Unannounced Finance Inspection Report
26 July 2018

Carryduff Nursing Home

Type of Service: Nursing Home
Address: 19 Church Road, Carryduff, BT8 8DT
Tel No: 028 9181 4862
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 23 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: Carryduff Nursing Home **Responsible Individual:** Edwin Johnston Gerald Beattie	**Registered Manager:** Janine Curran
Person in charge at the time of inspection: Janine Curran	**Date manager registered:** Janine Curran - application received - "registration pending".
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:** 23

4.0 Inspection summary

An unannounced inspection took place on 26 July 2018 from 10:30 to 15.30 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: a safe place was available for the deposit of money or valuables; the regional administrator had participated in adult safeguarding training; transactions recorded in the income and expenditure records could be traced to supporting evidence, an appropriately named bank account was in place to manage the patient comfort fund monies; there were mechanisms in place to listen to and take account of the views of patients and their representatives; the regional support administrator was confident on how to respond to a complaint or escalate a concern under the home's whistleblowing procedures; written policies and procedures were in place to guide financial practices and each patient selected as part of the sample had a signed written agreement with the home and evidence that the home had notified patients or their representatives of a change to the agreements with the agreements shared for signature.

Areas requiring improvement were identified in relation to: ensuring that persons making a deposit of personal monies for patients' expenditure receive a receipt on each occasion; ensuring that the patients' comfort fund records are maintained using a standard financial ledger format; ensuring that treatment records 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' property records are reconciled on at least a quarterly basis, with the records signed by a staff member and countersigned by a senior member of staff 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	5

Details of the Quality Improvement Plan (QIP) were discussed with Janine Curran, manager, the regional manager and regional administrator 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 18 December 2012

A finance inspection was carried out on 18 December 2012; the findings from the inspection were not brought forward to the inspection on 26 July 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.

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.

During the inspection, the inspector met with Janine Curran, manager, the regional manager and regional administrator. 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 "Residents'" information guide"
- Three patients' individual written agreements with the home

- A sample of income and expenditure and records of checks performed
- A sample of records in respect of hairdressing and podiatry treatments facilitated in the home
- A sample of comfort fund records
- Three patients' records of furniture and personal possessions (in their rooms)
- The "valuables record"/record of safe contents
- A sample of three written agreements with patients
- A sample of hairdressing and podiatry treatment records
- A sample of written policies and procedures including:
    - Comfort fund – 2016
    - Gifts to staff and donations to the home – 2016
    - Whistleblowing – 2017
    - Complaints – 2017
    - Record keeping – 2017
    - Accounting and financial control arrangements – 2017

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 22 March 2018

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

This 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 18 December 2012

As noted above, a finance inspection was carried out on 18 December 2012; the findings from the inspection were not brought forward to the inspection on 26 July 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 manager of the home and later, the regional manager and regional administrator who works across a number of the registered provider's services.

The manager confirmed that adult safeguarding training was mandatory for all staff members and confirmed that the regional administrator had most recently participated in this training in August 2016; a subsequent update was planned for September 2018.

The manager 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 and access was limited to specific persons. On the day of inspection, money belonging to a number of patients was deposited for safekeeping, as were several valuables. Discussion established that a record of the valuables in the safe was held on computer and the record provided for review was printed, signed and dated on the day of the inspection. The manager was reminded that there should be evidence in place to ensure that a reconciliation of the (money) and valuables deposited for safekeeping is signed and dated by two people on at least a quarterly basis.

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 and the regional administrator had participated in adult safeguarding training.

Areas for improvement

No areas for improvement were identified during 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.

Discussions with the three staff members referred to above 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 receipt of the personal monies for patients whereby monies were deposited for expenditure by family representatives. Receipt books were in place to record the deposit of monies, however within a sample of deposits traced to the receipt books, several receipts had not been written.

There should be consistent practice in ensuring that persons making a deposit of personal monies for patients' expenditure receive a receipt on each occasion. Best practice would dictate that receipts are signed by the person receiving the money and by the person making the deposit (or failing this, two members of staff).

This was identified as an area for improvement.

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 in June 2018.

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 reviewed, this evidence was available.

Hairdressing and private podiatry treatments were being facilitated within the home and a sample of recent treatment records was reviewed. Routinely, the hairdressing treatment records were not signed by either the person delivering the treatment or by a representative of the home; podiatry treatment records had been signed by the podiatrist but not 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 related cost.

This was identified as an area for improvement.

The inspector discussed with the manager how patients' property (within their rooms) was recorded. A sample of three patient's records was chosen and it was noted that each patient had a "personal effects of resident" record in place. While it was noted that the records contained good detail such as "own small side table", none of the records were signed and dated.

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.

Discussions with the regional support administrator established that the home operated a patients' comfort fund and an appropriately named bank account was in place to manage the fund. However it was noted that the income and expenditure records were not maintained using a standard financial ledger format which is required. This was identified as an area for improvement.

Discussions established that the home did not operate a patients' (personal monies) bank account or a transport scheme.

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, an appropriately named bank account was in place to manage the patient comfort fund monies.

Areas for improvement

Four areas for improvement were identified during the inspection in relation to: ensuring that persons making a deposit of personal monies for patients' expenditure receive a receipt on each occasion; ensuring that the patients' comfort fund records are maintained using a standard financial ledger format; ensuring that treatment records 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' property records are reconciled on at least a quarterly basis, with the records signed by a staff member and countersigned by a senior member of staff.

	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 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 is admitted into the home.

Discussion with the manager 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 an annual questionnaire, relatives' meetings and one-to-one discussions with patients.

Arrangements for patients to access money outside of normal office hours were discussed with the manager. She described the arrangements which are 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 "Residents' information guide" contained information for a new patient including the home's terms and conditions of residency.

Written policies and procedures were in place which addressed areas including accounting and financial control arrangements, the management of the comfort fund, record keeping, gifts to staff and donations to the home and whistleblowing. Policies were easily accessible and were dated within the last three years. The inspector reviewed the policy on accounting and financial control arrangements and noted that this was worded exactly as per Standard 14 of the Care Standards for Nursing Homes (2015) and lacked any unique reference to the home's own specific practices. Advice was provided in respect to reviewing and updating this policy accordingly to suit the home's own practices.

Discussion with the regional support 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 three patients' individual written agreements was reviewed which established that each patient had an agreement on their care file; these were all dated 2017.

There was evidence of correspondence to the patients or their representatives detailing the general increase in fees which was applicable from 1 April 2018. Correspondence made reference to an updated agreement being enclosed, although it was noted that a copy had not been retained for the file (advice was provided to the manager in this regard). For the patient files chosen as part of the sample, the signed updated agreements had not yet been returned.

A review of a sample of the income and expenditure records identified that a document entitled "authorisation for use of cash" was on file for only one of eighteen patients for whom income and expenditure ledgers were being maintained. A written personal monies authorisation should be in place to authorise the home to make purchases of goods or services on behalf of individual patients. The inspector provided advice as to reviewing the content of the document itself to make it less generic in nature.

Ensuring that these documents are in in place for all relevant patients was identified as an area for improvement.

Areas of good practice

There were examples of good practice found: the regional support administrator was confident on how to respond to a complaint or escalate a concern under the home's whistleblowing procedures; written policies and procedures were in place to guide financial practices and each patient selected as part of the sample had a signed written agreement with the home and evidence that the home had notified patients or their representatives of a change to the agreements with the agreements shared for signature.

Areas for improvement

One area for improvement was identified in relation to ensuring that personal monies authorisations are in place for patients as appropriate.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Janine Curran, manager, the regional manager and the regional administrator as part of the inspection. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home.

The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005 and the 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 14.9 **Stated:** First time **To be completed by:** 27 July 2018	The registered person shall ensure that persons making a deposit of personal monies for patients' expenditure receive a receipt on each occasion. Best practice would dictate that receipts are signed by the person receiving the money and by the person making the deposit (or failing this, two members of staff). Ref: 6.5
	Response by registered person detailing the actions taken: The present acting manager ensures that when a person is making a deposit of personal monies for residents expenditure that a receipt on each occasion is issued . New receipt books have been obtained and staff have all been advised of this procedure. The manager and regional support administrator will continue to monitor this within the home.
Area for improvement 2 **Ref**: Standard 14.10 **Stated:** First time **To be completed by:** 12 August 2018	The registered person shall ensure that a standard financial ledger format is used to clearly and accurately detail transactions in the patient comfort fund records. 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 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: The acting manager and regional support administrator have commenced a standard financial ledger and this clearly details transactions in the patient comfort fund to include the date, a description of the entry, whether the entry is a lodgement or withdrawal. There is a running balance maintained of the total cash held and the ledger is always signed by two persons who are able to verify the entry on the ledger.
Area for improvement 3 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 27 July 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:

	The acting manager ensures that any service facilitated within the home that the person providing the service signs the record of treatment . A receipt is provided including the resident or staff members signature. The receipt issued includes the treatment or goods provided and the associated costs to each resident is shown on it and this is also documented in the homes residents ledger.
Area for improvement 4 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 26 August 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: The acting manager has issued inventories for all residents and staff at present are updating these with further detail being added as discussed during the inspection process. The inventory once updated will be reconciled quarterly and the record will be signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.
Area for improvement 5 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 26 August 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: The acting manager and regional support administrator are issuing personal allowance spending authorisation forms to all residents/relatives for signing in order to provide authority for the home to make purchases of goods and services. This form also includes authority for specific financial arrangements in place for relevant residents. Supporting documents to confirm authority from the resident/ their representative / HSC trust care managers will be made available and held on record.

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

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