Greenhaw Lodge Care Centre
RQIA ID: 1180
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Londonderry
BT48 8DA

Inspector: Heather Sleator
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# Unannounced Care Inspection
# of
# Greenhaw Lodge Care Centre

## 22 September 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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## 1. Summary of Inspection

An unannounced care inspection took place on 22 September 2015 from 09.45 to 16.30.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

### 1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 7 July 2014.

### 1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

### 1.3 Inspection Outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 3 | 6 |

The details of the Quality Improvement Plan (QIP) within this report were discussed with Ronagh McCaul, Registered Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

## 2. Service Details

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| **Registered Organisation/Registered Person:**<br>Larchwood Care Homes (NI) Ltd<br>Ciaran Sheehan | **Registered Manager:**<br>Ronagh McCaul |
| **Person in Charge of the Home at the Time of Inspection:**<br>Ronagh McCaul | **Date Manager Registered:**<br>7 March 2012 |
| **Categories of Care:**<br>NH-A, NH-DE | **Number of Registered Places:**<br>43 |
| **Number of Patients Accommodated on Day of Inspection:**<br>41 | **Weekly Tariff at Time of Inspection:**<br>£593 per week |

## 3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

**Standard 19: Communicating Effectively**
**Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)**

## 4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with six patients, five care staff, one registered nurse, three ancillary staff and one patient's visitors/representative.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care

## 5. The Inspection

### 5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced estates inspection dated 9 September 2015. The completed QIP will be approved by the specialist inspector on return to RQIA.

### 5.2 Review of Requirements and Recommendations from the Last Care Inspection

| Last Care Inspection Statutory Requirements | | Validation of Compliance |
|---|---|---|
| **Requirement 1**<br><br>**Ref:** Regulation 16 (2)<br><br>**Stated:** First time | The registered person shall ensure that the recommendations made by the Tissue Viability Nurse are undertaken and are recorded in the patient's care record. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of one patient's care record confirmed that the recommendations made by the Tissue Viability Nurse were undertaken and detailed records were maintained in respect of wound care management. | |
| **Requirement 2**<br><br>**Ref:** Regulation 20 (1) (c) (i)<br><br>**Stated:** First time | The registered person shall ensure that staff as appropriate are trained in the following areas:<br>• Care planning (registered nurses)<br>• Moving and handling (registered nurses and care assistants)<br>• Management of restraint (care assistants)<br>• Recording of fluid balance charts (care assistants) | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The registered manager confirmed the following:<br>• nine of the 12 registered nurses employed in the home had received updating in respect of care planning. This was completed during the review of their competency and capability assessment with the registered manager;<br>• 44 staff had undertaken training in moving and handling;<br>• 56 staff had received updating in relation to restrictive practice; and<br>• Nursing and care staff had been informed of the importance of accurately and consistently recording the fluid intake of patients. | |

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| **Requirement 3**<br><br>**Ref:** Regulation 20 (1) (a)<br><br>**Stated:** Third time | The registered person shall having regard to the size of the nursing home, the statement of purpose and the number and needs of patients:<br>Ensure that at all times suitably qualified competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients<br><br>This requirement is made in regard to the shortfall of one registered nurse from 8am - 2pm.<br><br>This requirement is made for the final time | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Confirmation was present on the staff duty rota that three registered nurses were on duty each day from 08:00 – 14; 00, the number of registered nurses on duty reduced from three to two from 14:00 to 20:00 hours. | |
| **Requirement 4**<br><br>**Ref:** Regulation 27 (2) (d)<br><br>**Stated:** First time | The registered person shall ensure that the identified patients' bedrooms are repainted. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>All bedrooms had been repainted from the date of the last inspection. New bedroom furniture and soft furnishings had also been purchased. | |
| **Last Care Inspection Recommendations** | | **Validation of Compliance** |
| **Recommendation 1**<br><br>**Ref:** Standard 5.3<br><br>**Stated:** First time | It is recommended that MUST (Malnutrition Universal Screening Tool) Assessments be recorded monthly or more often if deemed appropriate. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Nursing care records evidenced the MUST (Malnutrition Universal Screening Tool) had been reviewed on a monthly basis. | |

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| **Recommendation 2**<br><br>**Ref**: Standard 12.10<br><br>**Stated:** First time | It is recommended that the daily menu is displayed in a suitable format and in an appropriate location so that patients and their representatives know what is available at each meal time. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The daily menu was displayed on a television monitor in the dining room and it was clearly visible. | |
| **Recommendation 3**<br><br>**Ref:** Standard 5.3<br><br>**Stated:** Second time | It is recommended that patients repositioning charts are recorded appropriately. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Repositioning charts were being consistently recorded and were verified by registered nurses. | |

## 5.3 Standard 19 - Communicating Effectively

### Is Care Safe? (Quality of Life)

Policies and procedures regarding communicating effectively and breaking bad news were reviewed. These policies reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with some but not all staff confirmed that they were knowledgeable regarding this policy and procedure. Management should implement a system to verify that staffs have read the new policy documentation to ensure consistency of approach.

A sampling of training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives or on breaking bad news. 18 staff completed the HSC training programme 'Final Journeys' in April and May 2015. The training included developing communication skills at end of life. A review of the staff induction programme confirmed a section regarding communication impairments and communication techniques was included.

### Is Care Effective? (Quality of Management)

Four care records reviewed did not reflect patients' individual needs and wishes regarding the end of life care as there was no facility within the assessment schedule to discuss individuals' wishes. Recording within records did however include reference to the patient's specific communication needs, for example, where a patient had a sensory or cognitive impairment.

Care records did not evidence that the breaking of bad news was discussed with patients and/or their representatives or that options and treatment plans were also discussed, where appropriate. This was due to the lack of a facility within the assessment schedule and the need to further develop palliative/end of life care plans. This is discussed in more detail in section 5.4 of this report.

There was evidence within four records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs in all other areas.

Care staff were consulted with and they discussed their ability to communicate sensitively with patients and/or representatives. When the need for breaking of bad news was raised, care staff felt this was generally undertaken by nursing staff. However, staff were aware of communication aids/cues, for example, non-verbal cues and gestures. They also felt their role was to empathise and to support patients and their representatives following sensitive or distressing news.

**Is Care Compassionate? (Quality of Care)**

Discussion was undertaken with staff regarding how they communicate with patients and their representatives.

All staff presented as knowledgeable and had a strong awareness of the need for sensitivity when communicating with patients and their representatives.

A number of communication events were observed throughout the inspection visit which validated that staff embedded this knowledge into daily practice. These observations included staff assisting patients with meals, and speaking to patients with a cognitive or sensory impairment.

Staff recognised the need to develop a strong, supportive relationship with patients and their representatives from admission to the home. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required.

The inspector consulted with one visiting relative. The relative confirmed that staff treated patients with respect and dignity and were always welcoming to visitors.

A number of letters complimenting the care afforded to patients were viewed. Families stated their appreciation and support of staff and the care afforded in Greenhaw Lodge.

Comments included:
“We have witnessed ourselves the care and attention that our relative received from all staff.”
“The carers, nurses and even the cleaners all took time to speak to …..”
“It is with heartfelt thanks for your dedication and kindness.”

**Areas for Improvement**

A management system should be implemented to verify that staff are knowledgeable of the policy documentation in respect of communicating effectively and the regional guidelines.

Nursing care records must provide nursing staff with the opportunity to discuss end of life with patients and/or their representatives.

Nursing care records should indicate that end of life wishes have been discussed, as far as possible.

| **Number of Requirements:** | **1** | **Number of Recommendations**: | **2** |
|---|---|---|---|

## 5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

### Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative care, end of life care and death and dying were available in the home. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects. However, as stated in section 5.3 not all staff who met with the inspector confirmed they had read the policy documentation in relation to communicating effectively, palliative and end of life care.

Training records evidenced that staff were trained in the management of death, dying and bereavement. Training which had been completed included:

- HSC Final Journeys, April and May 2015, 18 staff attended
- Regional Palliative and End of Life Care January 2013, one registered nurse
- European Certificate in Palliative Care, September 2014 to November 2014, one registered nurse

The registered manager stated staff that had not completed the 'Final Journeys' training would have the opportunity to do so in the near future.

The review of staff induction training records confirmed that end of life care was included.

A review of the competency and capability assessments for registered nurses evidenced that end of life care was included and the assessments had been validated by the registered manager.

There was an identified link nurse in respect of palliative and end of life care at the time of the inspection. The identified link nurse had completed specialist training.

Discussion with nursing staff and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the registered manager, one registered nurse and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with nursing staff confirmed their knowledge of the protocol.

Specialist equipment, for example, the use of a syringe driver was in not use in the home at the time of inspection.

**Is Care Effective? (Quality of Management)**

A review of care records and discussion with nursing staff evidenced that patients' needs for palliative and end of life care were assessed and referrals had been made to the specialist palliative care service. However, the review of nursing care records did not evidence that palliative/end of life care plans had been written. Nursing care records did not afford for a nursing assessment in conjunction with the patient and/or their representative regarding end of life wishes. Where a patient had been referred and assessed by the palliative care team from the Healthcare Trust, a corresponding plan of care had not been written. The recommendations of the palliative care team were interspersed throughout other plans of care, for example nutrition and hydration. To ensure a holistic approach to care, including the management of hydration and nutrition, pain management and symptom management, palliative/end of life care plans, should have been developed and care needs monitored and evaluated. A requirement has been made.

Discussion with the manager, staff and a review of care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying, patients bedrooms are single rooms' and patients representatives were enabled to stay for extended periods of time without disturbing other patients in the home.

A review of notifications of death to RQIA during the previous inspection year, evidenced they were appropriately submitted.

**Is Care Compassionate? (Quality of Care)**

Discussion with staff evidenced that patients and/or their representatives had been consulted in respect of their spiritual preferences regarding care. Staff gave examples from the past, of how they supported the spiritual wishes of patients and of how staff stayed and gave emotional support to patients at the end of life. Staff stated they were able to sit with patients, if family members were not available so as no patient passed away with no one present.

From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives. There was evidence within compliments records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. The manager confirmed that arrangements were in place to support staff following the death of a patient. The arrangements included for example, bereavement support and staff meetings.

**Areas for Improvement**

Care plans in respect of palliative/end of life wishes and care must be developed, monitored and evaluated in accordance with the assessed needs of patients. The recommendations of the specialist palliative care team should be reflected in patients' care plans, where applicable.

| Number of Requirements: | 1 | Number of Recommendations: | 0 |
|---|---|---|---|

## 5.5 Additional Areas Examined

### 5.5.1. Questionnaires

As part of the inspection process, we issued questionnaires to staff and patients representatives. On this occasion, questionnaires were not given to patients but we observed care practice and spoke to patients on an individual and/or small group basis.

**Staff Views**

Comments on the three returned staff questionnaires were generally positive. Staff confirmed patients were afforded privacy dignity and respect at all times.

Comments included:

"I feel the staff team work well together to provide good quality care."
"Staff are always willing to give up their own time to ensure patients get out on day trips."
"I feel all staff bring different skills and activities to the team and do their very best for all patients."
"The staff at Greenhaw Lodge work as a team to meet patients' needs to the highest standard."
"This team even involves domestic and kitchen staff as their interaction contributes greatly to the patients day."
"Management have an 'open door' policy' encouraging relatives to feel comfortable communicating their relatives needs and/or any concerns or complaints."
"I feel staff work well as part of a team and I have every confidence in my nurse in charge to lead the team."

Comments were also received which should be considered and actioned by the management team of the home, and included:

"Sometimes feel unsupported by District Nurse and GP."
"This is a dementia home; sometimes it is not a quiet environment for a dying patient."
"There is no specific policy on pain management."
"There are no supportive systems in place if staff experience traumatic death."

Management should also consider and action the following areas where staff expressed dissatisfaction in the returned questionnaires:

Two staff were not satisfied with training in respect of palliative and end of life care.
Two staff were not satisfied that there were supportive systems in place to inform patients and staff of a death.
One staff member was not satisfied with the training available on the management of distressing symptoms at end of life care.
One staff member was not satisfied with the training available on communicating effectively and breaking bad news.
One staff member was not satisfied with the training available regarding patient consent and capacity.
One staff member expressed dissatisfaction regarding patients being well supported and enabled to have a dignified death.

**Patients' Views**

Comments received from patients included:
"I like it here and I like my room."
"I am happy."
"Staff are good to me."
"Staff are helpful."

**Patients' Representatives' Views**

One relative took the opportunity to meet with the inspector during the inspection. All comments made were very positive regarding care and communication in the home. The relative commented that staff were very attentive and caring. No issues of concern were raised by this relative.

**5.5.2. Dementia Care Practice**

**Meals and Mealtimes**

The inspector observed the serving of the midday meal. The following comments were made;

Dining tables should be appropriately presented and include, for example, tablecloth/ placemats, crockery which is a distinguishing colour, a range of condiments and serviettes to facilitate independence and enhance the dining experience for patients. This was discussed with staff who stated that they had, in the past, set dining tables but found that patients 'lifted' serviettes, cutlery etc. The dining experience should be a pleasurable and relaxed experience for patients. This was discussed with the registered manager who informed that to her knowledge dining tables were appropriately set. The manager agreed to review the dining arrangements in the home. A recommendation was made.

In discussion with the cook regarding the menu, the cook stated patients who require a specialised diet do not have a choice of meal. The meal choice of patients who require a therapeutic diet should be clearly evident, patients should not all receive the same pureed meal choice. The arrangements for specialised diets were discussed and the cook was advised that the current arrangements of reheating the previous day's meat course for those on a specialised diet should be discontinued. A requirement has been made.

**The Environment**

Greenhaw Lodge is a large single storey home with most bedroom and other facilities coming off a continuous corridor. During the year the bedrooms have been repainted and new bedroom furniture purchased. A good standard of cleanliness and hygiene was evident.

However, consideration should be given to the environment from the perspective of a person with dementia. More signage would provide orientation markers for patients and the use of some lounge areas should be reviewed. Two of the lounges could be designated as lounge/dining areas to provide patients with a smaller and quieter area for daily living. The activities room was well resourced and interesting however; the flooring was in a poor state and requires to be replaced.

The registered manager stated a number of patients present with behaviours that challenge. The environment is a crucial factor and best practice indicates that smaller, more domesticated environments may reduce other stimuli which may exacerbate behaviours for example; noise levels, an unfamiliar environment and lack of social and recreational opportunities. Management should complete a dementia audit to assist with the review of the environment. A requirement has been made.

An activities coordinator is employed in the home and discussed her role very knowledgeably and enthusiastically. In discussion, the activities coordinator stated the importance of one to one time with patients and that the focus of her role was to include all patients in social activities and opportunities. Life story work had not been developed with patients. The need to develop life story information was discussed so as to inform staff how best to engage and care for patients. A recommendation has been made.

## 6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ronagh McCaul, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

### 6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

### 6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

## 6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

| Quality Improvement Plan | |
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| **Statutory Requirements** | |
| **Requirement 1**<br><br>**Ref:** Regulation 16 (1)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 October 2015 | The registered person must ensure care plans in respect of palliative/end of life wishes and care must be developed, monitored and evaluated in accordance with the assessed needs of patients. The recommendations of the specialist palliative care team should be reflected in patients' care plans, where applicable.<br><br>**Ref: Section 5.4** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Care plans in respect of pallative/ end of life wishes has been developed in accordance with the assessed need of patient. The reccommendations of specialist teams are reflected in the care. |
| **Requirement 2**<br><br>**Ref:** Regulation 12 (1)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015 | The registered person must ensure the environment of the home enhances the lived experience of patients. A dementia audit should be undertaken and a management plan implemented to address the shortfalls identified in the audit. The management plan should be submitted to RQIA on completion.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The company's enviromental/ Estates Director is attending the Dementia design school course which is lead by sterling university on the 11.11.15, following this a full audit will be undertaken and a management plan will be implemented to address any shortfalls identified . The plan will be submitted to the RQIA completion. |
| **Requirement 3**<br><br>**Ref:** Regulation 12 (4)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 October 2015 | The registered person must ensure patients are offered a choice at mealtimes and include patients who require a specialised diet. Written records should be maintained to evidence choice has been offered.<br><br>**Ref: Section 5.2.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Patients are offered a choice at mealtimes which includes specialised diets. Written records are maintained in the home to evidence choice has been offered. |

| Recommendations | |
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| **Recommendation 1**<br><br>**Ref:** Standards 19 and 32<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 October 2015 | A system to evidence that staff have read the policy documentation regarding communicating effectively and palliative/end of life care should be implemented.<br><br>**Ref: Section 5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A record of supervision reflects a system that staff have read policy documentation regarding communicating effectively on pallative/ end of life care. |
| **Recommendation 2**<br><br>**Ref:** Standard 32.1<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 October 2015 | The assessment schedule within patients care records should include a section on end of life wishes.<br><br>**Ref: Section 5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A full section on end of life wishes is being reviewed by the company which will be implemented when concluded. |
| **Recommendation 3**<br><br>**Ref:** Standard 32.1<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 October 2015 | Nursing care records should evidence that the end of life wishes have been discussed with the patient and/or the patient's representative.<br><br>**Ref: Section 5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>End of life wishes are discussed with patients representives which are evidenced in nursing care records. |
| **Recommendation 4**<br><br>**Ref:** Standard 12.21<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 October 2015 | The dining experience for patients should be in accordance with best practice in dementia care. Dining tables should be appropriately set with tablecloths, serviettes, condiments and dementia specific crockery according to the needs of patients.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The dining experience for patients is in accordance with dementia care guidelines. Dining tables are set appropiately and according to individual need. |

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| **Recommendation 5**<br><br>**Ref:** Standard 4.3<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 December 2015 | Life story information should be gathered and developed into a booklet/reference source for staff to assist staff in engaging with patients in a person centred manner.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Life story information has been gathered and developed into a booklet. |
| **Recommendation 6**<br><br>**Ref:** Standard 43<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 December 2015 | The environment of the home should be reviewed to ensure it is dementia enabling. The use of signage should be reviewed. Consideration should be given to the use of some of the other facilities in the home and maximise their potential for persons with dementia, for example move the nurses station out of a patients lounge.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The company's enviromental/ estates directors is attending the dementia design school course on 11.11.15. The nurses station is not a patients lounge. |

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| **Registered Manager Completing QIP** | Ronagh Mc Caul | **Date Completed** | 04.11.15 |
| **Registered Person Approving QIP** | Ciaran Sheehan | **Date Approved** | 09.11.2015 |
| **RQIA Inspector Assessing Response** | Heather Sleator | **Date Approved** | 24/11/15 |

***Please ensure the QIP is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address***