Unannounced Finance Inspection Report
12 December 2017

Kilwee Care Home

Type of Service: Patiential Home
Address: 42f Cloona Park, Dunmurry, Belfast, BT17 0HH
Tel No: 02890618703
Inspector: Joseph McRandle

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 registered nursing home which is registered to provide nursing care for up to 48 persons living with a range of care needs as detailed in section 3.0.

3.0 Service details

Organisation/Registered Provider: Merit Retail Ltd **Responsible Individual(s):** Therese Elizabeth Conway	**Registered Manager:** See box below
Person in charge at the time of inspection: Charlyn Pontino, Deputy Manager	**Date manager registered:** Catherine Lacey – acting, no application required
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 48 A maximum of 36 patients in category NH-DE and 12 patients in categories NH-I, NH-PH and NH-PH(E).

4.0 Inspection summary

An unannounced inspection took place on 12 December 2017 from 10:55 to 14:45 hours.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 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 in relation to: providing a place for patients to deposit items for safekeeping, the controls surrounding the safe place, up to date safe register, members of staff involved in managing patients' finances receiving adult safeguarding training, the financial policies and procedures operated at the home, recording the reconciliations of patients' monies, retaining authorisation forms in patients' files for members of staff to purchase essential items on behalf of patients, facilitating journeys on behalf of patients, offering support to patients for managing their finances, retaining records of charges to patients, retaining records of amounts paid by patients for fees, up to date patients' agreements, recording transactions undertaken on behalf of patients and issuing receipts when monies are deposit at the home on behalf of patients.

Areas requiring improvement were identified in relation to: updating inventory records with items brought into the home by, or on behalf of, patients following admission, reviewing the system for recording transactions undertaken from the patients' comfort fund, ensuring that all authorisation forms are signed by the patient or their representative, ensuring that a system is implemented for recording the services provided by the hairdresser and podiatrist.

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	4

Details of the Quality Improvement Plan (QIP) were discussed with Charlyn Pontino, deputy manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent Medicines management inspection dated 30 November 2017

Other than those actions detailed in the QIP, no further actions were required to be taken following the most recent inspection on 30 November 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records: recent written and verbal communication received since previous medicine management inspection, notifiable events submitted in relation to finance issues, there were no financial issues identified. The inspector from the previous inspection was contacted who confirmed that there were no issues to follow up.

During the inspection the inspector met with the deputy manager, the home's administration assistant and the senior administration assistant.

The following records were examined during the inspection:

- Two patients' finance files
- Two patients' individual written agreements
- Monies held on behalf of four patients
- Valuables held on behalf of two patients
- A sample of records of reconciliations between monies and valuables held on behalf of patients and the records of monies and valuables held.
- two patients' forms authorising members of staff to make purchases on behalf of patients
- The patients' guide

- A sample of records of safe contents
- A sample of records of payments for fees paid by, or on behalf of, two patients
- A sample of records of payments for hairdressing and podiatry services
- A sample of records of purchases undertaken on behalf of two patients
- A sample of records of monies deposited at the home on behalf of two patients
- A sample of records from patients' comfort fund
- Written Financial policies and procedures.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent care inspection dated 30 November 2017

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 medicines management inspection.

6.2 Review of areas for improvement from the last finance inspection

The home has not previously received an RQIA finance inspection.

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.

A safe place was provided within the home for the retention of patients' monies and valuables. At the time of the inspection there were satisfactory controls around the physical location of the safe place and the staff members with access. Monies held on behalf of four patients were counted, the amount retained agreed to the balance recorded at the home.

A safe contents book was in place and up to date at the time of the inspection. A sample of valuables held on behalf of two patients was examined. Records agreed to the items held in the safe place. Records also showed that the items held were checked on a regular basis.

A review of records confirmed that members of staff involved in managing patients finances had received training in relation to the safeguarding of vulnerable adults. The members of staff contacted during the inspection were able to demonstrate knowledge of their specific role and responsibilities in relation to any concerns raised regarding patients' finances.

Comprehensive policies and procedures for the management and control of patients' finances were in place at the time of the inspection. The policies and procedures reflected the financial operational areas of the home.

Discussion with staff confirmed that there were no finance related restrictive practices in place for any patient.

Areas of good practice

There were examples of good practice found in relation to providing a place for patients to deposit items for safekeeping, the controls surrounding the safe place, up to date safe register, members of staff involved in managing patients' finances receiving adult safeguarding training and the financial policies and procedures operated at the home.

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.

Review of records and discussion with staff confirmed that no member of staff acted as an appointee for any patient, i.e. a person authorised by the Social Security Agency (SSA) to receive and manage the social security benefits on behalf of an individual.

Discussion with staff also confirmed that no member of staff acted as an agent for any patient, i.e. a person authorised by a patient or their representative to collect social security benefits on the patient' s behalf.

Review of records confirmed that as in line with standard 14.25 of the Care Standards for Nursing Homes (April 2015) monies and valuables held on behalf of patients were reconciled to the safe contents book at least quarterly. Good practice was observed as the records were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Discussion with staff confirmed that no bank account belonging to any patient was managed at the home.

Review of records and discussion with staff confirmed that a comfort fund was operated on behalf of patients. Monies held for the fund at the time of the inspection were counted and agreed to the balance recorded at the home. Discussion with staff confirmed that purchases from the fund were for the benefit of all patients. A review of a sample of records of purchases showed that receipts were in place from the purchases. Two members of staff had signed each of the transactions recorded. It was noticed that a number of entries had been written over and no initials were recorded against the amendments. No explanation for the errors was also recorded.

An area for improvement was identified for the system of recording transactions from the patients' comfort fund to be reviewed in order to improve the accuracy of recording and to facilitate the audit process.

Discussion with the deputy manager and review of records confirmed that an inventory of patients' property was maintained when patients were admitted to the home. The deputy manager was unsure if the records were up to date with items brought into the home by or in behalf of patients for which staff had been informed about e.g. televisions or items of furniture located within patients' bedrooms. This was identified as an area for improvement.

Areas of good practice

There were examples of good practice found in relation to recording the reconciliations of patients' monies.

Areas for improvement

Two areas for improvement were identified during the inspection. These related to updating patients' inventory records with items brought into the home by, or on behalf of, patients following admission and reviewing the system for recoding transactions undertaken from the patients' comfort fund.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The home did not provide a transport scheme at the time of the inspection. Discussions with staff confirmed that alternative arrangements were in place to support patients wishing to undertake journeys; this included the use of taxis which were paid for by the patients or their representatives.

As in line with good practice forms were in place authorising members of staff to purchase essential items on behalf of patients when required e.g. toiletries. A review of two patients' files showed that authorisation forms were retained within both files. Both forms were signed by a representative from the home. One form was not signed by the patient or their representative. This was identified as an area for improvement.

Discussion with staff confirmed that arrangements were in place to offer support to patients for managing their own monies.

Areas of good practice

There were examples of good practice found in relation to retaining authorisation forms for members of staff to purchase essential items on behalf of patients, facilitating journeys on behalf of patients and offering support to patients for managing their finances.

Areas for improvement

One area for improvement was identified during the inspection. This related to ensuring that all authorisation forms were signed by the patient or their representative.

	Regulations	Standards
Total number of areas for improvement	0	1

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Review of records confirmed that copies of payment remittances from the health and social care trusts showing the weekly fee charged for each care managed patient were retained at the home. The remittances also showed the amount of fees paid by the trust on behalf of patients and the contribution owed by patients towards their fee. Records were also available showing the weekly fee charged to private patients.

Review of records showed that details of the amount of fees paid by, or on behalf of, patients were retained at the home. Review of a sample of payments made by two patients showed that the amounts paid agreed to the contribution owed by each patient.

A patient's guide was in place at the time of the inspection. The guide included the details of the services provided to patients as part of their weekly fee and a list of additional services charged to patients e.g. hairdressing.

The patient's guide included a written agreement which was issued to patients on admission to the home. A Review of two patients' files evidenced that individual written agreements were in place for both patients. As in line with good practice, the agreements showed the current weekly fee paid by, or on behalf of, patients. Both agreements were signed by the patient or their representative and a representative from the home.

Review of records confirmed that a weekly third party contribution (top up) was paid on behalf of care managed patients. Discussion with staff confirmed that the third party contribution was not for any additional services provided to patients but the difference between the tariff for Kilwee and the regional rate paid by the Health and Social Care Trusts.

As in line with regulation 5 (1) of The Nursing Homes Regulations (NI) 2005 the agreements reviewed showed the current amounts of the additional third party contributions paid on behalf of the patients. Records showed that all third party contributions were paid to the home via the health and social care trust.

Discussion with staff confirmed that care managed patients were not paying an additional amount towards their fee over and above the amount agreed with the Health and Social Care Trusts.

Review of records and discussion with staff confirmed that a transaction sheet was maintained for each patient. The sheets were used to record the details of transactions undertaken on behalf of patients, including purchases of items and payments for additional services e.g. hairdressing. The transaction sheets were also used to record monies deposited at the home on behalf of patients.

A review of records of two purchases undertaken by staff, on behalf of two patients, showed that as in line with good practice the details of the purchases, the date and the amount of the purchases were recorded in the transaction sheets. Two signatures were recorded against each entry in the sheets. Receipts from the purchases were available at the time of the inspection.

A sample of records of payments to the hairdresser was reviewed for two patients. No receipts were issued by the hairdresser and no records were available showing the names of the patients receiving the service, the service provided to the patients and the amount charged to each patient. Review of records and discussion with staff confirmed that the hairdresser and a member of staff had signed the patients' transaction sheets to confirm that the service took place. A sample of records of payments to the podiatrist was also reviewed. Records showed that the podiatrist issued receipts after providing the service. The podiatrist and a member of staff had signed the receipt to confirm that the service took place. An area for improvement has been listed within the QIP of this report for the registered person to implement a system for recording the services provided by the hairdresser and podiatrist in order to aid the audit process.

Two records of monies deposited at the home on behalf of two patients were reviewed. The amounts deposited were recorded in the patients' transaction sheets. Two signatures were recorded against each of the transactions. As in line with good practice receipts were issued to the person depositing the monies.

Areas of good practice

There were examples of good practice found in relation to: retaining records of charges to patients, retaining records of amounts paid by patients for fees, up to date patients' agreements, recording transactions undertaken on behalf of patients and issuing receipts when monies were deposited at the home on behalf of patients.

Areas for improvement

One area for improvement was identified during the inspection. This related to ensuring that a system is implemented for recording the services provided by the hairdresser and podiatrist.

	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 Charlyn Pontino, deputy manager, as part of the inspection process. 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 Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (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 DHSSPS Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 35.21 **Stated:** First time **To be completed by:** 26 January 2018	The registered person shall implement a system for recording transactions from the patients' comfort fund in order to improve the accuracy of recording and to facilitate the audit process. Ref: 6.5
	Response by registered person detailing the actions taken: The system will be reviewed to provide greater detail for each transaction. A numbered receipt book will correspond to each entry to give greater clarity and accuracy.2 signatures will be available for each transaction.
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure that the inventory of patients' possessions is reviewed and brought up to date with any additional items brought into the home or items that have been disposed of following admission e.g. televisions or items of furniture . The records should be signed and dated by two members of staff. Ref: 6.5
	Response by registered person detailing the actions taken: A full inventory will be completed and updated as changes occur to record resident's belongings.
Area for improvement 3 **Ref**: Standard 14.7 **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure that all forms retained within patients' files authorising members of staff to make purchases on behalf of patients are signed by the patient or their representative. Ref: 6.6
	Response by registered person detailing the actions taken: An audit is in process to ensure that all residents who require it have a valid authorisation form signed and available on file.

Area for improvement 4 **Ref**: Standard 35.21 **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall implement a system for recording the services provided by the hairdresser and podiatrist in order to ensure that the details of the patients receiving the service, the details of the service provided and the amount charged to each patient are recorded. The hairdresser should provide receipts subsequent to being paid for the service provided. Ref: 6.7
	Response by registered person detailing the actions taken: A recording sheet has been implemented to give individual records of services provided to residents. The hairdresser now provides a receipt for the payment she receives. This is countersigned by a staff member.

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

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