Unannounced Finance Inspection Report
14 September 2017

Woodmount

Type of Service: Nursing Home
Address: 15 Melmount Road, Strabane, BT82 9ED
Tel No: 0287188 4234
Inspector: Briege Ferris

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 servicefrom their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 32 beds that provides care for older people and/or those with a physical disability.

3.0 Service details

Organisation/Registered Provider: Woodmount	**Registered Manager:** Amanda Craig
Person in charge at the time of inspection: Hazel McSparron and Norah Kelly (Nurses in charge)	**Date manager registered:** 08/04/2016
Categories of care: NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 32

4.0 Inspection summary

An unannounced inspection took place on 14 September 2017 from 10.30 to 14.40 hours.

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

The inspection assessed progress with any areas for improvement identified since the last finance inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found for example, arrangements were in place to secure patients' monies or valuables deposited for safekeeping; the home had a range of methods in place to encourage feedback from patients or their representatives and there was evidence of audit mechanisms in operation.

Areas requiring improvement were identified for example, in relation to records of patients' income and expenditure and reconciliations of money and valuables held, records of patient' personal property and individual patient agreements.

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.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	9

Details of the Quality Improvement Plan (QIP) were discussed with Amanda Craig, the 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.

5.0 How we inspect

Prior to the inspection, the record of notifiable incidents reported to RQIA in the last twelve months was reviewed; this established that none of these incidents related to patients' money or valuables. The record of calls made to RQIA's duty system was also reviewed and this did not identify any relevant issues; the inspector who had most recently visited the home was contacted prior to the inspection.

During the inspection, the inspector met with both nurses in charge, the home administrator; and the registered manager who arrived midway through the inspection.

The following records were examined:

- The "Patient Information Guide"
- Three patients' finance files
- A sample of income and expenditure records maintained on behalf of patients
- The safe record - "Safe file"
- A sample of treatment records in respect of hairdressing services facilitated in the home
- A range of written policies and procedures including those in respect of:
    - "Handling of Residents Finances'" dated December 2016
    - "Handling of Residents Valuables and Personal Money" dated December 2016
    - "Comfort Fund Policy" dated January 2017
    - "Destruction/Disposal of Obsolete records" dated December 2016
- A sample of comfort fund records
- A sample of records identifying that correct amounts had been charged to patients or their representatives (for care and accommodation)
- Three records of patients' personal property (in their rooms)

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 August 2017

The most recent inspection of the home was an unannounced care inspection. The Quality Improvement Plan from this inspection will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last finance inspection dated 06 July 2010

A finance inspection of the home was carried out on behalf of RQIA on 06 July 2010; the findings from this inspection were not brought forward to the inspection on 14 September 2017.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The inspector met with the home administrator who was able to clearly describe the home's controls in place to safeguard patients' money and valuables. She advised that she had worked in the home for approximately one year and had been provided with sufficient training and development opportunities to enable her to carry out her role. She confirmed that she had completed adult safeguarding training in July 2017.

Discussions with the nurses in charge 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 two safe places available for the deposit of cash or valuables belonging to patients; one of which was used to hold patients' personal monies and valuables. The second safe place was accessible only by the registered manager. The inspector was satisfied with the physical location of the safe places; however discussions with the nurses in charge established that all of the nurses in the home (approximately 12), had access to the pin-coded safe to enable the deposit or withdrawal of monies or valuables on behalf of patients at any time.

The inspector highlighted that the registered manager should review the appropriateness of this number of people having access to the safe place, as this should be limited to as few people as is absolutely necessary.Carrying out a review of access arrangements to the safe place containing patients' monies and valuables was identified as an area for improvement.

A file was in place which contained records of monies or valuables deposited for safekeeping or withdrawn from the safe place over time, entries had been written in a continuous sequence, there was no composite, up to date safe record in place. Entries in the sequence had routinely been signed only by the home administrator. Records entitled "Monthly audit of Patients Personal Monies and Safe Items by Manager" were held on file, these identified that only a sample of balances/items held had been checked ie: between one and two patients each month. The inspector highlighted that this did not constitute a reconciliation of the safe place ie: when the entire contents should be agreed to the written records held for each patient.

The way in which the safe contents was recorded, was identified as an area for improvement. The reconciliation of money and valuables in discussed further in section 6.5 of this report.

Areas of good practice

There were arrangements in place to secure patients' monies or valuables deposited for safekeeping and the staff spoken to were able to clearly describe the home's controls in place to safeguard patients' money and valuables.

Areas for improvement

Arrangements for staff to access the safe place and the records of safe contents/safe reconciliations were identified as areas for improvement during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Arrangements in place for the home to receive the personal monies for any patient directly were discussed. It was noted that no representative of the home was acting as nominated appointee for any patient (ie: managing and receiving social security benefits on the patient's behalf).

Discussions also established that the home was in direct receipt of the personal monies for one identified patient; this patient's personal allowance monies were received from the Western HSC trust for safekeeping by the home on the patient's behalf. There were clear and up to date records maintained of the monies received and spent on identified goods or serviceson the patient's behalf.

The home maintained records of income and expenditure for all patients in one book. On review, the bookwas foundto be cramped and did not allowsufficient space for entries to be written clearly; entries for a number of patients were spread throughout the book. This was discussed with the registered manager and it was recommended that the use of the book should cease and that it should be held in line with the home's archiving procedures. New methods of recording income and expenditure were discussed with suggestions and options available to improve these processes.

This was identified as an area for improvement.

A review of a sample of patients' income and expenditure records identified that entries were not routinely signed by two people. The importance of this control in protecting both patients and the member of staff making the record was emphasised to the registered manager in inspection feedback. The sample of records reviewed also contained errors which had not been appropriately dealt with, entries had been scribbled or out amended, making it difficult to read the original entries.

These were identified as areas for improvement.

A sample of transactions was traced in order to establish whether the appropriate supporting evidence was in place (for instance a receipt for a deposit of monies or a purchase receipt for expenditure).

This identified that the supporting documents were in place for the sample chosen and that receipts for the deposit of monies (in order to pay for goods or services for which there was an additional fee) were routinely signed by two people.

A sample of the "personal allowance audit check" documents was provided for review; the administrator noted that these were carried out monthly. A review of these documents identified that they were routinely signed only by the administrator. The safe contents checks referenced in section 6.4 of this report also identified that they were routinely signed by only one representative of the home.

In inspection feedback with the registered manager and administrator, it was highlighted that a quarterly reconciliation should be carried out for any money (in the home or in bank accounts), valuables or property belonging to patients (including patients' records of furniture and personal possessions (referred to below). Reconciliations should be carried out, recorded and signed and dated by two people.

This was identified as an area for improvement.

As noted above, hairdressing treatments were being facilitated within the home and a sample of recent records was reviewed. Treatment records identified the patients treated on any given day, the treatment provided and the cost. The treatment records reviewed were routinely signed and dated by both the hairdresser and a representative of the home to verify that the treatment had been received by the patient.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see the completed property records. The home administrator provided the "Residents' personal Belongings Log" which had written on the spine "Please review 6 monthly for each resident". Before reviewing the contents, the inspector selected three patient names at random. A review of the file identified that each of the three patients selected had a written "Patients personal items in home" record on file. Two of the records were dated 29 August 2017 and had been signed and dated by two people, the remaining record had been dated 06 December 2016 and had been signed by only one person. This represented an inconsistency in the approach to recording patients' personal property.

It was noted that the Care Standards for Nursing Homes (2015) require that records of patients' property are signed and dated by two people, one of whom should be a senior member of staff, and that the records should be reconciled on a quarterly basis, not six monthly as noted on the file reviewed.

This was identified as an area for improvement.

The home had a patients' comfort fund and a bank account was in place to administer the funds; the bank account was appropriately named in favour of the patients in the home. Records were available to identify how the funds were used and this appeared consistent with the home's written comfort fund policy and procedure. Records of income and expenditure were available, however these were not maintained on a standard financial ledger format and it was noted that this should be implemented. There were no records of reconciliations of the comfort fund monies. The use of a standard financial ledger format and performing quarterly reconciliationshas been discussed above and identified as areas for improvement.

The home administrator confirmed that the home did not operate a transport scheme nor were any bank accounts managed on behalf of the patients with the exception of the patients' comfort fund.

A sample of charges made for care and accommodation were also reviewed and this identified that the correct charges had been made in each case.

Areas of good practice

There were examples of good practice found for example, in respect of the availability of mechanisms to record income and expenditure and maintain the required supporting documents.

Areas for improvement

Five areas for improvement were identified during the inspection. These related to records of patients' income and expenditure, records of the reconciliations of money and valuables deposited for safekeeping and records of patients' personal property.

	Regulations	Standards
Total number of areas for improvement	0	5

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 arrangements to support patients with their money on day to day basis were discussed with the nurses in charge and the home administrator. Staff described how the arrangements to store money safely in the home or pay fees etc.would be discussed with the patient or their representative around the time the patient was admitted to the home.

Discussion established that the home had a number of methods in place to encourage feedback from patients or their representatives in respect of any issue, including ongoing day-to-day feedback and relative and patient meetings and care management reviews.

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

Areas of good practice

There were examples of good practice identified in relation to listening to and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

The home's "Patient Information Guide" encompassed a range of information for a new patient. The section on financial matters addressed the general arrangements regarding fees and the services provided as part of this and directed patients to whom they could contact in the HSC trust for more information on charging arrangements.

A range of written policies and procedures were available to guide record keeping and financial practices in the home. Discussion with the home administrator established that she was clear on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures. The nurses in charge confirmed that no complaints had been received regarding the home's management of patients' monies or valuables.

Discussion was held regarding the individual written agreements in place with patients and three patients'records were sampled in order to review the agreements in place with the home. This review evidenced that agreements were on file for each patient that had been signed by a representative of the home; however there was no evidence that these had been shared for signature with patients or their representatives. This was discussed with the registered manager and the home administrator who noted that the home was currently working to bring paperwork up to date, including patients' written agreements.

This was identified as an area for improvement.

A review of the home's current individual patient agreement template identified that while a broad range of information was included, it was not entirely consistent with the expected content as set out in standard 2.2 of the Care Standards for Nursing Homes (2015).

It was noted that the registered person should arrange to review the current content of the home's standard individual patient agreement and update as necessary.

This was identified as an area for improvement.

The administrator described how a personal monies authorisation document was used to document the authority for the home to spend a patient's money on identified goods and services or to set out any particular financial arrangement in place between the home and a patient.

The sample of three patient files referred to above evidenced that each patient had a personal monies authorisation on their file; however two of these had only been signed by a representative of the home while the third had not been signed at all.

It was noted that any personal monies authorisations which have not been completed appropriately or require updating should be shared with patients or their representatives.

This was identified as an area for improvement.

Areas of good practice

There were examples of good practice found for example, in respect of the availability of written policies and procedures to guide record keeping and financial practice in the home, and the existence of a written agreement and personal monies authorisation templates.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to patients individual written agreements, reviewing the content of the home's standard written agreement with patients and ensuring that personal monies authorisation documents are shared with patients or their representatives and that the home maintains evidence of this.

	Regulations	Standards
Total number of areas for improvement	1	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Amanda Craig, the registered 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 Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered providershould confirm that these actions have been completed and return the completed QIP via Web Portal forassessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 5 (1) **Stated:** First time **To be completed by:** 26 October 2017	The registered person shall provide individual agreements to each patient currently accommodated in the home (or their representative) which detail the current fees and financial arrangements in place in respect to the individual patient. Individual patient agreements should comply with requirements under Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and meet Standard 2.2 of the DHSSPS Care Standards for Nursing Homes (April 2015), which details the minimum components of the agreement. A copy of the signed agreement by the patient or their representative and the registered person must be retained in the patient's records. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where a HSC trust-managed patient does not have a family member or friend to act as their representative, the patient's individual agreement should be shared with the HSC trust care manager. Ref: 6.7
	Response by registered person detailing the actions taken: Individuals agreements have been sent to each patient/family for completion and a record of returns is being monitored by administrator. Reminder letters have also been sent regards return of agreements.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14 **Stated:** First time	The registered person shall ensure that a review of the current arrangements for staff to access the safe place; containing patients' monies and valuables is carried out. Ref: 6.4
To be completed by: 21 September 2017	**Response by registered person detailing the actions taken:** At present this has been brought down to two staff nurses and administrator. We are in the process of getting a safe which is key access only and will therefore be only kept on the CD key for nurse in charge to hold and be responsible for.
Area for improvement 2 **Ref**: Standard 14.9 **Stated:** First time	The registered person shall ensure that records of deposits or withdrawals of items from the safe register should be signed and dated by two people. A composite up to date written safe register should be reconciled to the contents of the safe place at least quarterly, with the record signed and dated by two people. Ref: 6.4
To be completed by:	

30 September 2017	**Response by registered person detailing the actions taken:** Safe file now up to date with all records of safe contents. Quarterly audits will be carried out and signed by administrator and home manager.
Area for improvement 3 **Ref**: Standard 14.9 **Stated:** First time **To be completed by:** 18 September 2017	The registered person shall ensure that the book being used to record income and expenditure for all patients is no longer used. The book should be retained in line with the home's archiving policy. A new method of recording these transactions should be implemented from the date indicated. Ref: 6.5
	Response by registered person detailing the actions taken: Record book has now been archived and a personal allowance log has been set up to log any future expenditures and lodgements. Primary source of recording is completed by nurse in charge if out of office hours, which is logged in a personal allowance file and then transferred over to a computer system operated by administrator.
Area for improvement 4 **Ref**: Standard 14.10 **Stated:** First time **To be completed by:** 18 September 2017	The registered person shall ensure that a standard financial ledger format is used to clearly and accurately detail transactions for patients. The format should capture the following information each time an entry is made on the ledger: the date; a description of the entry; whether the entry is a lodgement or withdrawal; the amount; the running balance of the patient's cash total held; and the signatures of two persons able to verify the entry on the ledger. Ref: 6.5
	Response by registered person detailing the actions taken: Personal allowance file set up and updated onto computer system by administrator. Nurse in charge logs any expenditure or lodgements with description. date of entry, lodgement or withdrawel, amount and two signatures. Running balance can only be accessed by administrator through computer records.
Area for improvement 5 **Ref**: Standard 14.11 **Stated:** First time **To be completed by:** 15 September 2017	The registered person shall ensure that records made on behalf of patients are legible and mistakes appropriately dealt with on the face of the ledger (ie a clear line crossed through the incorrect entry with an amendment on the line below and initialled by the member of staff recording the entry). Correcting fluid should not be used to amend records. Ref: 6.5
	Response by registered person detailing the actions taken: It is reflected on the weekly transaction sheets that if any errors occur no correction fluid to be used and one line crossed through mistake so that it is clearly identified and initialed by whoever made the error.

Area for improvement 6 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 30 September 2017 and at least quarterly thereafter	The registered person shall ensure that a reconciliation of money and valuables held and accounts managed on behalf of patients is carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.5
	Response by registered person detailing the actions taken: Reconcilation of personal allowace money completed quarterly for all patients and audit of record kept on file signed by administrator and home manager.
Area for improvement 7 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 21 September 2017	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.5
	Response by registered person detailing the actions taken: Inventory file set up for each patient and completed on admission with two signatures from staff member and manager. This will be reviewed quarterly and updated as and when required for each patient.
Area for improvement 8 **Ref**: Standard 2.2 **Stated:** First time **To be completed by:** 26 October 2017	The registered person shall ensure that the content of the home's standard written agreement is consistent with the content requirements of a patient's individual agreement, as set out in standard 2.2. Ref: 6.7
	Response by registered person detailing the actions taken: Patient guide has been reviewed and updated to include the content and changes to the individual patient agreement. terms and conditions of the patients agreements will be sent out yearly once client contribution reviewed.
Area for improvement 9 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 26 October 2017	The registered person shall ensure that written authorisation is obtained from each patient or their representative to spend the patient's personal monies to pre-agreed expenditure limits. The written authorisation must be retained on the patient's records and be updated as required. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the patient is managed by a HSC Trust and does not have a family member or friend to act as their representative, the authorisation about their personal monies must be shared with the HSC Trust care manager. Ref: 6.7

	Response by registered person detailing the actions taken: Personal allowance expenditure form known as (financial assessment 3) has been sent out to all patients/families for completion as to what limit of expenditure is needed for each patient and what to be spent on. Copy of same kept on file to review quarterly and reminder letters sent out for return of same.

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

The Regulation and Quality Improvement Authority

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