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REGULATION AND QUALITY
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IMPROVEMENT AUTHORITY

Unannounced Finance Inspection
of
Fishbourne House

13 October 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced finance inspection took place on 13 October 2015 from 09:20 to 13:30. 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, the financial arrangements were found to be contributing to safe, effectiveness and compassionate care; however there are some areas identified for improvement, which 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 Mr William Brown, the responsible person and Mrs Rosemary Lunn, the registered manager; 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	6	3

The details of the QIP within this report were discussed with Mrs Rosemary Lunn, 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: William Brown & James Alexander Speers	**Registered Manager:** Rosemary Lunn
Person in Charge of the Home at the Time of Inspection: Ms Lynne Carlisle	**Date Manager Registered:** 18 November 2010
Categories of Care: RC-I, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 22
Number of Patients Accommodated on the Day of Inspection: 19	**Weekly Tariff at Time of Inspection:** Regional Tariff, no Third Party Top Up

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 Responsible Person, Mr William Brown and Mrs Rosemary Lunn, the registered manager
- 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 examined during the inspection:

- The "Residents' Guide"
- The home's policy on "Safeguarding Residents' Money and Valuables"
- The home's policy on "Residents' Comfort Fund"
- Three patient agreements
- Evidence of correct care fees raised
- Receipts for payment of fees and sundry expenditure
- The Comfort Fund bank account
- Hairdressing and Chiropody treatment receipts
- The safe record detailing items deposited for safekeeping with the home
- Three records of patients' inventory/property in their rooms

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 4 June 2015; the returned quality improvement plan was approved by the care inspector. We were not required to follow up on any matters arising from the previous inspection.

5.2 Review of Requirements and Recommendations from Previous Finance Inspection

There has been no previous finance inspection of the home.

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 "Residents' Guide", a copy of which was provided to us during the inspection. We noted that the guide included information for patients on the additional services facilitated within the home and arrangements for patients to bring personal items of furniture to the home should they wish.

We noted that the home have a standard written agreement, referred to as the patient's "contract", an individual copy of which is provided to each admitted patient. We chose a sample of four patients and asked to see the contracts which they had in place with the home.

The registered manager provided us with agreements for three of the four sampled patients; the registered manager advised that the written agreement with the fourth patient could not be located.

We reviewed the three available agreements and noted that they had been signed in 2014 and 2013, and therefore they did not contain the current fee and payment arrangement details for the individual patients.

We were also provided with a blank copy of the patients "contract". We noted that the contract did not contain all of the legislative requirements. We clarified that in order to comply with Regulation 5 (1) of the Nursing Care Homes Regulations (Northern Ireland) 2005; a patient's agreement must clearly state the weekly fee, the person(s) by whom the fees are payable and the respective methods of payment.

We also highlighted that Standard 2.2 of the Care Standards for Nursing Homes (April 2015), details all of the components which must be included in each patient's individual agreement with the home. We noted that the home must compare the current standard agreement with Standard 2.2 of the Care Standards for Nursing Homes to ensure that all of the elements are included; an updated agreement with the current fees and relevant financial arrangements must be provided to each patient in the home.

A requirement has been made in respect of these findings.

Is Care Effective?

We noted that the home has a policy and procedure, "Safeguarding Residents' Money and Valuables" to guide practice in the home.

Is Care Compassionate?

We evidenced that patients had not been previously notified of any increases in fees over time. We noted that every patient or their representative must be advised in writing of changes to the fees payable and that these changes must be agreed in writing in the patient's individual agreement with the home.

A requirement has been made in respect of this finding.

Areas for Improvement

Overall on the day of inspection, financial arrangements were found to be contributing to safe, effective and compassionate care. However, there were two areas identified for improvement; these related to the providing up to date agreements to patients which reflect Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and Standard 2.2 of the Care Standards for Nursing Homes (2015) and notifying all patients of any changes to the fees and ensuring that these changes are agreed in writing in each patient's individual agreement with the home.

Number of Requirements	2	Number Recommendations:	0

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 trusts' 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 to their weekly care fees in full or part, directly to the home. For all other patients, the home is paid directly by the relevant HSC trust. A review of a sample of charges established that the correct amounts were being charged by the home.

The home is not directly in receipt of any personal allowance monies belonging to patients in the home. Discussions established that the cost of additional items or services required by patients is initially met by the home, and subsequently billed to the patients' representatives. Therefore no money is deposited with the home to pay for items or services, and no money is held by the home (except for small amounts of money which identified patients had on their person at the time of admission to the home).

The responsible person advised that the cost of toiletries and newspapers is met by the home. We noted that the only costs being billed to patient's representatives (excluding care fees) were those for hairdressing and chiropody services facilitated in the home.

We reviewed the invoice style template used for billing patients' representatives; it was not clear whether copies of the bills provided to patients' representatives were retained. We recommended that copies of the invoices sent to patients' representatives are retained as proof that the patient's representative has been charged the correct amount.

A recommendation is made in respect of this finding.

We also reviewed the records of receipts for money received in respect of care fees or for the payment of hairdressing and chiropody bills. We noted that a receipt book was in place, however this was not a duplicate receipt book and the stubs detailing the lodgement were not signed.

We noted that best practice would be for the home to retain a copy of any receipt given to a person paying a bill and that the receipts should be signed by both parties, i.e. the person providing the money and the person receiving it.

A recommendation has been made in respect of this finding.

We reviewed the hairdressing treatment records and noted that the records detailed the name of the patient, the date of the treatment, the treatment received and the cost. We noted that the treatment records were signed by the hairdresser and a representative of the home.

We also reviewed the chiropody treatment records and noted that while the date, name of the patient and the treatment provided was recorded; the cost and the signature of the chiropodist were not recorded. We noted that these additional items must be detailed on the records.

A requirement has been made in respect of this finding.

Discussions established that the home operates a fund for the benefit of the patients in the home; this is referred to in the home as the comfort fund. A bank account for the fund is in place which is named appropriately. We also noted that a written policy and procedure exists in respect of the management of the comfort fund.

Discussion established that there was not an income and expenditure ledger for the fund. We noted that robust record keeping practices must be in place to administer the fund and appropriately record income and expenditure. We also noted that reconciliations of the comfort fund 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?

The registered manager confirmed that no representative of the home was acting as nominated Appointee for any patient, nor was the home in direct receipt of the social security benefits or the personal allowance monies for any patient in the home.

We queried whether the home had any written authorisation from patients or their representatives to engage in financial transactions on behalf of each patient; the registered manager confirmed that written authorisations were not in place.

We highlighted that these authorisations provide the home with formal permission to purchase goods and services on behalf of each patient and act as a protection for both the patient and the home. We noted that these must be obtained for any patient for whom the home engage in financial transactions.

A requirement has been made in respect of this finding.

Is Care Compassionate?

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, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were five areas identified for improvement.

Number of Requirements	3	Number Recommendations:	2

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 or their representatives to deposit cash or valuables, should they wish. We reviewed the safe place within the home and were satisfied with the controls around the physical location of the safe place and the persons with access. On the day of inspection, a small number of items were deposited for safekeeping. A written record existed to verify the entries of the individual items to the safe place, the entries were signed and dated by two people, good practice was observed.

We noted that a safe record exists to record any additions or withdrawals of valuables from the safe place. A review of the record identified that the record is routinely reconciled and signed and dated by two people, however we noted that the most recent reconciliation was recorded on 20 May 2015. We highlighted that reconciliations should be carried out at least quarterly. We also noted that the reconciliation routinely stated "...checked contents, all correct and returned to safe...." We emphasised that it is best practice to detail the items specifically, rather than use a statement such as that above.

A recommendation 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 advised that there were none.

We requested the inventory/property records for four sampled patients. The registered manager provided written records of property for two of the patients; the remaining two patients did not have a written record in place at the time the records were requested. During the inspection, the registered manager returned with the property record for a third patient in the sample, having completed this during the inspection; this record was also made available to us.

Records of property had been made on a template entitled "Personal Belongings on Admission". We noted that items recorded were almost exclusively clothing. Records had been signed and dated by one person.

We discussed these findings with the registered manager and noted that these records must be available at all times for updating purposes and that any addition or disposal from the record of items must be signed and dated by two people.

We also noted that the Care Standards for Nursing Homes (April 2015) require that records of furniture and personal possessions are updated at least quarterly. We highlighted that all of the property records should be reviewed and updated and that the records must be signed and dated by two people.

A requirement has been made in respect of this finding.

Is Care Compassionate?

A safe place exists within the home to enable patients or their representatives to deposit cash or valuables should they wish. We queried how patients would know about the safe storage arrangements in the home; discussions with the responsible person and the registered manager established that these matters would be discussed at the time of admission. It was noted that patients are not encouraged to bring any significant valuables to the home, however the facility to store small items or money belonging to patients in the home exists, should the need arise.

Areas for Improvement

Overall on the day of inspection, the financial arrangements in place were found to be contributing to safe, effective and compassionate care. There were two areas identified for improvement, these related to the frequency and detail of the safe contents reconciliations and records of patients furniture and personal possessions in their rooms.

Number of Requirements	1	Number Recommendations:	1

5.6 Statement 4 - Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

Is Care Safe?

The home does not provide transport services to patients.

Is Care Effective?

As noted above, transport services are not provided by the home.

Is Care Compassionate?

There is no transport scheme or services in operation by the home.

Areas for Improvement

Overall on the day of inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care. There were no areas of improvement identified in respect of Statement 4.

Number of Requirements	0	Number Recommendations:	0

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 Mrs Rosemary Lunn, 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 Home 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 RQIA's office 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:** 24 November 2015	The registered person must 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 must be reviewed for compliance with requirements under Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and must meet Standard 2.2 of the DHSSPS Care Standards for Nursing Homes (2015), which detail 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.
	Response by Registered Person(s)Detailing the Actions Taken: NEW AGREEMENTS HAVE BEEN COMPILED AND FILED IN RESIDENTS RECORDS.
Requirement 2 **Ref**: Regulation 5 (2) (a) (b) **Stated:** First time **To be Completed by:** From the date of the next change	The registered person must provide at least 28 days written notice to each patient or their representative of any increase in the fees payable by or in respect of the patient, or any variation in the method of payment of the fees or the person by whom the fees are payable. The registered person must ensure that any changes to the individual patient's agreement are agreed in writing by the patient or their representative. The patient's individual agreement must be updated accordingly. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded.
	Response by Registered Person(s)Detailing the Actions Taken: ALL RESIDENTS OR THEIR REPRESENTATIVE WILL BE GIVEN 28 DAYS NOTICE OF ANY CHANGE IN FEES.

Requirement 3 **Ref:** Regulation 19(2) Schedule 4 (9) **Stated:** First time **To be Completed by:** 20 October 2015	The registered person must ensure that a standard financial ledger format is used to clearly and accurately detail transactions for the patients' comfort fund. This format must 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 a withdrawal; the amount; the running balance of the comfort fund monies held and the signatures of two persons to verify the entry in the ledger. The record should reflect the amount of a withdrawal and the return of change (if any), not the amount of money spent, as receipts should be available to verify this. If a receipt is not available for expenditure, the record should be annotated to reflect this. Records made 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. Correction fluid must not be used. A reconciliation of the patients' comfort fund must be carried out and recorded and signed and dated by two people at least quarterly.
	Response by Registered Person(s)Detailing the Actions Taken: IN PLACE.
Requirement 4 **Ref:** Regulation 19(2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that the chiropody treatment records detail the cost and are signed by the chiropodist to verify that the treatment has been provided. A member of staff should continue to countersign the records to evidence that the detailed treatment has been received and the patient has incurred the associated cost.
	Response by Registered Person(s)Detailing the Actions Taken: CHIROPODIST NOTIFIED ACCORDINGLY
Requirement 5 **Ref:** Regulation 19(2) Schedule 4 (3) **Stated:** First time **To be Completed by:** 24 November 2015	The registered person must ensure that written authorisation is obtained from each patient or their representative to spend the personal monies of patients on pre-agreed expenditure. The written authorisation must be retained on the patient's records and updated as required. The registered person must ensure that where any representative of a patient (including care manager or next of kin) have signed a document for the home on behalf of the patient, the representative's name and relationship to the patient are clearly stated on the document. 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 personal monies authorisation should be shared with the HSC trust care manager.

	Response by Registered Person(s)Detailing the Actions Taken: DETAILS INCLUDED IN NEW AGREEMENT
Requirement 6 **Ref**: Standard 19 (2) Schedule 4 (10) **Stated:** First time **To be Completed by:** 24 November 2015	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. 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 at least quarterly). Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry. 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.
	Response by Registered Person(s)Detailing the Actions Taken: REVISED FORMS ALREADY IN PLACE.
Recommendations	
Recommendation 1 **Ref**: Standard 35.21 **Stated:** First time **To be Completed by:** From the date of inspection	It is recommended that a duplicate book is introduced to provide receipts for money received by the home in respect of fees or the payment of sundries which have been billed to family representatives. Receipts should be signed by the person lodging the cash and by a representative of the home. The copy receipt should be retained by the home.
	Response by Registered Person(s)Detailing the Actions Taken: CURRENTLY IN PLACE.

Recommendation 2 **Ref:** Standard 35.21 **Stated:** First time **To be Completed by:** From the date of inspection	It is recommended that the registered person retains copies of the invoices sent to patients' representatives as evidence that the person has been charged the correct amount by the home.
	Response by Registered Person(s)Detailing the Actions Taken: NOW RETAINED
Recommendation 3 **Ref:** Standard 14.25 **Stated:** First time **To be Completed by:** From the date of inspection	It is recommended that the registered person ensure that the reconciliations of the safe contents are carried out at least on a quarterly basis. In addition, the specific details of the items reconciled should be recorded at each reconciliation.
	Response by Registered Person(s)Detailing the Actions Taken: IN PLACE.

Registered Manager Completing QIP	Rosemary Lunn	**Date Completed**	3/12/15
Registered Person Approving QIP	[signature] Brown	**Date Approved**	3/12/15.
RQIA Inspector Assessing Response	[signature]	**Date Approved**	16/12/15

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