The Regulation and Quality Improvement Authority

Unannounced Finance Inspection Report
30 October 2018

Beechill

Type of Service: Nursing Home
Address: 12 Royal Lodge Road, Belfast, BT8 7UL
Tel No: 028 9040 2871
Inspector: Briege Ferris

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.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 34 beds that provides care for patients with a dementia.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** Ailish Devlin
Person in charge at the time of inspection: Priscilla Abrenica	**Date manager registered:** Priscilla Abrenica - application received - registration pending
Categories of care: Nursing Home (NH) DE - Dementia	**Number of registered places:** 34

4.0 Inspection summary

An unannounced inspection took place on 30 October 2018 from 10.40 to 13.45 hours.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes (April 2015).

The inspection assessed progress with any areas for improvement identified since the last finance inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

There were examples of good practice found in relation to:

- the availability of a safe place to enable patients to deposit money or valuables for safekeeping
- a written safe record was in place
- the existence of a separate patient bank account and comfort fund bank account
- records of income, expenditure and reconciliation (checks performed) were available including supporting documents
- arrangements were in place to support patients to manage their monies
- mechanisms were available to obtain feedback from patients and their representatives
- the home administrator was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures
- detailed written policies and procedures were in place to guide financial practices in the home and
- there were mechanisms in place to ensure that patients experienced equality of opportunity.

Areas requiring improvement were identified in relation to:

- ensuring that each patient has a written record made of the furniture and personal possessions which they brought to their room

- ensuring that patients' personal property records are reconciled and signed and dated by two people at least quarterly
- ensuring that hairdressing treatment records are countersigned by a member of staff in the home and that chiropody treatment records are maintained in the same manner as hairdressing treatment records
- ensuring that there is evidence that any changes to patients' agreements have been made with the updated agreement shared by the home with the patient or their representative for signing/agreement and
- ensuring that personal monies authorisation forms are in place for all relevant patients.

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	4

Details of the Quality Improvement Plan (QIP) were provided to the manager of the home at the conclusion of the inspection. 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, the record of notifiable incidents reported to RQIA in the last twelve months was reviewed; this established that none of these incidents related to patients' money or valuables. The record of calls made to RQIA's duty system was reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with the manager and the home administrator.

The inspector provided to the manager written information explaining the role of RQIA, the inspection process, the name of the inspector and the date of the inspection. It was requested that this information be displayed in a prominent position in the home so that relatives or visitors who had not been present during the inspection could contact the relevant inspector should they wish to discuss any matter or provide any feedback about their experience of the home.

One relative spoke with the inspector and provided feedback in respect of their satisfaction with the care that their relative was receiving. Some of their comments included

- "the staff are brilliant, they go 200% down the road"
- "the staff go beyond the call of duty"
- "[the manager and home administrator] are very genial presences in the home"

The following records were examined during the inspection:

- A sample of income, expenditure and reconciliation records (records of checks performed)
- A sample of bank statements in respect of the patients' pooled bank account
- A sample of comfort fund records
- A sample of written financial policies and procedures
- A sample of patients' personal property records (in their rooms)
- A sample of patients' individual written agreements
- A sample of patients' "financial assessment" documentation
- A sample of treatment records for services facilitated within the home for which there is an additional charge to patients

The findings of the inspection were shared with the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 12 June 2018

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

6.2 Review of areas for improvement from the last finance inspection dated 24 April 2014

A finance inspection of the home was carried out on 24 April 2014; the findings from which were not brought forward to the inspection on 30 October 2018.

6.3 Inspection findings

6.4 Is care safe?

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

The manager confirmed that adult safeguarding training was mandatory for all staff in the home; the home administrator had participated in adult safeguarding training in 2018.

Discussions with the manager established that there were no current suspected, alleged or actual incidents of financial abuse, nor were there any finance-related restrictive practices in place for any patient.

The home had a safe place available for the deposit of cash or valuables belonging to patients; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, cash and valuables were being held for patients.

A written safe contents record "FSHC Valuables record" was in place to detail the contents of the safe; this had been reconciled and signed and dated by two people in September 2018.

Areas of good practice

There were examples of good practice found for example, in relation to the availability of a safe place to enable patients to deposit money or valuables for safekeeping and a written safe contents record.

Areas for improvement

No areas for improvement were identified as part of the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Discussion with the manager and home administrator established that no person associated with the home was acting as appointee for any patient. It was noted that the home was not in direct receipt of the personal monies for any patient. For the majority of patients, monies for patients' personal expenditure or to pay for additional goods and services not covered by the weekly fee were deposited with the home by family members.

Records of income and expenditure were available for patients, including supporting documents e.g.: a lodgement receipt or an expenditure receipt. A sample of transactions was chosen to ascertain whether the supporting documents were available within the records, and for the sample chosen, these were found to be in place. Evidence was in place identifying that those depositing monies routinely received a receipt which was signed by two people.

As noted above, records of income and expenditure were available detailing that reconciliations, signed by two members of staff were available in the home, the most recent record of reconciliation available in the home was in respect of the August 2018 month-end.

A patients' pooled bank account was in place to administer patients' monies. The account was named appropriately and records were available to evidence that the account was reconciled and signed and dated by two people on a monthly basis. This had most recently been reconciled in respect of the August 2018 month-end.

Hairdressing and chiropody treatments were being facilitated within the home and a sample of these treatment records was reviewed. The sampled hairdressing records evidenced inconsistency in the record keeping. A number of records were signed by the hairdresser and a member of staff while the majority of the records in the sample were not signed by a member of staff to verify that the patient had received the treatment.

Discussions with the home administrator established that treatment records for chiropody services were not maintained. Rather, following treatments, the home received an invoice from the provider of the treatment detailing who had been treated and requesting payment. The inspector noted that treatment records should be maintained in the same manner as hairdressing treatment records ie: they should detail the information set out within standard 14.13 of the Care Standards for Nursing Homes (2015).

An area for improvement was identified in respect of this finding.

The inspector discussed with the home administrator how patients' property (within their rooms) was recorded and requested to see a sample of the property records maintained. The home administrator provided the records for three patients and it was noted that two of the patients had a record of personal property on their files entitled "Schedule of personal effects". One of the records had been signed by two people, as is required; this record was dated February 2014. A second record however, was unsigned and undated.

The inspector highlighted that these records should be updated/reconciled on a quarterly basis by a member of staff and countersigned by a senior member of staff as per standard 14.26 of the Care Standards for Nursing homes, 2015. As this evidence was not available, this was identified as an area for improvement.

The third patient's records which were sampled established that the patient had a template of the "Schedule of personal effects" document on their file, however the document was blank. Therefore there was no record of the patient's furniture or personal possessions in place and this was also identified as an area for improvement.

The home administrator confirmed that the home operated a comfort fund and a policy and procedure was in place to administer the fund. A separate bank account, which was appropriately named, was also in place.

The cash and banking records in respect of the fund had been reconciled and signed and dated by two people most recently for the July 2018 month-end.

The home administrator confirmed that the home did not operate a transport scheme.

Areas of good practice

There were examples of good practice found in relation to the existence of a separate patient bank account and comfort fund bank account; and records of income, expenditure and reconciliation (checks) were available including supporting documents.

Areas for improvement

Three areas for improvement were identified during the inspection in relation to ensuring that a record is made of each patients' furniture and personal possessions, ensuring that patients' personal property records are reconciled and signed and dated by two people at least quarterly and ensuring that treatment records are in place and detail the information set out within standard 14.13 of the Care Standards for Nursing Homes (2015).

	Regulations	Standards
Total number of areas for improvement	1	2

6.6 Is care compassionate?

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

Day to day arrangements in place to support patients were discussed with the manager and the home administrator. They described a range of examples of how the home supported patients with their money. Discussion established that arrangements to appropriately support patients with their money would be discussed with the patient or their representative at the time of the patient's admission to the home.

Discussion with the manager established that the home had a range of methods in place to encourage feedback from patients or their representatives in respect of any issue. This included the homes "Quality of Life" initiative whereby feedback is provided to the home via an accessible IPad, HSC trust care management reviews and relatives' meetings.

Arrangements for patients to access money outside of normal office hours were discussed with the manager. This established that there were arrangements in place to ensure that the individual needs and wishes of patients could be met in this regard.

Areas of good practice

There were examples of good practice found in respect of the arrangements in place to support individual patients discussed during the inspection and mechanisms to obtain feedback and views from patients and their representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

Written policies and procedures were in place to guide financial practices in the home, including the administration of the patients' comfort fund and the management of patients' personal allowance monies.

Discussion with the home administrator established that she was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures.

Individual patient agreements were discussed with the home administrator and a sample of three patients' finance files were requested for review.

A review of the information established that amendments to each patient's original agreements were not up to date and gaps in the annual amendment to the terms and conditions existed. Two patient's amendment documents were unsigned by both the patient or their representative and a representative of the home, making it difficult to evidence whether these documents had been shared with patients or their representatives and if so, how and when. The third patient had a signed amendment to the terms and conditions on their file which detailed the 2017/2018 fees, not the 2018/2019 fees which were increased regionally in April 2018.

It was noted that there should be evidence that each patient or their representative has been advised of any changes to their original written agreement, with the change agreed in writing with the patient or their representative.

Ensuring that each patient's agreement is updated and shared for signature with the patient or their representative was identified as an area for improvement.

A review of the information on file for the three patients whose files were sampled, identified that documents entitled "financial assessment part 3" were in place for two of the patients, (albeit that one of these documents was signed in 2012 and did not reflect the current up to date template). The third patient's record contained an unsigned template. There was therefore no evidence of when this may have been shared with the patient or their representative for signing. The home should have written authority to spend a patient's money on identified goods and services.

Ensuring that personal monies authorisations are in place for all relevant patients was identified as an area for improvement.

The inspector discussed with the manager the arrangements in place in the home to ensure that residents experienced equality of opportunity and that staff members were aware of equality legislation whilst recognising and responding to the diverse needs of patients. The manager noted that all staff participated in equality and diversity e-learning.

Areas of good practice

There were examples of good practice found: the home administrator was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures, detailed written policies and procedures were in place to guide financial practices in the home and there were arrangements in place to ensure patients experienced equality of opportunity.

Areas for improvement

Two areas for improvement was identified as part of the inspection in relation to ensuring that each patient's agreement is updated with the update shared for signature by the patient or their representative and that personal expenditure authorisation forms are in place for all relevant patients.

	Regulations	**Standards**
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the manager of the home, at the conclusion of the inspection. 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 Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes (April 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 DHSSPS Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall ensure that a record is maintained of the furniture and personal possessions which each patient brings bring into their room. Ref: 6.5
	Response by registered person detailing the actions taken: This has been addressed. All staff have been made aware to record the furniture and personal possessions which each relative brings in for each patient. Relatives have been informed that whenever they are bringing items in, to always inform the staff so that they will be aware and can record the said item.
Action required to ensure compliance with the DHSSPS Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 31 October 2018	The registered person shall 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 or goods provided and the associated cost to each patient. Chiropody treatment records should be available and be maintained in the same manner as hairdressing treatment records (as set out above). Ref: 6.5
	Response by registered person detailing the actions taken: This has been actioned. A robust system has now been put in place to ensure that the service provided (Chiropody) should be signed by the member of staff who witnessed that the service was provided. Also discussion took place with the Chiropodist that they have to ask the staff to sign after every service/treatment given to the patient.
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:**	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.5

30 November 2018	**Response by registered person detailing the actions taken:** This has been addressed. A robust system is now in place to monitor the inventory record of property belongings of each patient. Quarterly checks are being done and signed by the senior member of staff.

Area for improvement 3 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 09 November 2018	The registered person shall ensure that any changes to the individual agreement are agreed in writing by the resident or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the resident or their representative is unable to or chooses not to sign the revised agreement, this is recorded. Ref: 6.7
	Response by registered person detailing the actions taken: This has been actioned. The agreement was updated and now reflected. The record has been signed by the resident's representative.
Area for improvement 4 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall ensure that written authorisation is obtained from each resident or their representative to spend the resident's personal monies to pre-agreed expenditure limits. The written authorisation must be retained on the resident's records and updated as required. Where the resident or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the resident is managed by a 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. Ref: 6.7
	Response by registered person detailing the actions taken: This has been actioned. Written authorisation is now obtained in resident's record and shared with the HSC Trust Care Manager.

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

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