Unannounced Finance Inspection Report
29 July 2016

Deanfield

Type of Service: Nursing Home
Address: 19 Deanfield, Limavady Road, Londonderry, BT47 6HY
Tel No: 02871344888/02871341754
Inspector: Briege Ferris

1.0 Summary

An unannounced inspection of Deanfield took place on 29 July 2016 from 10:30 hours to 15:40 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?

The administrator was able to describe current practice in the home and referred to daily and month-end tasks. She noted that month-end information was sent to the finance manager at head office. While the home had a safe place available, the inspector alerted the nurse in charge to a weakness in the physical security of the safe place and noted during the inspection, that this should be addressed as a priority. Two areas for improvement were identified during the inspection; these related to ensuring that the home administrator received appropriate training for her role, including Protection of Vulnerable Adults (POVA) training; and adequately securing the safe place within the home.

Is care effective?

Six areas for improvement were identified during the inspection. These related to: ensuring that each patient in the home had a record of furniture and personal possessions which is maintained in line with DHSSPS minimum standards; ensuring that income and expenditure records are made on a standard financial ledger format and include all of the details as set out in DHSSPS minimum standards; clarifying and detailing within the patient's records, any person in the home acting as nominated appointee for any patient; ensuring that the registered provider contact the HSC trust again regarding the high balance held for one patient, which could be earning interest elsewhere; ensuring that records of treatments provided to patients which carry an additional cost are appropriately maintained and ensuring that a record of safe contents is introduced, which should be reconciled and signed and dated by two people at least quarterly.

Is care compassionate?

Compassionate practice was evidenced in discussions with the home administrator. A recommendation was made (as above) regarding her training which the inspector identified would further strengthen her awareness of the relevant issues as the key member of staff handling patients' money and valuables.

One area for improvement was identified during the inspection, this related to introducing contingency arrangements which would allow patients to have access to their money at all times.

Is the service well led?

While governance and oversight arrangements were identified, two areas for improvement were noted during the inspection. These related to ensuring that each patient in the home who does not have a written individual agreement is provided with one and ensuring that each patient for whom the home engages in purchases of goods or services, has a personal expenditure authorisation in place.

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	9

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

1.2 Actions/enforcement taken following the most recent finance inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered provider: Loughview Homes Ltd/Paul Steele & Michael Curran	**Registered manager:** Joy McLaughlin
Person in charge of the home at the time of inspection: Ciara McHugh (Nurse in Charge)	**Date manager registered:** 13 December 2007
Categories of care: NH-I	**Number of registered places:** 29

3.0 Methods/processes

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 issue. The care inspector for the home was contacted and confirmed that there were no matters to be followed up from the previous care inspection.

During the inspection, we met with the home's administrator and the nurse in charge, the registered manager was not in the home at the time of the inspection. 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.

Following the inspection, feedback was provided by telephone to Joy McLaughlin, the registered manager.

The following records were examined during the inspection:

- Financial Policies and Procedures including:
  "Accounting and Financial Control Arrangements Policy… Last reviewed April 2014"*
  "Procedures for handling residents' finances… Last reviewed April 2014"*
  Policy 125 "Policy on gifts to staff"* dated October 2008
  Policy 242 "Patients' property"* dated October 2008
  Policy 243 "Handling patients' money, property etc"* dated October 2008
  Policy 245 "Policy on Residents' Finances" dated October 2008
- Seven Patient Personal Finances Contracts
- Patient Contracts/Agreements
- A sample of records detailing hairdressing services facilitated in the home
- A sample of "Patients personal allowance records" and cash balances held
- The record of property/furniture and personal possessions for one patient

*Titles as detailed in the original record held in the home

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 July 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector. This QIP will be validated by the pharmacy inspector at the next pharmacy inspection.

4.2 Review of requirements and recommendations from the last finance inspection dated 31 March 2006

A finance inspection of the home was carried out on behalf of RQIA on 31 March 2006. The findings from the 2006 inspection were not brought forward as part of the inspection on 29 July 2016.

4.3 Is care safe?

The administrator stated that she had been in the role for just over one year. The administrator was able to describe and explain her daily and month-end tasks, noting that month-end information was sent to the finance manager at head office. She described how she had received a handover from her predecessor on commencement of employment; however she confirmed that she had not received any formal training for her role.

During the course of the discussions with the inspector, the administrator confirmed that she had not received training in the protection of vulnerable adults (POVA) and the inspector identified that she was not aware of whether the home had a policy and procedure on whistleblowing or complaints handling; as such, she was unable to confidently describe how she would approach these scenarios.

The administrator confirmed that she had not received formal supervision since commencing employment, nor had she received an annual appraisal. The inspector noted that the administrator should discuss this matter with the registered manager.

A recommendation was made to ensure that the home administrator receives formal POVA training and that opportunities are provided for all staff to update their knowledge and skills through training which is appropriate for their particular role.

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.

During the course of the inspection, we spoke with Ciara McHugh, the nurse in charge and highlighted to her one urgent matter to be dealt with in relation to the physical security of the safe place within the home.

A recommendation was made to ensure that the safe place within the home is adequately secured to mitigate the risk to the safe keeping of patients' money or valuables.

Two areas for improvement were identified during the inspection; these related to ensuring that the home administrator receives appropriate training for her role, including POVA training; and adequately securing the safe place within the home.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.4 Is care effective?

The inspector was provided with a number of records for review including the home's "Personal allowance" file. This contained a number of "Residents Personal Monies" documents detailing income and expenditure for fourteen patients. It was noted that the format followed a standard ledger format, however entries had not consistently been signed by two people, as the template required. Receipts detailing money lodged with the home and recorded as income on these ledgers were often not available or detailed the signature of only one party, normally the person receiving the money. The inspector evidenced money signed out to a patient, which had only been signed in the patient's ledger by the registered manager; in the absence of the patient signing the ledger, the inspector reviewed the duplicate receipt book in order to check had the patient signed a receipt in respect of this entry, however a corresponding receipt was not located in the duplicate book provided.

The inspector discussed these findings with the registered manager and highlighted the protection which the two signature control provided not only, to the patient but also to the vulnerability of a lone member of staff handling money and recording only one signature against a cash transaction.

It was noted that the home must use income and expenditure records which utilise a standard financial ledger format. The importance of two people signing each entry in the ledger was emphasised with the registered manager.

A recommendation was made in respect of this finding.

During discussions, the home administrator reported that as part of the month-end processes, that month's "Monthly review of Patients' Personal allowance records" was faxed to finance colleagues in head office for review. On reviewing the most recently completed document (for June 2016), the inspector noted that the record included space for those completing the record to detail whether (for the identified patients for whom the home held money) that "all of the receipts were available" and "all signatures in place". These two controls were both ticked on June 2016's record; however, on reviewing the individual records for one patient, only a small number had been signed by two people, as required.

As noted above, a review of a sample of the records failed to evidence that these controls as detailed in the monthly review had in fact, been consistently applied.

In reviewing a sample of records, it was evident that the home was in direct receipt of personal monies for at least two patients. Evidence was reviewed which detailed that the home administrator requested money from head office on behalf of these patients, as their balance of personal monies held within the home began to become low. Evidence was held on file of the requests being made by the home and subsequently authorised by head office.

As noted above, the inspector evidenced that the home were directly supporting a number of patients with their monies. The inspector noted that the balance of money being held within the residents' bank account was for one patient was notably high. The inspector discussed this observation with the registered manager and advised that the registered provider should contact the HSC trust to discuss arrangements to potentially move a substantial share of the balance held by the home to the HSC trust into an interest bearing account to be safeguarded by the HSC trust on the patient's behalf. A recommendation was made in respect of this finding.

Following the inspection, the registered manager provided the inspector with a copy of correspondence dated October 2015, which set out communication between the home and the patient's care manager. The correspondence from the home detailed the balance of money being held for the identified patient and requested direction on whether other options could be pursued with regards to where the patient's money could be held, in particular to earn interest. The inspector noted that this correspondence provided evidence that the home had been proactive in advocating for the identified patient in this regard. On the day of inspection, the inspector did not evidence any response from the HSC trust to the home in this regard and as such, the home should pursue this matter again with the HSC trust on the patient's behalf.

Records were also evidenced which detailed that a person, or persons associated with the home were acting as nominated appointee (managing the social security benefits) of at least one patient.

A review of one relevant patient's file failed to evidence any official documentation regarding the appointeeship, therefore it was not possible to confirm whether in fact a person associated with the home was acting as nominated appointee, or whether the relevant patient's social security benefits had simply been mandated to the home to be managed on the patient's behalf. Ultimately, the inspector was unable to obtain clarity from the records reviewed.

The inspector discussed these findings with the registered manager and noted that if a person associated with the home was acting as nominated appointee for a patient, there must be confirmation of the date they have been appointed from the Social Security Agency (SSA) on the patient's file. The patient's individual written agreement must also detail the name of the appointee, the date they were appointed by the SSA and what records the home will maintain in respect of this appointment.

A recommendation was made in respect of this finding.

Following the inspection, the registered manager provided the inspector with a copy of Form BF57 in respect of the identified patient; this identified that the organisation's finance manager was acting as nominated appointee for the patient. The correspondence from the registered manager confirmed that a copy of the correspondence would be placed on the patient's file in the home.

It was also noted that a representative of the home had signed documents both on behalf of the home and on behalf of the nominated appointee for one patient; these documents included the "Patient Personal Finance Contract". The inspector noted that it was not appropriate for a representative to sign both sides of a contract.

The inspector observed the same patient's file to be maintained in poor order; in the midst of an array of documents, the inspector found an envelope which purported to contain the wedding ring of the patient. The inspector discussed this with the registered manager following the inspection and noted that any items of such value must be held within the home's safe place.

In respect of file management, the inspector noted that each of the patient's files should ideally be sectioned off so that documents could be filed appropriately and securely and were easy to locate. The inspector noted this was especially important where the home were directly involved in supporting a patient to manage their money and as such, there was a greater responsibility to ensure that records were maintained in a manner which reflected professional standards of good practice.

As noted above, the home had a safe place available for the deposit of cash or valuables belonging to patients. On the day of inspection, cash and valuables belonging to patients were lodged with the home for safekeeping. The administrator confirmed that the home did not have a written safe record to detail property signed into, and out of the safe place.

A recommendation was made to ensure that the home introduce a written safe record, which should be reconciled and signed and dated by two people at least quarterly.

Following the inspection, the registered manager confirmed that a written safe record was in place in the home, however as noted above, the home administrator was not aware of this and therefore did not provide it to the inspector for review on the day.

The home administrator confirmed that the only treatment facilitated within the home at the time of inspection was hairdressing. A review of a sample of treatment records for hairdressing identified that the name, the treatment received and the cost was recorded. These records should be signed and dated both by the person providing the treatment and a representative of the home to verify that the treatment had been received. Fifteen completed templates were on file, seven of these had been signed by the hairdresser and only one was signed by the registered manager.

A recommendation was made to ensure that treatment records are maintained in line with the requirements of DHSSPS Minimum Standards.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see the completed property records for a sample of four randomly sampled patients. The nurse in charge provided the four care files for the patients selected, however she highlighted that some of the records may be in the home's records archive. A review of the four files evidenced that only one of the four patients had a personal property record on their file, entitled "Clothing/personal belongings at admission". The one available record had been signed and dated by one person; there was no evidence that the record had been updated since the patient had been admitted.

A requirement to ensure that a record of furniture and personal possessions/inventory belonging to each patient in the home is retained and kept up to date throughout their stay in the home. Any additions or disposals from a patient's property record must be signed and dated by two people. The inspector highlighted that DHSSPS Care Standards for nursing homes require that these records are reconciled at least every quarter by a member of staff and the record countersigned by a senior member of staff.

Areas for improvement

Six areas for improvement were identified during the inspection. These related to: ensuring that each patient in the home has a record of furniture and personal possessions which is maintained in line with DHSSPS minimum standards; ensuring that ensuring that income and expenditure records are made using a standard financial ledger format and include all of the details as set out in DHSSPS minimum standards; clarifying and detailing with the patient's records, any person in the home acting as nominated appointee for any patient; ensuring that the registered provider contact the HSC trust regarding the excessive balance held for one patient, which could be earning interest elsewhere; ensuring that records of treatments provided to patients which carry an additional cost are appropriately maintained and ensuring that a record of safe contents is introduced, which is reconciled and signed and dated by two people at least quarterly.

Number of requirements	**1**	**Number of recommendations**:	**5**

4.5 Is care compassionate?

Individual arrangements in place at the home to support patients with their money were discussed. The administrator was able to identify a number of patients for whom there were specific arrangements in place and a number of these patients formed part of the sample chosen for review by the inspector.

Arrangements for patients to access their money outside of normal office hours were discussed with the home administrator; she explained that at present there was no access for patients. She noted that she was not aware of any patient having requested their money from the weekend staff, thus far. However, the inspector noted that the home should have a contingency arrangement in place to address this possibility.

A recommendation was made for the registered manager to consider a contingency arrangement which would mean that any patient would have access to money at all times. During telephone feedback with the registered manager, she noted that the home had a sum of money available in case of emergency which was held within the treatment room and to which only the nurse in charge has access, these arrangements were not highlighted to the inspector on the day of inspection.

Areas for improvement

One area for improvement was identified during the inspection, this related to introducing contingency arrangements which would allow patients to have access to their money at all times.

Number of requirements	**0**	**Number of recommendations**:	**1**

4.6 Is the service well led?

There was a clear organisational structure within the home; following discussion with the administrator, it was evident that she was familiar with her role and record keeping responsibilities. However as previously noted, she could not confirm whether the home had a whistleblowing policy or complaints policy, and she could not, therefore explain the steps to take should be need to become involved in either process. As noted in section 4.3 of this report, a recommendation has been made to ensure that members of staff receive appropriate training.

A policy file was available within the managers/administration office; on review this contained a number of policies and procedures in respect of patients' money and valuables. Although some of these were dated 2008, a review of additional records evidenced more up to date policies were available.

The administrator provided the inspector with a file entitled "Signed Patient Contracts". This file contained six signed individual written agreements for patients in the home. The agreements had been signed between December 2015 and May 2016. The administrator was asked if the agreements in the folder provided were the only patient agreements and she confirmed this was the case. The inspector was also provided with a schedule which detailed the names of nineteen permanent patients and which detailed "Date the patient's contract provided/posted to patient/relative" together with other details such as when the agreement had been signed. The inspector noted that there were references on the schedule against identified patients' names that there was "No relatives to pass too" (as per the original record in the home).

In addition, where a date had been recorded for when the agreement had been provided to the patient or their representative, there was no additional evidence provided to suggest that the return of the signed contracts had been pursued by the home.

A requirement was made to ensure that each patient in the home who does not have a written agreement is provided with one. If a patient or their representative is unable to or unwilling to sign the agreement, this must be recorded. For any patient who does not have a family representative to review and sign the agreement, their agreement must be shared with their HSC trust care manager and/or any other official involved in supporting the patient with their money.

The inspector discussed these findings with the registered manager and noted that each patient's file should contain an up to date contract detailing the current terms and conditions of their residency (with any changes to these details such as the weekly fees, signed and dated by the patient or their representative). Files should evidence the attempts made by the home to secure a signed contract for the individual patient's files. Where a HSC trust managed patient does not have a representative to sign the written contract on their behalf, the contract should be shared with the patient's HSC trust care manager for review.

A review of the "Personal allowance" file evidenced that it contained a signed "Patient Personal Finances Contract" for seven patients. The home administrator had earlier confirmed that there were no further finance records for the inspector to review as part of the inspection, other than those which had been provided on the day. As such, it was noted that while only seven of the signed contracts were in place, the home had "Patients' personal allowance records" (as referred to in section 4.4 of this report) for fourteen patients.

A recommendation was made to ensure that a personal expenditure authorisation is provided to each remaining patient for whom the home engages in transactions for goods or services.

Areas for improvement

Two areas for improvement was identified during the inspection, these related to ensuring that each patient in the home who does not have a written individual agreement is provided with one and ensuring that each patient for whom the home engages in purchases of goods or services, has a personal expenditure authorisation in place.

Number of requirements	1	Number of recommendations:	1

5.0 Quality improvement plan

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

The registered person/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 person/manager 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 your premises.

The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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.

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 taken by the registered manager/registered provider

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered provider will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to finance.team@rqia.org.uk and assessed 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/manager 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/manager 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 (10) **Stated:** First time **To be completed by:** 08 September 2016	The registered person must ensure that a record of furniture and personal possessions brought by a patient into the room occupied by them is maintained throughout their stay in the home. Records of furniture and personal possessions belonging to all of the patients in the home must be reviewed and brought up to date. Records must be kept up to date on an ongoing basis, with any additions or disposals from the records signed off by two people. Property records should be reconciled at least quarterly.
	Response by registered provider detailing the actions taken: New documentation put in place. Staff all made aware and now all up to date. To be reviewed quarterly.
Requirement 2 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time **To be completed by:** 08 September 2016	The registered provider must provide to each patient, by not later than the date on which he becomes a patient, a statement specifying – (a) the fees payable by or in respect of the patient for the provision to the patient of any of the following services (i) accommodation, including the provision of food, and (ii) nursing and except where a single fee is payable for those services, the services to which each fee relates; (b) the method of payment of the fees and the person by whom the fees are payable.
	Response by registered provider detailing the actions taken: All documentated in the above requirement is specified in the patients contract and given on admission to the home. The home administrator has been updated in regards to the patients contract and record keeping of these
Recommendations	
Recommendation 1 **Ref**: Standard 13.11 **Stated:** First time **To be completed by:** 08 September 2016	The registered person should ensure that opportunities are provided regularly for staff to update their knowledge, and skills as well as for more advanced and specialised training in safeguarding and protection. Training is appropriate to the role of staff. Refresher training is provided at a minimum of every three years.
	Response by registered provider detailing the actions taken: SOVA training arranged for 12/09/16. Nurse Manager has carried out additional training on policies/procedures,supervision and apprasials for the administrator
Recommendation 2 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 12 August 2016	The registered person should ensure that the weakness in security (as highlighted to the home administrator and the nurse in charge on the day) has been appropriately addressed.
	Response by registered provider detailing the actions taken: The home safe has now been bolted to the wall

Recommendation 3 **Ref**: Standard 14.10, 14.11 **Stated:** First time **To be completed by:** 09 August 2016	The registered provider should ensure that a standard financial ledger format is adhered to detail transactions for patients. This 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 money held. The signatures of two persons should be recorded to verify each entry in patients' ledgers.
	Response by registered provider detailing the actions taken: All up to date and same incorporated in training programme with administrator
Recommendation 4 **Ref**: Standard 14.20, 14.21 **Stated:** First time **To be completed by:** 08 September 2016	The registered provider should ensure that if a person within the home acts as an appointee, the arrangements for this are discussed and agreed with the resident and (if involved) the referring Trust. These arrangements are noted in the individual agreement and a record is kept of the name of the appointee, the resident on whose behalf they act and the date they were approved by the Social Security Agency. Written authorisation from the Social Security Agency for the Registered Person or staff member to act as an appointee is retained with the resident's individual agreement.
	Response by registered provider detailing the actions taken: As discussed with the inspector all of the above are now in the patients file and will be adhered to in the future
Recommendation 5 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 08 September 2016	The registered provider should ensure that where a patient has a significant amount of personal money, this is not held in a pooled bank account, but where possible, transferred to an interest-bearing account in the patient's name. Contact should be made with the HSC trust again to explore whether transfer of excess funds held in the pooled bank account can be facilitated.
	Response by registered provider detailing the actions taken: Letter sent to patients care manager with regards to her funds. Awaiting reply
Recommendation 6 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 09 August 2016	The registered person should 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.
	Response by registered provider detailing the actions taken: The administrator and staff have all been advised to gain two signatures and receipts for all treatments.

Recommendation 7 **Ref**: Standard 14.9 **Stated:** First time **To be completed by:** 15 August 2016	The registered person should ensure that a safe record is maintained which details any money or valuables handed over for safekeeping. The record is signed and dated by the patient and a member of staff on receipt and return of the items. Records of money or valuables held on behalf of patients should be reconciled and signed and dated by two people at least quarterly.
	Response by registered provider detailing the actions taken: Administrator up dated through training and supervision
Recommendation 8 **Ref**: Standard 14.5 **Stated:** First time	The registered person should ensure that arrangements which ensure that patients' money is freely available to them at all times are reviewed. Relevant staff members (including the home administrator) should be made aware that the facility exists and the controls which exist around access, record keeping etc.
To be completed by: 08 September 2016	**Response by registered person detailing the actions taken:** Petty cash monies is available by the registered nurses at all times and can be used for patients needing funds out of office hours. All documentation in place for the procedure
Recommendation 9 **Ref**: Standard 14.6, 14.7 **Stated:** First time	The registered person should ensure that written authorisation is obtained from each patient or their representative to spend the patients' personal monies on pre-agreed expenditure. The written authorisation must be retained on the patient's records and updated as required.
To be completed by: 08 September 2016	**Response by registered person detailing the actions taken:** All up to date at present

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

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