Unannounced Finance Inspection Report
26 April 2018

Beverly Lodge

Type of Service: Nursing Home
Address: 186a Bangor Road, Newtownards, BT23 7PH
Tel no: 028 9182 3573
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 45 beds that provides care for patients living with a dementia.

3.0 Service details

Organisation/Registered Provider: Ashdon Care Ltd **Responsible Individual:** James Edward Russel Cole	**Registered Manager:** Janet Davison
Person in charge at the time of inspection: Janet Davison	**Date manager registered:** 22 April 2010
Categories of care: Nursing Home DE – Dementia.	**Number of registered places:** 45 The home is also approved to provide care on a day basis to 2 persons

4.0 Inspection summary

An unannounced inspection took place on 26 April 2018 from 10.00 to 13.45 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: the home had a safe place available for the deposit of money or valuables; access 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 sampled had a personal property record on their file (albeit that these required improvement); there were mechanisms to listen to and take account of the views of patients; the “service user” guide contained a range of information for a new patient and the home administrator was clear on how to deal with the receipt of a complaint or escalate any concerns under the home’s whistleblowing procedures.

Areas requiring improvement were identified in relation to: ensuring that a written safe contents record is introduced, which should be reconciled and signed and dated by two people at least quarterly; ensuring that patients’ individual income and expenditure records and those in respect of the patients’ comfort fund follow a standard financial ledger format with each transaction signed and dated by two people (these records should be reconciled and signed and dated by two people at least quarterly); ensuring that any comfort fund monies currently deposited within the business bank account are withdrawn and held 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 that the patient received the treatment detailed on the record; ensuring that the patients’ bank account is reconciled and signed and dated by two people at least quarterly; ensuring that a policy and procedure is in place addressing the

administration of the patients' comfort fund; 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; ensuring that personal monies authorisations are developed or reviewed and updated for patients as appropriate and ensuring that the regulation 29 monthly monitoring visits for the next three months include a review of the matters highlighted for improvement following the finance inspection.

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	11

Details of the Quality Improvement Plan (QIP) were discussed with Janet Davison, 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 06 March 2013

A finance inspection was carried out on 06 March 2013; the findings from the inspection were not brought forward to the inspection on 26 April 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 Janet Davison, the registered manager and the home administrator. The organisation's accountant was present for a short time at the beginning of the inspection. 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 "Service user" 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 treatments facilitated in the home
- Four patients' records of furniture and personal possessions (in their rooms)
- A sample of patients' comfort fund records
- A sample of banking records in respect of the patients' bank account

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 22 November 2017

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 06 March 2018

As noted above, a finance inspection was carried out on 06 March 2013; the findings from the inspection were not brought forward to the inspection on 26 April 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 manager who confirmed that adult safeguarding training was mandatory for all staff members. The home administrator confirmed that she had most recently received this training in 2017.

The registered manager charge 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; the inspector was satisfied with the location of the safe places and the persons with access.

On the day of inspection, money belonging to a number of patients was deposited for safekeeping. The home 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

The home had a safe place available for the deposit of money or valuables; access was limited to authorised persons.

Areas for improvement

One area for improvement was identified during the inspection, this related to 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	1

6.5 Is care effective?

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

Discussions with the registered manager and home 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 a Health and Social Care (HSC) trust.

The registered manager reported that monies were deposited for most of the patients by their relatives in order for additional goods and services to be purchased by the home on behalf of each patient. The home's mechanism was for each relative to deposit the monies in a locked post box within the home and to record in a book provided, the amount deposited, by whom and for which patient. The home administrator reported that this mechanism worked well and relatives had not expressed any dissatisfaction with the arrangement. She noted that the post box was opened routinely and the amount of money recorded within the patient's individual income and expenditure records (described further below).

Records of income and expenditure entitled "Residents monies weekly audit" documents were maintained for patients for whom the home engaged in purchases of goods or services. These detailed (for each transaction) the "week commencing" date, a column for each patient's name; whether the transaction related to a deposit or a withdrawal, and the running balance and a space for signatures. Discussion and a review of a sample of the records identified that any entry for individual patients within the same week would be recorded in the same small row. Feedback was provided to the registered manager in respect of how these records were maintained. It was highlighted that this this method did not constitute a standard financial ledger format. Individual records should be available for each patient, with each individual transaction signed and dated by two people.

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 chosen, this evidence was available.

Within the sample, two signatures had been recorded at the bottom of the page to indicate that it had been audited.

Hairdressing treatments were being facilitated within the home (the registered manager noted that podiatry services were included within the third party top up charge payable per week). A sample of recent hairdressing treatment records was reviewed. Routinely, the treatment records reflected the name of the patient, the treatment, the amount paid, and the signature of the hairdresser. However these records were not signed by a representative of the home to verify that the patient had received the treatment detailed.

This was identified as an area for improvement.

Discussions established that the home operated a patient bank account, which was named appropriately. The registered manager and the home administrator explained that this was in place to facilitate cashing cheques for personal monies for patients, received from the HSC trust or from patients' representatives. It was also noted that over time, any excess cash held on behalf of individual patients had been lodged to the account. However, on the day of inspection records detailing the amount of money belonging to each patient were not readily available. A record which had been made in September 2017 was identified on file detailing the breakdown of the balance, however this was not a bank reconciliation; there were no bank reconciliations of the account on the file provided for review.

The residents' bank account should be reconciled (a full bank reconciliation) at least quarterly, this should be signed and dated by two people. At any time, it should be possible to identify how much of a joint balance belongs to individual patients with monies deposited in the account.

This was identified as an area for improvement.

Discussions established that the home had a patients' comfort fund. Records which were provided for review detailing deposits and expenditure were not recorded using a standard financial ledger format. Entries in the records provided a description; however records had not been signed or dated.

The comfort fund records should be maintained using a standard financial ledger format. Again each transaction should be signed and dated by two people and the records should be reconciled at least quarterly.

An area for improvement (to ensure that income and expenditure records are made using a financial ledger format) has been identified as an area for improvement above.

Discussion with the home administrator also established that the comfort fund monies were held within the business bank account. It was noted that these monies should not be on deposit within a business bank and arrangements should be made to ensure that the monies are withdrawn and accounted for separately on behalf of the patients' in the home.

This was identified as an area for improvement.

The inspector discussed how patients' property (within their rooms) was recorded and was informed that each patient had a record on their care file. A sample of four patients was chosen and their files provided. A review of the files identified that each patient had a record of their furniture and personal possessions which had been made on a template. The records reviewed evidenced weaknesses in the record keeping.

Initial entries on the four patients' records had been made between 2014 and 2016, these entries had been signed by one person; none of the four records had been signed by two people as is required.

There was evidence that the records had been updated, however the more recent entries were all unsigned. 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.

Discussions with the registered manager established that the home did not operate a transport scheme.

Areas of good practice

There were examples of good practice found: an appropriately named bank account was in place to manage patients' monies; a sample of transactions recorded in the income and expenditure records could be traced to supporting evidence and each patient sampled had a personal property record on their file (albeit that these required improvement).

Areas for improvement

Five areas for improvement were identified during the inspection. These related to: ensuring that patients' individual income and expenditure records and those in respect of the patients' comfort fund are maintained following a standard financial ledger format with each transaction signed and dated by two people (these records should be reconciled and signed and dated by two people at least quarterly); ensuring that any comfort fund monies currently deposited within the business bank account are withdrawn and held 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 the patients' bank account is reconciled and signed and dated by two people at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	5

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 manager. 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 would be admitted to the home.

Discussion 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 monthly coffee afternoon and relatives and patients' meetings.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. She could clearly describe the arrangements which would be in place to meet the individual 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 service user guide contained information for a new patient including the organisational structure of the home; reference to the provision of a written agreement to each patient and reference to a number of home's general terms and conditions of residency in the home.

Written policies and procedures were discussed and the registered manager confirmed that policies were in place addressing areas including whistleblowing and complaints management. The registered manager confirmed that all of the policies were currently under review and the process of updating them had begun. She confirmed that at the time of the inspection, a policy addressing the administration of the patients' comfort fund was not in place.

A written comfort fund policy and procedure is required to be in place to guide the administration of the fund.

This was identified as an area for improvement.

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

Discussion was held regarding the individual written agreements in place with patients and the home. A sample of four patients was chosen to review the agreements in place between individual patients and the home. This review established that each patient had an agreement on their care file; however these were dated between 2014 and 2016 and the fee details set out within the agreements were those in place at that time. All of the agreements reviewed were therefore out of date and there was no evidence available to identify that the home had sought to update them as is required.

Patient agreements should be kept up to date to reflect any changes, which most frequently are changes to the fees and financial arrangements. Any change to a patient's agreement should be agreed in writing by the patient or their representative; the home should have evidence of how this has been sought. Any other existing individual financial arrangement in place to support the patient with their money (such as the use of any bank account to manage a patient's money, as described in section 6.5 above) should also be clearly detailed within the patient's agreement.

This was identified as an area for improvement.

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 persons paying the fees to the home and method(s) of payment were not detailed in the agreement or the prices of additional services such as hairdressing, as is required. 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 which details the type of expenditure which is home has been authorised to make on behalf of each patient is required to be in place. This should be shared with the patient or their representative for signature.

This was identified as an area for improvement.

Feedback was provided to the registered manager at the conclusion of the inspection and it was highlighted that given the scope of the areas for improvement, it may be helpful to ensure that registered provider regulation 29 monthly monitoring visits for the next three months include a review of the matters highlighted for improvement following the finance inspection.

Areas of good practice

There were examples of good practice found for example, the patient guide contained a range of information for a new patient; the home administrator was clear on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures.

Areas for improvement

Five areas for improvement were identified during the inspection. These related to ensuring that a policy and procedure is in place addressing the administration of the patients' comfort fund; ensuring that 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; ensuring that personal monies authorisations are developed or reviewed and updated for patients as appropriate and ensuring that the regulation 29 monthly monitoring visits for the next three months include a review of the matters highlighted for improvement following the finance inspection.

	Regulations	Standards
Total number of areas for improvement	0	5

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were shared with Janet Davison, 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:** 10 May 2018	The registered person shall ensure 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.) Ref: 6.4
	Response by registered person detailing the actions taken: Record created and system implemented to ensure quarterly audits are completed.
Area for improvement 2 **Ref**: Standard 14.9 **Stated:** First time **To be completed by:** 10 May 2018	The registered person shall ensure that patients' individual income and expenditure records and the patients' comfort fund records follow a standard financial ledger format which is used to clearly and accurately detail transactions for patients. The format captures the following information each time an entry is made on the ledger: the date; a description of the entry; whether the entry is a lodgement or withdrawal; the amount; the running balance of the resident's cash total held; and the signatures of two persons able to verify the entry on the ledger. Ref: 6.5
	Response by registered person detailing the actions taken: Systems implemented to ensure quarterly audits are completed with two staff members and records held. Ledgers created for all patients who's monies we are accountable for.
Area for improvement 3 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 27 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: Procedure implemented to ensure the person providing the service and the patient/staff member signs the associated record.

Area for improvement 4 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 31 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 is 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: Procedure implemented to ensure quarterly audits are completed. Monthly reconciliations are completed by the finance assistant and countersigned by a senior member of staff.
Area for improvement 5 **Ref**: Standard 14.28 **Stated:** First time **To be completed by:** 10 May 2018	The registered person shall ensure that the balance of patients' comfort fund monies currently deposited within the business bank account is withdrawn, accounted for and safeguarded separately. Ref: 6.5
	Response by registered person detailing the actions taken: Residents comfort funds withdrawn from the business account and deposited in a secure safe.
Area for improvement 6 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 07 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: Inventories all re-checked and amended. Procedures introduced to ensure quarterly recordings completed.
Area for improvement 7 **Ref**: Standard 14.30 **Stated:** First time **To be completed by:** 31 May 2018	The registered person shall ensure that a policy and procedure is in place addressing the aims and objectives of the comfort fund and providing guidance for staff on the ethos and operation of the fund. The policy and procedure should include reference to and inclusion of the resident and/or relative forum in the decision making process for expenditure from the comfort fund. Ref: 6.5
	Response by registered person detailing the actions taken: Policy created and implemented.

Area for improvement 8 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 07 June 2018	The registered person shall ensure that any changes to a patient's individual agreement are agreed in writing by the patient or their representative. The individual agreement is 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. Ref: 6.7
	Response by registered person detailing the actions taken: Individuals agreements updated and all future changes to the agreement will be agreed in writing by the patient or their representative.
Area for improvement 9 **Ref**: Standard 2.2 **Stated:** First time **To be completed by:** 07 June 2018	The registered person shall ensure that the content of the home's generic patient agreement is compared with the minimum content of a patient agreement as set out within standard 2.2. Ref: 6.7
	Response by registered person detailing the actions taken: Generic agreement ameded according to standard 2.2.
Area for improvement 10 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 07 June 2018	The registered person shall ensure that personal monies authorisations providing authority for the home to make purchases of goods or services and/or authority for specific financial arrangements to be in place with the home are updated 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: Procedure implemented to ensure detailed arrangements are in place regarding authorisation for the home to make purchases. Same updated for all relevant patients.
Area for improvement 11 **Ref**: Standard 35.7 **Stated:** First time **To be completed by:** May 2018 to July 2018 inclusive	The registered person shall ensure that the registered provider regulation 29 monthly monitoring visits for the next three months include a review of the matters highlighted for improvement following the finance inspection. Ref: 6.7
	Response by registered person detailing the actions taken: The person responsible for the completion of regulation 29 monitoring visits contacted and agreed to review matters highlighted for improvement.

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

The Regulation and Quality Improvement Authority

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