Unannounced Finance Inspection Report
11 November 2016

Silverdale

Type of service: Nursing Home
Address: 29a Castlegore Road, Castlederg BT81 7RU
Tel no: 02881679574
Inspector: Briege Ferris

1.0 Summary

An unannounced inspection of Silverdale took place on 11 November 2016 from 10:30 to 15:40 hours.

The inspection sought to assess progress with any issues raised during and since the last finance inspection and to determine if the nursing 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 members were familiar with controls in place to safeguard patients' money and valuables. Training opportunities had been afforded to relevant staff including training on the Protection of Vulnerable Adults. No areas for improvement were identified.

Is care effective?

Controls to ensure patients' money and valuables were safeguarded were found to be in place; however, three areas for improvement were identified during the inspection. These related to ensuring that: records of patients' property in their rooms are updated and signed by two people on an ongoing basis and ensuring that they are reconciled and signed and dated by two people at least quarterly; ensuring that a reconciliation of money and valuables is carried out and recorded by two people at least quarterly and ensuring that records of any treatments provided to patients (for which there is an additional charge) include the required detail.

Is care compassionate?

Significant effort was being made by the home to support a range of patients with their money and to ensure that appropriate, transparent arrangements were in place. No areas for improvement were identified.

Is the service well led?

Governance and oversight arrangements were found to be in place; however, four areas for improvement were identified during the inspection. These related to ensuring that: the home review its arrangements to ensure that records are at all times available to any person authorised by the Regulation and Quality Improvement Authority for the purposes of inspection; ensuring that written authorisation is obtained from each patient or their representative to spend the patient's money (on identified goods and services) to pre-agreed expenditure limits; providing a written agreement to each patient in the home who has not been provided with one and to ensuring that up to date individual agreements (reflecting the specific fees and financial arrangements for each patient) are provided to each of the current patients or their representatives and that these are updated on an ongoing basis.

This inspection was underpinned by Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	6

Details of the Quality Improvement Plan (QIP) within this report were provided to Geraldine Browne, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

1.2 Actions/enforcement taken following the most recent finance inspection

A finance inspection of the home was carried out on behalf of RQIA on 17 November 2008; the findings from this inspection were not brought forward to the inspection on 11 November 2016.

2.0 Service details

Registered organisation/registered person: SRB Care Ltd/Sarah Roberta Brownlee	**Registered manager:** Geraldine Browne
Person in charge of the home at the time of inspection: Patricia Kearney	**Date manager registered:** 10 June 2009
Categories of care: NH-DE, NH-I, NH-PH	**Number of registered places:** 41

3.0 Methods/processes

Prior to inspection the record of notifiable incidents reported to RQIA in the last 12 months was reviewed; this established that none of these incidents related to services users' money or valuables. 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 Geraldine Browne, the registered manager and the home's administrator. A poster detailing that the inspection was taking place was positioned at the entrance to the home, however no relatives or visitors chose to meet with the inspector.

The following records were examined during the inspection:

- The “Resident’s Guide”
- Training records for the home administrators/receptionists (Protection of Vulnerable Adults)
- Policies addressing: Accounting and financial control arrangements; Records management; Whistleblowing
- A sample of income and expenditure records
- A sample of receipts for hairdressing and podiatry services facilitated in the home
- The home’s “Safe register”
- A sample of charges (for care and accommodation) made to a sample of patients
- A sample of the patients’ pooled bank account statements and reconciliations
- Five patients’ finance files
- Four records of patients’ property in their rooms

4.1 Review of requirements and recommendations from the most recent inspection dated 17 August 2016

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

4.2 Review of requirements and recommendations from the last finance inspection

As noted above, a finance inspection of the home was carried out on behalf of RQIA on 17 November 2008; the findings from this inspection were not brought forward to the inspection on 11 November 2016.

4.3 Is care safe?

The home had a main finance administrator and two part time receptionist/administrators and evidence was reviewed which confirmed that they had all received training on the Protection of Vulnerable Adults (POVA). The main home administrator was familiar with the 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 financial-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 belonging to patients were deposited with the home for safekeeping. The home had a written record of cash held (discussed in section 4.4 below); and there was a written safe contents record “safe folder” in respect of the valuables held.

It was noted that while there was a written record of items signed into and out of the safe place, the record had not been reconciled on (at least) a quarterly basis. There is further discussion on the reconciliation of money and valuables in section 4.4 below).

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

Discussion with the registered manager and the home administrator established that no representatives of the home were acting as nominated appointee for any patient in the home. The home was, however, in direct receipt of the social security benefits for two identified patients. Monies were received directly into the business bank account; the home administrator was able to provide evidence of how the money received was subsequently apportioned. She explained that monies received were split between the portion belonging to the home (in part-payment of the weekly fee) and the personal monies owed to the patients (which were moved to the pooled patients' bank managed on behalf of patients.

It was possible to identify at any time, the money which belonged to individual patients with money in the account. The bank account was clearly named in favour of the patients in the home. Monthly bank reconciliations were being carried out and signed and dated by the home administrator and the manager of the home.

The home administrator was able to clearly explain the rationale behind the arrangements being in place and it was clear from the records that significant effort was being made to ensure the appropriate level of transparency in the arrangements.

Discussion established that for the majority of patients in the home, family representatives were highly involved in supporting patients with their money. Family representatives would mostly deposit an amount of money with the home for payment of the hairdresser or other sundry items. Records detailing income and expenditure incurred on behalf of patients were maintained in the "Patients personal allowance" records. Each patient had their own "personal allowance sheet(s)" detailing income and expenditure on behalf of the respective patients. These records also detailed those patients who had a balance within the pooled patients' bank account.

A sample of the records of income and expenditure incurred on behalf of patients were reviewed. It was noted that entries in the ledger followed a standard ledger format and entries were consistently signed by two people. The home administrator confirmed that she checked the balance of monies held to the records on a regular basis and this was reflected in the entries in a sample of the records reviewed. The inspector highlighted that a reconciliation (of both money and valuables held) should be carried out, recorded and signed and dated by two people at least quarterly.

A recommendation was made in respect of this finding.

Hairdressing and private podiatry services were being facilitated within the home. A sample of hairdressing receipts were reviewed, it was noted that the hairdresser wrote individual receipts for each patient treated on each treatment day. The records reflected the required information including the signature of the hairdresser and a person from the home who could verify that the patient had received the treatment detailed on the receipt.

Podiatry records did not reflect the (same) required information; receipts were routinely only signed by the podiatrist and not by a representative of the home. The inspector highlighted that the necessary information to consistently record was detailed in DHSSPS minimum standard 14.13.

A recommendation was made in respect of this finding.

A sample of the record of patients' property (within their rooms) was reviewed. From a sample of four records, all four patients had a "Patients records of personal possessions" form, however inconsistency was observed in the records. Some records (and pages detailing subsequent additions) had been signed by two people while other records were only signed by one person. There was no evidence that the records had been checked at least quarterly (as is required by DHSPS Minimum Standard 14.26).

A recommendation was made to ensure that additions or disposals from patients' property records are signed and date by two people; reconciliations of patients' property should be carried out at least quarterly.

Discussion with the home administrator and a review of the records evidenced that only those patients funding their places privately were notified of any increases in fees payable. The inspector noted that irrespective of how a patient's place was funded, patients or their representatives must be notified of any changes to their agreement (including the fees and financial arrangements) and that the changes(s) should be agreed in writing.

There is further discussion about individual patient agreements in section 4.6 below.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to ensuring that: records of patients' property in their rooms are updated and signed by two people on an ongoing basis and ensuring that they are reconciled and signed and dated by two people at least quarterly; ensuring that a reconciliation of money and valuables is carried out and recorded by two people at least quarterly and ensuring that records of any treatments provided to patients (for which there is an additional charge) include the required detail.

Number of requirements	0	**Number of recommendations**	3

4.5 Is care compassionate?

The day-to-day arrangements in place to support patients were discussed with the registered manager the home administrator and the home receptionist/part-time administrator. Specific examples of how the home was supporting a number of patients with their money with various arrangements were discussed and clearly described.

Discussion with the home administrator established that arrangements to safeguard a patient's money were discussed with the patient or their representative at the time of admission to the home. She noted that patients and their families were given the choice as to what arrangements they would prefer, however patients were offered the option of leaving money with the home for safekeeping on the patient's behalf and the arrangements for this would be explained.

Arrangements for patients to access their money outside of normal office hours were discussed with the registered manager. The registered manager was able to explain an arrangement whereby patients would have access to money outside of normal office hours.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Initial discussions with the registered manager established that records of fees payable including HSC trust payment remittances and the patients' pooled bank account information were not accessible on the day of inspection. Discussion revealed that the home's main administrator had access to these records; she was not working in the home on the day of inspection. The registered manager contacted the administrator and she arrived later in the inspection and subsequently provided the inspector with access to the relevant records.

A recommendation was made for the registered person to review the home's arrangements to ensure that records are at all times available to any person authorised by the Regulation and Quality Improvement Authority for the purposes of inspection.

The home had a number of written policies and procedures in place to guide practice in the area of safeguarding patients' money and valuables. There was a clear organisational structure within the home; discussion established that those involved in supporting patients with their money on a daily basis were familiar with their roles and responsibilities in relation to safeguarding patients' money and valuables. Discussion with the home's main administrator and receptionist/part-time administrator established that they were both confident in their understanding of the home's complaints handling procedures and initiating whistleblowing procedures if deemed appropriate.

A review of a sample of five files evidenced that personal monies authorisations were not in place between each patient and the home. The personal monies authorisation provides the home with written authority to spend a patient's money on identified goods and services on the patient's behalf. Discussion with the home's receptionist/part-time administrator confirmed that the home had ceased to provide these for recently admitted patients as HSC trust care management were reluctant to sign them. The inspector clarified that these should be signed by the patient or their representative. She noted that these should be shared with HSC trust care management in circumstances where the patient is unable to sign and there is no family representative available to review and agree to any financial arrangement detailed on the authorisation.

A recommendation was made to ensure to written authorisation is obtained from each patient or their representative to spend the patient's money (on identified goods and services) to pre-agreed expenditure limits. The written authorisation must be retained on the patients' records and updated as required.

A review of a sample of five patients' files identified that four patients had a signed agreement on their file detailing the terms and conditions of their residency in the home; however these detailed the fees which would have been payable at the time each patient was admitted to the

home. In addition, the fifth patient, who was admitted to the home in 2015, did not have a written agreement on their file; therefore there was no evidence that an agreement had been provided to the patient.

A requirement was made in respect of this finding.

In respect of the patients whose agreements did not reflect the current fees or financial arrangements, the home administrator confirmed that once agreements were provided to the patient or their representative on admission, they were not updated to reflect any changes. The inspector noted that fees and financial arrangements form part of a patient agreement and when these change over time, there must be a corresponding change to each patient's agreement with the home, with the changes agreed in writing by the patient or their representative.

The inspector noted that where any financial arrangement was in place between the home and an individual patient, this must also be included in that patient's individual agreement with the home. Earlier discussions had confirmed that a number of financial arrangements were in place which must be reflected in each patient's agreement accordingly.

A recommendation was made to ensure that each patient or their representative is given written notice of all changes to the agreement and these are agreed in writing. Up to date individual agreements reflecting the specific fees and financial arrangements for each patient should be provided to each of the current patients or their representatives.

Areas for improvement

Four areas for improvement were identified during the inspection. These related to ensuring that: the registered person to review the home's arrangements to ensure that records are at all times available to any person authorised by the Regulation and Quality Improvement Authority for the purposes of inspection; ensuring that written authorisation is obtained from each patient or their representative to spend the patient's money (on identified goods and services) to pre-agreed expenditure limits; providing a written agreement to each patient in the home who has not been provided with one and ensuring that up to date individual agreements reflecting the specific fees and financial arrangements for each patient are provided to each of the current patients or their representatives and updated on an ongoing basis.

Number of requirements	1	**Number of recommendations**	3

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were provided to Geraldine Browne, 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 provider 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 provider/manager 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 5 (1) **Stated:** First time **To be completed by:** 11 December 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 person by whom the fees are payable.
	Response by registered provider detailing the actions taken: The one Patient Agreement missing has now been signed. All other files checked and compliant on 14/11/16. All new Patients receive a Patient Agreement.
Recommendations	
Recommendation 1 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 11 December 2016 and at least quarterly thereafter	The registered provider should ensure that a reconciliation of money and valuables held and accounts managed on behalf of residents 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.
	Response by registered provider detailing the actions taken: The Bank account is reconciled monthly and signed by Sr Admin & Manager. The cash in safe is reconciled monthly and signed by Sr Admin but will now be signed by Manager/Home Owner as well. Valuables in safe are now signed quarterly by both the person carrying out the audit and Sr staff member.
Recommendation 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 12 November 2016	The registered provider 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 one receipt not signed by staff member has now been signed. All other receipts checked and compliant on 14/11/16.
Recommendation 3 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 11 December 2016	The registered provider should ensure that an inventory of property belonging to each resident 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.
	Response by registered provider detailing the actions taken: New inventory taken and completed on 9th Dec 2016 for all patients

	where applicable.
Recommendation 4 **Ref**: Standard 37.3 **Stated:** First time **To be completed by:** 11 December 2016	The registered provider should review its current arrangements for accessing records to ensure that records required under HPSS (Quality Improvement and Regulation) (NI) Order 2003 (Regulations) are up-to-date, accurate and available for inspection in the home at all times.
	Response by registered provider detailing the actions taken: Records have now been moved to ensure records are accessable for inspection.
Recommendation 5 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 11 December 2016	The registered provider should ensure that written authorisation is obtained from each resident or their representative to spend the resident's personal monies to pre-agreed expenditure limits. The written authorisation must be retained on the resident's records and updated as required. Where the resident or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the resident 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.
	Response by registered provider detailing the actions taken: The one authorisation missing has now been signed. All other records have benn checked and compliant on 14/11/16.
Recommendation 6 **Ref**: Standard 2.8 **Stated:** First time	The registered provider should ensure that any changes to the individual agreement are agreed in writing by the resident or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the resident or their representative is unable to or chooses not to sign the revised agreement, this is recorded.
To be completed by: 11 December 2016	**Response by registered provider detailing the actions taken:** An appendix has been issued to all patient/relatives in relation to the change in fees on 30/11/16.

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