Unannounced Finance Inspection Report
13 February 2019

Richmond

Type of Service: Nursing Home
Address: 19 Seafront, Cultra, BT18 0BB
Tel No: 028 9042 6558
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

Richmond is a nursing home which provides care for older patients, those with a physical disability other than sensory impairment or those patients who are terminally ill.

3.0 Service details

Organisation/Registered Provider: Richmond Nursing Home **Responsible Individual(s):** Sharon Ruth Radcliffe-Bryans	**Registered Manager:** Sharon Ruth Radcliffe-Bryans
Person in charge at the time of inspection: The nurse in charge	**Date manager registered:** 01/04/2005
Categories of care: Nursing NH-I - Old age not falling within any other category NH-PH - Physical disability other than sensory impairment NH-PH(E) - Physical disability other than sensory impairment –over 65 years NH-TI – Terminally ill	**Number of registered places:** 35

4.0 Inspection summary

An unannounced inspection took place on 13 February 2019 from 09.45 to 14.00 hours.

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

There were examples of good practice found in relation to:

- the availability of a safe place to enable patients to deposit money or valuables for safekeeping
- a written safe record was in place
- the home administrator had participated in adult safeguarding training
- records of income and expenditure were in place
- mechanisms were available to obtain feedback from patients and their representatives
- the home administrator confirmed she was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures, and
- there were mechanisms in place to ensure that patients experienced equality of opportunity

Areas requiring improvement were identified in relation to:

- ensuring that each patient's record of furniture and personal possessions is reconciled by two people at least quarterly

- ensuring that the patients' monies and valuables are reconciled, signed and dated by two people at least quarterly
- ensuring that each transaction in the income and expenditure records is signed by two people
- ensuring that treatment records are maintained in the home in the manner set out in standard 14.13 of the Care Standards for Nursing Homes, 2015
- ensuring that there is evidence that each patient has been provided with an individual written agreement setting out the terms and conditions of their residency in the home
- ensuring that each patient is provided with a personal monies authorisation record for signature detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services, and
- ensuring that financial policies and procedures are updated.

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	1	6

Details of the Quality Improvement Plan (QIP) were discussed with the general manager, the nurse in charge and the home administrator at the conclusion of the inspection. The timescales for completion commence from the date of inspection.

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

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 reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with the nurse in charge and the home administrator, the general manager was present for inspection feedback. A poster was provided for display in a prominent position in the home detailing that the inspection was taking place, however no relatives or visitors chose to meet with the inspector.

The inspector provided to the nurse in charge 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 safe contents record
- A sample of patients' income and expenditure records

- A sample of written financial policies and procedures
- A sample of patients' personal property (in their rooms)
- The service user guide
- A sample of patients' individual written agreements
- A sample of treatment records for services facilitated within the home for which there is an additional charge to patients.

The findings of the inspection were shared with the general manager, the nurse in charge and the home administrator at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 06 December 2018

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

6.2 Review of areas for improvement from the last finance inspection dated 07 April 2014

A finance inspection of the home was carried out on 07 April 2014; the findings were not brought forward to the inspection on 13 February 2019.

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 nurse in charge confirmed that adult safeguarding training was mandatory for all staff in the home including administrative staff. The home administrator confirmed she had participated in this training in 2018.

Discussions with the nurse in charge established 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 were being held for patients. A written safe record was in place which detailed the dates which items had been deposited into the safe place. The record had space to record a reconciliation of the safe contents however there was no evidence

that reconciliations had been completed and recorded by two people at least quarterly as is required. There is further discussion regarding the reconciliation of patients' money and valuables in section 6.5 of this report.

Areas of good practice

There were examples of good practice found for example, in relation to the availability of a safe place to enable patients to deposit money or valuables for safekeeping, a written safe record was in place and the home administrator had participated in adult safeguarding training.

Areas for improvement

No areas for improvement were identified as part of 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.

Discussion with the home administrator established that no person associated with the home was acting as appointee for any patient. Monies for patients' personal expenditure or to pay for additional goods and services not covered by the weekly fee were deposited with the home by patients' representatives. Receipts were in place to record the deposit of cash; these were routinely signed by two people. However, there were instances when only one signature had been recorded. Advice was provided to ensure that staff are reminded of the importance of obtaining two signatures on deposit receipts.

Records of income and expenditure were available and a review of a sample of records established that these followed a standard financial ledger format. While the majority of transactions had been signed by two people, a number of transactions had only been signed by one person.

Ensuring that transactions in patients' income and expenditure records are signed by two people was identified as an area for improvement.

A review of the records identified that reconciliations of the balances of patients' cash held had been recorded. However, a sample of the reconciliations evidenced that these were routinely carried out by the home administrator and therefore only signed by one person. In addition, within a sample of the records, there were significant gaps of more than three months between the reconciliations of patients' monies. As noted in section 6.4 above, a safe contents record was in place however while the template used to record the safe contents had space for the record to be reconciled, there was no evidence presented that this had been completed.

An area for improvement was identified to ensure that records of patients' monies and valuables held within the safe place are reconciled, signed and dated by two people at least quarterly.

Hairdressing and chiropody treatments were being facilitated within the home. The nurse in charge provided a template which was previously used to capture hairdressing treatments; however this was not in use at the time of the inspection. Discussion established that the

hairdresser maintained a record of those patients whom she treated however this record was held by the hairdresser and the home did not maintain a copy.

A sample of chiropody treatment records were reviewed which detailed the majority of the information required by standard 14.13 of the Care Standards, however they were not consistently signed by the chiropodist and none of the records reviewed had been signed by a representative of the home to verify that the patient had received the treatment.

An area for improvement was identified to ensure that treatment records are maintained in the home in the manner as set out within standard 14.13 of the Care Standards for Nursing Homes, 2015.

The inspector discussed with the nurse in charge how patients' property (within their rooms) was recorded and requested to see a sample of the property records maintained for three patients. The nurse in charge provided each of the records for the patients selected. One record had been dated and signed by two people; the remaining two records had been signed and dated by one person. The records were dated December 2017, February 2017 and May 2018. There was no evidence presented to identify that the records had been reconciled quarterly.

The inspector highlighted that each patient's record of furniture and personal possessions should be reconciled, signed and dated by two people at least quarterly. This was identified as an area for improvement.

A review of a sample of charges to patients or their representatives identified that the correct charges had been raised in respect of care and accommodation costs. The home administrator confirmed that the home did not operate a comfort fund or a transport scheme and no bank accounts were managed on behalf patients in the home.

Areas of good practice

There were examples of good practice found in relation to the existence of income and expenditure records and a sample of charges to patients or their representatives were correct.

Areas for improvement

Four areas for improvement were identified during the inspection in relation to: ensuring that transactions in patients' income and expenditure records are signed by two people; ensuring that records of patients' monies and valuables held within the safe place are reconciled, signed and dated by two people at least quarterly; ensuring that treatment records are maintained in the home in the manner as set out within standard 14.13 of the Care Standards for Nursing Homes, 2015 and ensuring that each patient's record of furniture and personal possessions is reconciled, signed and dated by two people at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	4

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.

Discussion with the home administrator established that arrangements to appropriately support patients with their money would be discussed with the patient or their representative at the time of the patient's admission to the home.

Discussion with the nurse in charge established that the home had a range of methods in place to encourage feedback from patients or their representatives in respect of any issue. These included getting feedback from patients' relatives and friends, an "open-door" policy, the home's complaints policy, the annual care management reviews.

Areas of good practice

There were examples of good practice found in respect of the arrangements in place to support individual patients discussed during the inspection and mechanisms to obtain feedback and views from 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 service user guide provided a range of information for new patients including the general arrangements for safeguarding patients' monies and valuables in the home.

A range of written policies and procedures were in place to guide financial practices in the home and the home administrator confirmed that policies were in place addressing complaints management and whistleblowing. A review of the home's policies in respect of "Resident's property" and "Financial procedures" were both dated August 2015 and were therefore outside of the three year time period for the review of policies and procedures. An area for improvement was identified in respect of updating the financial policies and procedures.

Discussion with the home administrator established that she was familiar with the home process regarding the receipt of a complaint and knew how to escalate any concerns under the home's whistleblowing procedures.

A sample of three patients' files was selected and a review of these identified that two of the three patients had a signed written agreement on their files; these had been updated to reflect

the most recent changes in fees in 2018. The third patient whose records had been sampled did not have a written agreement in place. The home administrator explained that she had endeavoured to obtain the signed agreement from the patient's representative however had been unsuccessful to date. While the home administrator could explain the rationale as to why the patient did not have an agreement, there was no evidence in place to identify that an agreement had been provided and if so when and what follow up actions the home had taken to pursue the matter.

An area for improvement was identified in relation to ensuring that there is evidence that each patient or their representative has been provided with an individual written agreement setting out the terms and conditions of their residency in the home. Advice was also provided in feedback with respect to ensuring that patient agreements clearly detail by whom fees will be paid to the home.

The sample of three patients' files was reviewed to identify whether they contained a personal monies authorisation detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services. Both of the patients' agreements which were reviewed also included a personal monies authorisation document. As the third patient whose records were sampled did not have a written agreement in place, they therefore did not have a personal monies authorisation document in place. This was identified as an area for improvement.

The inspector discussed with the nurse in charge the arrangements in place in the home to ensure that patients experienced equality of opportunity and that staff members were aware of equality legislation whilst recognising and responding to the diverse needs of patients. The nurse in charge confirmed that this issue was covered by e-learning training which staff participated in and by the home's focus on person-centred care.

Areas of good practice

There were examples of good practice found: the home administrator confirmed that she was familiar with the home complaints process and the process for escalating any concerns under the home's whistleblowing procedures. The home's service user guide contained a range of information for a new patient and there were arrangements in place to ensure patients experienced equality of opportunity.

Areas for improvement

Three areas for improvement were identified as part of the inspection in relation to: ensuring that there is evidence that each patient or their representative has been provided with an individual written agreement setting out the terms and conditions of their stay in the home; ensuring that each patient is provided with personal monies authorisation for signature detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services and ensuring that financial policies and procedures are updated.

	Regulations	Standards
Total number of areas for improvement	1	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the general manager, the nurse in charge and the home administrator, at the conclusion 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 DHSSPS 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 5 **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall ensure that there is evidence that each patient or their representative has been provided with an individual written agreement setting out the terms and conditions of their residency in the home. Ref: 6.7
	Response by registered person detailing the actions taken: Residents or their representatives are given a pack which includes all agreements which is completed on admission. In exceptional circumstances where it cannot be completed, this is recorded showing dates documents issued.
Action required to ensure compliance with the Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 14.12 **Stated:** First time **To be completed by:** 28 February 2019 and at least quarterly thereafter	The registered person shall ensure a reconciliation of patients' personal monies and valuables in the safe place are carried out and signed and dated by two people at least quarterly. Ref: 6.5
	Response by registered person detailing the actions taken: A reconciliation of residents' items held in the safe is carried out on a quarterly basis and signed and dated by two staff.
Area for improvement 2 **Ref**: Standard 14.10 **Stated:** First time **To be completed by:** 14 February 2019	The registered person shall ensure that each transaction in the patients' income and expenditure records are signed by two people. Ref: 6.5
	Response by registered person detailing the actions taken: Two staff continue to sign all transactions in residents' income and expenditure records.
Area for improvement 3 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 14 February 2019	The registered person shall ensure that hairdressing and podiatry treatment records are maintained in the home and detail the information required by standard 14.13. Ref: 6.5
	Response by registered person detailing the actions taken: An amended template is in place to verify hairdressing and podiatry treatments and any associated cost to the residents.
Area for improvement 4 **Ref**: Standard 14.26	The registered person shall ensure that records of patients' furniture and personal possessions which they have brought to their rooms are reconciled and signed and dated by a staff member and countersigned

Stated: First time **To be completed by:** 13 April 2019	by a senior member of staff at least quarterly. Ref: 6.5
	Response by registered person detailing the actions taken: An amended template is in place to record residents' furniture and possessions and will be updated for each resident and will be reconciled on a quarterly basis.
Area for improvement 5 **Ref**: Standard 36.4 **Stated:** First time **To be completed by:** 13 April 2019	The registered person shall ensure that financial policies and procedures are subject to review at least every three years. Ref: 6.7
	Response by registered person detailing the actions taken: All policies are reviewed on a three yearly cycle.
Area for improvement 6 **Ref**: Standard 14.6 **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall ensure that each patient is provided with a personal monies authorisation record for signature detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services. Ref: 6.7
	Response by registered person detailing the actions taken: A personal monies authorisation form is included in the pack given to residents or their representatives on admission. In exceptional circumstances where it cannot be completed, this is recorded showing dates documents issued.

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