Unannounced Care Inspection Report
10 April 2017

Lansdowne

Type of Service: Nursing Home
Address: 41-43 Somerton Road, Belfast, BT15 3LG
Tel no: 028 9037 0911
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Lansdowne took place on 10 April 2017 from 09.25 to 17.45 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Relevant checks were conducted within the recruitment process prior to a staff member commencing in post. RQIA were suitably informed of notifications under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Accidents and incidents were reviewed monthly to identify any potential patterns or trends. A requirement was made in regard to compliance with best practice in infection prevention and control (IPC). Recommendations were made on staffing arrangements, staff training and the homes generator.

Is care effective?

Risk assessments had been conducted and informed subsequent care plans. There was evidence of engagement with patients' representatives. Staff consulted knew their role, function and responsibilities. Patients and representatives were confident in raising any concerns they may have with the staff and/or management. A requirement was made in regards to the storage of patient care records. Recommendations were made in regards to the consistency of record keeping and the management of staff meetings.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. A requirement was made to address dignity issues observed within a lounge. One recommendation has been made in regard to a review of the provision of activities within the dementia unit.

Is the service well led?

Appropriate certificates of registration and public liability insurance were on display. Complaints received had been managed appropriately and systems were in place to monitor the quality of nursing care. Systems were in place to monitor and report on the quality of nursing and other services provided. No requirements or recommendations were made in this domain.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Alexandra Martins, Deputy Manager, and Lorraine Kirkpatrick, Regional Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 11 October 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Karen Agnew
Person in charge of the home at the time of inspection: Alexandra Martins (Deputy Manager)	**Date manager registered:** 10 March 2016
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI A maximum of 17 patients in category NH-DE to be accommodated in the Dementia Unit.	**Number of registered places:** 86

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 previous care inspection report and the returned QIP
- pre inspection assessment audit.

During the inspection we met with12 patients individually and others in small groups, three patient representatives, five care staff, two registered nurses and one ancillary staff member.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Ten patient, ten staff and eight patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- duty rota for the period 3 to 16 April 2017.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 October 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector and will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 August 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 20 (c) (ii) **Stated:** First time	The registered provider must ensure that the NISCC register is monitored regularly and maintained appropriately.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that the NISCC register is monitored regularly and maintained appropriately.	
Requirement 2 **Ref:** Regulation 18 (2) (a) **Stated:** First time	The registered person must ensure that all patients within the home have a nurse call provision in their bedroom to summon help if needed.	**Met**
	Action taken as confirmed during the inspection: All patients observed within their bedrooms had access to a nurse call provision.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4 Criteria (1) **Stated:** Second time	The registered provider should ensure that continence assessments are completed in full and signed by the person completing the assessment.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that continence assessments had been completed in full and signed by the person completing the assessment.	
Recommendation 2 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** Second time	It is recommended that care records should evidence patients and/or their representatives' involvement in the assessment; planning and evaluation of the patients' care to meet their needs. If involvement is not possible, then the reason why should be clearly documented within the patient's care record.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced involvement of patients and/or their representatives as appropriate.	
Recommendation 3 **Ref**: Standard 44 Criteria (1) **Stated:** Second time	It is recommended that patients' bedroom furniture and radiator covers are reviewed and any furniture with exposed wood evident should be repaired or replaced accordingly.	**Met**
	Action taken as confirmed during the inspection: An ongoing refurbishment plan was in place. Radiator covers reviewed had been repaired or replaced.	
Recommendation 4 **Ref:** Standard 17 **Stated:** First time	The registered person should ensure a system is in place to manage safety alerts and notifications.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and staff and a review of records evidenced a system was now in place to manage safety alerts and notifications.	

4.3 Is care safe?

The manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 3 April 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels. Five staff consulted on inspection and a staff respondent within a questionnaire expressed concerns with staffing arrangements. This was discussed with the manager and a recommendation was made to review the staffing arrangements in response to the concerns raised by staff.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of records confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. An induction booklet was completed and signed by the new employee and the staff member responsible for completion of the induction. Staff consulted also commented that when they were transferred to work in other homes, the induction and orientation programme was not satisfactory and in some cases did not happen. This was discussed with the regional manager who agreed to review staffs' concerns with the registered managers in the identified homes.

Discussion with the manager and review of training records evidenced that a system was in place to monitor staff attendance at mandatory training. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. However, compliance training achieved in adult safeguarding training was observed to be 56 percent and infection prevention and control was observed to be at 63 percent achieved. This was discussed with the manager and a recommendation was made to ensure that training requirements in these identified areas were met in a timely manner.

The manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 22 August 2016 confirmed that these were appropriately managed. Accidents and incidents were reviewed monthly to identify any potential patterns or trends.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Rooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction.

The following issues were not managed in accordance with best practice guidelines in infection prevention and control:

- inappropriate storage in identified rooms
- unlaminated signage
- shower chairs not effectively cleaned after use

The above issues were discussed with the manager and an assurance was provided by the manager that these areas would be addressed with staff and measures taken to prevent recurrence. A requirement was made.

During the inspection it was found during discussion with home staff that the standby generator was not checked regularly to ensure that it would operate in the event of a mains electrical failure. Subsequent correspondence between RQIA Estates inspector and Four Seasons Health Care Property Manager also indicated that the generator had not been serviced over the past year. The Property Manager stated that the equipment would be serviced during the next week.

The provider must ensure that the home's standby generator is serviced and that the equipment is checked regularly in line with manufacturer's instructions and current good practice to ensure that the home can continue to operate in the event of a mains electrical supply failure in accordance with Health Technical Memorandum (HTM) 06-01, Electrical services supply and distribution. This should include on-load running of the equipment on a monthly basis. If the generator is not to be maintained as above, alternative arrangements should be put in place to ensure that the home can continue to operate in the event of a mains electrical supply failure. The provider should provide RQIA with details of these arrangements if applicable. A recommendation was made.

Areas for improvement

It is required that the registered person ensures the IPC issues identified on inspection are managed to minimise the risk and spread of infection.

It is recommended that the staffing arrangements in the home are reviewed to ensure the needs of patients are met on an ongoing basis.

It is recommended that the training requirements on safeguarding and infection prevention and control are met in a timely manner.

It is recommended that the generator in the home is maintained in accordance with manufacturer's guidance and legislation.

Number of requirements	1	**Number of recommendations**	3

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had been personalised to meet the individual needs of the patients and had been reviewed monthly.

However, a requirement was made in relation to the storage of records. Current patient care records were stored in an unlocked cupboard at the nurses' station. The nurses' station was frequently unattended during the day and everyone had access to the nurses' station as it was in an open environment.

Supplementary care charts such as repositioning, bowel management and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. However, supplementary records were observed on a patient's table in an identified lounge and not stored securely. This has been subsumed into the requirement made above.

During a review of patient care records, a 'diet notification sheet' indicated that the patient was assessed as able to consume normal thin fluids. Discussion with staff and a review of the patient's care plan evidenced that the patient's needs had changed and now had a fluid requirement of a stage two consistency. This was discussed with the manager and a recommendation was made to ensure that all records relating to the patient's fluid requirement were amended to reflect the patient's current need.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift.

Discussion with the manager and staff confirmed that staff meetings were conducted regularly for registered staff. Minutes of these meetings were available and included details of attendees; dates; topics discussed and decisions made. Records indicated that care staff had two opportunities to attend staff meetings in the past year. All staff consulted were not satisfied with the management of staff meetings. This was discussed with the manager and a recommendation was made to review the management of staff meetings.

A 'Quality of Life' (QOL) feedback system was available at the entrance to the home. The manager confirmed that the home aimed to achieve service feedback from a variety of staff; visiting professionals; patients and patient representatives.

Staff consulted knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the manager. However, three staff consulted indicated they felt concerns raised were not taken seriously. This was discussed with the regional manager who agreed to review this. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

It is required that patient care records within the home are stored securely in accordance with professional guidance and The Nursing Homes Regulations (Northern Ireland) 2005.

It is recommended that when a patient's fluid requirement need changes, all records relating to this change are amended to reflect the change of need.

It is recommended that staff meetings are conducted in accordance with the DHSSPS Care Standards for Nursing Homes 2015.

Number of requirements	1	**Number of recommendations**	2

4.5 Is care compassionate?

Two registered nurses, five carers and one ancillary staff member was consulted to ascertain their views of life in Lansdowne Nursing Home. Ten staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. One of the questionnaires was returned within the timescale for inclusion in the report.

Some staff comments were as follows:
"I'm happy here."
"Everyone gets on well here."
"It can be very stressful working here."
"I sometimes have no feeling of stability."
"I really like working here."
"I don't feel concerns I raise are taken seriously."
"We need more regular staff meetings."

Twelve patients were consulted and the patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Ten patient questionnaires were left in the home for completion. One of the questionnaires was returned within the timescale.

Some patient comments were as follows:
"I have no complaints at all in here."
"It's alright in here."
"It's good. The staff are very attentive."
"It's quite alright. I like it here."
"It's ok."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Three patient representatives were consulted with on the day of inspection. Eight relative questionnaires were left in the home for completion. Two relative questionnaires were returned. Both respondents indicated that they were satisfied with the care provided in the home.

Some relatives' comments were as follows:
"It's absolutely brilliant care here. Staff keep me up to date."
"I haven't seen any stimulation for patients in Dementia unit."
"The care here is very good."

Staff interactions with patients were observed to be compassionate, caring and timely. Staff were observed in conversation with patients when assisting them and to knock on bedroom doors before entering them. However, practices observed in a lounge were not deemed dignified for patients who were sitting there. For example, 12 plastic cases of nutrition drinks were stored to one side of the lounge. Two bottles of water belonging to staff members had been placed beside the television. One staff member's coat and handbag was sitting on a chair beside a patient. Patients' supplementary records had been placed on a table beside patients' chairs. These records were moved from the table to a couch and were observed impeding a patient wishing to lie down on the couch (see section 4.3 regarding the storage of patient records). An electrical extension cable was placed on a patients table beside patient chairs. This was discussed with the manager and a requirement was made.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

The serving of lunch was observed in the main dining room within the Dementia unit. Patients were seated around tables which had been appropriately laid out for the meal. Food was served from the kitchen when patients were ready to eat or be assisted with their meals. Food appeared nutritious and appetising. The mealtime was well supervised. Staff were observed to encourage patients with their meals. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. Patients were observed to be assisted in an unhurried manner. Condiments were not available on tables and were not observed to be offered to patients. A pictorial menu board was on the wall though not in use for the mealtime observed. Inappropriate background music was played during the mealtime which was immediately changed when identified by the inspector to a member of staff. These issues were discussed with the manager who agreed to review them. A range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience.

The provision of activities was reviewed within the dementia unit. A programme of the previous week's activities was on display on the door leading to the lounge. There were no activities observed on the day of inspection in the unit. A relative commented that, in their opinion, there was not enough stimulation for patients in the dementia unit. This was discussed with the manager and a recommendation was made.

Areas for improvement

It is required that the registered person ensures the dignity issues identified on inspection are managed to prevent recurrence.

It is recommended that the provision of activities in the dementia unit is reviewed to ensure positive and meaningful outcomes for patients.

Number of requirements	1	**Number of recommendations**	1

4.6 Is the service well led?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the manager evidenced that the home was operating within its registered categories of care.

Discussion with the manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints procedure was displayed at reception.

A compliments file was not maintained to record and evidence compliments received. This was discussed with the manager and it was agreed that a compliments file would be maintained to evidence compliments received and for staff to review.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Areas for improvement have been identified in the safe, effective and compassionate domains with regard to IPC, storage and content of records, dignity issues, staffing arrangements, staff training, staff meetings, provision of activities and the homes generator. Compliance with these requirements and recommendations will further drive improvements in these domains.

Areas for improvement

No areas for improvement were identified during the inspection under this domain.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Alexandra Martins, deputy manager and Lorraine Kirkpatrick, regional manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP via web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 14 April 2017	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** The issues identified by the inspector have been addressed and compliance with the expected standard is being monitored during daily walkarounds by the Registered and Deputy Manager.
Requirement 2 **Ref:** Regulation 19 (1) (b) **Stated:** First time **To be completed by:** 14 April 2017	The registered person must ensure that patient care records maintained within the home are stored securely in line with legislative and professional guidance. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** Supervision has been completed with the nurses and care teams. Locks have been replaced on the cupboard doors and care staff are reminded not to leave supporting documents unattended but to store them in the cupboards provided in both units. Compliance is monitored daily and outcomes recorded in the QOL Daily Managers Audit
Requirement 3 **Ref:** Regulation 13 (8) (a) **Stated:** First time **To be completed by:** 11 April 2017	The registered person must ensure that the dignity issues identified on inspection are managed to prevent any reoccurrence. **Ref: Section 4.5** **Response by registered provider detailing the actions taken:** Supervision has been completed with the staff team and expected standards clearly identified. Personal belongings are now stored in the lockers already provided for staff use.
Recommendations	
Recommendation 1 **Ref:** Standard 41 **Stated:** First time **To be Completed by:** 14 April 2017	The registered person should review staffing levels to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** Chess dependency tool was completed on 23rd March and dependencies rechecked again on 18th April. Review of the duty rota indicates there were sufficent staff on duty to meet the needs of the residents. Chess dependencies are calculated on a monthly basis and retained within the home.

Recommendation 2 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 1 June 2017	The registered person should ensure that the training requirements on safeguarding and IPC are met in a timely manner. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: As discussed with the Inspector, due to a computer glich requiring the reseting of these modules, the training stats for both safeguarding and infection control only reflected the training undertaken since 22nd February 2017. As of 1st June 2017 - 100% of staff have completed Safeguarding and 97% have completed IPC
Recommendation 3 **Ref:** Standard 44 Criteria (8) **Stated:** First time **To be completed by:** 10 June 2017	The registered person should ensure that the home's standby generator is serviced and that the equipment is checked regularly in line with manufacturer's instructions and current good practice. If the generator is not to be maintained as above, alternative arrangements should be put in place and RQIA provided detail of these arrangements. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The homes generator was serviced on 9th May 2017. A review of generator provision across the FSHC Estate is currently taking place. The Estate's Director is visiting the site on 9th June 17. In the interim both the Property Manager and H&S Manager will be contacted in the event of a power failure to assist staff in the manual switching on of the generator.
Recommendation 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 17 April 2017	The registered person should ensure that when a patient's fluid requirement need changes, all records relating to this change are amended to reflect the change of need. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: An audit of all nursing and care records pertaining to nutrition and hydration has been completed. Deficits identified have been fully addressed. The 24 hour report completed by the staff for the home manager requires that they report when a SALT assessment takes place. This acts as a prompt for the Manager or Deputy Manager to review the records and ensure they are correlated.
Recommendation 5 **Ref:** Standard 41 Criteria (8) **Stated:** First time **To be Completed by:** 31 August 2016	The registered person should ensure staff meetings take place on a regular basis and at a minimum quarterly. Records are kept which include: • The date of all meetings • The names of those attending • Minutes of discussions • Any actions agreed **Ref: Section 4.4**

	Response by registered provider detailing the actions taken: A record of all meetings conducted is available within the home. Meetings with all the staff teams were conducted following the inspection. A copy of the planned meetings for the remainder of 2017 has been displayed on the staff notice board. Staff will continue to be invited to meetings using the careblox messaging facility.
Recommendation 6 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 1 May 2017	The registered person should review the provision of activities in the dementia unit to ensure meaningful activities are offered to patients. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: Pool Activity Assessments have been updated for all residents in the Dementia Unit in May 2017. This was cross referenced with the current activity plan to ensure appropriate activites were being arranged. Review of wellbeing scores and the low number of distressed reactions in this unit indicated that residents are appropriately stimulated . The Dementia Unit achieved the Four Seasons Dementia Care Framework Accredidation on 1st June 2017

Please ensure this document is completed in full and returned via web portal

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