

Unannounced Finance Inspection Report

5 April 2016



Parkview

Address: Glencairn Road, Forthriver Road, Belfast BT13 3PU

Tel No: 02890391393

Inspector: Briega Ferris

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Parkview took place on 5 April 2016 from 09.15 to 13.30.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care, and if the service was well led.

Is care safe?

No requirements or recommendations have been made in respect of this domain.

Is care effective?

Two recommendations have been made in relation to how patients' property is recorded and the records of the cost of services for which there is an additional charge.

Is care compassionate?

No requirements or recommendations have been made in respect of this domain.

Is the service well led?

One recommendation has been made in relation to updating written agreements with patients.

This inspection was underpinned by The 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	0	3

Details of the quality improvement plan (QIP) within this report were discussed with Ms Gill Finlay, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent finance inspection

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

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/Dr Maureen Claire Royston	Registered manager: Ms Gill Finlay
Person in charge of the home at the time of inspection: Ms Gill Finlay	Date manager registered: 18 March 2005
Categories of care: RC-LD(E), NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	Number of registered places: 71

3.0 Methods/processes

Prior to the inspection, it was established that no incidents involving services users' finances had been reported to RQIA in the last twelve months.

During the inspection the inspector met the registered manager and the home administrator.

The following records were examined during the inspection:

- Four patient finance files
- Four signed patient agreements
- A sample of patients' income and expenditure records
- Evidence of the reconciliation of patients' monies
- A sample of treatment receipts for hairdressing and chiropody services facilitated in the home
- The safe audit record
- Financial policies and procedures
- Four records of patients' property

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 10 March 2016

The most recent inspection of the home was an unannounced care inspection. The care inspector was contacted and confirmed that there were no matters to be followed up from the previous inspection.

4.2 Review of requirements and recommendations from the last finance inspection dated 31 March 2007

The findings from the inspection in 2007 were not brought forward as part of this inspection.

4.3 Is care safe?

The home's administrator explained the training which she received when she joined the home. She noted that training took a number of forms, including on the job and e-learning. It was noted that protection of vulnerable adults training (including indicators of financial abuse) and information governance training (including good record keeping, confidentiality and data protection) was mandatory on an annual basis.

The administrator demonstrated exceptional knowledge of the controls in place in the home to safeguard money and valuables. The inspector used some scenarios to establish whether or not the administrator could identify the salient issues; the administrator was able to clearly and concisely describe the relevant issues and what steps to take to safeguard a patient's money and valuables. Unprompted, the administrator also offered specific examples of individualised arrangements in place to help support identified patients in the home.

The home had a range of policies and procedures in place to guide practice and day-to-day procedures relating to how patients' money and valuables were safeguarded; the inspector noted that these were easily accessible for staff on the day. Prior to the inspection, the inspector reviewed records of any incidents notified to RQIA over the previous twelve months; none of these were finance-related.

During discussion, the registered manager confirmed that there were no current suspected, alleged or actual incidents of financial abuse. Scenarios were discussed with the administrator to establish whether she was aware of what steps to take in the event of suspected financial abuse of a patient; the home's administrator was confidently able to explain the correct steps to take in such circumstances.

Discussion with the registered manager established that there were no 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0
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4.4 Is care effective?

During the course of the inspection, the inspector reviewed a sample of records which evidenced that in the main, record keeping was in accordance with legislation, standards and best practice guidance. Three recommendations were made as part of the inspection; these are set out in the QIP.

The registered manager confirmed that the home had a policy and procedure which addressed the creation, storage, recording, retention and disposal of records.

A review of a sample of patients' finance records and discussion with the registered manager and the home administrator evidenced that consultation with stakeholders, including family representatives and HSC trust care management, was ongoing.

Discussion established that the home did not operate a transport scheme; patients were supported to access other means of transport, appropriate to meet their individual needs and requirements.

A review of a sample of income and expenditure established that personal allowance account statements were maintained detailing transactions for individual patients. There were weekly transaction sheets signed by two people, and a monthly reconciliation had been carried out, also signed and dated by two people.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see a sample of the completed property records for four patients. Each patient's file contained a "schedule of personal effects" form which was part of the admission process; the inspector noted that none of the four records had been signed and that additions which had been made on the records were also neither signed nor dated. The inspector evidenced additions such as "TV" and noted that the level of detail required for descriptions of items (e.g. make/model/size) should be clarified by the registered manager and communicated to relevant staff.

A recommendation was made in respect of this finding.

The registered manager confirmed that no patient in the home had been assessed as incapable of managing their finances and property. The registered manager also confirmed that no representative of the home was acting as appointee for any patient in the home.

As noted above, weekly transaction sheets and month-end records were signed by both the home administrator and the registered manager. In addition, it was noted that the month-end records were also sent to the organisation's audit team for review. The home administrator advised that the home also had a regional business support administrator who visited the home on an unannounced basis to carry out spot checks on a sample of the records. The inspector noted that a written reconciliation of the safe place was carried out on a monthly basis which was signed and dated by the home administrator and the registered manager.

A review of a sample of the records identified that a hairdresser and a private chiropodist routinely visited the home to provide services to patients. These services attracted an additional cost payable by the patient or their representative and treatment records were maintained by the home accordingly. Records of hairdressing treatments were made on a template which captured information such as the name of the patient, the type of treatment they had received and the associated cost. However, we evidenced that the records were routinely signed only by the hairdresser; the column "staff confirmation hair done" had not been completed by staff.

The inspector reviewed a sample of the chiropody treatment records and noted that these had been typed by the home administrator from records provided by the chiropodist. Similarly, these records had not been signed by a member of staff who could confirm the treatments detailed had been provided to patients.

A recommendation was made in respect of this finding.

Following discussion with the registered manager and the administrator, it was evident that when necessary, other allied healthcare professionals were contacted in response to issues impacting on the safety and security of patients' money and valuables. Examples of such contact were evidenced in a sample of written records reviewed.

Areas for improvement

Two areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	2
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4.5 Is care compassionate?

The inspector discussed the day to day arrangements in place in the home to support patients. The registered manager and home administrator both described examples of how identified patients were at the centre of decisions regarding their money and what measures were in place at the home to support them effectively.

The registered manager described how the home had a "quality of life" initiative to ascertain the views of patients and those visiting the home. In addition, the manager noted that annual care reviews and the home's complaints procedures allowed feedback to be provided.

The registered manager explained how listening to patients and their families was key to understanding the individual needs and wishes of the patients. She described the importance of getting to know each patient's background, so that each patient could feel as comfortable in the home as possible. Both the registered manager and home administrator provided real-life examples of how listening to patients (and their families) and seeking their individual preferences had led to improved outcomes for the individual patients discussed.

There was evidence on a sample of files reviewed that the home had engaged with HSC trust care management and finance representatives to ensure that arrangements in place to support individual patients were transparent and had been agreed with the relevant persons.

The registered manager explained that when a patient was admitted to the home, the patient and/or their representative would usually meet with either herself or the home administrator to go through arrangements regarding money and valuables. The home administrator stated that the range of services on offer would be explained and the option of storing any money or valuables in the safe place would be offered to the patient.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0
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4.6 Is the service well led?

Written policies and procedures for the management of patients' money and valuables were in place; the registered manager confirmed that these were reviewed at least every three years. As noted above, the inspector evidenced that policies were easily accessible by staff.

Discussions clarified that the home's governance arrangements highlight and promote the identification and management of risk to patients' money and property.

The registered manager confirmed that the home had a complaints policy which was in accordance with legislation and DHSSPS guidance. In addition, she noted that records of all complaints and compliments are kept and that these are also logged so that the organisation's head office can review this information. Discussion with the home administrator identified that she could explain the steps to take should someone wish to make a complaint.

The registered manager explained that the home had a clear procedure for managing any incidents or notifiable events concerning patients' money and property. She also confirmed that in respect of any future finance-related incidents, the home has arrangements in place for staff supervision and appraisal and where necessary, performance management.

There is a clear organisational structure within the home; the registered manager noted that there was effective support from senior colleagues within the organisation. Following discussion with the registered manager and administrator, it was evident that they were familiar with their roles and responsibilities in relation to safeguarding patients' money and valuables.

The registered manager confirmed that the Statement of Purpose and Patient Guide were continually kept under review, and provided examples of how changes in management led to the most recent review and update of the above documents.

Four sets of patients' records were sampled in order to view the signed agreements in place with the home. All four patients had a written agreement in place; however, the four agreements did not reflect the current terms and conditions, such as the current fees payable. The agreements in place were dated between 2012 and 2015.

The inspector evidenced on one patient's finance file, a letter dated February 2016 to the patient's representative, enclosing an up to date agreement and requesting that this be returned to the home; similar letters were not available on the other three patients' files. The inspector highlighted these findings during feedback and noted that each patient's agreement must be kept up to date, with any changes agreed in writing by the patient or their representative.

A recommendation was made in respect of this finding.

Discussion established that there were good working relationships with relevant stakeholders to ensure financial arrangements for patients in the home were transparent and agreed to. The registered manager confirmed that regulatory matters were responded to as required, and that a whistleblowing policy existed. Separate discussions with the home administrator established that she was familiar with the home's whistleblowing procedures.

Areas for improvement

One area for improvement was identified during the inspection.

Number of requirements:	0	Number of recommendations:	1
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5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Gill Finlay, 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s 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 person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to 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 by the registered manager. Once fully completed, the QIP will be returned to finance.team@rqia.org.uk and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations

<p>Recommendation 1</p> <p>Ref: Standard 14.26</p> <p>Stated: First time</p> <p>To be completed by: 17 May 2016</p>	<p>The registered person 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.</p> <p>Response by registered person detailing the actions taken: This is currently being addressed. The inventory records are being reconciled quarterly. The records are being signed by staff members undertaking the reconciliation and countersigned by a senior member of staff.</p>
<p>Recommendation 2</p> <p>Ref: Standard 14.13</p> <p>Stated: First time</p> <p>To be completed by: From the date of inspection</p>	<p>The registered person 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.</p> <p>Response by registered person detailing the actions taken: This is currently being addressed-the person providing the service and the member of staff of the home signs the treatment record.</p>
<p>Recommendation 3</p> <p>Ref: Standard 2.8</p> <p>Stated: First time</p> <p>To be completed by: 17 May 2016</p>	<p>The registered person 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.</p> <p>Response by registered person detailing the actions taken: This is currently being addressed-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.</p>



The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews