Unannounced Finance Inspection Report
16 May 2018

Beechvale Nursing Home

Type of Service: Nursing Home
Address: 35 Beechvale Road, Killinchy, BT23 6PH
Tel No: 028 9754 1166
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 42 beds that provides care for older patients or those living with a physical disability other than sensory impairment or those patients who are terminally ill.

3.0 Service details

Organisation/Registered Provider: Beechvale Nursing Home Limited **Responsible Individual:** Richard Porter	**Registered Manager:** Kathie-Anne Stevenson
Person in charge at the time of inspection: Kathie-Anne Stevenson	**Date manager registered:** 10 October 2017
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 registered places:** 42

4.0 Inspection summary

An unannounced inspection took place on 16 May 2018 from 10.25 to 15.15 hours.

This inspection was underpinned by Nursing Homes Regulations (Northern Ireland) 2005 and the 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.

Evidence of good practice was found: access to the safe place was limited to authorised persons; a sample of transactions recorded in the income and expenditure records could be traced to the appropriate supporting evidence in place; each patient file sampled contained a personal property record; there were mechanisms to listen to and take account of the views of patients; the “Resident’s guide” contained a range of information for a new patient; the senior finance administrator was confident on how to deal with the receipt of a complaint or escalate any concerns under the home’s whistleblowing procedures and each patient selected as part of the sample had a signed written agreement with the home.

Areas requiring improvement were identified in relation to: ensuring the safe place is appropriately secured; ensuring that a written safe contents record is introduced, which should be reconciled and signed and dated by two people at least quarterly (any entries recording deposits or withdrawals from the safe place should also be signed and dated by two people.); ensuring that patients’ personal monies currently deposited within the business bank account are withdrawn and safeguarded separately; ensuring that each patient’s record of their furniture and personal possessions is kept up to date and is signed and dated by a staff member and senior member of staff at least quarterly; ensuring that treatment records (hairdressing) are signed by the person providing the treatment and a member of staff who is in a position to verify

the patient received the treatment detailed on the record and ensuring that patients' money and valuables are reconciled and signed and dated by two people at least quarterly; ensuring that individual written agreements with patients are brought up to date with the update/changes agreed in writing by the patient or their representative; ensuring that the content of home's generic patient agreement is compared with standard 2.2 of the Care Standards for Nursing Homes and ensuring that personal monies authorisations are developed for patients as appropriate.

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	0	9

Details of the Quality Improvement Plan (QIP) were discussed with Richard Porter, registered provider and Kathie-Anne Stevenson, registered manager as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent finance inspection dated 28 March 2013

A finance inspection was carried out on 28 March 2013; the findings from the inspection were not brought forward to the inspection on 16 May 2018.

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 also reviewed and this did not identify any relevant issues; the inspector to visit the home most recently was also contacted prior to the inspection, they confirmed there were no matters to be followed up from that inspection.

During the inspection, the inspector met with Richard Porter the registered provider, the senior finance administrator and later in the inspection, Kathie-Anne Stevenson, the registered manager. A poster was displayed detailing that the inspection was taking place, however no relatives or visitors chose to meet with the inspector.

The following records were examined during the inspection:

- The "Resident's guide"
- Four patients' individual written agreements with the home
- A sample of income and expenditure and reconciliation (check) records maintained on behalf of patients

- A sample of treatment records in respect of hairdressing, chiropody and barbering treatments facilitated in the home
- Four patients' records of furniture and personal possessions (in their rooms)
- A sample of written policies and procedures including:
    - "Beechvale nursing home policy on archiving and storage of documentation storage" 2016
    - "Beechvale nursing home policy on patient belongings and valuables" 2016
    - "Beechvale private nursing home Resident's monies and valuables" 2016

The findings of the inspection were provided to the registered provider and the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 08 February 2018

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last finance inspection dated 23 March 2013

As noted above, a finance inspection was carried out on 28 March 2013; the findings from the inspection were not brought forward to the inspection on 16 May 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 inspector met with the registered provider and the senior finance administrator who confirmed that adult safeguarding training was mandatory for all staff members. The senior finance administrator confirmed that she had most recently received this training in June 2015 and that this was due to be updated no later than June 2018.

The registered provider confirmed 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. It was noted that the safe place was not appropriately secured. The registered provider explained that this was due to the office being reorganised and that this had not yet been addressed. Bolts used to secure the safe place previously were visible protruding from the rear of the safe and the registered provider was advised the safe place should be appropriately secured.

Ensuring that the safe place is appropriately secured within one week of the date of the inspection was identified as an area for improvement.

On the day of inspection, money belonging to a number of patients was deposited for safekeeping. The senior finance administrator reported that a number of valuables belonging to patients were lodged for safekeeping; however no record of safe contents was in place to agree to the contents.

Ensuring that a written record of safe contents is introduced which is reconciled by two people at least quarterly was identified as an area for improvement.

Areas of good practice

There were examples of good practice found in relation to: a safe place was available for the deposit of money or valuables; access was limited to authorised persons.

Areas for improvement

Two areas for improvement were identified in relation to: ensuring the safe place is appropriately secured and ensuring that a written safe contents record is introduced, which should be reconciled and signed and dated by two people at least quarterly. (Any entries recording deposits or withdrawals from the safe place should also be signed and dated by two people.)

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

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

Discussions with the registered provider and senior finance administrator established that no representative of the home was acting as appointee for any patient (ie: managing a patient's social security benefits on their behalf). These discussions also established that the home was in direct receipt of the personal monies for one patient, this money was received by cheque from either a Health and Social Care (HSC) trust or a legal representative acting on behalf of the patient.

The senior finance administrator reported that for the majority of patients in the home, the cost of any additional goods or services that were not covered by the weekly fee was initially met by the home and subsequently billed to the patient/their representative on a quarterly basis. Records were available in the home to evidence this procedure had been followed. For a small number of patients, a cash balance was held within the home from which the cost of additional

goods or services was met; families in turn topped up the balance of cash. This was the exception to the rule and there were infrequent withdrawals from the sums deposited.

A trace of a sample of the cash balances on hand, agreed to the balances recorded in the ledgers. A standard financial ledger format was in use to record patients' individual income and expenditure records. Two signatures were routinely recorded against transactions. A review of the records identified however, that the most recent reconciliation of the cash records which was signed and dated by two people was carried out at the end of January 2018. A further reconciliation was due on or before the end of April 2018; however this had not been performed.

The senior finance administrator reported that this had been due to annual leave and that it was intended that this would be carried out without delay. The inspector stated that this should be performed and signed and dated by two people within two weeks of the inspection date.

This was identified as an area for improvement.

A sample of transactions recorded in the records was traced to establish whether the appropriate supporting evidence was in place. For the sample of transactions inspected, this evidence was available.

Hairdressing, barbering and private chiropody treatments were being facilitated within the home. A sample of recent treatment records was reviewed. Routinely, the treatment records were not signed by either the person delivering the treatment or by a representative of the home. The inspector highlighted that these records should be signed by both the person providing the treatment and by a representative of the home. This would verify that the patient had received the treatment detailed and therefore had incurred the cost detailed.

This was identified as an area for improvement.

Discussions established that the home did not operate a patient bank account. These discussions established that for two patients, the balance of monies received from either the HSC trust or from a legal representative were currently held within the home's business account used for the day to day running of the home. These two balances had been in the account in excess of 28 days respectively. It was stated that this was not acceptable practice and that the registered person should arrange to withdraw the monies from the aforementioned account and safeguard these monies separately on behalf of the two patients.

This was identified as an area for improvement.

The inspector discussed with the senior finance administrator how patients' property (within their rooms) was recorded and was informed that each patient had a record. A sample of four patient's records was chosen and their files provided. One of these records was retrieved from the records archive within the home. While each patient sampled had a record in place, these evidenced there were weaknesses in the record keeping. Three of the four records were printed from the home's "Goldcrest" computerised care records package; these records had not been signed. The record retrieved from the archive dated 2015, had been signed. For the records printed from Goldcrest, only "on admission" had been recorded in respect of the date the record had been made. For all four records, there was no evidence that they had been updated over time.

The inspector noted that any record relating to the deposit or disposal of an item of personal property belonging to a patient should be signed and dated by two people. In addition, records

of patients' property should be reconciled on at least a quarterly basis, with the records signed by a staff member and countersigned by a senior member of staff.

This was identified as an area for improvement.

A record of charges to patients or their representatives for care and accommodation fees was available for review by the inspector and a sample of charges reviewed identified that the correct amounts had been charged.

Discussions with the senior finance administrator established that the home did not operate a transport scheme and at the date of the inspection, there was no balance of funds within the patients' comfort fund.

Areas of good practice

There were examples of good practice found in relation to: transactions recorded in the income and expenditure records which could be traced to supporting evidence and each patient sampled had a personal property record on their file.

Areas for improvement

Four areas for improvement were identified during the inspection in relation to: ensuring that patients' personal monies currently deposited within the business bank account are withdrawn and safeguarded separately; ensuring that each patient's record of their furniture and personal possessions is kept up to date, signed and dated by a staff member and senior member of staff at least quarterly; ensuring that treatment record are signed by the person providing the treatment and a member of staff who is in a position to verify the patient received the treatment; and ensuring that patients' money and valuables are reconciled and signed and dated by two people at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	4

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.

The arrangements to support patients with their money on day to day basis were discussed with the registered provider and the senior finance administrator. Discussions identified that arrangements to store money safely in the home or pay fees etc would be discussed with the patient or their representative around the time a patient is admitted into the home.

Discussion with the registered provider established that the home had a number of methods in place to encourage feedback from families or their representatives in respect of any issue, including a "family forum" and encouraging patients or their representatives to provide reviews on "carehome.co.uk."

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. She clearly described the arrangements which are in place to meet the individual finance needs of patients living in the home.

Areas of good practice

There were examples of good practice identified in relation to listening to and taking account of the views of patients.

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.

The home's "Resident's Guide" contained information for a new patient including the organisational structure of the home; the home's terms and conditions of residency and a copy of the home's complaints procedure.

Written policies and procedures were discussed and the registered manager confirmed that policies were in place addressing areas including whistleblowing and complaints management. Written policies were reviewed including those in respect of general records management and the management of patients' monies, belongings and valuables. The registered provider confirmed that these policies were reviewed in 2016 and at the time of the inspection, new financial policies were being finalised for implementation within the home.

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

Discussion was held regarding the individual written agreements in place with patients and the home. A sample of four patients' individual written agreements was reviewed which established that each patient had an agreement on their care file; these were dated either 2017 or 2018.

There was evidence of correspondence to a number of patients or their representatives detailing the general increase in fees which was applicable from 1 April 2018. The registered provider explained there was a third party top up payable and the home was awaiting confirmation of acceptance of the increase in this (by the relevant HSC trust) before contacting affected patients to advise of the increase.

The registered provider was advised that following discussions with the HSC trust(s) the home should ensure that patient agreements are updated accordingly once new fee and financial arrangements in place for individual patients are finalised.

A schedule of which patients or their representatives who had not yet returned a signed agreement to the home was available and the registered manager reported that this was regularly reviewed. The record reflected all outstanding patient agreements, irrespective of how long the patient had lived in the home.

A review of the home's generic patient agreement identified that it was not wholly consistent with standard 2.2 of the Care Standards, for example, the person(s) paying the fees to the home and method(s) of payment were not detailed. The generic patient agreement should be compared with standard 2.2 of the Care Standards to ensure it contains the minimum detail required before they are updated and shared with patients or their representatives.

This was identified as an area for improvement.

A review of a sample of the records identified that personal monies authorisations were not in place for patients for whom the home engaged in purchases of goods or services. A written personal monies authorisation where the home was authorised to make purchases on behalf of the patient and this should be in place. This should be shared with the patient or their representative for signature.

This was identified as an area for improvement.

Areas of good practice

There were examples of good practice found in relation to: the "Resident's guide"; the senior finance administrator's knowledge in relation to responding to a complaint or escalating a concern under the home's whistleblowing procedures; and each patient selected as part of the sample had a signed written agreement with the home.

Areas for improvement

Three areas for improvement were identified in relation to: ensuring that individual written agreements with patients are brought up to date; reviewing the content of home's generic patient agreement; and ensuring that personal monies authorisations are developed for patients as appropriate.

	Regulations	Standards
Total number of areas for improvement	0	3

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were shared with Richard Porter registered provider and Kathie-Anne Stevenson, registered manager, following 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 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 Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 23 May 2018	The registered person shall ensure that a written safe contents record is introduced, which should be reconciled, signed and dated by two people at least quarterly. Any entries recording deposits or withdrawals from the safe place should also be signed and dated by two people. Ref: 6.4
	Response by registered person detailing the actions taken: Completed and in place 18th May 2018.
Area for improvement 2 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 23 May 2018	The registered person shall ensure that the physical security of the safe place is robust. Ref: 6.4
	Response by registered person detailing the actions taken: Safe fixed to wall on 18th May 2018.
Area for improvement 3 **Ref**: Standard 14.4 **Stated:** First time **To be completed by:** 30 May 2018	The registered person shall ensure that any monies belonging to a patient that is held within a business account is withdrawn and accounted for separately. Ref: 6.5
	Response by registered person detailing the actions taken: Completed 17th May 2018.
Area for improvement 4 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 30 May 2018 and at least quarterly thereafter	The registered person shall ensure that a reconciliation of money and valuables held and accounts managed on behalf of residents is carried out at least quarterly. The reconciliation should be recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.5
	Response by registered person detailing the actions taken: Process has always been in place, we have now set reminders to check quarterly. Implemeneted 23rd May 2018.

Area for improvement 5 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 17 May 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 resident 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 resident. Ref: 6.5
	Response by registered person detailing the actions taken: Treatment record commenced 17th May 2018.
Area for improvement 6 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 27 June 2018	The registered person shall ensure that an inventory of property belonging to each resident 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
	Response by registered person detailing the actions taken: Process in place from 17th May 2018. New file created.
Area for improvement 7 **Ref**: Standard 2.2 **Stated:** First time **To be completed by:** 27 June 2018	The registered person shall ensure that the content of the home's generic patient agreement is reviewed and amended to ensure it is consistent with standard 2.2. Ref: 6.7
	Response by registered person detailing the actions taken: New resident agreement posted out to all clients on 25th May 2018.
Area for improvement 8 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 27 June 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 should be 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 should be recorded. Ref: 6.7
	Response by registered person detailing the actions taken: Completed as above on 25th May 2018.

Area for improvement 9 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 27 June 2018	The registered person shall ensure that the following records are updated: • personal monies authorisations providing authority for the home to make purchases of goods or services • authority for specific financial arrangements in place for all relevant patients. Evidence should be available to confirm that there is authority from the patient/their representative/ HSC trust care manager (where relevant) for the detailed arrangements. Ref: 6.7
	Response by registered person detailing the actions taken: This has been included in revised resident agreement.

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

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