Unannounced Finance Inspection Report
7 February 2017

Daleview House

Type of service: Nursing Home
Address: Shepherds Way, Dungiven Road, Londonderry BT47 5GW
Tel no: 02871348015
Inspector: Briege Ferris

1.0 Summary

An unannounced inspection of Daleview House took place on 7 February 2017 from 10:10 to 15:10 hours.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care, and if the service was well led.

Is care safe?

A safe place in the home was available and staff members were familiar with controls in place to safeguard patients' money and valuables; no areas for improvement were identified during the inspection.

Is care effective?

A number of controls to ensure patients' money and valuables were safeguarded were found to be in place however three areas for improvement were identified during the inspection. These related to: ensuring that the identified patient's file evidences official confirmation of the identity of the nominated appointee and the records which will be kept in respect of the appointment (these details should also be reflected in the patient's individual written agreement with the home); ensuring that records of treatments provided to patients (for which there is an additional charge) are signed by a representative of the home and by the person providing the treatment; and ensuring that the registered person maintains a record of the furniture and personal possessions which each patient has brought into their room (this must be carried out for each of the current patients in the home).

Is care compassionate?

Discussion with staff members evidenced an empathic attitude to ensuring patients' money and valuables were appropriately safeguarded; no areas for improvement were identified.

Is the service well led?

Evidence of governance arrangements were identified; no areas for improvement were identified during the inspection.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the (DHSSPS) Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	1

Details of the quality improvement plan (QIP) within this report were discussed with Marcella McCorkell, 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.

2.0 Service details

Registered organisation/registered person: Apex Housing Association/Gerald Kelly	**Registered manager:** Marcella Harriet McCorkell
Person in charge of the home at the time of inspection: Marcella McCorkell	**Date manager registered:** 31 December 2008
Categories of care: NH-I	**Number of registered places:** 25

3.0 Methods/processes

Prior to the inspection, the record of notifiable incidents reported to RQIA in the last 12 months was reviewed; the record of calls made to RQIA's duty system was reviewed and this did not identify any relevant issues. The care inspector was contacted prior to the inspection and confirmed that there were no matters to be followed up from the previous care inspection.

During the inspection, the inspector met with Marcella McCorkell, the registered manager; the home administrator and two members of nursing staff. A poster detailing that the inspection was taking place was positioned at the entrance of the home, however no visitors or relatives chose to meet with the inspector.

The following records were examined during the inspection:

- A new patient admission pack
- A sample of written policies
- Four patient finance files, including four written patient agreements
- Three written personal monies authorisations
- A sample of income, expenditure and reconciliation records
- A sample of records for hairdressing services facilitated in the home
- A sample of records relating to the patients' comfort fund
- The record of safe contents

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 10 January 2017

The most recent inspection of the home was an unannounced medicines management inspection; a quality improvement plan was not issued as a result of the inspection.

4.2 Review of requirements and recommendations from the last finance inspection dated 13 October 2009

A finance inspection of the home was carried out on 13 October 2009 on behalf of RQIA; the findings from this inspection were not brought forward to the inspection on 7 February 2017.

4.3 Is care safe?

The home had a part-time administrator and evidence was reviewed which confirmed that she had received adult safeguarding training. The home administrator had worked in the home for approximately 14 years and was familiar with the controls in place to safeguard patients' money and valuables in the home. Discussion established that further training opportunities were also available.

During discussion, the registered 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; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, cash and valuables belonging to a number of patients was lodged for safekeeping.

The home had a written record of items held for safekeeping on behalf of individual patients; it was noted that these had been checked weekly and were signed and dated by two people.

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

Discussion with the registered manager and the administrator established that Apex was acting as nominated appointee for one identified patient in the home. Staff described that this arrangement had been in place for some time. A review of the patient's finance file identified that there was no official details of the appointee contained within the file, nor were any such details contained in the patient's agreement with the home (there is further discussion in respect of written patient agreements in section 4.6 of the report).

Staff reported that the patient's benefits were received by Apex head office and no money was received directly by the home in respect of the patient. The home administrator confirmed that the home did not maintain a cash float for the patient as the cost of sundry expenditure was met by a representative of the patient.

The home administrator contacted Apex head office during the inspection in order to clarify the arrangements for Apex to receive money on behalf of the patient and for charging the patient their assessed care contribution. The inspector also spoke with an Apex representative by telephone; however this failed to clarify a number of queries. The most recent Western HSC trust payment remittance was reviewed; this evidenced that the patient had to contribute an identified amount towards the cost of the care. The remittance also detailed that a third party charge was payable per week, which was not being paid via the HSC trust.

Following the inspection, RQIA contacted the registered manager to request further clarification. Correspondence from Apex confirmed that the home was charging the patient the assessed contribution, as detailed on the HSC trust payment remittance. However in addition to this, Apex confirmed that the patient was paying the weekly third party top up charge from their personal monies. Apex reported that this arrangement was agreed between the patient and their social worker.

This arrangement is in contravention to DHSSPS Circular HSC (ECCU) 1/2010, part 3 Para 82 which states: "Case managed service users are not permitted to made additional payments from their own resources, including the PEA (personal expense allowance). The additional cost must be met by a third party." This arrangement is also is contravention to section 8.018 of the DHSSPS Charging for Residential Accommodation Guide (2013) which states that "Residents cannot use their own resources to pay for more expensive accommodation i.e. act as their own third party".

RQIA has written to the Western Health and Social care Trust in respect of this finding.

On the day of inspection, there were no records held in the patient's finance file to identify who was acting as nominated appointee or what records were to be kept in respect of this appointment. There was a lack of clarity regarding the appointee arrangements for the patient. This was particularly disappointing given that staff had advised this was the only patient in the home for whom this type of financial arrangement was in place.

A requirement was made for the registered person to ensure that the identified patient's file evidences official confirmation of the identity of the nominated appointee and the records which will be kept in respect of the appointment. These details should also be reflected in the patient's individual written agreement with the home.

During the inspection, the home administrator confirmed that the home was not in direct receipt of the personal money for any patient from a HSC trust, a solicitor or other party. She also noted that the home did not operate a patients' bank account.

On the day of inspection, the home was safeguarding money on behalf of 13 patients, which had been received from the family/friends of patients. Money had been deposited in order to pay for additional services facilitated within the home for which there was an additional charge, such as hairdressing, or newspapers and other sundries.

A sample income and expenditure records maintained on behalf of patients was reviewed and these were found to be clearly and neatly maintained. Detailed records made using a standard financial ledger format were evidenced; entries were routinely signed by two people.

A review of a sample of the records identified that over time, a weekly reconciliation of the money held on behalf of patients was recorded and signed and dated by two people. The inspector traced a sample of transactions recorded in the records and was able to locate the relevant documents; for example, a receipt for expenditure or a hairdressing treatment record. As noted above, hairdressing treatments were being facilitated within the home. Records were in place to evidence the patients treated on any given day and the cost of the respective treatments. A review of a sample of the hairdressing records evidenced that a template was in use to record treatments. The template included the majority of information which is required, however it was noted that the treatment records were not signed by either the hairdresser or a representative of the home to verify that the treatment had been recorded.

A recommendation was made to 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.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see a sample of the completed property records for four patients. Discussion with the registered manager and two members of nursing staff established that the required records were not available.

A requirement was made to ensure that the registered person maintains a record of the furniture and personal possessions which each patient has brought into their room (this must be carried out for each of the current patients in the home).

Discussion established that the home also administered a patients' comfort fund; a written policy and procedure was in place to guide the administration of the fund. A bank account was in place which was appropriately named in favour of the patients in the home. A sample of the comfort fund "cash record" entries was reviewed and expenditure appeared consistent with the home's written policy and procedure. A sample of the records evidenced that entries were checked and signed and dated by two people on a weekly basis.

During the inspection, the registered manager confirmed that the home did not provide transport to patients.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to: ensuring that the identified patient's file evidences official confirmation of the identity of the nominated appointee and the records which will be kept in respect of the appointment (these details should also be reflected in the patient's individual written agreement with the home); ensuring that records of treatments provided to patients (for which there is an additional charge) are signed by a representative of the home and by the person providing the treatment; and ensuring that the registered person maintains a record of the furniture and personal possessions which each patient has brought into their room (this must be carried out for each of the current patients in the home).

Number of requirements	2	**Number of recommendations**	1

4.5 Is care compassionate?

The day to day to day arrangements in place to support patients were discussed with the registered manager and the administrator. Staff described specific examples of how the home supported a number of patients with their money. It was evident from discussion that some patients handled money their independently and there were varying degrees of support provided depending on the individual patient's needs.

Discussion with the registered manager identified that the home had a range of methods in place to encourage feedback from families or their representatives in respect of any issue, including ongoing verbal feedback, relatives/patients' meetings and questionnaires.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. The registered manager explained the contingency arrangement in place in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures addressing matters relating to record keeping, escalating concerns and safeguarding patients' money and valuables were available and these were easily accessible by staff on the day.

There was a clear organisational structure within the home and discussion with the home administrator established that she was clear on her role and her responsibility to escalate any concerns.

Individual patient agreements were discussed and a sample of four patients' files was selected for review. The home's standard written agreement with patients contained a range of information including an appendix detailing the cost of additional services facilitated in the home; appendix 2 contained a table detailing the change in fees over time, the method of payment and the person(s) by whom the fees were payable. The agreements for three of the four patients contained up to date details which agreed to the most HSC payment remittance reviewed during the inspection.

The written agreement for the identified patient discussed in section 4.4 was reviewed. The agreement detailed the weekly fee for the patient and separately, the third party top up charge payable. The patient's agreement detailed that the HSC trust were paying this amount to the home. However, subsequent clarification from the organisation's head office clarified that the details on the patient's written agreement were, in fact, incorrect and the patient was in fact, personally funding the top up charge which must be paid by a third party. As noted in section 4.4 above, RQIA has written to the Western Health and Social care Trust in respect of this finding.

A review of the patient's agreement detailed that it did not contain the details of the patient's appointee or the records which were to be kept in respect of this appointment. Subsequent correspondence with Apex confirmed that Apex is the patient's appointee. A requirement has been made under section 4.4 in this report in respect of this finding.

A sample of patients' personal monies authorisation forms were reviewed (i.e. providing the home with the authority to spend the patient's money on identified goods and services.) A review of the sample identified that each patient ad a signed authorisation in place with the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Marcella McCorkell, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

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5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have

been completed and return the completed QIP to finance.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref**: Regulation 19 (2) Schedule 4 (3) **Stated:** First time **To be completed by:** 2 March 2017	The registered provider must ensure that a record is maintained of all accounts relating to the home, including a record of patient's fees and financial arrangements that are handled by the nursing home and a record of persons working at the home acting as the appointee or agent of a patient. The details of the appointee for any patient should be detailed in their individual written agreement with the home alongside the records to be kept in respect of the appointment.
	Response by registered provider detailing the actions taken: The centralised nature of the Associations housing management is conducted at head office. Records maintained include a record of patient fees, financial arrangements and a copy of the care agreement. A new Care Agreement has now been drafted for the identified patient which contains details of the patient's fees and evidence that Apex have been awarded appointeeship. A copy of this new agreement is also held in the patient's file.
Requirement 2 **Ref**: Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be completed by:** 2 March 2017	The registered provider must ensure that a record is maintained of furniture and personal possessions brought by a patient into the room occupied by him.
	Response by registered provider detailing the actions taken: A record is now maintained of furniture and personal possessions brought by a patient into the room occupied by them.

Recommendations	
Recommendation 1 **Ref**: Standard 14.13 **Stated:** First time	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.
To be completed by: 8 February 2017	**Response by registered provider detailing the actions taken:** When any service is facilated within the home the person providing the service and the patient or a member of staff of the home will sign the treatment record or receipt to verify the treatment or goods provided and the associated costs to each patient.

Please ensure this document is completed in full and returned to finance.team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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