Unannounced Care Inspection Report
12 and 13 November 2019

Seabank

Type of Service: Residential Care Home
Address: 12a Bath Terrace, Portrush BT56 8AN
Tel no: 02870824285
Inspectors: Priscilla Clayton and 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 Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a registered residential care home which provides care for up to 37 residents within the categories as shown in section 3.0 of this report.

3.0 Service details

Organisation/Registered Provider: Seabank Private Residential Home **Responsible Individuals:** Amanda Duncan Diane Risk	**Registered Manager and date registered:** Charlotte Fiona Simpson 13 April 2018
Person in charge at the time of inspection: Charlotte Fiona Simpson	**Number of registered places:** Total number 37 comprising: RC – I RC – MP (max – 3 residents) RC – MP (E) RC – DE (max- 5 residents) RC – PH (E) RC – PH (max -1 resident)
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia MP - Mental disorder excluding learning disability or dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment PH (E) - Physical disability other than sensory impairment – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 35

4.0 Inspection summary

An unannounced inspection took place on 12 November 2019 from 11.00 hours to 15.30 hours. The supporting finance inspection took place on 13 November 2019 from 11.00 hours to 14.45 hours.

The inspection assessed progress with all areas for improvement identified in the home from the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to; the homely atmosphere, effective team working, staffing; training; care records; and the provision of a culture and ethos which supported residents' rights and the values of dignity and respect, independence, equality and diversity, choice and consent. There were examples of good practice found throughout the inspection in relation to the hairdresser signing records along with a member of staff; two signatures recorded against purchases undertaken on behalf of residents; the retention of receipts from the purchases; and residents issued with up to date written agreements.

Areas requiring improvement were identified in relation to the development of a system for the monitoring of staff NISCC annual registration retention dates; the recording of errors in the residents' transactions book; the recording of the checks of residents' monies; recording of residents' personal property within a set timeframe; and the recording of at least two signatures when monies are deposited on behalf of residents.

Residents described living in the home as being a good experience/in positive terms. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others / with staff.

Comments received from residents, people who visit them and staff during and after the inspection, are included in the main body of this report.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	5

Details of the Quality Improvement Plan (QIP) were discussed with Charlotte Simpson, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent inspection dated 21 February 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 21 February 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the findings from the previous care inspection, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life

- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

Three completed questionnaires were returned to RQIA following the inspection.

During the inspection a sample of records was examined which included:

- staff duty rotas from 4 November to 12 November 2019
- staff training schedule
- three staff recruitment and induction records
- three residents' records of care
- complaint records
- compliment records
- governance audits/records
- accident/incident records
- reports of visits by the registered provider/monthly monitoring reports (September, October 2019)
- RQIA registration certificate
- liability insurance
- fire risk assessment / weekly and monthly fire equipment checks
- kitchen records / menu
- three residents' finance files including copies of written agreements
- residents' personal allowance monies, residents' fees, payments to the hairdresser and purchases undertaken on behalf of residents
- records of monies deposited on behalf of residents
- residents' personal property records
- financial policies and procedures

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

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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 last care inspection dated 21 February 2019

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 **Ref**: Regulation 19.1 (b) **Stated:** First time	The registered person shall ensure that residents' information and records are kept securely in the home at all times. Ref: 6.3	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation of the storage and security of records evidenced that these were retained in a safe secure area.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to residents and clients from the care, treatment and support that is intended to help them.

On arrival at the home all residents were observed to be up washed and dressed with obvious care and attention given to personal care needs. Several residents sat within the lounge while others choose to move freely around the home or relax within their bedroom watching television or reading. Residents told us they had breakfast which was served in the dining room or if they wished within their bedroom.

The ambience within the home was calm and pleasant with staff quietly providing necessary support, reassurance and assistance to residents in a respectful, unhurried manner.

Staffing levels, as discussed with the registered manager and staff and as reflected within the duty roster were considered to be satisfactory in meeting the needs of residents currently accommodated.

The registered manager confirmed that the placement of residents accommodated were appropriate for the residential setting and should their needs change requiring nursing care the commissioning trust care manager would be notified and a nursing assessment arranged to determine the most appropriate placement of the resident to ensure the needs were met.

Staffing levels, as discussed with the manager and staff and as reflected within the staff duty roster, were considered to be satisfactory in meeting the needs of residents accommodated. The manager explained that consistent, knowledgeable and skilled staff were employed so that residents can provide the appropriate care to meet the needs of each resident. Staffing levels in the home were based on in accordance with the number and dependency levels of residents accommodated, layout of the home, fire safety and statement of purpose. Confirmation was also provided by the manager that the placement of current residents accommodated was appropriate and should their needs change to require nursing care a care management review and nursing assessment would be arranged and conducted to determine the most appropriate placement to safely meet the holisyic needs of residents.

The staff duty roster reviewed accurately reflected the staff on duty, hours worked and who was in charge.

Discussion with the manager, staff and review of induction programme evidenced that all new staff appointed had completed an induction programme and monitoring to ensure they can work safely within the home. Like all other care staff they have ongoing supervision to provide support and opportunity to discuss issues / concerns, additional training, and review of the care they provide.

A record of staff registrations with the Northern Ireland Social Care Council (NISCC) was recorded discussed with the manager. Two new staff members were awaiting their registration response from NISCC. One improvement was made in regards to development of a monitoring system of staff NISCC annual retention of registrations. This was readily agreed by the manager.

Review recruitment and selection records evidenced all necessary documentation was in place including the Enhanced Access NI, which is a vetting process of applicants to ensure they are suitable to work in the home. .

We were told by staff that they received regular mandatory training which was provided to ensure they were kept up to date with best practice. In addition other professional development training included, for example: update personal care, dementia awareness, mobility, handling of residents' finances, diversity and equality. Records of all training provided were retained and reviewed. The manager advised that she was sourcing staff training for all employed staff in the Mental Health Capacity Act (Northern Ireland) – Deprivation of Liberty Safeguards (DoLS).

Appropriate management arrangements were in place to ensure that all staff attend adult safeguarding training and have sufficient awareness of the home's policy to help ensure that this is embedded into practice. Staff who spoke with us demonstrated a good understanding of how to recognise and respond to potential safeguarding incidents. The outcome of one safeguarding incident notified to the trust which was discussed with the manager, is to be forwarded to RQIA.

Restrictive practices within the home were discussed with the manager who explained that these included the use of some bed rails, alarm exit doors, sensor alarm mats and management of smoking materials. Associated risk assessments were in place for each restriction. The manager explained that restrictions in place were deemed necessary for resident safety, were reflected within care plans and had been discussed with the commissioning trust. Under the Mental Health Capacity Act all proposed restrictive practice will

require to be assessed and authorised and agreed by the commissioning trust following capacity assessment of the resident.

A review of governance records provided assurance that notifiable events had been submitted to RQIA. It was further noted that the management of falls included the falls tool kit: risk assessments, care plans reflecting measures in place to minimise falls recurring and monthly audits undertaken to identify trends and patterns with action taken to address issues. The manager confirmed that one notification regarding a fall was forwarded to RQIA during the inspection.

Discussions with staff and the manager provided assurance that staff were effectively supported by the senior care staff and manager through informal discussions and a process of regular individual and group supervision and annual appraisal. Staff who spoke to us expressed a high level of satisfaction with the support they received.

Staff told us how the daily care to be provided was planned and delegated to them each morning following receipt of the night staff hand over report. Any changes to residents care needs / care plan are discussed with the team coming on duty so that they are fully informed. Staff who spoke with us knew the residents well and demonstrated good understanding of residents' individual needs and planned care as reflected within person centred care plans which were available to them. Staff confirmed they would always report any observed changes in the health and well- being of residents to the senior care assistant or manager and that the residents' representatives were also kept informed.

We spoke with residents, some individually and with others in small group format. Some of the residents were unable to articulate their views were observed to be relaxed and comfortable in their surroundings and in their interactions with others / with staff. Other residents told us they were "content and happy with their care and that the staff were second to none." No issues or concerns were raised or indicated by residents or staff during the inspection.

Inspection of the home evidenced that all areas, including bathrooms, washrooms, communal lounge / dining area were exceptionally clean, organised, tidy, fresh smelling and comfortably heated. A good standard of hygiene was evidenced with an adequate stock of infection prevention and control resources available to staff. The activities lounge situated on the first floor contained a wide range of resources including craft / art work materials, work tables, comfortable seating and many items of therapeutic activity work completed by residents displayed. This is to be commended.

All fire doors were closed and fire exits unobstructed. The home's fire risk assessment was dated 5 June 2019. Staff training in fire safety was provided during October 2019. Fire drills were undertaken and recorded as required. Weekly and monthly fire equipment checks were being recorded. A smoking area outside of the home was available to residents who smoke. The home has a no smoking policy in place.

Three resident / representative satisfaction questionnaires were completed and returned to RQIA following the inspection. All respondents indicated they were very satisfied that the care provided was safe. One comment included: "The care my relative receives is of a high standard. We couldn't ask for more."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, recruitment, staff induction, infection prevention and control, environmant and staff training.

Areas for improvement

One area identified for improvement was in relation to the development of a system for the monitoring of NISCC registrations / annual retention.

	Regulations	Standards
Total numb of areas for improvement	0	1

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Three residents' care records provided were reviewed and discussed with the manager. Records contained holistic needs assessments which were complemented with a range of risk assessments. Person centred care plans reflecting actual and potential needs were in place. Daily progress notes were recorded. Care management review reports were also retained. Written records reviewed were legible, up to date, signed and dated by the staff member making the entry.

Risk management was discussed with the manager and associated records reviewed included risk assessments relating to falls, moving and handling and nutrition. Care plans reviewed reflected evidence of interventions in place to minimise identified risks.

Discussion with the manager and review of care records evidenced of the commissioning trust multi - professional team collaboration in order to meet the identified needs of residents which included; included general practitioner (GP), social worker, speech and language therapist (SALT), district nurse, dietician, podiatrist, optician and speech and language therapist. Records examined showed residents' weights were recorded on a monthly basis which were monitored by staff to ensure that any weight loss or excessive gain can be followed up with referral to the general practitioner.

Systems in place for monitoring the frequency of resident's health screening included: dental, optometry, and podiatry; and other social care services appointments; referrals where necessary were made to the appropriate service.

The manager explained that the district nurse visited the home on a regular basis to administer various nursing treatments, for example; wound management, injections and the recent anti-flu vaccinations administered to residents who had capacity to agree. Consent was sought from the representatives of residents who were unable to comprehend.

Staff advised us of their daily routine and delegation of work in accordance with their role and responsibilities. During the night staff hand over report to the day team each morning they were given information in respect of each resident, how residents slept, any incidents occurring and any changes to their care plans. The delegation of duties for staff is given by the senior care

assistant which commences with assistance and support to residents in getting up washed and dressed in preparation for breakfast. Planned individual and planned group therapeutic and social activity for the day is discussed. Administration of medications is undertaken by the senior care assistant.

Staff told us that they felt very well supported by senior care staff and manager and explained that they would not hesitate to report any changes to the senior care assistant or manager if required. Staff had a good knowledge of residents' abilities and level of decision making; staff knew how and when to provide comfort to people because they knew their residents very well.

Information from staff, observation and review of records retained evidenced there were good modes of communication to ensure staff, residents and their representatives were kept fully informed of all aspects of the service. For example, care reviews, monthly monitoring visits, residents meetings, staff meetings, daily hand over reports, staff meetings, staff supervision and appraisals were undertaken with records retained. Notice boards contained information relating to scheduled activities, social events organised, how to complain and various health related information.

Residents and their representatives were invited to trust annual care review meetings to provide opportunity for them to participate and give their views regarding the effectiveness of care provided, agree improvements if necessary and the continued appropriateness of the resident's placement to ensure their needs were being met. Staff confirmed they were informed of any changes to the resident's care plan following reviews held.

The manager demonstrated awareness of the importance of ongoing review of each resident's care needs and when these become more complex the necessity to inform the trust care manager.

Residents and staff who spoke with us made comments which included:

- "We get the best care and I would not want to move from here." (resident)
- "We have all resources to ensure that the care provided is effective." (staff)

Three resident / representative satisfaction questionnaires were completed and returned to RQIA following the inspection. All respondents indicated they were very satisfied that the care provided was effective. Comments included:

- "Wouldn't want my relative anywhere else, staff are very kind and would do anything she asks." (relative)
- "Very good home, my mother is well looked after." (relative)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, care reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The atmosphere throughout the home was observed to be calm, encouraging and good humoured. Residents accommodated had various degrees of mobility. While many moved independently others used various types of walking frames. Some residents had various degrees of dementia and those who were able to comprehend gave positive feedback on the caring support they received. Residents were observed to be calm and relaxed with no aimless wandering around the home observed. Several resident choose to remain in the main lounge most of the day watching television, quietly conversing with each other and staff and watching the comings and goings as the lounge is close to the main reception area of the home. Some residents left the home, accompanied by relatives, while other chooses to stay in their rooms relaxing, reading or watching television. Planned activity therapy included reminesence including the use of memory albums for residents living with dementia.

Residents told us that felt staff listens to them and encourages them to take part in the activity plans scheduled each day. Staff told us activity programmes are worked out with each resident's agreement and there was evidence of changes being made in order to maintain people's interest and involvement. Residents commented on their enjoyment in the activities provided especially the sing songs. Activities schedules included, for example; passive exercise, arts / crafts, sing a longs,reminesence, musical entertainment by invited people and musical groups. Clergy also visit and communion each Sunday. Records of activities provided are maintained.

A resident satisfaction survey on the care provided was undertaken during the year. The manager explained that the summary of the analysis was a work in progress. The manager advised that responses were in the main positive which was encouraging.

The serving of the mid-day meal was discreetly observed. This was undertaken by staff in a respectful, unhurried manner. Staff provided supervision and assistance to residents as required. Meals were nicely presented with adequate portions of food served. Residents told us they enjoyed their meals and that choice was always afforded. Special dietary meals are provided as recommended by the dietician. Morning, afternoon and evening snacks were provided and served to residents as they sat in various locations of the home. Seasonal four weekly menus were provided.

Review of three care records and minutes of residents meetings held evidenced consultation with residents in regard to their likes, dislikes, choice and preferences. Residents advised that they were consulted in the planning of the four weekly rotating menus.

The home received many complementary cards and letters from resident representatives. These were retained and shared with staff. This is to be commended.

Residents told us that they felt they were always treated with dignity and respect by staff. No issues or concerns were raised or indicated.

Three relatives who spoke with us made the following comments:

- "This is a very good home. The staff are very caring and we couldn't wish for any better place for our relative."
- "We are happy and can leave this home knowing our relative is well looked after."

Three resident / representative satisfaction questionnaires were completed and returned to RQIA following the inspection. All respondents indicated they were very satisfied that the care provided was compassionate.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to culture and ethos of the home; dignity and privacy; listening to and valuing residents and their representatives and taking account of the views of residents; meals and mealtimes; and range of therapeutic and social activities.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The manager explained she is supported in her role at operational level by a mixed skill team of care and ancillary staff. At managerial level good support was also provided from the homes responsible persons, who are in the home daily. Frequent governance and quality assurance meetings are held including discussions of on-going quality improvements. Arrangements for the Christmas celebrations were established.

Discussion with the manager and staff alongside review of a range of records including: minutes of staff meetings, staff supervisions / appraisals, staff training, and accidents, audits monthly monitoring and review reports provided evidence that effective leadership and management arrangements were in place.

The RQIA registration certificate and current liability insurance were displayed in a prominent position within the hallway. Manuals of policies and procedures were observed to be readily available to staff. Policies and procedures were not examined at this inspection; however, staff demonstrated good knowledge and understanding of key topics such as adult safeguarding, and infection prevention and control.

Discussion with the manager, senior care assistant and staff alongside review of staff training records evidenced that mandatory training and additional training specific to meeting the needs of residents was evident.

Monthly monitoring reports of visits conducted were available. These were found to reflect details of the service provided, views of residents and staff ascertained about the quality of the service provided and any actions taken by to ensure that the home was being managed in accordance with good practice.

Review of complaints records and discussion with the manager evidenced that no complaints were received since the previous care inspection. Notices on how to complain were displayed and a group of residents informed us that they knew how and to whom they could complain if they were unhappy about anything.

Monitoring the quality of the service and associated governance arrangements in regard to the provision of the service was discussed with the manager and selection of records reviewed. A resident / representative satisfaction survey which was completed during the year reflected positive responses in regard to the provision of care and life in the home. Audits undertaken included, for example, accident / incident audits conducted monthly to identify trends and patterns; infection, prevention and control measures such as observed spot checks of hand washing; general cleanliness of the home; weekly and monthly fire safety equipment checks; and medications. Where required action plans were developed to address identified areas for improvement.

Management of service users' monies

Financial systems in place at the home were reviewed. These included the systems for recording transactions undertaken on behalf of residents; retaining receipts from transactions; recording the reconciliations (checks) of residents' monies; recording the amounts of fees received on behalf of residents; recording residents' personal property; and retaining residents' personal monies.

A review of a sample of records from transactions undertaken by staff on behalf of residents showed that that a number of entries had either been written over or scored out. No initials were recorded against the amendments and no explanation for the errors was recorded. It was also noticed that correction fluid was used on a number of the records. This was discussed with the registered manager and identified as an area for improvement under the standards.

A review of records confirmed that although monies held on behalf of residents were checked periodically, they were not checked at least quarterly in line with the Residential Care Homes Minimum Standards (August 2011). The last recorded check on residents' monies was 03 July 2019. This was discussed with the registered manager and identified as an area for improvement under the standards

A sample of personal property records for three residents evidenced that no records were retained for one of the residents. The records for the remaining two residents had not been updated and checked at least quarterly in line with best practice. This was discussed with the registered manager and identified as an area for improvement.

A review of a sample of transactions of monies deposited on behalf of a resident showed that only one signature was recoded against the entries in the records. Records also showed that

when the resident was handed the money over by a member of staff, only one signature was recorded. The resident had not signed the records. This was discussed with the registered manager and identified as an area for improvement.

A review of three residents' files evidenced that copies of signed written agreements were retained within all three files. The agreements showed the current weekly fee paid by, or on behalf of, the residents. One of the agreements showed that a third party payment (Top Up) was received on behalf of the resident. A review of a sample of records of fees showed that the

third party was invoiced the additional charge prior to the date the third party payments were implemented by the home.

Discussion with staff on the day of the inspection could not confirm if the charge was appropriate. Following the inspection the registered manager contacted RQIA to confirm that the charge was made in error and the home was in the process of reimbursing the third party. The inspector advised the registered manager to inform RQIA when the third party was refunded the monies.

Review of a sample of purchases undertaken on behalf of residents showed that in line with the Residential Care Homes Minimum Standards (August 2011) details of the purchases were recorded. Two signatures were recorded against each entry in the residents' transaction sheets and receipts were available from each of the purchases reviewed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the hairdresser signing records along with a member of staff, two signatures recorded against purchases undertaken on behalf of residents, the retention of receipts from the purchases and residents issued with up to date written agreements.

Areas for improvement

Areas for improvement were identified in relation to: the recording of errors in the residents' transactions book, the recording of the checks of residents' monies, recording of residents' personal property within a set timeframe and the recording of at least two signatures when monies are deposited on behalf of residents.

	Regulations	Standards
Total number of areas for improvement	0	4

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Charlotte Fiona Simpson, registered manager, 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 residential care 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 Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

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 DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 20.3 **Stated:** First time **To be completed by:** 31 November 2019	The registered person shall ensure that a system for the monitoring of staff NISCC registrations and annual retention fees is established. Ref: 6.3
	Response by registered person detailing the actions taken: A spreadsheet is activated with staff registrations and due date of fees entered.
Area for improvement 2 **Ref**: Standard 20.14 **Stated:** First time **To be completed by:** 14 November 2019	The registered person shall ensure that the errors are crossed out and a new line used to record the transaction. A reason for the error should be recorded and initialled by the staff member recording the transaction. The practice of writing over records and the use of correction fluid should cease immediately. Ref: 6.6
	Response by registered person detailing the actions taken: If an error occurs, the reason will be recorded and initialled by a staff member. Use of correction fluid ceased.
Area for improvement 3 **Ref**: Standard 15.12 **Stated:** First time **To be completed by:** 30 November 2019	The registered person shall ensure that residents' monies are reconciled (checked) at least quarterly and recorded. The record of the reconciliations should be signed by the person undertaking the reconciliation and countersigned by a second member of staff to evidence that they have taken place. Ref: 6.6
	Response by registered person detailing the actions taken: Resident's monies will be checked at least quarterly and reconciliation countersigned.

Area for improvement 4 **Ref**: Standard 8.7 **Stated:** First time **To be completed by:** 31 December 2019	The registered person shall ensure that the records of personal property belonging to each resident are updated and checked at least quarterly. The records are to be signed by the staff member undertaking the checks and countersigned by a senior member of staff. Ref: 6.6
	Response by registered person detailing the actions taken: Personal property records are being checked at least quarterly and countersigned.
Area for improvement 5 **Ref**: Standard 15.6 **Stated:** First time **To be completed by:** 14 November 2019	The registered person shall ensure that at least two signatures are recorded when monies are deposited on behalf of residents. Two signatures should also be recorded when the monies are handed over to the resident by a member of staff. If the person depositing the monies and the resident are unable to sign or chooses not to sign, two members of staff sign and date the records to confirm the transactions. Ref: 6.6
	Response by registered person detailing the actions taken: Two signatures are now recorded when monies are deposited or handed over to residents.

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

The Regulation and Quality Improvement Authority

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