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Unannounced Finance Inspection
of
Arches

5 January 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced finance inspection took place on 5 January 2016 from 10:10 to 16:05. A poster detailing that the inspection was taking place that day was positioned at the entrance to the home.

Overall on the day of the inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were some areas identified for improvement, which are set out in the Quality Improvement Plan (QIP) appended to this report. This inspection was underpinned by the Nursing Homes Regulations (Northern Ireland) 2005.

We met with the acting manager, Ms Violet Graham, and the home's administrator; no relatives or visitors chose to meet with us during the inspection. We would like to thank those who participated in the inspection for their co-operation.

The home provides residential and nursing care; for the purposes of this report, the term patient will be used throughout.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	4

The details of the QIP within this report were discussed with Ms Violet Graham, the acting home manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care/Maureen Claire Royston	**Registered Manager:** Ms Violet Graham (Acting)
Person in Charge of the Home at the Time of Inspection: Ms Violet Graham	**Date Manager Registered:** 14 December 2015 (Acting)
Categories of Care: NH-PH, NH-PH(E), NH-LD, NH-LD(E)	**Number of Registered Places:** 33
Number of Patients Accommodated on the Day of Inspection: 26	**Weekly Tariff at Time of Inspection:** £593.00 to £1,736.80

3. Inspection Focus

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

Inspection Theme: Patients' finances and property were appropriately managed and safeguarded

Statement 1
The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care.

Statement 2
Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained.

Statement 3
A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained.

Statement 4
Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative.

4. Methods/Process

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

- Discussion with the acting home manager and the home administrator
- Review of records
- Evaluation and Feedback

Prior to inspection the following records were analysed:

- Records of incidents notified to RQIA in the last twelve months, none of which were finance related

The following records were reviewed during the inspection:

- The service user guide
- The home's policy on "Management and Recording of Personal Allowances"
- The home's policy on "Other Cash Floats and Sundry Funds"
- Four patient finance files
- Most recent Health and Social Care (HSC) trusts' payment remittances
- Confirmation of correct fees charged to a sample of patients for care/accommodation
- A sample of Income/lodgements and expenditure, including comfort fund records
- A sample of hairdressing and chiropody treatment receipts
- Records of items deposited for safekeeping with the home
- Four records of patients' personal property/inventory in their rooms

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection carried out on 10 December 2015; we were not required to follow up on any matters related to the previous inspection.

5.2 Review of Requirements and Recommendations from the Last Finance Inspection

A finance inspection of the home was carried out on 28 August 2010; the findings from the previous inspection were not brought forward as part of this inspection.

5.3 Statement 1 - The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Is Care Safe?

A service user guide was available which detailed information for patients on the general terms and conditions of residency, and a number of appendices including the home's current scale of charges. A standard written agreement, "Terms and Conditions" was in place. The home administrator confirmed that an individualised copy of the terms and conditions is provided to each newly admitted patient. We selected a random sample of four patients' financial files in order to view the agreements in place between the home and those patients.

A review of the four patients' files established that only three of the sampled patients had a signed agreement on their file. The fourth patient had a completed agreement on file; however this was unsigned. The three signed agreements had been signed in 2013 and reflected the respective weekly fees payable at that time (discussions established that updated agreements reflecting 2014 rates had not been provided to patients or their representatives).

The administrator provided us with a file of agreements which had been updated to reflect the 2015 weekly fees applicable for each of the patients in the home. She explained that the file of updated agreements had been prepared in order to obtain signatures from family members as they visited the home. She highlighted the difficulty she had experienced in securing signatures from family members, hence why the updated agreements were not on the files sampled. She provided evidence of signed, updated agreements on a number of other files which did not form part of our sample.

We reviewed the file of drafted agreements awaiting signature and noted that they clearly detailed the up to date fees payable, the method of payment and the person by whom the fees were payable.

We accepted the difficulty in securing signatures from patients' representatives; however we noted that the patients' files should provide written evidence of attempts made to secure signatures to agree to the completed terms and conditions.

A recommendation has been made in respect of this finding.

Discussion established that the home administrator had received training in the Protection of Vulnerable Adults in October 2014.

Is Care Effective?

We queried whether there was any involvement by the home in supporting individual patients with their money; the home administrator advised that there was involvement by the home in respect of a number of identified patients and she explained the respective arrangements in place. This matter is further detailed in Statement 2 of this report.

We noted that the home had a number of policies and procedures in place addressing controls in place to safeguard patients' money and valuables.

Is Care Compassionate?

A review of a sample of the files evidenced that notification of changes to the fees payable had been provided to patients most recently in 2015 and that there was evidence the home had attempted to have the changes agreed in writing within the patient's written agreement.

Areas for Improvement

Overall on the day of inspection, financial arrangements in place were found to be contributing to safe, effective and compassionate care. There was one area identified for improvement which related to individual written agreements with patients.

Number of Requirements	**0**	**Number Recommendations**:	**1**

5.4 Statement 2 - Arrangements for receiving and spending patients' monies on their behalf were transparent, have been authorised and the appropriate records were maintained

Is Care Safe?

A review of the records identified that copies of the Health and Social Care (HSC) trusts' payment remittances were available confirming the weekly fee for each patient in the home. There was an identified number of patients in the home who contribute to their weekly care fees in full or part, directly to the home. For all other patients, the home was paid directly by the relevant HSC trust. A review of a sample of charges established that the correct amounts were being charged by the home.

Discussions established that the home was in direct receipt of the social security benefits for six patients and the personal allowance monies from the HSC trust for a further two patients. For one patient, the home requests the personal allowance monies of the patient from the HSC trust as and when required for the patient.

The home administrator described how on a monthly basis, the organisation's head office provided a breakdown of the amounts which had been received on behalf of the eight patients. For each of the six patients for whom the home was in receipt of social security benefits, the organisation's head office arranged to retain the share of the patient's benefits which were owed to the home from each patient, as part of the cost of their care; the remaining balance was transferred to the patient's pooled personal allowance account in favour of the identified patients. Discussions established that Four Seasons Health Care was acting as Corporate Appointee for these six patients; a review of a sample of their finance records evidenced that official confirmation of these details was held on file.

Only the personal allowance monies were received from the HSC trust in respect of two further patients, and their monies were directed in full to the personal allowance bank account. For the majority of the remaining patients in the home, family representatives deposited money with the home for safekeeping in order to pay for additional goods and services not covered by the weekly fee (such as for hairdressing and chiropody services). A review of the records identified that the home provided a receipt to anyone depositing cash; we noted that receipts were routinely signed by two people.

Records of income and expenditure were maintained on personal allowance account statements detailing transactions for individual patients. There were weekly transaction sheets signed by two people, and a monthly reconciliation was carried out; good practice was observed. As noted above, a pooled bank account was in place to hold the personal monies belonging to patients; the bank account was named appropriately, in that it clearly denoted the money belonged to the patients in the home. We sampled a number of transactions from the records and were able to trace these entries to the corresponding records to substantiate each transaction, such as a receipt for a cash lodgement or an expenditure receipt.

A review of the records identified that a hairdresser and a chiropodist visited the home to provide services to patients. In each case, treatment records were made on a template which recorded all of the necessary information such as the name of the patient, the type of treatment they had received and the associated cost. We noted that the records were routinely signed by the hairdresser/chiropodist; however they were only countersigned by a member of staff once every two to three visits. We noted that each treatment record should be signed by both the hairdresser and a member of staff consistently, in order to verify that the patient had received the service detailed and incurred the associated cost.

A recommendation was made in respect of this finding.

A review of the records established that that the home operates a fund for the benefit of the patients in the home called the “residents’ social fund”. We noted that records relating to income and expenditure for the fund were maintained and a weekly and monthly reconciliation of the comfort fund monies was recorded, signed and dated by two people; good practice was observed. We noted that a bank account was in place for the administration of the fund and that the account was named appropriately.

We reviewed a sample of records for expenditure undertaken from the fund and noted that the expenditure appeared consistent with the home’s policy addressing the administration of the fund.

Is Care Effective?

As noted above, there were a number of financial arrangements in place in the home to support patients with their money. The home has standard documents entitled “Financial Assessment 1, 2 and 3” which are used to record the precise details of these arrangements for individual patients.

We selected a sample of patient files in order to review whether the completed financial assessment documents were in place and detailed the precise arrangements for individual patients selected as part of the sample.

On reviewing the files, we noted that three of the four patients had completed financial assessment documents on their file; the fourth patient's documents had been completed, but had not been signed to evidence agreement by the patient or their representative. The home administrator explained the difficulty in securing signatures from representatives in some cases; however we noted that there must be evidence on the patient's file of any attempts made by the home to secure agreement to the documented financial arrangement.

We recommended that all of the "financial assessment" documents be reviewed to ensure that they continued to reflect the existing financial arrangements in place to support individual patients. A renewed attempt should be made to secure the signature of patients' representatives, with written evidence of the home's efforts retained on file.

A recommendation has been made in respect of this finding.

Is Care Compassionate?

We queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the acting home manager confirmed that none of the patients had any known assessed needs or restrictions.

Areas for Improvement

Overall on the day of inspection, the financial arrangements in place were found to be contributing to safe, effective and compassionate care. However, there were two areas identified for improvement; these related to financial assessment/personal allowance authorisation documents for patients and to consistently counter-signing records of hairdressing and chiropody treatments facilitated within the home.

Number of Requirements	**0**	**Number Recommendations**:	**2**

5.5 Statement 3 - A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records were maintained

Is Care Safe?

A safe place exists within the home to enable patients to deposit cash or valuables; we were satisfied with the controls around the physical location of the safe place and the persons with access. We viewed the contents of the safe place and established that on the day of inspection, both cash and other items belonging to patients were deposited for safekeeping.

The home also had a composite record of the items in the safe place; we noted that the safe record was most recently reconciled by two people in May 2015. Since then, the administrator had completed a monthly reconciliation of the safe contents which she had signed and dated; we noted however that money and valuables belonging to patients should be reconciled, and signed and dated by two people at least quarterly.

A recommendation was made in respect of this finding.

Is Care Effective?

We enquired how patients' property within their rooms was recorded and requested to see a sample of the completed property records for four patients. We were advised that the property records were contained within the patients' care files and we were subsequently provided with the four property records for review.

We noted that each patient's file contained a "schedule of personal effects" form which was part of the admission process; however we noted that none of the four records had been signed or dated. One record was blank, while a second record reflected that the patient had only two items of personal possessions in their room. We noted that the home had to significantly improve the way that patients' personal possessions were recorded. We highlighted that the home must review and update these records for every patient in the home and ensure that they were kept up to date.

We stressed that any additions or disposals from patients' property records must be signed and dated by two people and that the Care Standards for Nursing Homes (2015) require that these records of patients' property in their rooms are updated at least quarterly and are signed and dated by two people.

A requirement has been made in respect of this finding.

Is Care Compassionate?

There were safe storage arrangements within the home to enable patients to deposit cash or valuables, should they wish to. We enquired as to how patients would know about the safe storage arrangements; the home administrator explained that when a patient is admitted, she would explain arrangements for safeguarding the patient's money and valuables and the day to day arrangements for receiving and spending the patient's money on their behalf.

Arrangements for patients to access their money from the safe place in the home outside of office hours were discussed. The administrator explained that at the present time, the needs of patients were such that access to their money during office hours was currently sufficient to meet their needs but that arrangements would be kept under review.

Areas for Improvement

Overall, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were two areas identified for improvement; these related to how patients' property was recorded and to ensuring that reconciliations of patients' monies was carried out, recorded and signed and dated by two people at least quarterly.

Number of Requirements	**1**	**Number Recommendations**:	**1**

5.6 Statement 4 - Arrangements for providing transport to patients were transparent and agreed in writing with the patient/their representative

Is Care Safe, Effective and Compassionate?

On the day of inspection, the home did not operate a transport scheme for patients.

Areas for Improvement

No areas for improvement were identified in respect of Statement 4.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.7 Additional Areas Examined

There were no additional areas examined as part of the inspection.

6. Quality Improvement Plan

The issues identified during this inspection were detailed in the QIP. Details of this QIP were discussed with Ms Violet Graham, the acting home manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

6.1 Statutory Requirements

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

6.2 Recommendations

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

6.3 Actions Taken by the Registered manager/Registered Person

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

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

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be Completed by:** 5 February 2016	The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by all newly admitted patients. The registered person must also ensure that a retrospective record is made of the furniture and personal possessions owned by existing patients accommodated in the home. All inventory records should be updated on a regular basis. Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry.
	Response by Registered Person(s)Detailing the Actions Taken: An up to date inventory of resident personal possessions and furniture they have brought into the home has been commenced and will be updated on a regular basis. When addition or disposal have to be made this will be dated and signed by two members of staff
Recommendations	
Recommendation 1 **Ref**: Minimum Standard 2.8 **Stated:** First time **To be Completed by:** From the date of the next change	The registered person should ensure that any changes to the individual agreement are agreed in writing by the patient or their representative. The individual agreement should be updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded.
	Response by Registered Person(s)Detailing the Actions Taken: When there is any changes in the residents Terms & Conditions i.e. Fee Rates and the residents next to kin is unable to sign agreement The residents care manager will be contacted and all correspondence from next of kin and care managers will be kept in the residents personal file.
Recommendation 2 **Ref**: Standard 14.13 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person should ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the patient or a member of staff of the home signs the treatment record or receipt to verify the treatment and the associated cost to each patient.
	Response by Registered Person(s)Detailing the Actions Taken: The nurse in charge will verify the treatment and cost and sign the treatment record

Recommendation 3 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be Completed by:** 5 February 2016	The registered person should ensure that written authorisation is obtained from each patient or their representative to spend the patient's monies on pre-agreed expenditure. The written authorisation must be retained on the patient's records and updated as required. Where the patient or their representative is unable to, or chooses not to sign the authorisation, this must be recorded. Where a patient is managed by an HSC trust and does not have a family member or friend to act as their representative, the authorisation about their personal monies must be shared with the HSC trust care manager.
	Response by Registered Person(s)Detailing the Actions Taken: If next of kin is unable to sign PA agreement then care manager will be contacted and all correspondence from next of kin and care manager held in residents personal file.
Recommendation 4 **Ref**: Standard 14.25 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person should ensure that a reconciliation of money and valuables held and accounts managed on behalf of patients is carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.
	Response by Registered Person(s)Detailing the Actions Taken: Home manager is checking and signing the contents of safe both money and valuables with the administrator monthly.

Registered Manager Completing QIP	Violet Graham	**Date Completed**	22/02/2016
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	22.02.16
RQIA Inspector Assessing Response		**Date Approved**	24/02/2016

Please ensure this document was completed in full and returned to finance.team@rqia.org.uk from the authorised email address