Unannounced Finance Inspection Report
13 September 2018

Strathearn Court

Type of Service: Nursing Home (NH)
Address: 229 Belmont Road, Belfast, BT4 2AH
Tel No: 028 9065 6665
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 55 beds that 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: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** Ruth Murphy
Person in charge at the time of inspection: Ruth Murphy	**Date manager registered:** 28 April 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:** 55

4.0 Inspection summary

An unannounced inspection took place on 13 September 2018 from 10.30 to 13.30 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 existence of a separate patient bank account and comfort fund bank account; records of income, expenditure and reconciliation (checks) were available including supporting documents; arrangements were in place to support patients with their monies; mechanisms were available to obtain feedback from patients and their representatives; 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, detailed written policies and procedures were in place to guide financial practices in the home and there were mechanisms in place to ensure that patients experienced equality of opportunity.

An area requiring improvement was identified in relation to ensuring that patients' personal property records are reconciled and signed and dated by two people 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 shared with the registered manager 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 registered manager and the home administrator.

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:

- A sample of income, expenditure and reconciliation records
- A sample of bank statements in respect of the patients' pooled bank account
- A sample of comfort fund records
- A sample of written financial policies and procedures
- A sample of patients' personal property records (in their rooms)
- A sample of patients' individual written agreements
- A sample of patients' "financial assessment" documentation
- 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 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 18 July 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 October 2014

A finance inspection of the home was carried out on 20 October 2014; the findings from which were not brought forward to the inspection on 13 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 registered manager confirmed that adult safeguarding training was mandatory for all staff in the home; the home administrator had participated in adult safeguarding training in April 2018.

Discussions with the registered manager 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 contents record “FSHC Valuables record” was in place to detail the contents of the safe; this had been reconciled and signed and dated by two people in September 2018.

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 and a written safe contents record.

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 registered manager and home administrator established that no person associated with the home was acting as appointee for any patient. It was noted that the home was not in direct receipt of the personal monies for any patient. For the majority of patients, 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 family members.

Records of income and expenditure were available for patients, including supporting documents e.g.: a lodgement receipt or an expenditure receipt. A sample of transactions was chosen to ascertain whether the supporting documents were available within the records, and for the sample chosen, these were found to be in place. Evidence was in place identifying that those depositing monies routinely received a receipt which was signed by two people.

As noted above, records of income and expenditure were available detailing that reconciliations, signed by two members of staff were available in the home, the most recent record of reconciliation available in the home was dated 07 September 2018 in respect of the August month-end.

A patients' pooled bank account was in place to administer patients' monies. The account was named appropriately and records were available to evidence that the account was reconciled and signed and dated by two people on a monthly basis.

Hairdressing and chiropody treatments were being facilitated within the home and a sample of these treatment records was reviewed. The sampled records routinely detailed the information required to be recorded by the care standards.

The inspector discussed with the home administrator how patients' property (within their rooms) was recorded and requested to see a sample of the property records maintained. The home administrator provided the records for four patients and it was noted that each patient had a record of personal property on their files entitled "Schedule of personal effects". Within the sample, there was limited evidence of updating, and the records evidenced inconsistency in respect of signing and dating the records. Two of the four records had been signed by two people (as is required), only one record had been dated.

It was highlighted that these records should be reconciled and signed and dated by a staff member and countersigned by a senior member of staff on at least a quarterly basis.

This was identified as an area for improvement.

The home administrator confirmed that the home operated a comfort fund. A separate bank account, which was appropriately named, was also in place. The cash and banking records in respect of the fund had been reconciled and signed and dated by two people on 08 September 2018 for the August month-end.

The registered manager confirmed that the home did not operate a transport scheme.

Areas of good practice

There were examples of good practice found in relation to the existence of a separate patient bank account and comfort fund bank account; and records of income, expenditure and reconciliation were available including supporting documents.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that patients' personal property records are reconciled and signed and dated by two people 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.

Day to day arrangements in place to support patients were discussed with the registered manager and the home administrator. They described a range of examples of how the home supported patients with their money. Discussion 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 registered manager established that the home had a range of methods in place to encourage feedback from patients or their representatives in respect of any issue. This included relatives' meetings, day to day verbal feedback and the home's "Quality of Life" initiative.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. This established that there were arrangements in place to ensure that the individual needs and wishes of patients could be met in this regard.

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.

Written policies and procedures were in place to guide financial practices in the home. Policies were in place addressing areas of practice including general record keeping, confidentiality, the administration of the patients' comfort fund and the management of patients' personal allowance monies.

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

Individual patient agreements were discussed with the home administrator and a sample of four patients' finance files were requested for review. A review of the information established that each of the four patients sampled had a signed individual written agreement with the home. In addition, annual updates to each patient's original agreement with the home were held on each patient's file. These amendment documents detailed the changes to the (regional) fees over time and had been shared for signature with patients or their representatives. Good practice was observed in this regard.

A review of the information on file for the four patients whose files were sampled, identified that documents entitled "financial assessment part 3" were in place setting out the express authority granted to the home to spend the patient's money on identified goods and services.

A review of the documents on file for the four patients evidenced that all four patients had this document on file which had been signed by their respective representatives.

The inspector discussed with the registered manager the arrangements in place in the home to ensure that residents experienced equality of opportunity and that staff members were aware of equality legislation whilst recognising and responding to the diverse needs of patients. The registered manager was able to describe examples of the way this was achieved within the home. She noted that all staff participated in "equality and diversity" e-learning as well as adult safeguarding training and that the home had a "valuing diversity" policy and procedure.

Areas of good practice

There were examples of good practice found: 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 and detailed written policies and procedures were in place to guide financial practices in the home and there were arrangements in place to ensure 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 Ruth Murphy, registered manager, 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 DHSSPS Care Standards for Nursing Homes (April 2015)	
Area for improvement 3 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 13 November 2018	The registered person shall ensure that an inventory of property belonging to each patient 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 inventory record of valuable property belonging to each patient is now being reconciled quarterly, signed by the staff member undertaking the reconciliation and countersigned by senior staff. A template has been produced for completion dates of checks to be monitored by the Home Manager.

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

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