Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended

Centre name:	Baldoyle Residential
Centre ID:	OSV-0002340
Centre county:	Dublin 13
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Michael Farrell
Lead inspector:	Anna Doyle
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	2

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
03 March 2017 08:40	03 March 2017 18:40

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the second inspection of the designated centre. The last inspection took place in August 2015. The centre is registered. The purpose of this inspection was to follow up on two notifications that had been submitted by the provider to HIQA in relation to this centre. As part of the inspection four outcomes were inspected and the actions from the last inspection under these outcomes were followed up. However, over the course of the inspection information relating to residents care and the premises were also inspected.

Description of the Service:
The centre is located in a seaside residential suburb of Co Dublin and is located on the first floor of a large three storey institutional building. The ground floor of this building comprises of a primary school for children with disabilities, a day care facility for adults and a swimming pool. Administration offices are located on the second floor where monthly outpatient clinics are also held. Access to the designated centre is through a large reception area for the entire building and there is a lift and stairs available to residents. The entire property is owned by St. Michael's House (SMH).

The designated centre is made up of twelve single bedrooms and two double bedrooms. Fourteen residents reside in the centre. The centre is closed to admissions from external agencies as the centre is classified as a congregated setting and the provider intends to move residents to community based settings. One resident was in the process of trying to find suitable accommodation and was being

supported with this by their circle of support and an independent advocate. The provider also submitted information to HIQA post inspection outlining their plans to move other residents out on a phased basis with a proposed completion date of 2019.

How we gathered evidence:
Over the course of this inspection the inspector met with one resident and met six other residents informally. Two staff members were met, along with the fire officer for the centre. Some of the residents were unable to express their views on the quality of services in the centre but the inspector observed some interactions between staff and residents. All residents were attending day services or other activities on the day of the inspection.

In addition, documents were reviewed such as risk assessments and fire records. The person in charge attended the centre for a short time on the day of the inspection. A clinic nurse manager and the service manager were available throughout the inspection, both of whom attended the feedback meeting. The provider attended the centre and while they did not attend for formal feedback, informal feedback was provided to them by the inspector.

Overall findings:
Overall the inspector found that residents appeared well cared for in the centre and staff were observed to treat residents with respect. The centre was clean and decorated to a good standard. However, improvements were required to the premises so as to ensure that resident's privacy was maintained.

Of the six outcomes inspected, four were found to be in moderate non-compliance with the regulations. These included premises, health and safety, healthcare and workforce. The inspector found that the provider had taken actions in response to the two incidents notified to HIQA and remedial actions were either implemented or in progress so as to eliminate the likelihood of a reoccurrence. The action plan at the end of this report outlines the improvements required.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that the layout of the centre was not respecting residents' rights to privacy in the centre.

The provider had measures in place to ensure that unauthorised visitors could not gain access to the building. However, the building was configured to provide a number of additional services as outlined in the summary of this report.

The designated centre is located on the first floor of the building which can be accessed via two lifts and two staircases in the building. Both of which are accessible to other personnel and visitors to the building.

The centre had two entrance areas from the lift and stairs. One entrance area had double doors which were closed with a sign saying residential services. However, there were no other measures in place to ensure that entry was restricted to the centre. The other entrance had no visible doors to indicate that it was a residential centre and any visitors could walk into the centre from the lift or staircase.

The inspector was not satisfied that this was respecting resident's privacy and dignity in the centre.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector found that there were systems in place to protect residents, visitors and staff from being harmed in the centre. However, improvements were required in a fire safety measures in the centre and risk management.

There were risk management procedures in place in the centre. A sample of incidents reviewed found that seven incidents had occurred in the centre over the last year. Two of which had been reported to HIQA.

The inspector found that one incident had been reviewed by relevant team members and actions had been formulated from this to ensure that the learning from the incident was implemented into practice. A copy of the incident review was made available to the inspector and all of the agreed actions had been followed up.

The second incident was being investigated by the provider and the report was due to be finalised next week. A copy of this review is to be submitted to HIQA once complete. The initial findings from this found that one residents support needs had not been implemented into practice by staff on duty and this had resulted in an injury to the resident.

In addition, other records were submitted post inspection confirming that one control measure was being addressed in relation to staff training as a result of this incident.

There were fire systems in place in the centre. All staff had completed fire training and regular evacuation training was completed with staff in the centre. Staff were clear about the evacuation procedures in place in the centre.

Fire drills were completed in the centre; however there were no records to demonstrate that residents could be evacuated in the centre when staffing levels were at a minimum level. This had been an action from the last inspection.

Daily fire safety checks were completed in the centre; however there were gaps in the records maintained. It was also noted that some identified issues had not always been followed up. For example, the inspector found that an issue had been identified regarding emergency lighting in the centre and this had not been followed up. Records were submitted post inspection confirming that this was followed up after the inspection.

Fire equipment was maintained in the centre. A fire prevention officer from the fire authority had recently inspected the building and while remedial actions had been identified to address failings found at this, the fire officer for the centre had devised a

plan to address these failings.

Residents had personal emergency evacuation plans in place that outlined the supports required to ensure a safe evacuation for the centre.

However, improvements were required so as to include any medical equipment that may be required for residents in the event of a full evacuation of the centre. The inspector acknowledges that from speaking to the fire officer that there were measures in place, however they were not included in the evacuation plans to guide practice.

A pre plan fire assessment had also been submitted to the local fire brigade that outlined the needs of resident and the requirement for additional resources in the event of a fire occurring in the centre.

A fire warden was on duty each day in the centre. They were responsible for overseeing an evacuation of the centre should it be required. A walkie talkie was used to alert other personnel in the building of the location of the fire and whether a complete evacuation of the building was required and to coordinate the evacuation.

Infection control procedures were not inspected at this inspection.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector found that there were measures in place to protect residents being harmed or suffering abuse in the centre. However, improvements were required in the use of one restrictive practice in the centre. Behaviour support plans were not reviewed as part of this inspection.

There was a policy in place in the centre for the prevention and detection of abuse in the centre. Staff spoken to were clear about the procedures to follow in the event of an

allegation of abuse. Staff had completed training in this area and refresher training was scheduled to take place for all staff.

One resident who spoke to the inspector said they would raise concerns with the person in charge if they were not happy. The inspector was informed that there were no safeguarding concerns in the centre on the day of the inspection.

A number of mechanical restraints were used in the centre that had been notified to HIQA. They were all prescribed by an allied health professional based on the residents' assessed needs. One mechanical restraint was at the request of a resident and the inspector confirmed this with the resident.

However, there was one possible prescribed chemical restraint in place for a resident. This was recorded as being prescribed for agitation. It had been administered to the resident on a number of occasions over the last month. However, the records did not clearly demonstrate the rationale for this.

For example, the PRN protocol in place and the care intervention in place stated that it was for agitation but there were no indicators of how the resident presented when agitated in order to guide practice.

The details of this were discussed at the feedback meeting and are not discussed in this report to protect anonymity.

Judgment:
Substantially Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that the measures in place around residents' end of life plans were not in line with best practice and required improvements.

No other aspect of this outcome was inspected against. At the opening meeting and from talking to staff the inspector was informed that some residents' had end of life plans in place. Given the age profile of the residents in the centre, the inspector reviewed a sample of these plans.

The inspector found that one plan did not guide practice for staff and the information contained in one plan conflicted with other records relating to this on the residents plan.

The inspector spoke to the residents' general practitioner on the day of the inspection and the issue was resolved prior to the end of the inspection. While there was evidence of good practices relating to this practice. The details of this are not discussed in this report in order to protect anonymity.

However, the inspector found that the records contained in some residents personal plan did not all guide practice in terms of demonstrating:
- A clear rationale for decisions made.
- That the capacity of the resident in the decision making process had been considered.
- That consultation with all allied health professionals involved in the care of the resident had occurred.
- Some care interventions in place required more detail in order to guide practice. For example when to transfer to hospital a resident to hospital in the event of them being unwell.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector found that there was a clearly defined management structure in place in the centre that identified lines of accountability.

The person in charge attended the centre during the inspection for a short time. They were suitably qualified and were supernumerary in their role in order to oversee service provision in the centre.

The person in charge reported to a service manager who is also a person participating in the management of the centre. They had only recently been appointed to this centre. Their fitness was not assessed as part of this inspection. The service manager reported

to the provider nominee.

The person in charge was supported by a clinic nurse manager who was also supernumerary in their role. They reported to the person in charge and were present on the day of the inspection. They were very knowledgeable of the residents needs in the centre and had oversight over some areas of service provision in the centre.

Staff said that they felt supported in their role by the person in charge and could raise concerns with management whenever the need arose.

An unannounced quality and safety review had been completed in the centre and another one was due to be completed in the coming weeks.

An annual review had also been completed in January of this year for 2016.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector found that the there were enough staff to meet the needs of residents. However, there were no contingencies in place to cover sick leave and the staffing was not always organised around residents assessed needs. In addition, improvements were required in the staff rotas.

The statement of purpose for the centre stated that there were eight healthcare assistants and two staff nurses on every day from 8.00 to 20.00 hours. They were supported by a clinic nurse manager from nine to five every day. Four health care assistants and two staff nurses were rostered on every night.

However, from a review of staff rotas, the inspector found that some days planned sick leave was not always covered in the centre and a clinic nurse manager was not always on duty. For example, some days there were only nine staff on duty and while the clinic

nurse manager was available to support the care of residents during the day, there was no contingency for the evening part of the shifts.

The inspector also found from talking to staff, one resident, and a review of two residents plans that residents social care needs could not always be met in the centre. For example, weekend activities for residents were not planned and were dependent on drivers being on duty at the weekends.

Staff informed the inspector that residents were supported to access local amenities when no drivers were available. However, when the inspector reviewed the records for two residents they had very little community activities that did not involve a drive or a walk. One residents' records showed that over a four month period that they had five community activities recorded.

The inspector acknowledges that there is currently a vacancy in the centre for a clinic nurse manager and this vacancy was currently in the process of being filled. In addition, the person in charge endeavoured to fill vacancy shifts with permanent members of staff so as to reduce the need for agency and improve consistency of care for residents.

At the last inspection the provider had undertaken to employ a social care worker to provide expertise to all staff around meeting residents social care needs. The inspector found that this had not been implemented.

However, there were some social care staff employed on nights in the centre and a number of nurses in the centre were registered nurses for intellectual disabilities who could provide expertise in this area.

There was a planned and actual rota in place, however, improvements were required in this so as to ensure that the records were accurate and reflected the vacancies in the centre. For example, staff grades were not included on the rota. The vacant shifts in the centre were not highlighted and an 'ex' marked beside a staff's name indicated that they were doing an extra shift. The rationale for this shift was not clear.

Staff met said that they were supported by the person in charge. Supervision was in place for all staff last year and the person in charge informed the inspector that a they were scheduling supervision for staff this year and intended to change the template for supervision to ensure that it was more meaningful and outcome based.

Regular staff meetings were held in the centre. This included weekly unit meetings with day staff and night staff to review residents healthcare needs. Staff meetings were held separately with healthcare assistants and nursing staff. The rationale for this was not clear. However, the last staff meeting had included all grades of staff and the inspector was informed at the feedback meeting that going forward this would be the practice in the centre.

Training records made available to the inspector demonstrated that all staff had completed mandatory training. All staff were due to complete safe guarding refresher training and there was a plan in place to address this. Staff spoken to were aware of the training dates. Regular fire evacuation training was also held in the centre and the

inspector saw records demonstrating this.

Personnel files were not reviewed as part of this inspection.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002340
Date of Inspection:	03 March 2017
Date of response:	05 May 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout of the centre was not respecting residents' rights to privacy in the centre.

1. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Please state the actions you have taken or are planning to take:
Please state the actions you have taken or are planning to take:

1. Frosted contact will applied to the required number sets of doors to obscure any view into the residential area.
2. The sets of double doors at both entrance areas to residential services will be painted a different colour to highlight that they are an entrance to a residential area.
3. New signage will be placed in the two lifts clearly showing which floors to exit for various clinics.
4. A new sign advising visitors that the first floor is a residential area will be placed in areas which are clearly visible as the lift doors open on the first floor.
5. Staff have been advised and are being reminded to keep doors closed.
6. A wall mounted sliding screen has been ordered and will be installed to block access from the main lift leading into the residential section of the building.

Proposed Timescale:
1. 12/04/2017
2. 28/04/2017
3. 07/04/2017
4. 07/04/2017
5. 11/04/2017
6. 19/05/2017

Proposed Timescale: 19/05/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk assessments in place around residents assessed needs had not been implemented into practice.

2. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
1. All staff have been reminded that they are to follow clinical guidelines regarding residents support needs. This was discussed at staff meeting which took place on March 21st, and scheduled for discussion at all future staff meetings.
2. The organisations Health and Safety Manager will attend staff meeting on the 11th April to discuss safety awareness.

Proposed Timescale: 11/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no records to demonstrate that residents could be evacuated in the centre when staffing levels were at a minimum level.

Personal emergency evacuation plans were required so as to include any medical equipment that may be required for residents in the event of a full evacuation of the centre.

3. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
1. All fire drill records will now include how many staff took part in the actual sideways evacuation exercises.
2. Fire drills will be scheduled in the residential services with support from the residential staff team only, to ensure minimum staffing levels can carry out the required sideways evacuation.
3. Records from a Fire Drill dated 6th April 2017 record the evacuation of residents with minimum staff. Fire Drills throughout the year will be organised to run when staffing levels are at the agreed minimum both during the day shift and the night shift.

Proposed Timescale: 06/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failings identified from a recent fire inspection were not all implemented.

One issue identified from fire safety checks completed in the centre had not been followed up.

4. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
1. Emergency lighting identified at the recent Fire Inspection has been fixed.
2. Staff have been reminded to pass on fire safety requirements to Reception for inclusion into the Maintenance List as soon as they are identified. Staff have been reminded to ensure there are no gaps in records and that all checks are completed.

This will also be discussed at the next staff meeting

Proposed Timescale: 06/03/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The care intervention in place for one prescribed medication which may be considered a chemical restraint did not guide practice.

5. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
1. All PRN Protocols for this medication have been reviewed by the Consultant Psychiatrist to ensure detailed information is contained within regarding the rationale for and appropriate stage to administer PRN medication.
2. A referral has been made to the relevant committee for their consideration.

Proposed Timescale:
1. 07/04/2017
2. 05/05/2017

Proposed Timescale: 05/05/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The records contained in some residents end of life plans did not all guide practice in terms of demonstrating:
- A clear rationale for decisions made
- That the capacity of the resident in the decision making process had been considered.
- That consultation with all allied health professionals involved in the care of the resident had occurred.
- Some care interventions in place required more detail in order to guide practice. For example when to transfer to hospital a resident to hospital in the event of them being unwell.

6. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
The residents GP will review the documentation in relation to the End of Life Plans. The required information in relation to the rationale, the consideration of capacity, professional consultation and all information required to guide practice shall be part of this review.

Proposed Timescale: 14/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The planned and actual rota in place, required improvements so as to ensure that the records were accurate and reflected the vacancies in the centre.

7. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
Changes have been made to the roster template which now include the grade of all staff, clear legends and show clearly the exact hours worked.

Proposed Timescale: 06/04/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no contingencies in place to cover sick leave in the centre and staffing levels were not always organised around residents assessed needs.

8. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
1. A roster review has commenced and is underway, conducted by the PIC, the Administrative Manager, the HR Manager and the Service Manager.

2. Changes will be made to the Statement of Purpose to ensure the shift pattern information is accurate.

1. 01/05/2017
2. 07/04/2017

Proposed Timescale: 01/05/2017