Finance Inspection Report
9 August 2016

Lisburn Care Home

Type of service: Nursing Home
Address: 119a Hillsborough Road, Lisburn BT28 1JX
Tel No: 02892666763
Inspector: Briege Ferris

1.0 Summary

An unannounced inspection of Lisburn Care home took place on 09 August 2016 from 10.20 to 14.30 hours.

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?

Evidence was reviewed which confirmed that the two home administrators had recently completed training in the protection of vulnerable adults. Controls in place to protect patients' money and valuables were described by the administrator on duty on the day of inspection and a review of sample of records evidenced these in practice; no areas for improvement were identified.

Is care effective?

Systems were found to be in place to effectively record monies received and spent on behalf of patients; one area for improvement was identified during the inspection. This related to ensuring that treatment records are consistently signed by the person providing the treatment and by a representative of the home.

Is care compassionate?

There was evidence in a sample of files reviewed, that patients were involved to make decisions affecting their care, including arrangements to support them with their money. The administrator spoke in a caring and compassionate manner about how the patients in the home were supported with their money and valuables.

One recommendation was made for the home to ensure that there are appropriate contingency arrangements in place to ensure that patients have access to money at all times.

Is the service well led?

A review of a sample of records evidenced that robust governance and oversight arrangements were in place in the home.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the (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	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Karen Moriarty, 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

There has been no previous RQIA finance inspection of Lisburn Care Home.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/Maureen Claire Royston	**Registered manager:** Karen Moriarty
Person in charge of the home at the time of inspection: Karen Moriarty	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 38

3.0 Methods/processes

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 services users' money or valuables. The record of calls made to RQIA's duty system was also reviewed and this did not identify any relevant issues. Contact was also made with the inspector who had most recently visited the home.

On the day, the inspector met with the registered manager, one of the home administrators and the regional business support administrator. A poster detailing that the inspection was taking place was positioned at the entrance to the home; however, no relatives or visitors chose to meet with the inspector.

The following records were examined during the inspection:

- Training record (Protection of Vulnerable Adults) for both home administrators
- A sample of HSC Trust payment remittances
- Financial Policy SOP- 15 "Management and recording of personal allowance" dated May 2016
- Financial Policy "Maintenance of personal allowance records" dated May 2016
- Financial Policy "Person in care - social and other cash floats" dated May 2016
- A sample of care and accommodation fees charged in respect of patients contributing to the cost of their care

- A sample of income, expenditure and reconciliation records
- A sample of records for hairdressing and podiatry services facilitated in the home
- A sample of resident social fund records
- Four patient finance files
- Four records of patients' property within their rooms

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 28 June 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector. This QIP will be validated by the pharmacy inspector at the next pharmacy inspection.

4.2 Review of requirements and recommendations from the last finance inspection

There has been no previous RQIA inspection of the home.

4.3 Is care safe?

Evidence was provided which confirmed that both of the home administrators had recently received training on the Protection of Vulnerable Adults (POVA); it was noted that this training was mandatory for all staff on a regular basis. The administrator who was in the home on the day had worked in the home for approximately 14 years and was very familiar with the home's controls to safeguard patients' money and valuables.

During discussion, the registered 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; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, cash and valuables belonging to patients were lodged with the home for safekeeping. The most recent "FSHC Valuables record" was provided; the record had been checked at the end of the July 2016.

The home administrator confirmed that a check of the safe contents formed part of the month end processes. Two people had signed and the safe contents reconciliation.

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

Discussion with the registered manager confirmed that no representative of the home was acting as nominated appointee for any patient in the home. The home does however; receive the social security benefits for one patient directly and official documentation (re acting as agent) for this patient were held on the patient's file. The home administrator confirmed that the home was not in direct receipt of any other patient's personal money for example, from the HSC trust or Office of Care and Protection.

In respect of the one patient discussed, there was robust evidence available to confirm the amount and timing of transfers of money received on behalf of the patient to their respective personal monies balance maintained by the home.

The home also received money from family representatives which is left in with the home in order to pay for additional services which attract an additional fee, such as hairdressing or personal toiletries etc.

The inspector reviewed a sample of the records for income and expenditure incurred on behalf of patients (such as that in respect of hairdressing and podiatry). The inspector noted that the home maintain clear records on "personal allowance account statements" detailing income and expenditure, together with other records to substantiate each transaction, such as a receipt for cash/cheque lodgement or hairdressing or podiatry treatment record. The inspector traced a sample of transactions and was able to evidence all of the related documents. There was evidence that records of personal monies held on behalf of patients were reconciled and signed and dated by two people on a monthly basis.

As noted above, hairdressing and podiatry treatments were being facilitated within the home. Records were in place to evidence the patients treated on any given day and the cost of the respective treatments. A review of a sample of the hairdressing records evidenced that records contained all of the relevant information including the names of the patients treated and the respective costs; records were consistently signed by the hairdresser and a representative of the home to verify that the treatments as detailed, had been provided.

A review of a sample of completed podiatry treatment records evidenced that treatment records were consistently signed by a representative of the home, which was good to note, but that they had not been signed by the podiatrist. The inspector noted that the home had a duty to ensure that records contained all of the required details as per DHSSPS Minimum Standards i.e.: in this case, the signature of the podiatrist in each case.

A recommendation was made in respect of this finding.

The home had a number of written policies and procedures addressing matters relating to safeguarding money and valuables, record keeping requirements and other relevant issues such as complaints and whistleblowing. It was noted that these policies had been reviewed and updated recently.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see a sample of the completed property records. Each patient sampled had a record made on a "Schedule of personal effects form", all four of the records had been signed and dated by two people and there was evidence that each record had been updated recently.

It was noted that the home also had a residents' comfort fund, a written policy and procedure existed to guide the administration of the fund. It was noted that income and expenditure records were maintained which were reconciled and signed and dated by two people every month.

It was confirmed that the home did not provide transport to patients. The home administrator described scenarios whereby a number of patients were supported to leave the home with the help of family members.

Areas for improvement

One area for improvement was identified during the inspection. This related to ensuring that treatment records are consistently signed by the person providing the treatment and by a representative of the home.

Number of requirements	**0**	**Number of recommendations**:	**1**

4.5 Is care compassionate?

A sample of fees raised by the home was reviewed and these evidenced that the correct amounts were being charged by the home.

Day to day to day arrangements in place to support patients was discussed with the administrator who was able to describe specific examples of how the home supported a range of patients with their money. Discussion also established how arrangements to safeguard a patients' money were discussed with their patient or their representative at the time of admission.

A review of a sample of files evidenced that each patient sampled had a signed personal monies authorisation in place with the home, granting the home authority to spend personal monies lodged with the home on specific goods or services. There was evidence of engagement with other stakeholders involved in supporting a sample of patients which ensured that respective patients had sufficient funds lodged with the home to ensure that each patient had access to their money, if required.

A review of the records established that the home had a range of methods in place to encourage feedback from families or their representatives in respect of any issue; these were discussed with the registered manager and included the home's "Quality of Life Programme".

The welcome pack for new patients and their families also contained a range of information for a new patient including clear information on fees and funding-related matters.

Arrangements for patients to access their money outside of normal office hours were discussed with the registered manager. She noted that at present, access to the safe place within the home was available during normal office hours. She confirmed that there was no access outside of these times.

A recommendation was made to ensure that home review its arrangements to ensure that patients have access to money at all times.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that the home reviewed its arrangements to ensure that patients have access to money at all times.

Number of requirements:	0	Number of recommendations:	1

4.6 Is the service well led?

Oversight and governance arrangements for safeguarding patients' money were found to be in place and operating effectively. Regular audits of money were recorded and signed and dated by two people; as noted above, a trace of a random sample of transactions evidenced that records were available to substantiate the entries in each patient's personal monies account statement.

As referred to above, the home had a range of detailed policies and procedures in place to guide practice in the area of safeguarding patients' money and valuables.

There was a clear organisational structure within the home; discussion established that those involved in supporting patients with their money on a daily basis familiar with their roles and responsibilities in relation to safeguarding patients' money and valuables.

The inspector requested a list of the current patients in the home which was provided by the administrator; from this list, the inspector selected a sample of four finance files for review. All four patients had a signed agreement on their file, which was signed and dated and which reflected the up to date terms and conditions, including the current fees.

There was evidenced that over time, patients has been advised of changes in the fees and financial arrangements over time, with the changes agreed in writing by the patient or their representative.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

5.0 Quality improvement plan

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

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the Nursing Home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises 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 provider meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to finance.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 14.5 **Stated:** First time **To be completed by:** 16 September 2016	The registered provider should confirm the home's arrangements to ensure that patients have access to money at all times.
	Response by registered provider detailing the actions taken: We have introduced a small float of money to be left in a secure place to enable the Nurse in Charge to access monies for residents outside of normal office hours.This ensures that residents have access to their money at all times.
Recommendation 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 02 September 2016	The registered provider should ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the resident or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each resident.
	Response by registered provider detailing the actions taken: We now have a system in place to ensure that the person providing the service ie Chiropodist and Hairdresser signs along with the resident/nurse in charge the Treatment record to verify they received the treatments/goods and the cost incurred..

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