Unannounced Care Inspection Report
28 July 2020

Wood Lodge

Type of Service: Nursing Home (NH)
Address: 50 Mill Hill, Castlewellan BT31 9NB
Tel No: 028 4377 8511
Inspectors: Julie Palmer & Joseph McRandle

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 49 patients.

3.0 Service details

Organisation/Registered Provider: G & M Lodge Care Ltd **Responsible Individual:** Marie McGrady (Acting)	**Registered Manager and date registered:** Ann Marie Frost 8 November 2019
Person in charge at the time of inspection: Ann Marie Frost	**Number of registered places:** 49 There shall be a maximum of 14 named residents receiving residential care in category RC-I and 1 named resident receiving residential care in category RC-PH.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 39

4.0 Inspection summary

An unannounced inspection took place on 28 July 2020 from 09.30 to 17.30 hours. The inspection was undertaken by the care and finance inspectors.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

The most recent inspection of the home was undertaken on 17 October 2019; since then RQIA had been appropriately informed that the home was under new management.

The following areas were examined during the inspection:

- staffing
- personal protective equipment (PPE)
- infection prevention and control (IPC) measures
- care delivery
- care records
- management of patients' finances
- governance and management arrangements.

Patients said:

- “It’s grand here.”
- “There are plenty of staff to help me.”
- “It’s brilliant.”

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients’ experience.

The term ‘patients’ is used to describe those living in Wood Lodge which provides both nursing and residential care.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	5

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ann Marie Frost, Manager, and Marie McGrady, Responsible Individual, 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.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with ten patients, two patients’ relatives and eight staff. Questionnaires were left in the home to obtain feedback from patients and patients’ relatives/representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line; no responses were received.

The inspector provided the registered manager with ‘Have we missed you cards’ which were then placed in a prominent position to allow patients and their relatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

The following records were examined during the inspection:

- duty rotas for all staff from 27 July to 9 August 2020
- staff training records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff supervision matrix
- two staff recruitment files
- a selection of governance audits
- complaints and compliments records
- incident and accident records
- seven patients' care records
- nurse in charge competency assessment records
- a sample of monthly monitoring reports
- RQIA registration certificate
- three patients' finance files including copies of written agreements
- a sample of financial records including patients' personal allowance monies, patients' valuables, patients' fees and purchases undertaken on behalf of patients
- a sample of records of payments to the hairdresser and podiatrist
- a sample of records of monies deposited on behalf of patients
- a sample of records of reconciliations of patients' monies
- a sample of records of patients' personal property
- a sample of records of monies held in the patients' bank account.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 17 October 2019.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref: Regulation 5** **Stated: First time**	The registered person shall ensure that there is evidence that each patient or their representative has been provided with an individual written agreement setting out the terms and conditions of their residency in the home.	**Met**

	Action taken as confirmed during the inspection: A review of three patients' files evidenced that signed written agreements were retained within all three files. The agreements reviewed set out the terms and conditions of the patients' residency within the home. The agreements were signed by the patients, or their representatives, and a representative from the home; this area for improvement had been met.	
Area for improvement 2 **Ref:** Regulation 20 (3) **Stated:** First time	The registered person shall ensure that any registered nurse, given the responsibility of taking charge of the home in the absence of the manager, must first complete a competency and capability assessment pertinent to this role.	**Met**
	Action taken as confirmed during the inspection: Review of the relevant records evidenced that all nurses who took charge of the home had completed an up to date competency and capability assessment; this area for improvement had been met.	
Area for improvement 3 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time	The registered person shall ensure that falls management in the home is maintained in accordance with best practice guidance such as National Institute for Health and Care Excellence guidance.	**Met**
	Action taken as confirmed during the inspection: Review of care records for patients who had had a fall evidenced that falls management was in accordance with best practice guidance; this area for improvement had been met.	
Area for improvement 4 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure that harmful chemicals in the home are not accessible to patients in keeping with COSHH legislation.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced that no harmful chemicals were accessible to patients; sluices were secured with keypad locks; this area for improvement had been met.	

Area for improvement 5 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time	The registered person shall ensure that wound care management is in accordance with best practice guidance such as National Institute for Health and Care Excellence guidance.	**Met**
	Action taken as confirmed during the inspection: Review of care records evidenced that wound care management was carried out in accordance with best practice guidance; this area for improvement had been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 14 **Stated:** First time	The registered person shall ensure that an up to date written safe contents record is available. The safe contents record should be reconciled and be signed and dated by two people at least quarterly.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that a system was in place to record patients' items deposited to and withdrawn from the safe place. Records of items held in the safe place were up to date at the time of the inspection. Records showed that the contents of the safe place were reconciled at least quarterly. Two members of staff had signed the records to confirm the items were checked. This area for improvement had been met.	
Area for improvement 2 **Ref**: Standard 14.10 **Stated:** First time	The registered person shall ensure that each transaction in the patients' income and expenditure records are signed by two people.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of records of transactions undertaken on behalf of five patients showed that all of the transactions were signed by at least two members of staff. This area for improvement had been met.	
Area for improvement 3 **Ref**: Standard 14.9 **Stated:** First time	The registered person shall ensure that (cash) deposit receipts are available in the home. It is best practice for these receipts to be signed by two people.	**Met**

	Action taken as confirmed during the inspection: A review of a sample of records of monies deposited at the home on behalf of two patients showed that receipts were available for each of the transactions. The receipts were signed by the person depositing the monies and countersigned by a member of staff. This area for improvement had been met.	
Area for improvement 4 **Ref**: Standard 14.9 **Stated:** First time	The registered person shall ensure that expenditure receipts are available to evidence how a patient's money has been spent on their behalf. If monies are withdrawn and provided to individual patients for their own use, the ledgers must detail this specifically.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of records of purchases undertaken on behalf of four patients evidenced that receipts were available for each of the purchases. Records also identified if monies were handed to patients for their own use, the records were signed by the patient and a member of staff or two members of staff. This area for improvement had been met.	
Area for improvement 5 **Ref**: Standard 14.25 **Stated:** First time	The registered person shall ensure a reconciliation of patients' personal monies and valuables in the safe place are carried out and signed and dated by two people at least quarterly.	**Met**
	Action taken as confirmed during the inspection: A review of records confirmed that reconciliations of patients' monies and valuables were undertaken at least quarterly in line with the Care Standards for Nursing Homes (2015) The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff. This area for improvement had been met.	
Area for improvement 6 **Ref**: Standard 14.13 **Stated:** First time	The registered person shall ensure that hairdressing and podiatry treatment records are maintained in the home and detail the information required by standard 14.13.	**Met**

	Action taken as confirmed during the inspection: A review of a sample of records of payments to the hairdresser and podiatrist showed that the required information was included in the records e.g. names of patients receiving treatment, details of the treatment provided and the cost of each treatment. The records were signed by both the hairdresser and podiatrist and countersigned by a member of staff to confirm that the treatments took place and the cost of each treatment. This area for improvement had been met.	
Area for improvement 7 **Ref**: Standard 14.26 **Stated:** First time	The registered person shall ensure that records of patients' furniture and personal possessions which they have brought to their rooms are reconciled and signed and dated by a staff member and countersigned by a senior member of staff at least quarterly.	**Met**
	Action taken as confirmed during the inspection: A review of three patients' property records evidenced that, since the last inspection, the records had been updated and reconciled in line with the Care Standards for Nursing Homes (2015). The records were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff. This area for improvement had been met.	
Area for improvement 8 **Ref**: Standard 14.6 **Stated:** First time	The registered person shall ensure that each patient is provided with a personal monies authorisation record for signature detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services.	**Met**
	Action taken as confirmed during the inspection: A review of three patients' files evidenced that written authorisation forms for members of staff to undertake transactions on behalf of patients were retained in the files. The authorisation forms were signed by the patients or their representatives and a representative from the home. This area for improvement had been met.	

Area for improvement 9 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that care plans are updated to reflect patients' changing needs.	**Met**
	Action taken as confirmed during the inspection: Review of the care records for a patient whose condition had changed evidenced that these had been appropriately and contemporaneously updated; this area for improvement had been met.	
Area for improvement 10 **Ref**: Standard 4.7 **Stated:** Second time	The registered person shall ensure that patients' daily fluid intake is evaluated at the end of each 24 hour period to determine if they have achieved their daily target.	**Met**
	Action taken as confirmed during the inspection: Review of fluid intake and output records evidenced that a daily evaluation was undertaken and care plans reflected the action to be taken in the event of a target not being met; this area for improvement had been met.	
Area for improvement 11 **Ref**: Standard 40 **Stated:** First time	The registered person shall ensure that a system is in place to ensure that registered nursing and care staff employed receive two recorded supervisions annually.	**Met**
	Action taken as confirmed during the inspection: Review of the supervision schedule which had been developed and discussion with staff evidenced that this area for improvement had been met.	
Area for improvement 12 **Ref**: Standard 4 Criteria (9) **Stated:** First time	The registered person shall ensure that repositioning records are completed in full to include the position the patients have been repositioned from and to.	**Met**
	Action taken as confirmed during the inspection: Repositioning records reviewed evidenced that the position of patients was recorded; this area for improvement had been met.	

Area for improvement 13 **Ref**: Standard 21 Criteria (11) **Stated:** First time	The registered person shall ensure that bowel function, reflective of the Bristol stool chart is recorded on admission as a baseline measurement and thereafter in the patients' daily progress records.	**Met**
	Action taken as confirmed during the inspection: Review of care records for bowel function evidenced that these were reflective of the Bristol stool chart; this area for improvement had been met.	

6.2 Inspection findings

Staffing

The manager told us that planned daily staffing levels were subject to regular review to ensure that the assessed needs of patients were met. On the day of the inspection we observed that staffing levels were satisfactory and patients' needs were met by the levels and skill mix of staff on duty. Staff attended to patients' needs in a caring and timely manner.

We reviewed recruitment records for two members of staff; these evidenced that the appropriate pre-employment checks had been completed prior to the staff member commencing employment and that a period of induction had been undertaken.

There was a system in place to ensure that registered nurses maintained their registration with the NMC and that care staff were registered, or in the process of registering, with NISCC.

A record of staff training was maintained. Discussions with staff evidenced that training was mainly provided online at present due to social distancing restrictions. Staff told us that they felt well trained to carry put their role and had been kept up to date with information required in relation to the COVID-19 pandemic.

Staff spoken with told us that teamwork was good, the manager was approachable and they enjoyed working in the home; comments included:

- "I love it."
- "Training has been very, very good."
- "We are just like a family."
- "We are very well supported."
- "New managers are very approachable."

Personal protective equipment (PPE)

Staff had been provided with a separate entrance and changing facilities to enable them to put on their uniform and the recommended PPE before they entered the home. No personal belongings were taken into the home. Staff had a temperature and symptom check completed prior to commencing their shift. We also changed and had our temperature checked prior to entering the home.

PPE was readily available throughout the home; stations were well stocked and replenished regularly. Staff told us that good supplies of PPE were maintained at all times. We observed that staff carried out hand hygiene appropriately and very regularly. Staff were observed to use PPE in accordance with the regional guidance and to put on and take off PPE correctly. The manager told us that staffs' use of PPE was monitored through observations and audits.

Staff were wearing masks and visors during their shift; the manager recognised that this was tiring and encouraged staff to take regular breaks. Staff had been provided with a designated break area where they could safely remove their PPE and had room to socially distance.

Infection prevention and control (IPC) measures

Signage had been put up at the entrance and throughout the home to reflect the current guidance on COVID-19.

We reviewed the home's environment; this included observations of a sample of bedrooms, bathrooms, lounges, dining rooms, treatment rooms, sluices and storage areas. Sluices and storerooms had keypad locks in situ and those reviewed were secured to ensure patients could not access them. The home was found to be warm, clean, tidy and fresh smelling throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. Patients' bedrooms were attractively decorated and personalised.

The manager and responsible person discussed the extensive refurbishment planned for the home; unfortunately, some initial minor improvements had been delayed due to COVID-19 but will commence as soon as possible, following appropriate risk assessment.

Staff were observed to be following IPC best practice guidelines, for example, cleaning hoists and other equipment between patient use.

Domestic staff were also observed to use PPE correctly and to carry out enhanced cleaning of frequently touched surfaces in the home.

Care delivery

Patients looked well cared for and were observed to be content and settled in their surroundings and in their interactions with staff. It was obvious that staff knew the patients well; staff were observed to display a warm and friendly attitude towards the patients and to treat them with kindness and respect.

We observed that patients who were in their rooms had call bells within reach; some patients were comfortably seated in the lounges. Staff were seen to be attentive to patients and to answer call bells promptly.

The food on offer at lunchtime smelled appetising and was well presented. Staff demonstrated their knowledge of individual patients likes and dislikes and any modified diet and fluid requirements. Patients were offered discreet assistance as required. Social distancing measures were maintained as far as possible; some patients took their meals in the dining rooms, others in their own bedrooms as they preferred.

We spoke to a senior nurse from the South Eastern Health and Social Care Trust (SEHSCT) Enhanced Care at Home (ECAH) team who was in the home to discuss anticipatory care with the manager. The ECAH nurse told us that she found staff in the home made timely and

appropriate referrals to the team, were responsive to recommendations and ensured that these were followed.

Patients spoken with commented positively about their experience of living in Wood Lodge, they told us:

- "My room is lovely."
- "The food is lovely."
- "I feel well looked after."
- "They do their best."
- "It's lovely in here."
- "There is not always enough staff but they do their best."
- "I think the chef is quite good."
- "It's all good."
- "The food is great."
- "It's brilliant."

One completed patient questionnaire was returned; this indicated satisfaction with the care provided but did note a delay in answering the call bell at times.

Comments made by patients were brought to the attention of the manager for information and action if required.

Care records

We reviewed seven patients' care records which evidenced that individualised care plans had been developed to direct the care required and were regularly evaluated to reflect any changes.

Review of falls management evidenced that in the event of a fall neurological observations were completed if a head injury was confirmed or suspected, medical advice was sought if required and the relevant risk assessments and care plans were updated. Falls in the home were monitored on a monthly basis for patterns or trends.

Food and fluid intake charts reviewed were up to date, the total daily fluid intake had been calculated where required and care plans directed action to be taken in the event of fluid targets not being met. Wound care records were up to date and reflective of the care directed in wound care plans. There was evidence of referral to and recommendations from the tissue viability nurse (TVN) speech and language therapist (SALT) and dietician where required.

Repositioning records reviewed did include the position the patient had been repositioned to and from. However, we noted that these records were not always accurately completed to indicate the individual patient's skin condition at the time of repositioning, staff did not always use the appropriate, meaningful abbreviation that was indicated on the form; an area for improvement was made.

A record of bowel function was maintained and was reflective of the Bristol stool chart. Daily records reviewed were informative and up to date.

Management of patients' finances

Financial systems and controls in place at the home regarding patients' monies were reviewed; these included the system for recording transactions undertaken on behalf of patients, the

system for recording the reconciliations of patients' monies, the system for recording patients' personal property and the system for retaining patients' personal monies.

Discussion with staff confirmed that social security benefits were received on behalf of one patient. It could not be confirmed at the time of the inspection if a representative from the home was acting as the patient's appointee .i.e. a person authorised by the Social Security Agency (SSA) to receive and manage the social security benefits on behalf of an individual. Following the inspection the manager contacted RQIA confirming that a representative from the home was acting as an appointee and that the home was in the process of relinquishing the appointeeship to the patient's next of kin. A copy of the correspondence from the SSA authorising the representative from the home to act as the patient's appointee was also forwarded to RQIA.

The manager was advised to ensure that the patient's care manager was involved in the discussions agreeing to transfer appointeeship to the patient's next of kin.

The benefits received for the patient were paid into a bank account; the account could not be accessed at the time of the inspection as it was managed off site. Following the inspection the manager provided assurances to RQIA that the bank account was checked at least quarterly and that the balance of monies owned by the patient was up to date.

The home's office manager was managing a bank account for one patient and post office account for another. A review of a sample of records of withdrawals from the accounts showed that the amounts deposited at the home on behalf of the patients did not correspond with the amounts withdrawn from the accounts on the same day. Discussion with the office manager confirmed that the variance in the amount of monies was due to purchases undertaken on behalf of the patients on the same day as the withdrawals. Receipts from the purchases were available which agreed to the variance between the monies withdrawn from the accounts and the monies deposited at the home.

In line with best practice and to facilitate the audit process the corresponding amount withdrawn from the accounts should be recorded in the patients' transaction sheets and any subsequent purchases should be recorded separately. This was discussed with the manager and identified as an area for improvement.

A review of records showed that statements from the patient's bank account were maintained by the office manager and checked regularly. There was no evidence of segregation of duties as the member of staff making withdrawals from the bank account was also reconciling the bank statements. This was discussed with the manager and identified as an area for improvement.

There was written authorisation from one of the patients for the home to manage their bank account, there was no record of authorisation to manage the post office account on behalf of the remaining patient. Following a discussion the manager agreed to contact the patients' care managers requesting a review of the current arrangements of managing both accounts. Two areas of improvement were identified under the standards.

Discussion with staff confirmed that cigarettes purchased on behalf of patients were retained by members of staff at the home and dispensed to the patients when required. Records were available showing when the cigarettes were dispensed to patients; the records were signed by two members of staff. There was no evidence that the records were included in the quarterly checks of monies and items held on behalf of patients. The manager agreed to include the cigarette records in the quarterly checks. The manager also agreed to sign the records when the checks had been completed.

Governance and management arrangements

Discussion with the manager and review of a sample of auditing records evidenced that systems were in place to assure the quality of care and other services provided in the home. Audits had been completed regarding, for example, IPC measures, falls/accidents, care records, PPE and hand hygiene.

A system was in place to record and manage complaints received. Monthly monitoring reports had been completed remotely during the COVID-19 pandemic; families had been consulted with via telephone and action plans had been developed as required.

Review of records evidenced that systems were in place to ensure that notifiable events were reported to RQIA or other relevant bodies appropriately.

The manager told us that good working relationships were maintained and that the new management arrangements had not affected the day to day running of the home or the quality of care provided.

Areas of good practice

Areas of good practice were identified in relation to staffing, use of PPE, IPC measures, the care provided, care records, treating patients with kindness, dignity and respect, teamwork, maintaining good working relationships and management arrangements.

Areas for improvement

An area for improvement was identified in relation to completion of repositioning records to accurately reflect patient's skin condition; four additional areas for improvement were identified in relation to the management of patients' finances.

	Regulations	Standards
Total number of areas for improvement	0	5

6.3 Conclusion

Patients in the home were observed to be well cared for and content in their surroundings. Staff were friendly, kind and attentive to patients; they obviously knew them well.

The home was clean, tidy and well maintained.

Staff were commended for their good practice regarding adherence to the regional guidance in IPC measures and use of PPE. It was obvious that training in these areas had been very well embedded into practice.

Additional information requested in relation to management of patients' finances was provided to RQIA appropriately and in a timely manner following the inspection.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ann Marie Frost, Manager, and Marie McGrady, Responsible Individual as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that repositioning records are accurately completed to reflect the individual patient's skin condition at the time of repositioning. Ref: 6.2 **Response by registered person detailing the actions taken:** Staff informed to use appropriate abbreviations on Repositioning charts and to include Patients skin condition, charts to be signed off by Staff Nurse at end of shift and Audited monthly to ensure compliance and identify if further training required
Area for improvement 2 **Ref**: Standard 35.21 **Stated:** First time **To be completed by:** 29 July 2020	The registered person shall ensure that the corresponding amount withdrawn from the patients' bank and post office accounts are recorded in the patients' transaction sheets and any subsequent purchases are recorded separately. Ref: 6.2 **Response by registered person detailing the actions taken:** Recommendation fully ahered to and implemented from day of Inspection
Area for improvement 3 **Ref**: Standard 35.21 **Stated:** First time **To be completed by:** 29 July 2020	The registered person shall ensure that the member of staff reconciling the statements from the patient's bank account is not the member of staff making the withdrawals from the account. Ref: 6.2 **Response by registered person detailing the actions taken:** Recommendation fully adhered to and implemented from day of Inspection - Reconciliation being done by Registerd Manager and Financial Controller
Area for improvement 4 **Ref**: Standard 14.6 **Stated:** First time **To be completed by:** 31 August 2020	The registered person shall ensure that written authorisation is obtained from the patient, identified during the inspection, for the home to manage their post office account. A copy of the signed authorisation should be retained in the patient's file. Ref: 6.2 **Response by registered person detailing the actions taken:** Written Authorisation obtained from Patient indicated on day of Inspection and retained in Patients file

Area for improvement 5 **Ref**: Standard 35.21 **Stated:** First time **To be completed by:** 31 August 2020	The registered person shall ensure that the care managers for the two patients identified during the inspection, are contacted to request a review of the current arrangements of managing the bank and post office accounts. Ref: 6.2
	Response by registered person detailing the actions taken: Care Managers of two identified Patients contacted to request review of current arrangements and specific Care Plans regarding this formulated

Please ensure this document is completed in full and returned via Web Portal

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