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A designated centre for people with disabilities operated by Health Service Executive, Wexford

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002633
Centre county:	Wexford
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	TJ Dunford
Lead inspector:	Ide Batan
Support inspector(s):	Kieran Murphy
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	0

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: 28 January 2015 10:30 To: 28 January 2015 17:00

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

Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 14: Governance and Management

Summary of findings from this inspection

This was the second inspection of this centre by the Health Information and Quality Authority (the Authority). This was an unannounced triggered inspection on foot of a notification of alleged abuse received by the Authority. The Registered Provider on behalf of the Health Service Executive failed to notify the Authority within three working days of the alleged incident and take appropriate action to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored. Inspectors could not ascertain any valid rationale for the significant delay in the commencement of a full investigation notifying the Authority of the alleged incident. On the day of inspection this investigation still had not started despite the incident occurring one month prior to inspection. This is actioned under Outcome 14.

The centre consists of a large detached house in the community and residents are provided with access to day services at the day centre which is approximately 12km away. The inspectors were informed that the majority of the residents had significant intellectual disabilities and some of the residents also required additional significant supports in relation to behaviours that challenged.

During this inspection inspectors met with some of the residents and staff members. They reviewed the premises, observed practices and reviewed documentation related to risk management, residents' records, accident and incident reports, medication management, staff supervision records logs, policies and procedures and a sample of staff files. There was evidence that residents had access to members of a multidisciplinary health care team and it was obvious to inspectors during inspection that staff knew the residents and their individual preferences well. Many of the residents required a high level of assistance and monitoring due to the complexity of

their individual needs.

Overall the inspectors found that governance arrangements were inadequate. There were not effective management systems in place to support and promote the delivery of safe and quality services as outlined under Outcome 14. There was no annual review of the quality and safety of care as required by legislation.

There was significant non compliance in relation to some fundamental and essential components of the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 including core aspects of governance which included management of complaints, reviewing quality and safety of care and submission of notifications to the Authority.

The action plans at the end of this report identifies where significant improvements are required to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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 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):

No actions were required from the previous inspection.

Findings:

There was a policy for the management of an allegation of abuse and the national Health Service Executive (HSE), 'Trust in Care' procedural document was available in regard to responding to an allegation of abuse. It was noted during the day of inspection that staff seemed to know the residents well and they were generally observed communicating with residents in a respectful manner. Staff training records indicated that staff had been provided with opportunities to attend training in the prevention, detection and response to abuse and challenging behaviour.

In the sample of healthcare files reviewed by inspectors there were proactive risk assessments in place that contained measures and actions in place to control the specified hazards including:

- unexpected absence of a resident
- accidental injury
- aggression and violence
- self-harm
- residents tampering with water controls
- residents taking off clothes.

Each identified hazard had been assessed in accordance with an outline of whether it was a green (low risk), amber (medium risk) or red (high risk). The controls in place to manage the hazards specifically outlined staff responsibilities and roles. All staff spoken with by inspectors were knowledgeable in relation to their response to these hazards. There was evidence that these risk assessments had been reviewed within the last three months. For one resident there had been a further specific risk assessment undertaken in relation to climbing over the gate and fence from the garden into the soft play area.

There was an incident reporting process and inspectors were satisfied that all incidents were being recorded accurately with an appropriate review following the incident. Inspectors saw that a record was maintained of each time a staff member had been injured by a resident. Records seen by inspectors indicated that 18 such incidents had occurred between June and December 2014. The incident reporting system also recorded clinical incidents and records indicated that in 2014 there had been:

- 22 instances of residents engaging in self-injurious behaviour, including hitting their own head against windows and opening old wounds
- 5 instances of residents assaulting other residents, (including attempted);
- 1 medication error which involved the omission of a prescribed medication;
- 1 injury to a resident who sustained a fall.

There was also a separate recording of instances of challenging behaviour called behaviour analysis reporting. This report recorded the date of the episode, time and who were the staff on duty. It also included the type of behaviour that occurred, how long the episode lasted. It recorded data on what the antecedent to the behaviour was, i.e. what was the resident doing immediately prior to the incident and also what actions had been taken in response to the incident. For one resident, inspectors saw ten completed behaviour analysis reports for the period of August to December 2014.

In the sample healthcare files seen by inspectors there were behaviour support plans in place for residents displaying challenging behaviour. These plans provided clear instruction to staff on how to support the resident who was engaging in challenging behaviour. In one support plan it specifically referenced allowing the resident to have control over their own personal space while under close supervision. Staff explained to inspectors that at times residents were observed from within the unit as experience had shown that the residents' behaviour escalated if staff were in close proximity.

One staff member had received a specialist qualification in behaviour support and there was evidence that she had undertaken a specific support plan for one resident. This plan identified short term and long-term objectives in relation to the introduction of:

- decreasing the use of medicine to manage behaviour.
- introducing alternative forms of communication
- maintaining established communication skills.

There was evidence that all alternative options were considered before medication was administered in relation to the management of behaviour that challenged. All medication, including medication in relation to reducing anxiety, was being administered as prescribed by a consultant psychiatrist. Some residents had medication prescribed on a "as required" or PRN basis in relation to behaviour management. Inspectors requested medication the charts for four residents. Three residents had not received any such medication during 2014 and in the case of one resident as required medication had been administered on two occasions in 2014.

There was evidence that each resident had been assessed in October 2014 by either an occupational therapist or speech and language therapist as part of a private service providing clinical assessment and therapy. The assessment reports included recommendations relating to:

- communication during activities of early sensory experiences

- residents being offered choice between items on a regular basis
- photographs of objects being available throughout the centre
- visual picture schedule.

Throughout the inspection there was evidence that these recommendations were being implemented by staff. Picture enhanced communication tools were available throughout the unit, with pictures of each resident on the door to their bedroom. The kitchen, bathroom and living room were all identified through the use of pictures on the door. In the dining area each resident had a place mat which identified their food likes/dislikes and also if they required adaptive tableware like spoons or forks. Staff were observed using alternative forms of communication like the Lámh manual sign system which was specifically used for people with intellectual disability.

In addition two residents had sensory integration assessment reports undertaken in October 2014. This included recommendations relating to:

- Auditory sensation
- Vestibular processing (i.e. balance and movement)
- Visual processing
- Taste

The healthcare files also had evidence of referral and assessment by psychologists and consultant psychiatrists.

The senior clinical nurse manager outlined to inspectors that each resident attended a day service during the week. On the day of inspection four residents remained in the unit and four were in the day service. Each resident had a specific programme of activities, with some residents enjoying swimming for example and attending as part of their routine. There was a van available to take residents to the various activities. The senior clinical nurse manager outlined that she was currently in the process of facilitating a review of activities for residents. This was being undertaken by a clinical nurse specialist in activation.

Where some residents exhibited aspects of behaviour that is challenging on occasions, staff were familiar with potential triggers and efforts were made to identify and alleviate the underlying causes for each individual resident. Although residents were unable to express feeling safe, the inspectors observed they appeared comfortable with staff and did not exhibit behaviours associated with distress or anxiety.

Judgment:

Compliant

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The Authority were in receipt of a notification of incidents of alleged abuse of residents. Inspectors reviewed practice areas in relation to the alleged incidents during inspection. Inspectors were not satisfied that the practice around the management of the complaint was consistent with local policies and procedures.

The person in charge did not give notice within three working days of any allegation suspected or confirmed of abuse of any residents as required by legislation. The person in charge did not ensure a written report was provided to the Chief Inspector at the end of each quarter in relation to any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used as required by legislation.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

The governance and management structures required review as the person in charge and the registered provider were actively managing a number of other centres and services across a broad geographical area.

The person in charge was employed full time and was found to have the qualifications, skills and experience necessary to manage the centre. It was unclear who the provider nominee for the centre was on behalf of the Health Service Executive (HSE). During the inspection it was outlined to inspectors that the provider nominee did not have an active role in the management of the centre since appointment to another role. During that time the person in charge had liaised with the general manager of the HSE community services in relation to the governance of the centre. They had met infrequently (on three occasions) since June 2014 in relation to this and other centres but there were not any minutes of these meetings available. The Authority had been notified in December 2014 that the HSE intended to change the existing provider nominee, with the general manager continuing on an interim basis.

The inspectors outlined their concern that these management arrangements across a

number of centres could not ensure effective governance, operational management and administration of the designated centres concerned.

The Authority received notification on 15 January 2015 of an alleged incident that may have occurred on the 17 December 2014.

The person in charge did not know on the day of inspection the line of enquiry that the notification received by the Authority would follow. The person in charge did not know when the investigation into the alleged incidents would commence nor was she aware whether or not it would be managed under the national Health Service Executive (HSE), 'Trust in Care' procedural document. Inspectors could not ascertain any valid rationale and were not given any reasonable explanation for the significant delay of commencement of a full investigation into matters and notifying the Authority of the alleged incident.

Inspectors saw that the centre was not following its own policies such as Trust in Care or the local HSE policy "Your service your say". The person in charge and management team confirmed to inspectors that they were in breach of their own policies in relation to complaints management. The clinical nurse manager who assumed responsibility for the running of the house had not seen the complaint even though she was aware of its existence.

The person in charge is based in a day centre approximately 12km from the house. She is available to staff on a daily basis by phone or email and she sees residents when they attended the day service. However the person nominated on behalf of the HSE had not carried out an unannounced visit as required by the regulations. In addition:

- there was not an annual review of the quality and safety of care and support as required by the regulations
- written reports were not available on the safety and quality of care and support provided as required by the regulations

An actual and planned rota was in place. Inspectors saw that there was 1.5 whole-time equivalent nursing hours vacant on the roster. Absences were covered primarily by agency staff. Inspectors viewed the agency nursing staff roster from September 2014 to January 2015 and saw that agency staff were usually the same people which provided consistency for residents. The person in charge acknowledged that there had been a significant turnover of staff in the last twelve months. However it was noted by inspectors that the CNM that they had been in post since June 2014 and two staff nurses that inspectors spoke with were new to the service also. One had been in post for a year and the other had commenced employment in December 2014.

The clinical nurse manager told inspectors that she was not familiar with the night time routine in the house and had never been requested by management to make an unannounced visit to the house at night. Staffing rosters viewed by inspectors confirmed that all staff rotate between day and night duty.

Inspectors saw there were formal support and supervision arrangements in place for staff which identified goals and objectives, any issues in relation to performance and training needs that staff may require. The clinical nurse manager who was also relatively new to the centre is responsible for the day to day running of the house. She told

inspectors that she endeavours to meet all staff twice per year for supervision. However inspectors saw that one employee had been in the centre for a year and no formal documented supervision had taken place. The clinical nurse manager told inspectors that this employee had received induction to the service.

The person in charge told inspectors that that she holds nurse manager meetings on a monthly basis. The person in charge told inspectors that she had not conducted any unannounced visits to the centre. Inspectors reviewed a sample of staff records and found evidence of compliance in regard to maintenance of the records that are required for staff as per schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) and Regulations 2013.

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:

Ide Batan
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:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002633
Date of Inspection:	28 January 2015
Date of response:	12 March 2015

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 09: Notification of Incidents

Theme: Safe Services

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

The person in charge did not give notice within three working days of any allegation suspected or confirmed of abuse of any residents as required by legislation.

Action Required:

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

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

The registered provider will ensure that all complaints advised directly will be forwarded to the Person in Charge in a timely manner in order for HIQA notification purposes and to comply with HSE policy

Proposed Timescale: 08/01/2015

Theme: Safe Services

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

The person in charge did not ensure a written report was provided to the Chief Inspector at the end of each quarter in relation to any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used as required by legislation.

Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

This was implemented for January 2015 quarterly returns and will be submitted, in accordance with regulation going forward

Proposed Timescale: 30/01/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The Authority received notification on 15 January 2015 of an alleged incident that may have occurred on the 17 December 2014. Inspectors could not ascertain any valid rationale for the inordinate delay of:

Commencement of a full investigation
notifying the Authority of the alleged incident.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

1. The disability services manager post has been filled effective of 09 February 2015
2. This post holder will work in conjunction with the following nurse managers within the management structure of WRIDS
 - Director of Nursing- Person In Charge
 - CNM3 – Person Participating in Management (PPIM)
 - CNM2 – Day to Day Service Manager (PPIM) – Radharc Nua.
 - CNM1
3. The Registered Provider, will carry out two unannounced inspections within each year.
4. An enhanced regime of unannounced visits will also be implemented. The Registered Provider, in conjunction with the PIC and the PPIM's will carry out co-ordinated, unannounced inspections. The findings of these will be shared with the above post holders and action plans instigated where required.
5. Formal staff supervision structures are in place however we will devise and implement a service supervision policy to enhance the current practice.
6. CNM3 Coordinates training for all nursing and support staff and a comprehensive database is maintained and monitored
7. The PIC with the support of the Provider nominee and general manager is progressing an aggressive recruitment process through various channels to reduce reliance on agency staff. Local interviews for locum panel completed and NRS interviews for National panel to fill approved posts scheduled
8. Holistic Life plans are in place and are updated as required and formally reviewed on a 6 monthly basis.
9. Each service user has a proactive risk assessment and support plans in place. Monitoring and management of incidents will be enhanced by its inclusion, as a standing item, on our senior nurse managers monthly team meeting. This forum will provide dedicated time for problem solving and shared learned.
10. A comprehensive Formal Auditing process is in place to evaluate service delivery and identify areas of deficit and where necessary develop action plans

Proposed Timescale:

1. 09 February 2015
2. 09 February 2015
3. 08 February 2015
4. Commenced 10 February 2015 and will be ongoing.
5. 01 May 2015 Supervision policy implementation
6. Ongoing
7. 05 March 2015 Locum panel formed. NRS interviews planned for week commencing 23 March 2015
8. Ongoing
9. Ongoing for service user risk assessments. Commenced inclusion of incident review on senior nurse Managers monthly meeting
10. Director of Nursing review of Quarter 1 2015 audit findings, will be completed by 01 May 2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

While there was a management structure this required review as the person in charge and the provider nominee were actively managing a number of other centres and services across a broad geographical area.

It was unclear to inspectors who the provider nominee for the centre was on behalf of the Health Service Executive (HSE). During the inspection it was outlined to inspectors that the provider nominee did not have an active role in the management of the centre since appointment to another role.

Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

1. The Disability Services Manager post has been filled effective of 09/02/2015
2. This Provider Nominee will work in conjunction with the following Nurse Managers within the Management structure of WRIDS.
 - Director of Nursing- Person In Charge
 - CNM3 – Person Participating in Management (PPIM)
 - CNM2 – Day to Day Service Manager (PPIM) – Radharc Nua.
 - CNM1
3. The PIC will review with the PPIM's the organisational structure, the roles and responsibilities of each staff member which will then be cascaded through the supervisory structures throughout the service to all staff members.

Proposed Timescale:

1. 09 February 2015
2. Ongoing
3. 30 June 2015

Theme: Leadership, Governance and Management

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

There was no annual review of the quality and safety of care and support in the designated centre.

Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The Registered Provider will ensure an annual review of the quality and safety of care

and support in the centre.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

The Registered Provider or a person nominated by the Registered Provider had not carried out any unannounced visits to the designated centre as required by the Regulations.

Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

- 1.The Registered Provider will carry out unannounced visits to the designated centre as required by legislation.
- 2.Written reports on the safety and quality of care and support provided in the centre to include a plan to address any concerns regarding the standard of care and support will be provided.
- 3.The Registered Provider will meet with the PIC on a weekly basis with review after three months. Supporting evidence will be provided.

Proposed Timescale:

- 1.Commencing 18 March 2015
- 2.These reports will be issued following two statutory unannounced visits by the Registered Provider
- 3.Commenced 09 February 2015

Theme: Leadership, Governance and Management

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

Inspectors saw that one employee had been in the centre for a year and no formal documented supervision had taken place.

Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

1. PIC confirmed with PPIM and staff member that support meeting did occur as per service practice. However this meeting was not formally documented in support meeting file
2. PIC reviewed with each PPIM their supervisory responsibilities.
3. PIC will include supervision responsibilities, as a standing item on the agenda at senior nurse managers monthly team meeting

Proposed Timescale:

1. 28 January 2015
2. 28 February 2015
3. 12 March 2015