Unannounced Finance Inspection Report
20 August 2018

Kings Castle

Type of Service: Nursing Home
Address: Kildare Street, Ardglass, BT30 7TR
Tel No: 028 4484 2065
Inspector: Briege Ferris

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 42 beds that provides care for older patients and/or those living with a physical disability other than sensory impairment or those patients who are terminally ill.

3.0 Service details

Organisation/Registered Provider: Kings Castle **Responsible Individuals:** Gerald Ward	**Deputy manager:** Wendy Miniss
Person in charge at the time of inspection: Mary Peake (deputy manager	**Date manager registered:** 11/02/2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of registered places:** 40 There shall be a maximum of 7 named residents receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 20 August 2018 from 11.10 to 14.50 hours.

This inspection was underpinned by Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

The inspection assessed progress with any areas for improvement identified since the last finance inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in respect of:

- a safe place was available for the deposit of money or valuables and access was limited to authorised persons
- a sample of income and expenditure transactions recorded could be to the supporting evidence (such as a treatment record)
- a sample of charges to patients for care and accommodation
- the mechanisms to listen to and take account of the views of patients and their representatives in respect of any issue
- the statement of purpose and the patients guide contained a range of information for new patients
- the home administrator was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures
- each patient record selected as part of the sample contained a signed written agreement with the home and evidence that amendments to the agreement had been shared with patients or their representatives and personal expenditure authorisation documents were in place for those patients

Areas requiring improvement were identified in relation to:

- ensuring that each patient's record of their furniture and personal possessions is kept up to date. This record is to be signed and dated by a staff member and senior member of staff at least quarterly.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with the deputy 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.

4.2 Action/enforcement taken following the most recent finance inspection dated 15 September 2014

A finance inspection was carried out on 15 September 2014; the findings from which were not brought forward to the inspection on 20 August 2018.

5.0 How we inspect

Prior to the inspection, the record of notifiable incidents reported to RQIA in the last twelve months was reviewed; this established that none of these incidents related to patients' money or valuables. The record of calls made to RQIA's duty system was also reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with the deputy manager and the home administrator. A poster was displayed detailing that the inspection was taking place, however no relatives or visitors chose to meet with the inspector.

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

The following records were examined during the inspection:

- The Statement of Purpose
- The Patients Guide
- Three patients' individual written agreements with the home

- A sample of income and expenditure and reconciliation (check) records maintained on behalf of patients
- A sample of records in respect of hairdressing treatments facilitated in the home
- Three patients' records of furniture and personal possessions (in their rooms)
- A sample of charges to patients/their representatives for care and accommodation costs
- A sample of written policies and procedures including:
    - "Finance policy" January 2016
    - "Clothing and Laundry" January 2016
    - "Whistleblowing" January 2016
    - "Policy on complaints" January 2016

The findings of the inspection were provided to the deputy manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 15 May 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last finance inspection dated 20 May 2013

As noted above, a finance inspection was carried out on 20 May 2013; the findings from which were not brought forward to the inspection on 20 August 2018.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The inspector met with the deputy manager and the home administrator who confirmed that adult safeguarding training was mandatory for all staff members. The home administrator confirmed that she had received this training in 2017.

The deputy manager confirmed that there were no current suspected, alleged or actual incidents of financial abuse, nor were there any finance-related restrictive practices in place for any patient.

The home had a safe place available for the deposit of cash or valuables belonging to patients. Cash belonging to a number of patients was deposited for safekeeping, no valuables were being held on behalf of patients. A review of a sample of balances on deposit agreed to the records held.

Areas of good practice

There were examples of good practice found in respect of a safe place available for the deposit of money or valuables; a process to restrict access to authorised persons and a written safe record was in place which was audited on a monthly basis.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Discussions with the deputy manager and home administrator established that no representative of the home was acting as appointee for any patient (i.e.: managing a patient's social security benefits on their behalf). These discussions also established that the home was not in direct receipt of the personal monies for any patient.

Clear, detailed income and expenditure records were available; for a sample of transaction selected, the supporting documents were available including deposit receipts and receipts for any expenditure incurred on behalf of the patients. Records were in place to detail that reconciliation of monies held were recorded accurately, signed and dated by two staff on a regular basis. The most recent reconciliation as recorded on 26 July 2018.

Hairdressing treatments were being facilitated within the home and a sample of recent treatment records was reviewed. Routinely, the hairdressing treatment records detailed the majority of the information required by the Care Standards for Nursing Homes (2015) however it was identified that the records reviewed had not been signed by the hairdresser, as is required It was noted that the records had been signed by two members of staff instead. Advice was provided to the deputy manager in respect of ensuring that one of the signatories on the records is the person who provides and receives payment for the treatment.

The inspector discussed with the home administrator how patients' property, within their rooms was recorded and it was noted that the home retained a computerised care record for each patient. These were printed off the system for the inspector. A review of the records identified that these were dated July 2018, September 2017 and November 2016 respectively. There was no evidence presented to establish that they had been reviewed and updated subsequently. As the records were computerised, none were signed.

Records of patients' property should be checked on at least a quarterly basis, with the records signed by a staff member and countersigned by a senior member of staff.

This was identified as an area for improvement.

A record of charges to patients or their representatives for care and accommodation fees was available for review by the inspector and a sample of charges reviewed identified that the correct amounts had been charged.

Discussions with the deputy manager established that the home did not operate a transport scheme or operate a patient comfort fund.

Areas of good practice

There were examples of good practice found in relation to expenditure transactions recorded in respect of goods or services provided to patients which are not covered by the weekly fee. A sample of transactions could be traced in support of this process. A sample of charges to patients or their representatives for care and accommodation was in accordance to that which should be charged.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that records of patients' furniture and personal possessions are kept up to date and are signed and dated by a staff member and senior member of staff at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

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

The arrangements to support patients with their money on day to day basis were discussed with the deputy manager and the home administrator. Discussions with the home administrator established that arrangements to pay fees and settle invoices for goods or services paid initially by the home, would be discussed with the patient and/or their representative at the time a patient was admitted to the home.

Discussion with the deputy manager established that the home had a number of methods in place to encourage feedback from families or their representatives in respect of any issue. This was noted to include an annual quality assurance questionnaire, displaying thank you cards from representatives in a prominent position, and feedback on a day to day basis.

Areas of good practice

There were examples of good practice identified in relation to listening to and taking account of the views of patients and their representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of patients in order to deliver safe, effective and compassionate care.

The patient guide contained information for a new patient including the organisational structure of the home; the home's terms and conditions of residency including the current scale of charges and a copy of the home's complaints procedure.

Written policies were reviewed including those in respect of finance, whistleblowing and complaints management. Policies were easily accessible by staff and had been reviewed within the last three years.

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

Discussion was held with the home administrator regarding the individual written agreements in place with patients and the home. A sample of three patients' individual written agreements was reviewed which established that each patient had an agreement on their file; these were dated between 2016 and 2017 i.e.: the respective dates of admission of the patients. There was evidence available to identify that on an annual basis, updates to the agreements (namely because of regional changes in fees) had been shared with the patients or their representatives for signature.

Review of a sample of the records identified that authorisation documents were in place to spend the patients' money retained by the home on identified goods and services. A sample of three patient files was reviewed and these were in place on each of the files reviewed.

Areas of good practice

There were examples of good practice found in relation to the information contained in the patient guide; the home administrator's knowledge in relation to responding to a complaint or escalating a concern under the home's whistleblowing procedures. Patients records selected as part of the sample had a signed written agreement with the home and evidence that agreements had been updated to reflect any changes, with the updated agreements shared for signature; personal expenditure authorisation forms were in place.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mary Peake, deputy manager, at the close of the inspection. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home.

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

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 17 September 2018	The registered person shall 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. Ref: 6.5
	Response by registered person detailing the actions taken: A more detailed inventory of property belongings for each patient has been implemented within the home and clearly recorded and signed.

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

The Regulation and Quality Improvement Authority

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

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