

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Anne's Private Nursing Home
Centre ID:	OSV-0000387
Centre address:	Sonnagh, Charlestown, Mayo.
Telephone number:	094 925 4269
Email address:	kathsmyth@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Kathleen Smyth
Lead inspector:	Una Fitzgerald
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	4

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
28 November 2018 11:00	28 November 2018 18:30
29 November 2018 10:00	29 November 2018 14:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate
Outcome 08: Governance and Management		Non Compliant - Moderate
Outcome 12: Notification of Incidents		Non Compliant - Major

Summary of findings from this inspection

This thematic inspection focused on the care and welfare of residents who had dementia. Prior to the inspection, the centre completed the provider's self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

Overall, the inspector found that care was delivered to a good standard by staff who

knew the residents well and discharged their duties in a respectful and dignified way. This is the fourth inspection carried out in this centre in 2018. The inspector followed up on the action plan from the previous inspection in July 2018. Findings indicated that two of the four regulations from that inspection continue to be judged as not compliant. Firstly, Regulation 17 Premises - the centre does not have a bath that was due installation by 31/10/2018. Secondly, Regulation 31 - Notification of incidents - the inspector found evidence that a notification of an allegation of physical abuse was not submitted. The Health Information and Quality Authority had received unsolicited information relating to the allegation of physical abuse. Findings from this inspection evidence that the management team did not take the appropriate actions at the time of the allegation and did not send in a notification as required by the regulations. The inspector was informed that an investigation had taken place and the allegation was not substantiated. However, there was no documentation for review to confirm that investigation had occurred.

The inspector found that the management have worked cohesively as a team to bed down new systems. The role of person in charge is shared by two nurses. The management team responsible for the governance, operational management and administration of services and resources demonstrated good knowledge and an ability to meet regulatory requirements.

The management and staff of the centre were striving to continuously improve residents' outcomes. A person-centered approach to care was observed. Residents appeared well cared for. There was good evidence that independence was promoted and residents had autonomy and freedom of choice. The inspector met with the residents, some of whom had advanced dementia. The inspector also spoke with family members of residents who had dementia. The feedback was very positive.

St Anne's Private Nursing Home is a registered designated centre that provides care for a maximum of 28 residents. On the days of inspection there was a total of six residents with a formal diagnosis of dementia and a further five residents who had symptoms of dementia. The inspector tracked the care pathways of residents with dementia and spent periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule -QUIS was used to rate and record at five minute intervals the quality of interactions between staff and residents. Specific emphasis focused on residents who had dementia.

The inspector observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. The results from the formal and informal observations were positive and staff interactions with residents were patient and kind. The living environment was stimulating and provided opportunities for rest and recreation in an atmosphere of friendliness. Residents had free access to enclosed gardens.

During this inspection, of the eight outcomes assessed, one major non-compliant, three moderate non-compliances and one substantial non-compliance were identified. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The inspector focused on the experience of residents with dementia and tracked the journey prior to and from admission into the centre. In addition, files were reviewed on specific aspects of care such as nutrition, wound care, mobility, medication management and end of life care.

Following the April 2018 inspection, the centre had implemented a new care planning and documentation system. This system is now bedded down and staff are familiar and knowledgeable on the management of documentation. Policies and procedures around record management had been reviewed and communicated to all staff. The care planning system is clearly outlined and easily navigated. Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, falls and their skin integrity. In addition, an assessment using a validated tool of the level of cognitive impairment of residents admitted with a diagnosis of dementia was recorded and subject to regular review. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. The resuscitation status of all residents was recorded and nursing staff knew how to access this information in the event of a cardiac arrest. A care plan was developed following admission.

Arrangements were in place to evaluate existing care plans routinely on a four monthly basis. The care plans examined were updated or revised to reflect the residents' changing care needs. Family and residents confirmed that they are kept up to date on all changes. A record to demonstrate their involvement was not seen on all files reviewed and therefore required a review to close any gaps.

Arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge gathered information on all prospective residents prior to admission and a comprehensive pre

assessment of need was carried out. This arrangement enabled the centre to assess and determine if the service could adequately meet the needs of the resident.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to a general practitioner (GP) and allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability, dental, ophthalmology and podiatry services were available. In the file sample reviewed, information following the assessment, involvement and recommendations of allied healthcare professionals was reflected.

Staff provided end of life care to residents with the support of their GP and community palliative care services. There was no resident receiving end of life care on the days of inspection. 'End of life' care plans were documented in all files. Some included residents' expressed preferences regarding their preferred setting for delivery of care while others included that the family were to direct care at the end of life. The centre has a family room available for family and friends who wish to stay overnight within the centre. Staff outlined how religious and cultural practices were facilitated within the centre, Residents were satisfied with the arrangements in place. The centre has an oratory for resident use.

There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Procedures and care plans were in place in relation to nutritional care. The inspector saw that a choice of meals was offered and available to residents. There was a system of communication between nursing and catering staff to support residents with special dietary requirements. The inspector was told by the chef on duty that the menu changes constantly post consultation with resident wishes. The residents were very complimentary of the food served and felt that it was wholesome and nutritious. Mealtimes were seen as a social event with appropriate table settings. Staff sat with residents while providing encouragement or assistance with the lunch-time meal observed. The catering staff were familiar with the likes and dislikes of all of the residents.

Residents had access to a pharmacist and general practitioner (GP) of their choice. Residents were protected by medication practices and procedures found. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents that were implemented in practice. Medicine administration records were maintained in accordance with relevant professional guidelines.

Judgment:
Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a policy dated November 2018 on the procedures in place for the prevention, detection and response to an allegation of abuse. Staff records reviewed evidenced that all staff had received training on elder abuse. During conversations had, the inspector was satisfied that the care staff know what constitutes abuse and what to do in the event of an allegation, suspicion, or disclosure of abuse, including who to report this to. HIQA had received unsolicited information in relation to an allegation of physical abuse. This information was followed up on during the inspection. The inspector found that the management team did not respond to the allegation appropriately and in line with their own policy. The inspector was informed that post an investigation the allegation was not substantiated. There was no recorded detail of the allegation made or any subsequent investigation that was carried out. In addition, the allegation had not been reported to the office of the chief inspection which is a regulatory requirement.

The centre had a policy dated August 2018 on the procedures in place to support staff in working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. There was no resident within the centre on the day of inspection who had responsive behavioural issues.

The centre described and promoted a restraint free environment. Additional equipment to reduce the use of restraint such as low level beds, crash mats and sensor alarms were available. The inspector reviewed the documentation in place for the six residents currently using bedrails. Each file had a detailed risk assessment and a signed consent from.

The management team confirmed that the centre did not act as a pension agent for any of the residents.

There are no volunteers working within the centre.

Judgment:

Non-Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Residents were consulted about how the centre is planned and run. There are monthly resident forum meetings that are documented. The inspector reviewed the minutes of the past two meetings and noted there was good resident attendance at the meeting, including residents with dementia. The centre had also developed a newsletter documenting significant news like upcoming events, welcoming new residents and changes in staffing. Residents also had access to an independent advocacy service.

Residents are facilitated to exercise their civil, political, religious rights and are enabled to make informed decisions about the management of their care through the provision of appropriate information. There were information notice boards at strategic locations throughout the centre. There is a display board in the main sitting room that has the detail of the date, weather conditions and planned activities for the day. There are arrangements in place for each resident to receive visitors in private.

Activities developed for residents with dementia formed part of the daily activities programme. There is no dedicated member of staff to deliver activities. Activities and meaningful engagement between staff and residents is seen as the responsibility of all staff. This culture is strongly influenced by the persons in charge. Each resident has opportunity to participate in activities that are meaningful and purposeful to their needs, interests and capacities. Residents with advanced dementia were included in group activities. The staff were knowledgeable on the lives and life stories of residents prior to living in the nursing home. The inspector observed multiple one to one meaningful engagements between staff and individual residents. There is at all times, a member of staff supervising the main sitting room. The atmosphere was positive, welcoming and inclusive of all. Residents and family members told the inspector that there was enough activities in the centre and they were happy with the daily programme.

Residents spoken with confirmed that their religious and civil rights were supported. There was an oratory located in the centre which provided a quiet space for residents to pray and reflect and there was a weekly mass for catholic residents. There were appropriate systems in place to ensure all residents were included on the electoral register and residents had been facilitated to vote in the recent presidential vote.

A record of visitors to the designated centre was maintained. There were a number of areas available where residents could meet with visitors in private. Family members told the inspector that they were always made feel welcomed when they visited. Daily national newspapers and regional papers were also available.

Residents' families were encouraged to bring in pictures and ornaments belonging to the resident to personalise their bedrooms. The inspector observed personal photographs and pictures in the majority of bedrooms. Residents said they were able to exercise choice regarding the time they got up and went to bed. Breakfast was served at a time that suited them. Most residents opted to have dinner and evening meals in the dining room.

The inspector found that residents' privacy and dignity was respected. The staff were

observed knocking on bedroom and bathroom doors and waited for permission before they entered. They were heard explaining why they were coming into their room, e.g. to give medications or to assist the resident with care. Screens were provided in the shared bedrooms and they were observed to be in use when personal care was been provided.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia using a validated observational tool (the quality of interactions schedule, or QUIS) to rate and records at five-minute intervals the quality of interactions between staff and residents in the three communal areas. The observations took place in the main sitting room and observing the dining experience. The Inspector found that most of the observation period (total observation period of 60 minutes) the quality of interaction score was positive connective care. The staff knew the residents well and connected with them on a personal level. They greeted each resident by name when they came into the room and it was evident that they knew the resident's personally and could talk about their families and local events that were of importance to them.

Judgment:

Compliant

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were policies and procedures for the management of complaints. The complaints process was displayed in a prominent place along the corridor. The person's in charge were involved in the management of complaints received. The inspector reviewed the complaints log. Records indicated that complaints were minimal, a total of three to date in 2018. Residents were informed on admission of the complaints procedure.

The management and documentation of all complaints required a review. The management team had knowledge of all complaints and could verbally update the inspector on the detail of all complaints. However, a record of the outcome was not consistently documented and there was no evidence if the complainant was satisfied with the outcome. The provider representative acts as an appeals officer. The statement of purpose directed the complainant to the office of the Ombudsman if unhappy with the outcome.

Residents spoken with on the days of inspection told the inspector that they would not hesitate to make a complaint if they had one. Relatives voiced satisfaction with the care and were aware of who they could complain to if they needed.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:

The inspector reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of residents. Ongoing review of the care dependency levels of the residents is carried out by the person's in charge and discussed at the management meetings. This in turn informs the staffing compliment required to ensure the delivery of quality care. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities. The person's in charge explained the systems in place to supervise staff. Staff appraisals had been carried out. Documents reviewed were comprehensive and detailed. Recruitment and induction procedures have been significantly improved and enhanced. The inspector spoke with newly recruited staff who informed the inspector that they felt fully supported in their new role. Staff spoken with had spent time in a supernumery capacity working alongside a long term member of the team. All staff spoken with felt supported by the management team.

Evidence of current professional registration for registered nurses was seen by the inspector.

The training records were reviewed. Records evidenced that all staff were trained in safeguarding and safety, manual handling and fire safety training. In addition to mandatory training, the centre provides specific training in dementia care.

All documents required under Schedule 2 of the regulations are contained in the personnel files. All staff files reviewed had Garda Vetting disclosures in place. The management team confirmed that all current staff had completed a Garda vetting disclosure. There were no volunteers working within the centre.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:

The compliance plan response that was accepted following the July 2018 inspection had not been progressed. The centre management had stated that a bath would be installed and fitted by the 31/10/2018. Therefore this action is restated.

St. Anne's Private nursing home is a designated centre that can accommodate up to 28 residents. There are a mixture of single and double bedrooms. Each room has an ensuite with a toilet and wash hand basin. Two of the double bedrooms have a shower. The design and layout of the double bedrooms met with current residents needs and there was appropriate screening in place to ensure that their privacy and dignity was not compromised.

Rooms were personalised with photos, memorabilia and artefacts. At the entrance to all bedrooms was a picture, chosen by the residents, with their name in large writing. There was also signage on communal rooms stating the purpose and function of the room. For example, communal toilets had a picture of a toilet. Residents confirmed that they were encouraged to bring in items from home. Some rooms had a clock and calendar which help to orientate residents to time.

The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre. The centre was found to be well maintained, warm, comfortably and visually clean. Heating and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents sat during the day. Walking along the corridor that links the bedrooms to the sitting and dining rooms is a pleasant experience. The corridor walls are decorated with pictures and familiar memorabilia and traditional pieces of furniture.

Handrails were available in all circulation areas throughout the building, and grab rails were present in all toilets and bathrooms. Furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call bell facilities, remote control devices, hoists and mobility aids were seen in use by residents that promoted their independence. Residents had access to an enclosed garden.

Judgment:

Non-Compliant - Moderate

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability, and the management team's roles and responsibilities for the provision of care are unambiguous. The management team facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions. There was a focus on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

A new auditing schedule and review system was in place to capture statistical information in relation to resident quality outcomes, operational matters and staffing arrangements. Clinical audits were carried out that analysed falls management, medicine management, care plans and environmental audits. This information was available for inspection. All audits conducted had been reviewed by the person's in charge and action plans to close out any gaps had been identified and were in progress. The management team had carried out a full review of the Schedule 5 policies and procedures to ensure that they are centre specific and reflective of the practices in place.

The provider representative has a strong presence within the centre and is well known by all of the residents and staff. The centre has a quality manager in post to support the nursing management. The person in charge role is shared by two registered general nurses. There is a monthly management team meeting.

A judgment of moderate noncompliance was informed by cumulative findings. Two of the actions from the last inspection had not been adequately progressed and remained open. Firstly, the requirement for residents to have the option to have a bath. The second action was in relation to ensuring that the management systems in place ensure that the service provided was safe, appropriate, consistent and effectively monitored. During this inspection the inspector followed up on unsolicited information of concern that was received into HIQA. The inspector found evidence that the allegation had been made. There was no documentation for review on the steps taken by the management team. In addition the allegation had not been reported to HIQA as is required by the regulations.

Judgment:

Non-Compliant - Moderate

Outcome 12: Notification of Incidents

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings: An allegation of physical abuse had not been managed in line with the centre's own policy. HIQA had not received a notification on the allegation made. This non-compliance is restated from the last inspection carried out in July 2018.
Judgment: Non-Compliant - Major

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:

Una Fitzgerald
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St Anne's Private Nursing Home
Centre ID:	OSV-0000387
Date of inspection:	28/11/2018
Date of response:	20/12/2018

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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 02: Safeguarding and Safety

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

HIQA had received unsolicited information in relation to an allegation of physical abuse. The inspector found that the management team did not respond to the allegation appropriately and in line with their own policy.

1. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of

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

abuse.

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

The notification was submitted immediately it was identified. The management team will ensure that all allegations are responded to and investigated in line with the home's policy and all notifications submitted within the timeframe.

Proposed Timescale: 29/11/2018

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The management and documentation of all complaints required a review. The management team had knowledge of all complaints and could verbally update the inspector on the detail of all complaints. A record of the outcome was not consistently documented and there was no evidence if the complainant was satisfied with the outcome.

2. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

The management team will audit all complaints at their monthly meeting to ensure that they have been properly addressed, investigated and that the complainant is satisfied with the outcome and if so that it is concluded. In addition to this the home secretary will ensure that the administration for the complaint is followed through to its conclusion.

Proposed Timescale: 30/11/2018

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The compliance plan response that was accepted following the last inspection had not been progressed. The centre management had stated that a bath would be installed and fitted by the 31/10/2018. Therefore this action is restated.

3. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Due to issues with obtaining trades people there has been a delay. The bath will be installed by 28th February 2019

Proposed Timescale: 28/02/2019

Outcome 08: Governance and Management**Theme:**

Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Two of the actions from the last inspection had not been adequately progressed and remained open. The management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. During this inspection the inspector followed up on unsolicited information of concern that was received into HIQA. The inspector found evidence that the allegation had been made. There was no documentation for review on the steps taken by the management team. In addition the allegation had not been reported to HIQA as is required by the regulations.

4. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The notification was submitted immediately it was identified. The matter had been investigated and was unsubstantiated, however with immediate effect the management team will ensure that all allegations are responded to and investigated in line with the home's policy and all notifications submitted within the timeframe. In the event of an allegation being made one of the management team will be allocated to lead the investigation process and submit the notification. All governance, leadership and management issues are discussed formally and recorded at the monthly management team meeting and allegations and notifications will be now reviewed as a standing agenda item.

Proposed Timescale: 30/11/2018