Unannounced Finance Inspection Report
06 September 2018

Slieve Dhu

Type of Service: Nursing Home
Address: 43 Bryansford Road, Newcastle, BT33 0DW
Tel No: 028 4372 5118
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 47 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: Slieve Dhu **Responsible Individuals:** Micheal Rodgers	**Registered manager:** Mandy Lacey
Person in charge at the time of inspection: Mandy Lacey	**Date manager registered:** 11 March 2015
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:** 47 There shall be a maximum of 5 named residents receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 206 September 2018 from 10.40 to 13.40 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; access was limited to authorised persons
- a sample of income and expenditure transactions recorded agreed to the supporting evidence (such as a treatment record and deposit receipt)
- there were mechanisms to listen to and take account of the views of patients and their representatives in respect of any issue
- 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 or evidence that amendments to the agreement had been shared with patients or their representatives
- personal authorisation documents were in place
- written policies and procedures easily accessible; and
- the registered manager was able to describe specific examples of how patients experienced equality of opportunity.

Areas requiring improvement were identified in relation to:

- ensuring that a standard financial ledger format is used when recording income and expenditure on behalf of patients (in particular that two signatures are recorded against each transaction);
- ensuring that podiatry treatments are signed by the person providing the treatment and countersigned by a member of staff; and
- ensuring that each patient's record of their furniture and personal possessions is kept up to date. This record is 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	3

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

4.2 Action/enforcement taken following the most recent finance inspection dated 17 October 2013

A finance inspection was carried out on 17 October 2013; the findings from which were not brought forward to the inspection on 06 September 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 registered 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 registered manager 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:

- Two 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 treatment records in respect of hairdressing and podiatry treatments facilitated in the home
- Three patients' records of furniture and personal possessions (in their rooms)
- A sample of written policies and procedures including:
    - "Whistleblowing" November 2017
    - "Resident comfort fund policy" incorporating "Resident financial and comfort fund arrangements policy" March 2017
    - "Record Keeping policy" March 2017

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 17 May 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.

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last finance inspection dated 17 October 2013

As noted above, a finance inspection was carried out on 17 October 2013; the findings from which were not brought forward to the inspection on 06 September 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 registered manager and the home administrator who confirmed that adult safeguarding training was mandatory for all staff members. The home administrator confirmed that she had most recently received this training in April 2017. It was also noted that the office manager and the second home administrator, both of whom were not on duty during the inspection, had received this training in September 2018 and April 2017 respectively.

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. On the day of inspection, cash and a number of valuables were being secured within the safe place.

A written record of the items safeguarded within the safe place was available, records were available which evidenced that the items were checked and signed and dated by two staff members every month. A trace of several valuables and cash balances for patients identified that these 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; access was limited to authorised persons and a written safe record was in place which was checked 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 registered manager and home administrator established that no representative of the home was acting as appointee for any patient (ie: 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.

The home administrator described how family members deposited monies for expenditure on identified goods and services on behalf of each patients. Deposit receipts were provided to any person making a deposit; these were routinely signed by two persons. Income and expenditure receipts were maintained for any patient for whom the home handled cash as described above. A review of the records identified that they contained the majority of the information as set out within the Care Standards for Nursing Home (2015) however transactions were routinely initialled by one staff member. Transactions are required to be signed and dated by two people.

Ensuring the each transaction in the patients' income and expenditure records are signed and dated by two people was identified as an area for improvement.

A sample of transactions was chosen to ascertain whether the relevant supporting evidence was available; this review established that the relevant evidence was in place. Evidence was also available to identify that patients' cash balances secured within the safe place were checked and signed and dated by two staff members every month.

Hairdressing and private podiatry treatments were being facilitated within the home and a sample of recent treatment records was reviewed. Routinely, the hairdressing treatment records detailed the information required by the Care Standards for Nursing Homes (2015) however the majority of the podiatry treatment records reviewed were not signed by the podiatrist or by a member of staff, as is required.

An area for improvement was identified to ensure that treatment records include all of the details as required by the Care Standards.

The inspector discussed with the home administrator how patients' property (within their rooms) was recorded and was informed that each patient had a record. A book containing the records was provided and three patients' names chosen before reviewing the content of the book. Each of the patients had a record in place; however these evidenced weaknesses in the record keeping. Each of the records was only signed by one person (as opposed to two) and there was no evidence that the records had been updated since the original entries had been made.

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 patients' comfort fund was in place and a bank account was in place to manage the fund. The home administrator advised that the office manager oversaw the administration of the fund. Following the inspection, the office manager was contacted. It was confirmed that the bank account used to administer the fund was named appropriately.

Discussions with the registered manager established that the home did not operate a transport scheme.

Areas of good practice

There were examples of good practice found in relation to expenditure transactions recorded in respect of goods or services required by patients which are not covered by the weekly fee. A sample of transactions could be traced in support of this process and reconciliations were recorded monthly.

Areas for improvement

Three areas for improvement were identified during the inspection in relation to ensuring that treatment records are signed by the person providing the treatment and a member of staff who is in a position to verify the patient received the treatment; records in respect of patients' furniture and personal possessions are required to be kept up to date, signed and dated by a staff member and senior member of staff at least quarterly; and ensuring that two signatures are recorded against every transaction in the patients' income and expenditure records (ie: a standard financial ledger format).

	Regulations	Standards
Total number of areas for improvement	0	3

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 registered manager and the home administrator. These discussions established that the home had measures in place to be flexible to respond to the individual needs and preferences of patients.

Discussions with the home administrator established that arrangements to pay fees and handle safeguard patients' monies in the home, would be discussed with the patient or their representative at the time a patient was admitted to the home.

Discussion with the registered 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 included relatives' meetings, monthly "residents" meetings, and operating an "open-door" policy in the home.

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.

Written policies were reviewed including those in respect of whistleblowing, record keeping, managing patients' monies and the administration of the patients' comfort fund. 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 two patients had a signed agreement on their file which had been updated in 2018 to reflect the change in the regional rates in April 2018.

Letters were on file evidencing how these changes had been communicated appropriately to patients or their representatives. One patient did not have a signed agreement on file (however the letters as described above were on file). Discussions established that the patient's representative had not returned the agreement to the home. Advice was provided to the registered manager in respect of having a mechanism to follow up on any outstanding signed agreements and to considering keeping a copy of the agreement (as sent out for signature) on file.

A review of the files for each of the three patients identified that personal expenditure authorisation documents were in place providing the home with written authority to spend the patient's money on deposit with the home on identified goods and services.

The inspector discussed with the registered manager 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 residents. The registered manager was able to describe specific examples of the way this was achieved.

Some of the areas of equality awareness identified during the inspection included: comprehensive pre-admission assessments; discussion during new staff inductions, and the home's activities therapist engaging with each patient to establish which activities the individual patients would enjoy.

Areas of good practice

There were examples of good practice found in relation to: the home administrator's knowledge in relation to responding to a complaint or escalating a concern under the home's whistleblowing procedures; patient records selected as part of the sample had a signed written agreement with the home or evidence that agreements had been updated to reflect any changes, with the updated agreements shared for signature, personal authorisation documents were in place; written policies and procedures easily accessible; and the registered manager was able to describe specific examples of how patients experienced equality of opportunity.

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 Mandy Lacey, registered 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 14.10 **Stated:** First time **To be completed by:** 07 September 2018	The registered person shall ensure that a standard financial ledger format is used to clearly and accurately detail transactions for residents. The format captures 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 withdrawal; the amount; the running balance of the resident's cash total held; and the signatures of two persons able to verify the entry on the ledger. Ref: 6.5
	Response by registered person detailing the actions taken: A new financial ledger format has been implemented which includes all the recommended information. We have implemented a folder system whereby each resident that we hold money for has an individual sheet with the required info detailed on it along with two signatures . Draft template sent to Inspector and approved .
Area for improvement 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 07 September 2018	The registered person shall 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. Ref: 6.5
	Response by registered person detailing the actions taken: The Podiatry form has now been updated and in use with the required info detailed including two signatures to verify the treatment completed and the cost to each resident .
Area for improvement 3 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 18 October 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: The current property list has been amended to include all the recommended items of belongings and will be reviewed quarterly.

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

The Regulation and Quality Improvement Authority

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