Unannounced Finance Inspection Report
11 March 2019

Millcroft

Type of Service: Nursing Home
Address: 66 Mill Street, Enniskillen, BT74 6DW
Tel No: 028 6632 4000
Inspector: Briege Ferris

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 nursing home with 70 beds which provides care for older patients or those with a physical disability other than sensory impairment.

3.0 Service details

Organisation/Registered Provider: Carewell Homes Ltd **Responsible Individual(s):** Carol Kelly	**Registered Manager:** See below
Person in charge at the time of inspection: William Hayden	**Date manager registered:** William Hayden - application received - "registration pending"
Categories of care: Nursing I - Old age not falling within any other category PH - physical disability other than sensory impairment PH(E) - - physical disability other than sensory impairment –over 65 years	**Number of registered places:** 70

4.0 Inspection summary

An unannounced inspection took place on 11 March 2019 from 10.45 to 15.10 hours.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS 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.

There were examples of good practice found in relation to:

- the availability of a safe place to enable patients to deposit money or valuables for safekeeping
- a written safe record was in place
- the home administrator participated in adult safeguarding training
- records of income, expenditure and reconciliation (checks performed) were available including supporting documents
- arrangements were in place to support patients to manage their monies
- mechanisms were available to obtain feedback from patients and their representatives
- the home administrator was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures
- detailed written policies and procedures were in place to guide financial practices in the home and
- there were mechanisms in place to ensure that patients experienced equality of opportunity.

Areas requiring improvement were identified in relation to:

- ensuring that records of patients' personal property are in place
- ensuring that podiatry treatment records are maintained in the manner as set out in standard 14.13 of the Care Standards for Nursing Homes, 2015
- ensuring that income and expenditure records detail the amount withdrawn for expenditure and the change returned, as opposed to the actual cost
- ensuring that appointee information is detailed in the written agreement for one identified patient and
- ensuring that the agreement for one identified patient is shared with their representative for review and signature

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	1	4

Details of the Quality Improvement Plan (QIP) were discussed with the manager and the home administrator at the conclusion of the inspection. 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 reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with the manager and the home administrator.

The inspector provided to the home administrator written information explaining the role of RQIA, the inspection process, the name of the inspector and the date of the inspection. It was requested that this information be displayed in a prominent position in the home so that relatives or visitors who had not been present during the inspection could contact the relevant inspector should they wish to discuss any matter or provide any feedback about their experience of the home.

The following records were examined during the inspection:

- A sample of income, expenditure and reconciliation records (records of checks performed)
- Financial policies and procedures
- A sample of patients' personal property records (in their rooms)
- A sample of patients' individual written agreements
- A sample of hairdressing and podiatry treatment records

The findings of the inspection were discussed with the manager and the home administrator at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 February 2019

The most recent inspection of the home was an unannounced care inspection. The quality improvement plan resulting from the inspection will be reviewed by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last finance inspection dated 04 August 2015

A finance inspection of the home was carried out on 04 August 2015; the findings were not brought forward to the inspection on 11 March 2019.

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 manager confirmed that adult safeguarding training was mandatory for all staff in the home; the home administrator had participated in adult safeguarding training in February 2019.

Discussions with the manager established that there were no current suspected, alleged or actual incidents of financial abuse, nor were there any finance-related restrictive practices in place for any patient.

The home had a safe place available for the deposit of cash or valuables belonging to patients; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, cash and valuables were being held for patients.

A written safe contents record was in place to detail the contents of the safe; this had been reconciled, and signed and dated by two people in December 2018.

Areas of good practice

There were examples of good practice found for example, in relation to the availability of a safe place to enable patients to deposit money or valuables for safekeeping, a written safe contents record was in place and the home administrator participated in adult safeguarding training.

Areas for improvement

No areas for improvement were identified as part of 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.

Discussion with the home administrator established that a person associated with the home was acting as appointee for one patient. The official documentation from the Social Security Agency was on file detailing the name of the appointee and the date from which they were appointed. The individual written agreement for this patient was reviewed, and there is further reference to patient agreements in section 6.7 below.

It was noted that the home was in direct receipt of the personal monies for several patients. Clear, up to date written records were maintained of the dates and amounts of monies received on behalf of patients. The home administrator maintained meticulous records relating to the receipt of patients' monies and the transfer of any monies owed to patients once they had contributed to the costs of the their care (where relevant). Good practice was observed.

A bank account was in place for one patient which had been opened to hold excess monies on behalf of the identified patient. The account name clearly denoted that the monies in the account were held on behalf of the patient, albeit that a named person from the home was the addressee for the bank statements. Correspondence was in place on the patient's file from the bank approving the application to open the account on the basis that the applicant was acting in the role of appointee for the identified patient. The home administrator confirmed that only lodgements could be made to the account, withdrawals could not be made. Advice was provided to ensure that since this was a recent financial arrangement, that it be clearly reflected in the identified patient's individual written agreement with the home.

For the majority of patients, monies for patients' personal expenditure or to pay for additional goods and services not covered by the weekly fee were deposited with the home by patients' family members. Those making deposits received a receipt; these were usually signed by two people.

Records of income and expenditure were available for patients, including supporting documents e.g.: a lodgement receipt or an expenditure receipt. A sample of transactions was chosen to ascertain whether the supporting documents were available within the records, and for the sample chosen, these were found to be in place. It was noted however, that on occasion, where a staff member withdrew monies to make a purchase on behalf of a patient, the actual cost of the expenditure was recorded, rather than recording the withdrawal of the money from the cash held and the return of any change. Ensuring that income and expenditure is recorded using the latter method was identified as an area for improvement.

As noted above, records of income and expenditure were available detailing that reconciliations, signed by two members of staff were available in the home, these were generally recorded weekly. However, advice was provided to the home administrator to ensure that the

reconciliations signed by two staff were more clearly recorded on the ledgers, such as by taking a separate line and using a different colour of ink.

Hairdressing and podiatry treatments were being facilitated within the home and a sample of these treatment records was reviewed. The sampled hairdressing records evidenced that a record was made by the hairdresser which she signed, these were routinely signed by a member of staff in the home. Podiatry treatment receipts were written by the podiatrist and held within individual patient records. Podiatry treatment records were signed by the podiatrist; however, these were not signed by a representative of the home to verify that the treatment had been delivered.

An area for improvement was identified to ensure that podiatry treatment records are maintained in accordance with standard 14.13 of the Care Standards for Nursing Homes, 2015.

The inspector discussed with the home administrator how patients' property (within their rooms) was recorded and requested to see a sample of the property records maintained for patients. A book was provided for review and a sample of patient names were selected prior to reviewing the book. A review of the book contents established that none of the patients had their property recorded in the book.

An area for improvement was made to ensure that each patient should have a record of the property which they have brought to their room (she also noted that these records should be reconciled and signed and dated by two people at least quarterly). The manager noted that this would be done for all the patients in the home.

The home administrator confirmed that the home did not operate a transport scheme.

Areas of good practice

There were examples of good practice found in relation to the existence of records of income, expenditure, reconciliations and supporting documentation.

Areas for improvement

Three areas for improvement were identified during the inspection in relation to ensuring that: that podiatry treatment records are maintained in accordance with standard 14.13 of the Care Standards for Nursing Homes, 2015; ensuring that income and expenditure records detail the amount withdrawn for expenditure and any change returned and ensuring that each patient has a record of the property which they have brought to their room (these records should be reconciled and signed and dated by two people at least quarterly).

	Regulations	Standards
Total number of areas for improvement	1	2

6.6 Is care compassionate?

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

Discussion with the manager established that the home had a range of methods in place to encourage feedback from patients or their representatives in respect of any issue. This included ongoing feedback from patients and patients/relatives questionnaires.

The inspector discussed with the manager how he ensured that patients received equality of opportunity in the home and he confirmed that all staff participated in equality and diversity training.

Areas of good practice

There were examples of good practice found in respect of the mechanisms to obtain feedback and views from patients and in respect of arrangements to ensure that patients experienced equality of opportunity.

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 patient's guide contained a range of useful information for a new patient including the general terms and conditions of a patient's residency in the home, and those services included and excluded from the weekly fee. Information also detailed arrangements for patients to personalise their rooms and secure any valuables which they may bring to the home.

Written policies and procedures were in place to guide financial practices in the home, addressing the management of patients' personal monies and valuables. These were dated within the last three years and were easily accessible by staff.

Discussion with the home administrator established that she was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures.

Individual patient agreements were discussed with the home administrator and a sample of patients' agreements was requested for review. All but one of the sampled records contained a signed up to date written agreement and evidence was in place to identify that patient agreements were kept up to date to reflect any changes with the change agreed by the patient or their representative. Good practice was observed.

The home administrator explained that the patient, who did not have a signed agreement on file, did not have a representative to sign the document in their place. During the course of the inspection and having liaised with the patient's HSC trust care manager, it was established that the patient had a representative to whom their agreement could be sent. An area for improvement was made to ensure that the patient's agreement is shared with their representative for review and signature.

As noted in section 6.5 above, a representative of the organisation was acting as appointee for one identified patient. A review of this patient's written agreement failed to evidence that these details were clearly set out within the patient's agreement as is required. An area for improvement was made in respect of this finding.

Records authorising the home to spend the patient's personal monies on identified goods and services were included as an appendix to the home's generic patient agreement template. A review of several patient files identified that these were in place for a number of the patients. In one case, the record had been crossed through as if not applicable, however the home was making purchases on behalf of the patient in question. Advice was provided to ensure that this document be updated and be signed by the patient or their representative. The patient who did not have a signed agreement in place (as discussed above) also did not have a signed personal monies authorisation document in place. An area for improvement has already been listed for this patient's agreement (including the expenditure authorisation) to be shared with their representative for signature.

Areas of good practice

There were examples of good practice found: the home administrator was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures, detailed written financial policies and procedures were in place to guide practices in the home.

Areas for improvement

No areas for improvement were identified as part of the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the manager and home administrator, at the conclusion of the inspection. The timescales commence from the date of inspection.

The registered provider/registered 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 DHSSPS 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 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 Schedule 4 (10) **Stated:** First time **To be completed by:** 11 May 2019	The registered person shall ensure that each patient has a record of the property which they have brought to their room (these records should be reconciled and signed and dated by two people at least quarterly). Ref: 6.5
	Response by registered person detailing the actions taken: This is in place and records updated quarterly
Action required to ensure compliance with DHSSPS Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.10 **Stated:** First time **To be completed by:** 12 March 2019	The registered person shall ensure that income and expenditure records reflect the amount of any money withdrawn for expenditure and the return of any change from the purchase. Ref: 6.5
	Response by registered person detailing the actions taken: This has been actioned and in place
Area for improvement 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 12 March 2019	The registered person shall ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the patient or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each patient. Ref: 6.5
	Response by registered person detailing the actions taken: This has been actioned and in place
Area for improvement 3 **Ref**: Standard 14.20 **Stated:** First time **To be completed by:** 11 May 2019	The registered person shall ensure that the appointee details for the identified patient are reflected in their individual agreement with the home. Ref: 6.7
	Response by registered person detailing the actions taken: This has been actioned and in place

Area for improvement 4 **Ref**: Standard 2.5 **Stated:** First time	The registered person shall ensure that the individual written agreement for the identified patient is shared with their representative for review and signature. Ref: 6.7
To be completed by: 11 May 2019	**Response by registered person detailing the actions taken:** this has been actioned and in place

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

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