The Regulation and Quality Improvement Authority

Unannounced Finance Inspection Report
22 January 2019

Bloomfield Care Homes Limited

Type of Service: Nursing Home
Address: 115 – 117 North Road, Belfast, BT5 5NF
Tel No: 028 9065 7799
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 36 beds that provides care for patients with a dementia.

3.0 Service details

Organisation/Registered Provider: Bloomfield Care Homes Limited Responsible Individual(s): Desmond McLaughlin	Registered Manager: Jincy Mathew
Person in charge at the time of inspection: Jincy Mathew	**Date manager registered:** 14/03/2016
Categories of care: DE – Dementia	**Number of registered places:** 36

4.0 Inspection summary

An unannounced inspection took place on 22 January 2019 from 11.30 to 15.15 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
- 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 patients’ personal property records are reconciled and signed and dated by two people at least quarterly
- ensuring that records of money and valuables deposited for safekeeping and reconciled and signed and dated by two people at least quarterly
- ensuring that hairdressing treatment records are signed by the hairdresser and countersigned by a member of staff in the home who can verify that the treatment took place

- ensuring that staff members do not use personal store loyalty cards when making purchases on behalf of patients in the home.

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	4

Details of the Quality Improvement Plan (QIP) were provided to the registered 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 registered manager, the home administrator and briefly with the responsible individual.

The inspector provided to the registered 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.

The following records were examined during the inspection:

- A sample of income, expenditure and reconciliation records (records of checks performed)
- A sample of comfort fund records
- A sample of written policies and procedures
- A sample of patients' personal property records (in their rooms)
- A sample of patients' individual written agreements
- A sample of hairdressing treatment records
- A sample of charges to patients for care and accommodation costs

The findings of the inspection were shared with 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 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 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 registered manager confirmed that adult safeguarding training was mandatory for all staff in the home; the home administrator had participated in adult safeguarding training in April 2018.

Discussions with the registered 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 “Residents safe contents list” was in place to detail the contents of the safe; this had been recorded as being checked and had been signed in November 2018 by the home administrator. There is further discussion on reconciling patients’ monies and valuables deposited for safekeeping within section 6.5 of this report.

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 registered 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. Routinely, the main expenditure recorded within the sample of records reviewed was in respect of charges for hairdressing services.

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 dated 06 October 2018. The November and December 2018 reconciliations had been signed by the home administrator and were not countersigned by a second member of staff. It was noted that a quarterly reconciliation signed by two members of staff was therefore due on or before 06 January 2019. As noted above, the safe contents record was checked by the administrator and signed in November 2018, the record was not countersigned.

An area for improvement was made to ensure that records of patients' monies and valuables deposited for safekeeping are reconciled and signed and dated by two people at least quarterly.

Hairdressing 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 template was in place to record the signature of a member of staff to verify the treatment had been delivered, these detailed were not consistently completed and none of the records had been signed by the hairdresser as is required. It was noted that the hairdresser wrote individual receipts for each patient; however feedback was provided to the registered manager to ensure that the treatment record (the template) is maintained as 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 which were maintained on the home's computerised care package and were printed off for review.

A review of the records identified that only one record was dated and none were signed (given that they had been inputted on computer). The home administrator reported that the system did could not identify who had typed the record. 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 home administrator confirmed that the home operated a comfort fund and a policy and procedure was in place to administer the fund. No bank account was used to manage the fund; a sum of cash was maintained for expenditure. Records were maintained using a standard financial ledger format. A review of a sample of transactions evidenced that supporting receipts for purchases and deposits were in place. A sample of receipts were reviewed which identified a personal store points card had been used by staff when making purchases for patients from the comfort fund monies. It was highlighted that staff are precluded from benefiting from personal store points earned in this manner.

An area for improvement was identified to ensure that this practice ceases from the date of the inspection and that relevant staff members are advised accordingly.

The registered manager confirmed that the home did not operate a transport scheme or manage any bank accounts on behalf of patients in the home.

Areas of good practice

There were examples of good practice found in relation to the existence of records of income, expenditure and supporting documentation.

Areas for improvement

Four areas for improvement were identified during the inspection in relation to ensuring that: patients' personal property records are reconciled and signed and dated by two people at least quarterly; records of patients' monies and valuables deposited for safekeeping are reconciled and signed and dated by two people at least quarterly; ensuring that hairdressing treatment records are maintained as set out within standard 14.13 of the Care Standards for Nursing Homes (2015) and ensuring that staff members do not benefit personally from store loyalty points earned on purchases made on behalf of patients.

	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.

Discussion with the registered 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 operating an "open-door" policy, completion of an annual survey, quality monitoring reports and ongoing feedback from patients and relatives.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. This established that monies were rarely deposited for any purpose other than expenditure on hairdressing services.

Areas of good practice

There were examples of good practice found in respect of the 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, the management of patients' personal monies and valuables and records management.

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' agreements was requested for review. The home administrator printed the signed agreements off the home's computerised care package. A review of the information established that there were two places within the agreement for the patient or their representative to sign. These related to authorising the home to spend the patient's personal monies on identified goods and services and secondly, in respect of the remaining terms and conditions of the agreement (at the back of the agreement). Each of the three agreements was up to date and reflected the current fee arrangements for the respective patients. The first patient's agreement had been signed at the back, however the expenditure authorisation had not been signed, the second patient's agreement had been signed in both places, while the third patient's agreement had not been signed at the back; however the expenditure authorisation had been signed.

Advice was provided to the registered manager to ensure that when documents are returned reviewed to ensure that they have been completed appropriately.

The inspector discussed with the registered manager the arrangements in place in the home to ensure that patients experienced equality of opportunity and that staff members were aware of

equality legislation whilst recognising and responding to the diverse needs of patients. The registered 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 practices in the home and there were arrangements in place to ensure patients experienced equality of opportunity.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

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 registered manager of the home, at the conclusion of the inspection. The timescales commence from the date of inspection.

The registered provider/registered 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 Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 23 January 2019	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. Ref: 6.5
	Response by registered person detailing the actions taken: Implemented on date of inspection. Hairdressing form amended to ensure hairdresser signature provided against each resident treatment plus staff signature, instead of two staff signatures.
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 22 February 2019	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
	Response by registered person detailing the actions taken: Implemented on 18 February 2019. An Inventory of Property record is in place for residents valuable or sentimental items and will be reconciled quarterly by the residents key worker and countersigned by the lead nurse.
Area for improvement 3 **Ref**: Standard 14.16 **Stated:** First time **To be completed by:** 23 January 2019	The registered person shall ensure that where staff purchase items on behalf of patients, any store loyalty points earned are owned by the patient and this is documented on the receipt. Where a patient is not a member of a loyalty scheme, staff do not benefit from the transaction by using their personal loyalty cards. Receipts for such purchases are returned to the patient for their own records. Ref: 6.5
	Response by registered person detailing the actions taken: Implemented on date of inspection. Staff member informed and Financial Controls and Safeguarding Residents Monies Policy updated accordingly to state that no store cards or loyalty cards will be held by staff for residents. Also that staff must ensure if purchasing

	items on behalf of residents that personal store loyalty cards are not used so that staff do not benefit from the residents transactions.
Area for improvement 4 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 31 January 2019 and at least quarterly thereafter	The registered person shall ensure that where records of patients' monies and valuables deposited for safekeeping are reconciled and signed and dated by two people at least quarterly. Ref: 6.5
	Response by registered person detailing the actions taken: Implemented on 28th January 2019. Records of patients' monies and valuables deposited for safekeeping are reconciled monthly by the Administrator and signed and dated. The Nurse Manager or Deputy Manager (in the absence of Nurse Manager) will ensure that records are checked and countersigned at least quarterly.

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

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