetings, in particular with reference to non-routine interventions and how the organisation responds to them. Gaps in mandatory training for staff was also identified by the inspectors. Most items identified by inspectors was known by the director through their own audits and review in line with the relevant legislation, national policies and the National Standards for Children's Residential Centres,2018 (HIQA).

Staff at the centre, through their questionnaires, interviews and interaction with inspectors demonstrated that their induction, training and team support learning had given them a comprehensive understanding of the relevant policies and regulations.

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-cantered, safe and effective care and support.

The current manager was on maternity leave and there was an acting manager covering the role. The centre had an experienced acting manager who had been in charge of the centre since October 2019. The acting manager was assisted by a deputy manager. Both were suitably qualified for their role. The staff through interviews and questionnaires highlighted the support they received from the management team. Inspectors found that the acting manager had continued with the positive work ethic in the centre. Social work feedback also gave examples of good leadership and management in the organisation. Both the acting manager and deputy showed leadership through their interaction with the staff team and young people, decision making skills, provision of supervision, reflective team meetings, facilitation of training, and oversight of all written work at the centre. The young people gave positive feedback in their questionnaires about their experience of care and about the availability of staff to support them.

There was evidence of the oversight of all personnel from director level to social care worker across the centre records and across the manager's weekly operational records to the regional manager. There was knowledge of the internal and external management posts that exist within the organisation. There were job descriptions in place for all staff and they had been provided with an organisational map. There were clearly defined governance arrangements and structures which outlined the authority and accountability for the centre.

The registered proprietor had a contract in place with the funding body Tusla, The Child and Family Agency. The company did have an agreement with a health authority in Northern Ireland to facilitate the placement of a young person.

The director of care and quality and the registered proprietor were in on-going communication with the funding body Tusla and provided information relevant to staffing, governance and care practices.

The current person in charge was the acting centre manager and inspectors found that there was a clear understanding of the role and responsibilities which was evident in their daily work.

The centre had relevant policies and procedures which had been reviewed in August 2020. Inspectors found that the governance management meetings discussed policy development and inspectors recommend that managers should have input on the changes to policy within the organisation. There was no review date or version present on the current policies and procedures.

There was a risk management framework and set of procedures in place. There were supporting documents such as risk management plans and individual crisis management plans. These along with the individual development plans, group impact risk assessment and the absence management plans were regularly reviewed in collaboration with the multidisciplinary therapeutic team. Through the review of questionnaires and interviews, staff highlighted the number of new staff in the centre and working with complex behaviours and how it was an ongoing challenge. This risk should be identified in the centre risk register. There were on-call rosters in place and a system where advice and guidance was available for staff. The staff on duty undertook daily risk assessments if required and referred to their existing risk management plans as appropriate to the situation. The organisational risk register was in place and the organisation were currently establishing centre risk registers, as it was highlighted in a previous inspection within the organisation.

The deputy manager currently acts up if the acting manager is not present in the unit. There was evidence of a strong working relationship and understanding of the needs of the young people that could be overseen by the deputy in the manager's absence. The delegation of tasks was noted in supervision records both formal and informal from management to staff.

The response to the current Covid-19 pandemic was discussed and all guidelines from the HSE are being adhered to regarding sanitising stations, personal protective equipment and general cleaning of the house. There was an organisational contingency plan in place and an individual house contingency plan which outlines the requirements of staff, supplies and personal protective equipment in the case of an outbreak.

Standard 5.3 The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.

The statement of purpose and function identified this centre as providing a service for up to three children and young people. It was updated in October 2020 and clearly described the model of service delivered by the company through its central

hub. The centre has introduced the CARE model to the service which is mentioned in the updated statement of purpose and function. The aims, objectives and range of multidisciplinary therapeutic, educational, outdoor and clinical services it offered were well described. The statement did not list the management and staffing numbers for the centre however it did outline the senior team organisational structure of the company. There was no review date attached to this document.

Through interview and questionnaires staff showed knowledge of the CARE model but nine out of thirteen require training on this which had been delayed due to Covid-19 restrictions. The statement of purpose and function was available to staff in the office. Social workers were aware of the statement of purpose and function. The young person's booklet and family booklet identified the information relevant to the statement of purpose and function.

Evaluation of the statement of purpose and function will be included in the annual review of compliance once initiated by the director of care and quality.

Standard 5.4 The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.

The continuity of care shown by both the acting manager and deputy was evident to the inspectors throughout the inspection process. The acting manager and deputy ensured all relevant documentation was in place to guide the team in ensuring the safety and quality of the care of the young people, through reviewing the placement plans, individual crisis management plans and any other relevant documents. They ensure that staff received the required training to enhance their professional abilities to cater for the young people's needs.

The company have added to the quality, safety and continuity of care by reviewing what improvements were needed within the organisation. These reviews occur at team meetings, operational meetings, governance meetings and senior organisational meetings, which was evidenced in their minutes furnished to the inspectors. The actions identified were then brought forward to the relevant people whether that was the training co-ordinator, staff or the therapeutic team. The level of training undertaken by the team on a regular basis shows the oversight of the organisation in providing what is relevant to the staff team in order to be able to enhance the care provided and achieve better outcomes. The organisation have participated in

strategy meetings and significant event review group meetings in order to identify risk promptly and respond adequately to the need of the young people and staff.

There has been a delay with the auditing of centres due to the Covid-19 pandemic restrictions. There were no recent files shown to inspectors of previous audits carried out by a quality assurance compliance officer. Inspectors were shown documentation from a file audit that had occurred in November 2019 for each young person that was residing there at that time. There were internal audits carried out by the acting manager and were discussed with the regional manager during operational reports and supervision which were relayed back to the management meetings and governance management meetings. Governance management meetings were held monthly with the director of care and service, human resources staff, regional managers, training coordinator and members from the therapeutic team. Their meetings included discussions about their role within the service and how to adapt as required, the updating of risk registers, any "red flags" within the organisation and many more topics. The minutes were detailed and the discussions covered a multitude of governance tasks and assigned actions to relevant people.

Inspectors reviewed records including significant events and child protection reports. While it was clear that there was a focus on quality, accuracy and learning, inspectors found that a review was needed in order to address how to accurately record the details in these reports. The child protection reports contained confidential details which should not be written in the significant event. The child protection report should be referenced to in the significant event report with a reference number. The current systems didn't allow for this information to be picked up when reviewing the significant events. This content would need to be looked at moving forward when being reviewed by management.

Other outcomes and learning were evident relating to complaints, concerns and incidents. Complaints were investigated in house or referred to the social work department if required. The complaints were closed after the investigations had come to a conclusion. The young people were supported by staff in writing up the complaints. Incidents were reviewed at team meetings or strategy meetings if required and actions would be made to the team or therapeutic team. Training would be provided promptly to the team through the therapeutic services within the organisation. If external support was required, this was also sourced.

In reviewing strategy meeting minutes and significant event review group meeting minutes, it was evident that there were discussions around managing behaviours of

the young people which resulted in physical interventions being required to ensure everyone's safety. Feedback was given to the team through team meetings, handovers and supervision. Inspectors found that in the area of physical intervention and non-routine physical interventions, for one young person there had been eleven in the previous year. Therapeutic crisis intervention guidelines should be followed in only carrying out approved interventions that staff are trained in. Best practice regarding safe physical interventions should be undertaken as guided by the trainers, therapeutic teams and the young person's individual crisis management plan. There was evidence of guidance from management to staff around safe practices and ensuring support was available to the staff team. A training piece of work must take place with the team to enhance their skills around the recording of significant events and child protection reports, while incorporating the safeguarding policies and procedures. To further enhance this, inspectors feel there must be a robust review of the use of non-routine physical interventions. Some staff stated they had not written up significant events or child protection notifications. With this training in place for the team it would help with the ongoing monitoring and tracking of reports ensuring they are all aware of what is required.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.1** **Regulation 6.2**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 5.2** **Standard 5.3**
Practices met the required standard in some respects only	**Standard 5.1** **Standard 5.4**
Practices did not meet the required standard	**None identified**

Actions required

- The director of care and quality and the registered provider must update relevant policies and procedures regarding mandated and non-mandated people. A review date and version number details are to be added to this document.
- The centre manager and director of care and quality must review the recording and documenting of significant events and child protection reports

must be looked at by the organisation, including an internal training with the team regarding this and linking the safeguarding policies and procedures.

- The centre manager and the director of care and quality must review the restrictive practices policy to ensure only trained and approved interventions are used.
- The director of care and quality and the centre manager must create a centre risk register.

Regulations 6 Person in Charge
Regulation 7 Staffing

Theme 6: Responsive Workforce

Standard 6.1 The registered provider plans, organises and manages the workforce to deliver child-centred, safe and effective care and support.

Inspectors found that workforce planning was undertaken at both an organisational level and within the centre. Inspectors were shown a workforce planning document which took into account the numbers of new staff, staff leaving, maternity leave, study leave, annual leave, gaps and trends and any qualification issues arising.

There were the required number of staff in the centre, an acting manager, deputy manager and senior practitioner in training, six full time staff, three part-time staff. Inspectors found that there were sufficient numbers of social care qualified roles working in the centre. One staff was newly recruited and currently studying so therefore unqualified. There was a bank of staff assigned to the house. The relief staff are available to cover any leave required, however a number of them require training as their mandatory training in first aid and fire safety had lapsed over the Covid-19 period. The organisation created a role of houseparent to assist with day to day operations in the centre but was not directly involved in the care of young people. This person reported to the centre manager. The management stated that this role was really beneficial in the centre and that it gave social care workers time away from some daily tasks which allowed them to concentrate on their work with young people.

A total of ten staff have left since the last inspection for a variety of reasons, including relocating to employment closer to their home, going travelling, returning to education and due to stress related to the job. In response to this the organisation has looked at ways of ensuring staff retention. The induction process has been made more robust. Employee assistance programme was available internally through the

therapeutic team and externally through a private company. Senior management have looked at salary scales to ensure they are competitive. Since the beginning of the Covid 19 pandemic the organisation has been sending out health and wellbeing packages/hampers to all the houses and also sent gifts for staff in order to show their appreciation.

The organisation had kept its focus on maintaining relationship based work with children to enhance staff's experience of the service. Within the centre, management have been supportive to all the staff, in particular to the newer staff members providing guidance, regular supervision, in depth handovers, daily plans and training when required. Management need to continue to have more experienced staff paired with newer staff on their rota, in order to help staff's professional learning and development. Staff spoke positively of how they are supported within their working environment by the management.

When staffing issues were identified, they would be sent in operational reports to the regional manager and members of the senior management team including the human resource manager. There was a structured recruitment and induction process in place in line with the organisations policies.

There was a formal on-call procedure in place for both weekdays and weekends in line with the on-call and guidelines policy. There was set documentation completed to give information to the person that was on call.

Standard 6.2 The registered provider recruits people with required competencies to manage and deliver child – centred, safe and effective care and support.

There was a recruitment and selection policy in place that identified the steps involved in gaining employment within the organisation in line with Irish and European legislation. A sample of staff files were viewed by the inspectors of staff that were not reviewed in prior inspections. Three references were present for those reviewed both written and verbally checked in line with policy. There was a school reference for one staff member which would not be acceptable and inspectors recommended that a college reference would be required. The human resources manager agreed to follow up on this. Personnel files were securely maintained by the human resources manager and were made available for review by relevant persons upon request. Garda vetting and police vetting for other jurisdictions were all recorded on file aside from one file. Inspectors discussed this with the human

resources manager and they outlined that the relevant federal agency involved would not release vetting documents unless the individual was in the country. Human resources are linking in with a local state police department in the relevant country in an attempt to resolve the issue.

There was a written code of conduct in place and staff stated they were made aware of it during their induction. Staff were able to discuss aspects of the policy when asked during interviews.

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

There was strong evidence to show that a child-centred, safe and effective care response was in place. Staff appraisals were currently not taking place due to a review of the current format. This will commence once rectified. They had taken place in the past on an annual basis. Staff were aware of their roles and responsibilities which was shown through interviews and questionnaires. Staff also demonstrated their awareness of policies and procedures relevant to their roles. Staff expressed the support they received in their work was effective, in particular during de-briefs and in general on a day to day basis. Inspectors viewed daily logs, young people's records and other documentation which showed staffs own professional judgement and accountability. There was also oversight from management within this documentation which helped in supporting the staff with their professional progression.

Policies and procedures were in place to protect and minimise the risk to staffs' safety which were outlined in the risk management framework. Training was provided at induction on the therapeutic interventions used relating to the behaviour management of the young people. On call support, risk assessments, individual behaviour management plans and support from the therapeutic team were all utilised by the staff in order to minimise risk.

Reflective practice was used during supervision, handovers and team meetings to address learning and development within the team. Team meetings had been occurring monthly due to Covid-19 but are now bi-weekly. Placement plans and individual crisis management plans were discussed among the team to ensure the continuity of shared information for effective work practices. Training awareness programme sessions were occurring monthly for the staff, led by the therapeutic

team. This training identified specific training needs required by the team in caring for the young people, for example attachment training. TCI refreshers were cancelled due to Covid 19 restrictions. Child protection training was made available to some of the staff team when it was safe and in line with Covid 19 regulations. Feedback from the significant event review group meetings allowed for further growth and development of the team in addressing challenging behaviours. The deputy manager is a certified trainer in the CARE model which is beneficial to the team with enhancing their knowledge of its principles.

Some of the newer staff members had yet to receive training in the organisation's CARE model. This was delayed due to the Covid 19 pandemic and should be prioritised at the earliest opportunity using remote training, if required, until face to face training is possible.

Supervision was carried out monthly in line with the supervision policy. The newer staff members were provided with fortnightly supervision for the first three months of employment. Supervision agreements were in place and supervision records were signed by both parties. Supervision was carried out by an experience and qualified person. Supervisor training had been undertaken. There are a number of staff that require supervisee training that are new to the organisation. It would be recommended to ensure the staff receive the training to get the full benefit of the supervision process. Records of supervision were reviewed by inspectors and were in line with policy and offered the opportunity for reflection and learning.

There were supports in place to assist staff in managing the impact of working in the centre. These included, availability of an external counselling service, supervision, post-crisis responses, debriefing and reflective practice.

Standard 6.4 Training and continuous professional development is provided to staff to deliver child-centred, safe and effective care and support.

Opportunities for training and professional development was noted by the inspectors as identified by the staff during interviews and from questionnaires. There were induction processes in place with staff prior to being allocated to a centre. Once assigned, there were further induction processes which were guided by the deputy manager. Staff files showed records of this induction process and what areas were completed. Training for staff was provided by various trained members of the organisation. Mandatory training for staff included Children First, fire safety, first

aid, training in a recognised model of behaviour management and ongoing model of care training through the training awareness programme (TAP). Due to the emergence of the Covid 19 pandemic, significant deficits emerged in core training including first aid and fire safety for the staff team. Senior management have discussed this issue at governance meetings and have been actively attempting to solve this problem.

There was training needs analysis in place which was overseen by a training coordinator. It showed details of all training undertaken by staff and when they required a refresher. The training coordinator linked with management in the centre around the proposed training dates to ensure staff are made available on the roster to attend the required training. Training needs were identified by staff during supervision or at team meetings. These included ligature training and attachment training. Strategy meetings and the significant event review group meetings also recommended further training which would be beneficial to the team and young people. Staff files that were viewed by inspectors included the training certificates for training completed.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Standard 6.1** **Standard 6.4**
Practices met the required standard in some respects only	**Standard 6.2** **Standard 6.3**
Practices did not meet the required standard	**None identified**

Actions required

- The registered provider must ensure supervisee training and appraisals for all staff are carried out.
- The registered provider must ensure training on the CARE model is facilitated to all staff as a matter of priority.
- The registered provider must ensure that staff are fully Garda vetted, (including outside jurisdiction) in line with regulation and national standards.
- The registered provider must ensure that all mandatory training is completed by staff.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered provider and director of care and quality must update relevant policies and procedures regarding mandated and non-mandated people. A review date and version number details are to be added to this document.	With immediate effect, this was updated (17/12/20) by the Director of Care & Quality and will be ratified at the governance meeting on the 28.1.2021. All policies going forward will have a review date and version number attached	Policies will continue to be reviewed as directed by the Governance Committee. The subcommittee that works on policies will continue to meet on regular intervals to ensure that policies remain up to date.
	The centre manager and director of care and quality must review the recording and documenting of significant events and child protection reports must be looked at by the organisation, including an internal training with the team regarding this and linking the safeguarding policies and procedures.	This will be reviewed by the regional manager following the Christmas break alongside the home management team. The regional manager in conjunction with the organisation training officer will revise the internal training that the team require regarding recording and safeguarding. Dates booked starting February 2021	Regional management will continue to review the quality of recording in SENs via the SEN team and any further training required for the time will be highlighted through this forum. The organisation has now appointed an internal Child Protection trainer will be able to offer additional support and updates to the team re safeguarding policies and procedures. Safeguarding will also remain as a permanent agenda item on team meetings and will along for management to continue

			with in-house training
	The centre manager and director of care and quality must review the restrictive practices policy to ensure only trained and approved interventions are used.	The Director of Care & Quality alongside the Regional management team will review this policy before the governance committee on the 28.1.2020. Copy will be provided.	Policies will continue to be reviewed as directed by the Governance Committee. The subcommittee that works on policies will continue to meet on regular intervals to ensure that policies remain up to date.
	The director of care and quality and the centre manager must create a centre risk register.	The Director of Care & Quality alongside the regional management team will devise same and have it operational by the end of January 2021 to ensure consistency across all homes. All centres now have a centre risk register.	Regional Management will review the homes risk register via monthly management meetings
6	The registered provider must ensure supervisee training and appraisals for all staff are carried out.	With immediate effect, internal supervision training will now be rolled out for all staff. The appraisal format is currently being reviewed alongside our HR department and we aim to have this fully operational by the end of Jan 2021	The training co-ordinator will keep a record of this training as will the management team on supervision files. Any deficits in this training will be raised at the governance committee by the training co-Ordinator. Regional management will review the appraisals alongside management teams during management meetings.

	The registered provider must ensure training on the CARE model is facilitated to all staff as a matter of priority.	For existing staff, the management team will provide this training in line with the training format supplied by the training co-Ordinator. Running monthly starting February 2021.	CARE training has now been escalated as an agenda item to weekly Senior Management meetings.
	The registered provider must ensure that staff are fully Garda vetted, (including outside jurisdiction) in line with regulation and National Standards.	With immediate effect. Any outstanding vetting from outside the jurisdiction has been followed up on.	A member of the Senior Management Team will now oversee the HR department to ensure that there are no deficits in vetting.
	The registered provider must ensure that all mandatory training is completed by staff.	All new staff will receive this training via the training co-ordinator as part of their induction. Face to face training is planned for a role out from Feb 2021 in smaller groups	Any deficits in training is to be raised by the management team to regional management. Any deficits in accessing mandatory training is to be raised by the training co-ordinator to the governance committee.