Unannounced Finance Inspection Report
5 December 2016

Longfield Care Home

Type of service: Nursing Home
Address: 2 Longfield Road, Eglinton BT47 3PY
Tel no: 028 7181 2552
Inspector: Briege Ferris

1.0 Summary

An unannounced inspection of Longfield Care Home took place on 5 December 2016 from 10:20 to 15:30 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 were familiar with controls in place to safeguard patients' money and valuables; no areas for improvement were identified during the inspection.

Is care effective?

Controls to ensure patients' money and valuables were safeguarded were in place and there were arrangements in place to audit the effectiveness of these controls; however one area for improvement was identified. This related to ensuring that each patient has on file, a record of their furniture and personal possessions brought into their room, which is kept up to date and is reconciled by two people at least quarterly.

Is care compassionate?

The home had a range of methods in place to encourage feedback from families or their representatives. The welcome pack contained a range of information for new patients, including clear information on fees and funding-related matters. The home administrator spoke about the patients with empathy. No areas for improvement were identified during the inspection.

Is the service well led?

Indicators of oversight and governance arrangements were identified; up to date written agreements were evidenced on a sample of files reviewed, as were personal allowance monies authorisations. Written policies and procedures for handling cash and valuables were in place and had been recently updated. 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	0	1

Details of the quality improvement plan (QIP) within this report were discussed with Louise McCloskey, 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

A finance inspection was carried out on 31 March 2007 on behalf of RQIA; the findings were not brought forward to the inspection on 15 November 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons (Bamford) Ltd/Maureen Claire Royston	**Registered manager:** Louise McCloskey
Person in charge of the home at the time of inspection: Louise McCloskey	**Date manager registered:** 1 April 2005
Categories of care: NH-PH, NH-PH(E), NH-I	**Number of registered places:** 46

3.0 Methods/processes

Prior to the inspection, the record of notifiable incidents reported to RQIA in the last twelve months was reviewed; this identified one incident in relation to a patients' money or valuables which had been reported. The details of the reported incident were discussed with the registered manager; appropriate action had been taken by the home in respect of the incident. The record of calls made to RQIA's duty system was also reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with Louise McCloskey, registered manager; the home's administrator and the regional business support administrator. A poster detailing that the inspection was taking place was positioned at the entrance of the home, and the inspector met with one patient and three patients' representatives. The three patient representatives wished to pass on their positive feedback about the home and staff in general. One patient had a financial arrangement in place with the home; this is further detailed in section 4.6 below.

The following records were examined during the inspection:

- The home's welcome pack for new patients
- Training records for the home administrator (Protection of Vulnerable Adults)
- A sample of the home's policies addressing safeguarding patients' money and valuables
- A sample of income, expenditure, banking and reconciliation records

- The record of reconciliations of items held in the safe place
- A sample of records for hairdressing services facilitated in the home
- A sample of charges made to patients or their representatives (for care and accommodation)
- A sample of resident social fund records
- Four patient care files
- Four patient finance files
- Four records of patients' personal property (in their rooms)

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 October 2016

The most recent inspection of the home was an unannounced medicines management inspection. The inspection did not result in a Quality Improvement Plan being issued.

4.2 Review of requirements and recommendations from the last finance inspection

The home had one full time administrator and evidence was reviewed which confirmed that she had received training on the Protection of Vulnerable Adults (POVA). The administrator was able to describe the home's controls in place to safeguard patients' money and valuables in the home.

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 belonging to patients was lodged with the home for safekeeping, no valuables were being held.

The home had a written safe contents record; a review of this evidenced that the safe contents was reconciled and signed and dated by the home administrator and the registered manager every month.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3 Is care effective?

The inspector and the administrator discussed whether there were any arrangements in place for the home to receive the personal monies of any patient directly. One patient was identified; the home administrator confirmed that FSHC were acting as agent for this patient i.e.: receiving the social security benefits for the patient, although not acting as nominated appointee. A review of the patient's finance file evidenced correspondence between the home and the patient's HSC trust care manager/social worker; this confirmed the home's role as outlined above, and also that the patient had capacity to manage their personal allowance money independently.

The organisation's head office were in direct receipt of the social security benefits for the patient from which the patient's contribution to the weekly fee was retained, with the personal allowance monies transferred to the home to be safeguarded on the patient's behalf. Records were available to confirm the amount and timing of these transfers.

The inspector spoke with the identified patient and noted that they were aware of the arrangement being in place. They also confirmed that they were satisfied with the current arrangement and did not wish any aspect of it to change. The patient also confirmed that they did not want the inspector to suggest any change to the arrangement on their behalf.

Discussion with the home administrator established that the home were in receipt of small amounts of money lodged by family members to pay for additional services facilitated within the home for which there is an additional charge, mainly hairdressing. Money was being held on average for approximately twelve patients; for other patients in the home, family members paid the hairdresser directly for services received by their relative.

A sample of the records for income and expenditure incurred on behalf of patients were reviewed. It was noted that the home maintained "personal allowance account statements" detailing income and expenditure, together with other records to substantiate each transaction, such as a duplicate receipt for a cash/cheque lodgement or a hairdressing treatment record. The inspector traced a sample of transactions and was able to evidence the relevant documents; for example, a receipt for an item of expenditure or a receipt for a lodgement which had been made to the home. There was evidence that records of personal monies held on behalf of patients were reconciled and signed and dated by two people on a monthly basis.

As noted in section 4.3 of this report, a review of the home's safe contents records evidenced that the safe contents check was also reconciled and signed and dated by two people on a monthly basis.

As outlined above, hairdressing treatments were being facilitated within the home and records were in place to evidence the patients treated on any given day and the cost of the respective treatments. The information detailed on treatment records (as required by DHSSPS Minimum Standard 14.13) was being consistently recorded.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see the completed property records for four randomly sampled patients. The home administrator liaised with care colleagues in the home and later provided the records for the sampled patients. It was noted that a consistent method for recording patient property was not in place.

Three of the records were printed from the home's "Epicare" (computerised) records and one record was typed on plain paper. None of the four records were signed or dated, nor was there any evidence that the records had been updated or reconciled on a quarterly basis.

These findings were discussed with the registered manager, who noted that the home was currently reviewing the best way to record patients' property.

A recommendation was made to ensure that the home reviews each patient's record of furniture and personal possessions and that this is brought up to date. Each patient's record should be kept up to date and reconciled by two people at least quarterly.

It was noted that the home also had a residents' comfort fund, a written policy and procedure existed to guide the administration of the fund. It was noted that income and expenditure records were maintained, which were reconciled and signed and dated by two people every month.

The home administrator confirmed that the home did not provide transport to patients.

A review of a sample of four files evidenced that the organisation had provided written notification to patients or their representatives in advance of any increases in fees payable.

Areas for improvement

One area for improvement was identified during the inspection. This related to ensuring that each patient has on file a record of their furniture and personal possessions brought into their rooms. Each patient's record should be kept up to date and be reconciled by two people at least quarterly. The record should be signed by the staff member undertaking the reconciliation and be countersigned by a senior member of staff.

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

4.4 Is care compassionate?

Day to day to day arrangements in place to support patients was discussed with the home administrator. She described how she would speak with a patient or their representative at the time of or shortly after admission to explain the home's arrangements to safeguard money and valuables in the home or to discuss the payment of fees etc. The administrator described the sensitivities of these scenarios with great empathy.

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. The welcome pack contained a range of information for a new patient, including clear information on fees and funding-related matters.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager and home administrator; this established that there was a contingency arrangement in place to ensure that this could be facilitated.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is the service well led?

There was a clear organisational structure within the home, as outlined in the patient guide. The home had a range of written policies and procedures addressing matters relating to safeguarding money and valuables, record keeping requirements and other relevant issues such as complaints and whistleblowing.

A list of the current patients in the home was provided and a sample of four files selected for review. A review of the files identified that all four patients had a signed agreement on their file which reflected the up to date terms and conditions. Signed agreements detailing previous terms and conditions, were also maintained on the sampled patients' files.

A review of a sample of four patients' files evidenced that the home used documents entitled "Financial assessment Part 1, 2 and 3". These documents were used to detail the home's assessment of whether the patient could manage their own money (Part 1), what arrangements were in place regarding the management of the patient's personal allowance money (Part 2) and what authority the home had to make purchases of goods or services on behalf of the patient (Part 3).

A sample of four patient files was reviewed; this confirmed that these documents were on file and had been updated to reflect changing circumstances.

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 Louise McCloskey, 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.

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 **the web portal** 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	
Recommendations	
Recommendation 1 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 5 January 2017	The registered provider should ensure that each patient's record of furniture and personal possessions which they have brought into their room be reviewed and brought up to date. Each patient's record should be kept up to date and be reconciled by two people at least quarterly. The record should be signed by the staff member undertaking the reconciliation and be countersigned by a senior member of staff. **Response by registered provider detailing the actions taken:** Files of residents belongings are now in place for each resident and signed by the home manager and countersigned by the RN. This will be reviewed quarterly

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