

**Unannounced Finance Inspection
of
Dunmurry Manor**

30 July 2015

Summary of Inspection

An unannounced finance inspection took place on 30 July 2015 from 09:00 to 14:40. A poster detailing that the inspection was taking place that day was positioned at the entrance to the home.

Overall on the day of the inspection, we found care to be compassionate; the safety and effectiveness of care were found to be good, however there are some areas identified for improvement. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report. This inspection was underpinned by the Nursing Homes Regulations (Northern Ireland) 2005.

On the day of inspection, we met with the registered manager and the administrator; no relatives or visitors chose to meet with us during the inspection. We would like to thank those who participated in the inspection for their co-operation.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5	1

The details of the QIP within this report were discussed with Ms Norma McAllister, the registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Runwood Homes Ltd/Logan Logeswaran	Registered manager: Ms Norma McAllister (Acting)
Person in Charge of the Home at the Time of Inspection: Ms Norma McAllister	Date Manager Registered: 26 January 2015
Categories of Care: RC-DE, NH-DE	Number of Registered Places: 76
Number of Patients Accommodated on the Day of Inspection: 56	Weekly Tariff at Time of Inspection: £470.00 - £717.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following theme has been met:

Inspection Theme: Patients' finances and property are appropriately managed and safeguarded

Statement 1

The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Statement 2

Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Statement 3

A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained

Statement 4

Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with the registered manager and the administrator
- Review of records
- Evaluation and Feedback

Prior to inspection the following records were analysed:

- Records of incidents notified to RQIA in the last twelve months

The following records were reviewed during the inspection:

- The service user guide
- The home's "Accounting and Financial Control Arrangements" policy
- The home's "Donations and Amenity Funds" policy
- The home's current standard agreement with patients
- Four patient agreements
- Most recent HSC trust payment remittances
- Confirmation of correct fees charged to three patients for care/accommodation
- Personal allowance expenditure authorisations for two patients
- Income/lodgements and expenditure, including comfort fund receipts
- Hairdressing and Private Podiatry treatment records
- Four records of patients' personal property/inventory

- The administrator's completion of Protection of Vulnerable Adults Training record

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection on 23 April 2015; the completed Quality Improvement Plan was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last Finance Inspection

There has been no previous RQIA finance inspection of the service.

5.3 Statement 1 - The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Is Care Safe?

The home has a service user guide, a copy of which was provided to us for review during the inspection. We noted that a copy of the guide is provided on admission to the home. The home provides an individual agreement to each newly admitted patient. We asked to see both a copy of an up to date agreement and agreements which are already in place with a sample of four patients in the home.

Discussion with the registered manager and the administrator established that the agreements in place with the current patients in the home had recently been updated to reflect the increase in the weekly charges payable (based on regional increases in care fees). The administrator described how some had been returned and some had not at the time of inspection.

We reviewed the files for four patients and noted that only two of the four patients had a signed agreement on their file. The signed agreements reflected the current fees and specific payment arrangements in place. We noted that the two remaining files did not have a copy of the agreement sent out for signature or any record of when it was sent.

We discussed this with the registered manager and the home's administrator who explained that there were difficulties in getting documents signed by some family members. We accepted this, but noted that there must be written evidence on each relevant patient's file to confirm that the home have attempted to follow up on these matters. Copy documents sent for signature must be maintained along with the dates and details of follow up by the home.

A requirement has been made in respect of this finding.

During discussions about the patients agreements we noted that the Care Standards for Nursing Homes (April 2015) were recently issued and that these require a number of additional matters are included in a home's agreement with a patient. We noted that the home should arrange to review its standard agreement to ensure that agreements contain all of the necessary components as set out in Standard 2.2 of the Minimum Standards.

A recommendation has been made in respect of this finding.

Is Care Effective?

We queried whether there was any involvement by the home in supporting individual patients with their money; the registered manager advised that there was no involvement by the home in this regard.

We noted that the home has a policy and procedure addressing accounting and financial control arrangements which provide detail on the controls in place to safeguard money and valuables belonging to patients.

We noted that there was written confirmation in place identifying that the home's administrator had received training in the protection of vulnerable adults.

Is Care Compassionate?

We obtained confirmation that written notifications of increases in fees in response to changes in regional fee rates had provided to patients or their representatives, however as noted above, the home must follow up on any documents to be returned from patients' representatives regarding confirmation of increases in fees payable.

Discussions with the registered manager established that on the day of inspection, the home was not supporting any individual patient to manage their money.

Areas for Improvement

Overall on the day of inspection, we found care to be effective and compassionate. The safety and of care was found to be good, however there was one area identified for improvement; this related to providing individual written agreements to all patients which reflect the requirements of Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (2015).

Number of Requirements	1	Number Recommendations:	1
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5.4 Statement 2 - Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Is Care Safe?

A review of the records identified that copies of the HSC trust payment remittances are available confirming the weekly fee for each patient in the home. There is an identified number of patients in the home who contribute their weekly care fees directly to the home. A review of a sample of charges established that the correct amounts were being charged by the home to patients or their representatives. For all other patients, the home is paid directly by the relevant HSC trust.

The home is directly in receipt of the personal allowance monies belonging to an identified number of patients; these monies are received from the HSC trusts which send the monies to the home in order that the relevant patients have access to their personal monies for sundry expenditure. Written records are in place detailing the timings and amounts of money received from the HSC trusts on behalf of the patients. A number of the patients' representatives deposit

money with the home for safekeeping in order to pay for sundries which are normally additional goods and services not covered by the weekly fee (such as for hairdressing, toiletries, newspapers etc).

Discussion with the home's administrator established that the home copy the current page of the "residents' personal money sheet" and this is provided to any person depositing cash for safekeeping. The administrator advised that this works well, as relatives are also regularly obtaining updated information on how the money has been spent.

We discussed how patient expenditure was recorded on behalf of patients. We noted that each patient (for whom the home holds money) has a "resident personal money sheet". These detail each instance of income or expenditure made on behalf of the patient. We reviewed a sample of five residents personal money sheets and noted that entries on the sheets were clear and routinely signed by two people. The date and details of each entry or withdrawal were recorded as well as the running balance. There was evidence of very regular reconciliation of monies held, which were clearly recorded on the books as "checked". Good practice was observed.

We sampled a number of transactions from the records and were able to trace these entries to the corresponding records to substantiate each transaction, such as a receipt for a cash lodgement or a hairdressing treatment record.

We noted that hairdressing treatments were recorded on a hairdressing "schedule" and that these records detailed the name of the service user the treatment the cost and the signature of both the hairdresser and a member of staff to verify the treatment had occurred. The date the money was withdrawn from the patient's balance of money held was also included. We noted good practice. We also noted that a similar template was in place for private podiatry treatments facilitated within the home.

The registered manager confirmed that the home did not operate a bank account for the patients jointly nor were any bank accounts operated for individual patients.

Discussions established that the home operates a comfort fund for the benefit of the patients in the home. The registered manager explained that the home had recently done some fundraising and that an amount of cash was held within the safe place. The registered manager noted that there was an intention to open a bank account to manage the comfort fund monies and that this would be pursued as soon as possible.

We noted that receipts had been maintained for any items or services purchased from the comfort fund, however there were no records of income and expenditure in respect of the fund. We noted that the home must ensure that the same controls which are in place for individual patients' monies, must also be applied the comfort fund records.

A requirement has been made in respect of this finding.

A copy of the home's donations and amenity funds policy was provided to us on the day of inspection. We noted that the policy was issued on 30 June 2015 and made reference to guidance within the Care Standards for Nursing Homes (April 2015).

Is Care Effective?

Four patient files were reviewed which established that personal allowance authorisations (to provide the home with the necessary written authorisation to purchase goods and services on behalf of each patient) were in place on only two of four files reviewed. We discussed this with the registered manager and administrator who stated that these had not been returned by the patients' representatives. We noted that there must be written evidence of the attempts by the home to secure these authorisations.

A requirement has been made in respect of this finding.

The registered manager confirmed that no representative of the home was acting as nominated appointee for any patient.

Is Care Compassionate?

We asked about arrangements for patients to access their money from the safe place in the home outside of office hours. The registered manager explained that the home plan ahead to ensure that there are appropriate arrangements in place prior to the weekend.

We queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the registered manager confirmed that none of the patients had any known assessed needs or restrictions.

Areas for Improvement

Overall on the day of inspection, we found care to be compassionate. The safety and effectiveness of care were found to be good, however there were two areas identified for improvement; these were in maintaining records of income and expenditure for the comfort fund and following up on the return of important documentation from patients' representatives.

Number of Requirements	2	Number Recommendations:	0
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5.5 Statement 3 - A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained

Is Care Safe?

A safe place exists within the home to enable patients to deposit cash or valuables and we were satisfied with the controls around the physical location of the safe place and the persons with access.

We viewed the contents of the safe place and established that on the day of inspection, cash balances for a number of patients and non-cash items had been deposited for safekeeping by the home.

We noted that there was no safe record in place detailing the contents of the safe place. We highlighted that a reconciliation of the safe contents must be carried out and signed and dated by two people at least quarterly.

A requirement has been made in respect of this finding.

Is Care Effective?

We queried whether there were any general or specific arrangements in place to support patients with their money. The registered manager explained how the home engages with HSC trust representatives on an ongoing basis, however noted that there were no specific agreed arrangements in place to support any patient at present.

We enquired how patients' property within their rooms was recorded and requested to see a sample of the completed property records for four patients.

We were advised that the property records were contained within the patients' care files and we were provided with the four care files for review. We noted that each patient's file contained a record of property. We noted that there was inconsistency between the records for instance three of the four records had been signed by one person, while the fourth record had been signed by two people (as is required). We noted that while there was evidence that at least one record had been updated with an item of furniture purchased for the patient's room, this entry had not been signed or dated.

We discussed these findings with the registered manager and explained that additions or disposals of furniture and personal possessions brought into each patient's room must be signed and dated by two people and that these records must be updated at least quarterly. We noted that a retrospective record for each patient in the home must be made.

A requirement has been made in respect of this finding.

Is Care Compassionate?

As noted above, there are safe storage arrangements within the home to enable patients to deposit cash or valuables, should they wish to. We enquired as to how patients would know about the safe storage arrangements; the registered manager explained that these matters were discussed on admission. The registered manager confirmed that there were no formal agreed restrictions in place in respect to any current patient in the home.

Areas for Improvement

Overall, we found care to be compassionate; the safety effectiveness of care were found to be good, however there were two areas identified for improvement; these were in relation to introducing a safe book and appropriately maintain records of patients' property.

Number of Requirements	2	Number Recommendations:	0
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5.6 Statement 4 - Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

Is Care Safe?

On the day of inspection, the home did not operate a transport scheme for patients.

Is Care Effective?

As noted above, on the day of inspection, the home did not operate a transport scheme for patients, however we discussed options for patients to access other forms of transport and it was clear that arrangements exist in the home to support patients to access private transport and organised transport for outings or medical/hospital appointments.

Is Care Compassionate?

As above, we noted that the home has arrangements to support patients to access other means of transport.

Areas for Improvement

Overall on the day of inspection, we found care to be safe, effective and compassionate. No areas for improvement were noted in respect of Statement 4.

Number of Requirements	0	Number Recommendations:	0
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5.7 Additional Areas Examined

There were no additional areas examined as part of the inspection.

6 Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Norma McAllister, the registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Care Standards for Nursing Homes (April 2015) etc. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.


6.3 Actions Taken by the Registered manager/Registered Person

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to finance.team@rqia.org.uk and assessed by us.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 Ref: Regulation 5 (1) (a) (b) Stated: First time To be Completed by: From the date of inspection	<p>The registered person must ensure that where it is difficult to secure signatures on agreements from patients' representatives, a copy of the agreement sent for signature should be retained on file detailing the date it was sent and any follow up from the home to secure signature.</p> <p>A record of all agreements which are currently outstanding must be made and the relevant patient files updated as set out above.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: Going forward there is a copy of all correspondence in the residents file whilst awaiting signatures from residents representatives.</p>
Requirement 2 Ref: Regulation 19 (2) Schedule 4 (9) Stated: First time To be Completed by: From the date of inspection	<p>The registered person is required to ensure that a standard ledger format is used to clearly and accurately detail every transaction in relation to the patients' comfort fund. Each transaction should be supported by receipts and signed by two persons. If a receipt is not available, the reason for this should be recorded. Records made on behalf of patients must be legible and any mistakes appropriately dealt with on the face of the ledger i.e.: 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. Reconciliations of the monies held in respect of the patients' comfort fund must be performed, recorded, signed and dated by two persons at least quarterly.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: A ledger is being kept of all income and expenditure, signed by two persons and receipted, in the event of no receipt being available the reason is recorded and signed by the Home Manager. Mistakes are being recorded appropriately with one line being drawn through mistake. Reconciliations are performed quarterly and signed by two people.</p>
Requirement 3 Ref: Regulation 19 (2) Schedule 4 (3) Stated: First time To be Completed by: From the date of inspection	<p>The registered person must ensure that there is appropriate follow up of any outstanding documents from patients' representatives which provide the home with authority to spend a patient's money.</p> <p>Patient files must detail attempts by the home to follow up on required documentation.</p> <p>A record of all personal spending authorisations which are currently outstanding must be made and the relevant patient files updated as set out above.</p>

	<p>Response by Registered Person(s) Detailing the Actions Taken: All relatives representatives are being followed up with letters if they have not signed spending authorisations in place.</p>
<p>Requirement 4</p> <p>Ref: Regulation 19(2) Schedule 4 (9)</p> <p>Stated: First time</p> <p>To be Completed by: 13 August 2015</p>	<p>The registered person must ensure that a written "safe book/register" is introduced to record any items held within the safe place. This should record anything held within the safe place including items deposited for safekeeping on behalf of patients. Should any item be deposited for safekeeping, the record should reflect the date items were deposited and should be signed by two persons. Where items are returned to the patient or their representative, the record should be updated with the date the item(s) were returned and include two signatures to verify the return of the items.</p>
	<p>Response by Registered Person(s) Detailing the Actions Taken: A record is held of all of the contents of the safe that is double signed.</p>
<p>Requirement 5</p> <p>Ref: Regulation 19(2) Schedule 4 (10)</p> <p>Stated: First time</p> <p>To be Completed by: 30 September 2015</p>	<p>The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by all newly admitted patients. The registered person must also ensure that a retrospective record is made of the furniture and personal possessions owned by existing patients accommodated in the home.</p> <p>All inventory records should be updated on a regular basis. Care Standards for Nursing Homes, April 2015 require that a reconciliation of these records is recorded <u>at least quarterly</u>.</p> <p>Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry.</p> <p>The registered person should advise staff of the importance of recording inventory details consistently. Items of significant value or those requiring electrical safety testing should be distinctly highlighted on the record for ease of identification.</p>
	<p>Response by Registered Person(s) Detailing the Actions Taken: An inventory of possessions is in place for all residents. This is scheduled to be updated when residents bring in new items.</p>

Recommendations			
Recommendation 1 Ref: Minimum Standard 2.2 Stated: First time To be Completed by: 30 October 2015	It is recommended that the home review its standard agreement to ensure that it contains all of the necessary components as set out in Standard 2.2 of the Care Standards for Nursing Homes (2015).		
	Response by Registered Person(s) Detailing the Actions Taken: The standard agreement is in the process of being updated and will be completed by the 30 October 2015		
Registered manager Completing QIP	John Rafferty	Date Completed	23.09.15
Registered Person Approving QIP	Logan N Logeswaran	Date Approved	28.09.15
RQIA Inspector Assessing Response		Date Approved	11/10/2015

Please provide any additional comments or observations you may wish to make below:

Profuse apologies for the delay in this being returned.

Please complete in full and returned to finance.team@rqia.org.uk from the authorised email address