Unannounced Finance Inspection Report
24 April 2018

Bryansburn

Type of Service: Nursing Home
Address: 96-100 Bryansburn Road, Bangor, BT20 3RG
Tel No: 028 9127 5182
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 35 beds that provides care for patients living with a dementia.

3.0 Service details

Organisation/Registered Provider: Bryansburn **Responsible Individual(s):** James Kelly	**Registered Manager:** Luz Agnes Jainar
Person in charge at the time of inspection: Luz Agnes Jainar	**Date manager registered:** 18 March 2016
Categories of care: NH-DE	**Number of registered places:** 35 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 24 April 2018 from 09.50 to 14.15 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: the home had a safe place available for the deposit of money or valuables; access was limited to authorised persons; the registered manager was familiar with controls in place to safeguard patients' money and valuables; income and expenditure transactions recorded on behalf of patients were in place and were routinely signed by two people appropriate supporting evidence was in place and there was evidence that these had been reconciled on at least a quarterly basis; treatment records routinely reflected the relevant details as set out in the Care Standards for Nursing Homes; each patient sampled had a personal property record on their file (albeit that these required improvement); examples of good practice identified in relation to listening to and taking account of the views of patients; the patient guide contained a range of information for a new patient; the manager 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 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 the patients' comfort fund records 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) and ensuring that staff do not benefit from store loyalty points when making purchases on behalf of patients; 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 or reviewed and updated 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	1	6

Details of the Quality Improvement Plan (QIP) were shared with the registered manager and 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 14 February 2013

A finance inspection was carried out on 14 February 2013; the findings from the inspection were not brought forward to the inspection on 24 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, however they confirmed there were no matters to be followed up from that inspection.

During the inspection, the inspector met with Agnes Jainar, the registered manager and Briege Kelly, 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 home's patients guide
- Three 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 Return of Possessions Forms
- A sample of treatment records in respect of hairdressing and podiatry treatments facilitated in the home
- Three patients' records of furniture and personal possessions (in their rooms)
- A sample of patients' comfort fund records
- Written policies and procedures including those in respect of:
  - "Complaints policy" reviewed January 2018
  - "Gifts and legacies policy" reviewed January 2018

- ‘‘Personal allowance Policy” reviewed January 2018
- “Resident’s personal information policy” reviewed January 2018
- “Resident’s Property Policy” reviewed January 2018
- “Whistleblowing policy” reviewed January 2018
- “Data protection and confidentiality Policy” reviewed January 2018
- “Activity fund Policy” dated November 2017

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 11 September 2017

The most recent inspection of the home was an announced care inspection. The QIP from this 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 14 February 2013

As noted above, a finance inspection was carried out on 14 February 2013; the findings from the inspection were not brought forward to the inspection on 24 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 was able to describe the home’s controls in place to safeguard patients’ money and valuables. She confirmed that adult safeguarding training was mandatory for all staff members and that the home did not employ an administrator.

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, no valuables were being held. The registered manager provided records entitled “Return of Possessions Forms” which were maintained to evidence that two signatures were recorded against any cash or valuables previously deposited for safekeeping or returned to family members.

Areas of good practice

The home had a safe place available for the deposit of money or valuables; access was limited to authorised persons. The registered manager was familiar with controls in place to safeguard patients' money and valuables.

Areas for improvement

No areas for improvement were identified.

	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.

Discussions with the registered manager 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) nor was the home in direct receipt of the personal monies for any patient from a HSC or other appointed individual such as a solicitor

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. Duplicate receipt books were used to record deposits made, however a review of a sample of entries established that only the person receiving the cash routinely signed the receipt. The inspector discussed this with the registered manager and advice was provided in respect of also capturing the signature of the person making the deposit. It was emphasised that this represents best practice and acts as a protection for a staff member receiving cash.

Records of income and expenditure entitled "Personal allowance record sheet" documents were maintained for each patient for whom the home engaged in purchases of goods or services. These detailed (for each transaction) the date, whether the transaction related to a deposit or a withdrawal, and the running balance. While the template in use did not have dedicated columns for two signatures to be recorded against each transaction, the initials of two persons had been consistently recorded in the details column. (A sample of the signatures of staff making entries in the records was available with the records.)

During the inspection, advice was provided to the registered manager in respect of improving the layout of the template to reflect best practice. This included advice in respect of keeping separate the record of the deposit of cash or cheques for each relevant patient.

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.

Records of cash reconciliations performed were held on file. These were mostly carried out on a monthly basis; however the most recent reconciliation record which had been signed and dated by two people had been performed on 07 February 2018. (There is discussion in respect of the patients' bank account below).

Hairdressing and podiatry treatments were being facilitated within the home and a sample of recent records was reviewed.

Routinely, the treatment records reflected the relevant details as set out in the Care Standards for Nursing Homes (2015), however a recent entry had not been dated. Following the inspection, advice was provided to the registered manager to consider the use of a pre-printed template to record treatments by the hairdresser or podiatrist as this may avoid important details being inadvertently missed. The inspector also highlighted that the second signature on the records (ie: the member of staff) is recorded to evidence that the patients detailed have received the treatment, not that the hairdresser or podiatrist has been paid.

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 three patients were chosen and their files provided by the registered manager. 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 entitled "3 monthly resident belongings inventory" which was columnar in format to allow for updating in January, April, July and October of each year.

The records reviewed evidenced inconsistency in the record keeping. One patient's record had been completed each quarter from January 2017 to January 2018 ie: five times. However, only one person had signed one entry, the remaining four entries were unsigned. A second patient's record had again, been updated five times, however two of the five entries were dated and none of the five entries had been signed. A third patient's record contained only two entries between January 2017 and January 2018; the first entry had been signed by two people, while the second entry had been signed by one person.

Feedback on these findings was provided to the registered manager. It was noted that pursuant to the template in place to record patients' property, each patient's record was due to be updated by 30 April 2018. Within the sample of records reviewed were references to "TV" and "Radio" where the number of each item had been recorded. The inspector noted that in the forthcoming review and update of the patients' records, the make/model/approximate size of items should be captured as far as possible.

The inspector noted that these records 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 with a date for completion consistent with the home's template ie: 30 April 2018.

The registered manager confirmed that the home operated a patients' comfort fund. A written policy and procedure was in place in respect of the administration of the fund. The manager provided a book containing entries relating to the fund, however it was noted that these were not made using a standard financial ledger format.

This was identified as an area for improvement.

Within a sample of receipts for expenditure from the patients' comfort fund were receipts from a supermarket. A review of a sample of receipts identified that a store loyalty card had been used when making these purchases.

Ensuring that staff are reminded to not use their personal loyalty cards when making purchases on behalf of patients was identified as an area for improvement.

Discussion with the registered manager and a review of the records indicated that a patients' bank account was managed on behalf of patients in the home. The registered manager noted that this was used where families deposited cheques in respect of the personal monies of their relative in order to pay for additional goods and services over and above the weekly fee e.g.: hairdressing services. She also noted that the account was used to deposit excess cash so that this was not held exclusively within the safe place in the home.

The registered manager advised that records relating to the patients' bank account were held at the registered provider's head office where the company accountant is based. The inspector contacted the accountant following the inspection and requested information relating to the account including evidence that the account was being reconciled on a regular basis.

The organisation's accountant provided evidence that the bank account used to administer patients' monies was appropriately named and had been reconciled most recently in March 2018.

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: income and expenditure transactions recorded on behalf of patients were in place and were routinely signed by two people appropriate supporting evidence was in place and there was evidence that these had been reconciled on at least a quarterly basis; treatment records routinely reflected the relevant details as set out in the Care Standards for Nursing Homes; each patient sampled had a personal property record on their file (albeit that these required improvement).

Areas for improvement

Three areas for improvement were identified during the inspection. These related to 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 the patients' comfort fund records 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) and ensuring that staff do not benefit from store loyalty points when making purchases on behalf of patients.

	Regulations	Standards
Total number of areas for improvement	0	3

6.6 Is care compassionate?

Patients and clients 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 care reviews, comments slips, and operating “an open-door policy”.

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 patients’ guide contained information for a new patient including that in respect of the provision of a written agreement, the current fees payable and reference to the home’s relevant policies and procedures.

Written policies and procedures were available and policies were in place addressing areas including the activity fund (patients’ comfort fund), the management of patients’ personal allowances and residents’ property, whistleblowing and complaints managements.

Discussion with the manager 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. Three patients were sampled in order to review the agreements in place. The inspector was advised that agreements were not held in the home, they were held at the organisation’s head office.

These records are required to be held within the home and an area for improvement was made in respect of this finding.

The sampled agreements were emailed to the home from the organisation’s head office and these were reviewed. This established that each of the agreements did not agree to the current fees as set out within the HSC trust payment remittances. Individual patient agreements should be kept up to date to reflect any changes (including changes in the fees payable), with the change agreed in writing by the patient or their representative.

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. The patient agreement template included a catch-all statement to the effect that "*The weekly fee for placement in the home is £x this fee is inclusive of all aspects of care with the home. Fees are payable by the resident themselves and possibly a healthcare trust and/or a third party (usually a family member) depending on a financial assessment carried out by the appropriate healthcare trust*."

Each patient's agreement should detail the breakdown of the weekly fee, including a third party top or free nursing care element and of each part of the fee, who is going to pay the home and which method(s) will be used respectively, plus the detail of any other unique financial arrangement in place with the home to support that patient.

The home's generic patient agreement template should be compared with standard 2.2 of the Care standards to ensure that it reflects the minimum level of detail required by the standard.

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. The sample of patient income and expenditure records reviewed contained a brief general statement to the effect that " I hereby give consent for the home manager to use money for my ____ personal account in any event deemed to enhance their care." It was noted that this statement may be too broad in scope.

Ensuring that written personal monies authorisations which detail the type of expenditure which is home has been authorised to make on behalf of each relevant patient was identified as an area for improvement.

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 manager 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

Four areas for improvement were identified during the inspection. These related to 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 and ensuring that personal monies authorisations are developed or reviewed and updated for patients as appropriate.

	Regulations	Standards
Total number of areas for improvement	1	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 the registered manager and home 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 (2) Schedule 4 (3) **Stated:** First time **To be completed by:** 31 May 2018	The registered person shall ensure that individual written agreements or copies of the agreements with patients are held within the home. Ref: 6.7
	Response by registered person detailing the actions taken: A copy of all Resident Agreements are now retained within the Care Home
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 30 April 2018	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: Quarterly inventory record is now in place and reconciled and signed off accordingly.
Area for improvement 2 **Ref**: Standard 14.16 **Stated:** First time **To be completed by:** 30 April 2018	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: 6.7
	Response by registered person detailing the actions taken: Staff do not benefit from assisting residents in purchasing personal items.
Area for improvement 3 **Ref**: Standard 14.9 **Stated:** First time **To be completed by:** 01 May 2018	The registered person shall ensure that 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: Our existing Financial Ledger has been amended accordingly.
Area for improvement 4 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 31 May 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: Written agreement is sought from the resident or their representative (where appropriate) to any changes in the Resident Agreement. Any decision not to sign is recorded.
Area for improvement 5 **Ref**: Standard 2.2 **Stated:** First time **To be completed by:** 31 May 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: We have reviewed our Resident Agreement and made any necessary amendements.
Area for improvement 6 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 31 May 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: We have updated our authorisation section at the top of our ledger sheets detailing arrangments of what we are authorised to purchase on the residents behalf.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews