Spa Nursing Home
RQIA ID: 1301
77-79 Grove Road
Ballynahinch
BT24 8PW

Inspector: Briege Ferris
Inspection ID: IN024032

Tel: 02897562578
Email: Jocelyn.leyson@spanursing.co.uk

Unannounced Finance Inspection
of
Spa Nursing Home

6 January 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced finance inspection took place on 6 January 2016 from 09:30 to 14:00. A poster detailing that the inspection was taking place that day was positioned at the entrance to the home.

Overall on the day of the inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were some areas identified for improvement, which are set out in the Quality Improvement Plan (QIP) appended to this report. This inspection was underpinned by the Nursing Homes Regulations (Northern Ireland) 2005.

We met with the registered manager, Mrs Jocelyn Leyson-Bagood, and two members of nursing staff; no relatives or visitors chose to meet with us during the inspection. We would like to thank those who participated in the inspection for their co-operation.

The home accommodates those requiring both residential and nursing care; for the purposes of this report, the term "patient" shall be used throughout.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	7

The details of the QIP within this report were discussed with the registered manager, Mrs Jocelyn Leyson-Bagood, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Spa Nursing Homes Ltd/Chris Arnold	**Registered Manager:** Mrs Jocelyn Leyson-Bagood
Person in Charge of the Home at the Time of Inspection: Ms Nicola Boyd (Nurse in Charge)	**Date Manager Registered:** 12 August 2009
Categories of Care: RC-I, RC-PH, RC-PH(E), NH-TI, NH-PH, NH-I, NH-PH(E)	**Number of Registered Places:** 36
Number of Patients Accommodated on the Day of Inspection: 26	**Weekly Tariff at Time of Inspection:** £470.00 - £593.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following theme has been met:

Inspection Theme: Patients' finances and property were appropriately managed and safeguarded

Statement 1
The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care.

Statement 2
Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained.

Statement 3
A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained.

Statement 4
Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with the home manager and two members of nursing staff
- Review of records
- Evaluation and Feedback

Prior to inspection the following records were analysed:

- Records of incidents notified to RQIA in the last twelve months, none of which were finance related

The following records were reviewed during the inspection:

- The Residents' Guide
- The home's policy on "Pre-admission/Admission of a Resident/Emergency Admission"
- The home's policy on "Control of Residents' Personal Property/Valuables/Monies"
- The home's policy on "Management of Residents' Financial Affairs"
- The home's policy on "Accounts and Financial Control"
- Four patients' files
- The most recent HSC trust payment remittance
- Confirmation of correct fees charged to a sample of patients for care/accommodation
- A sample of Income/lodgements and expenditure, including comfort fund records
- A sample of hairdressing treatment receipts
- Four records of patients' personal property/inventory in their rooms

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection carried out on 12 November 2015; we were not required to follow up on any matters related to the previous inspection.

5.2 Review of Requirements and Recommendations from the Last Finance Inspection

There has been no previous finance inspection of the home.

5.3 Statement 1 - The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Is Care Safe?

A resident guide was available which detailed significant information for patients on the general terms and conditions of residency. A standard written agreement, "Residents' Agreement," was in place. The registered manager confirmed that an individualised copy of the terms and conditions is provided to each newly admitted patient. We read a copy of the most up to date standard agreement provided by the registered manager and noted that some necessary elements were absent. We discussed this with the registered manager and noted that she should compare the home's agreement with the items required in the minimum standards to ensure that all the elements were included.

A recommendation was made in respect of this finding.

We selected a random sample of four patients in order to view the agreements in place between the home and those patients. The registered manager provided the care files for the selected patients; however, on reviewing the files, only one of the four patients had a signed agreement on their file. We queried this with the registered manager who explained that she had archived a number of documents. The registered manager endeavoured to locate the agreements for the selected patients; however, by the end of the inspection; they could still not be located.

We highlighted that patients' records must be available in the home at all times for the purposes of inspection.

A requirement was made in respect of this finding.

We reviewed the one agreement which was available and noted that the agreement had been signed in 2012 and reflected the terms and conditions in place at that time. We noted that agreements must be kept up to date and agreement to the changes must be evidenced in writing by the patient or their representative.

A recommendation was made in respect of this finding.

Is Care Effective?

We queried whether there was any involvement by the home in supporting individual patients with their money; the home registered manager advised that there was no such involvement by the home.

We noted that the home have a number of policies and procedures in place addressing controls in place to safeguard patients' money and valuables.

Is Care Compassionate?

The registered manager advised that patients' agreements were updated annually; however, as noted above, we were not able to confirm this as previous agreements were not available for inspection.

Areas for Improvement

Overall on the day of inspection, financial arrangements in place were found to be contributing to safe, effective and compassionate care; however there were two areas identified for improvement which related to individual written agreements with patients and the availability of records in the home.

Number of Requirements	**1**	**Number Recommendations**:	**1**

5.4 Statement 2 - Arrangements for receiving and spending patients' monies on their behalf were transparent, have been authorised and the appropriate records were maintained

Is Care Safe?

Copies of HSC trusts' payment remittances are received directly to the organisation's head office in Belfast. Following the inspection, we contacted the organisation's head office and requested evidence that a sample of patients were being charged the correct amounts. This information was received and was satisfactory.

The registered manager confirmed that there were no Appointeeship arrangements in place with any of the current patients as it was not the home's policy to take over Appointeeship for any patient.

For the majority of the remaining patients, family representatives deposit money with the home for safekeeping in order to pay for hairdressing services. A review of the records identified that, while receipts were not routinely provided to anyone lodging cash, the person making the lodgement routinely countersigned the ledger as evidence of the details of the lodgement.

Records of income and expenditure for patients were maintained on "financial recording of residents' miscellaneous" which detailed transactions for individual patients. We noted that there were some shortcomings in the way the records were maintained; entries were written outside the margins of the page, entries were scribbled out and not initialled and entries were written on plain paper; we found the records to be generally disorderly. We discussed this with the registered manager and noted that she must ensure that staff are made aware of the importance of recording income and expenditure appropriately.

A recommendation was made in respect of this finding.

On reviewing the records, we also noted that there was no evidence of any reconciliations having been carried out. The registered manager stated that she spot checked the balances; however, we noted that this was insufficient as there was no written evidence of this, and we highlighted that reconciliations must be signed and dated by two people on at least a quarterly basis.

A recommendation was made in respect of this finding.

A review of the records identified that a hairdresser routinely visits the home to provide services to patients. Discussions established that the hairdresser provided an individual receipt for each patient treated which detailed the treatment provided, the cost and the signature of the hairdresser. The registered manager explained that the records are maintained in each patient's file as family members would ask for the receipts regularly. We therefore noted that the home did not retain this written evidence for the patients' financial records.

We noted that the home must ensure that a duplicate receipt of the treatment record is retained by the home. We also noted that treatment records should be signed by both the hairdresser and a member of staff in order to verify that the patient had received the service detailed and incurred the associated cost.

A recommendation was made in respect of this finding.

A review of the records established that that the home operates a fund for the benefit of the patients in the home called the "residents' fund". The registered manager advised that no cash was held in the home for the fund; monies received were sent to head office and requests for money were also therefore made to the organisation's head office. We noted that the home maintained a "financial record on residents funds" which detailed any income received directly by the home for the fund; records were routinely signed and dated by two people. There was no written evidence of any reconciliation of these monies, and as noted above a recommendation was made in respect of a similar finding during the inspection.

Is Care Effective?

We selected a sample of patient files in order to review whether there were written personal monies authorisations in place to evidence that the home had been given permission to spend the patient's money on identified goods and services.

Discussion with the registered manager established that written personal monies authorisations were not in place.

A recommendation was made in respect of this finding.

Is Care Compassionate?

We queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the registered manager confirmed that none of the patients had any known assessed needs or restrictions.

Areas for Improvement

Overall on the day of inspection, the financial arrangements in place were found to be contributing to safe, effective and compassionate care. However, there were four areas identified for improvement; these related to: how income and expenditure records are maintained by staff; recording reconciliations of money lodged for safekeeping by patients or their representatives; counter-signing records of hairdressing treatments facilitated within the home and ensuring that personal allowance authorisation documents for patients were provided for agreement and signature by each patient or their representative.

Number of Requirements	**0**	**Number Recommendations**:	**4**

5.5 Statement 3 - A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records were maintained

Is Care Safe?

A safe place exists within the home to enable patients to deposit cash or valuables; we were satisfied with the controls around the physical location of the safe place and the persons with access. We viewed the contents of the safe place and established that on the day of inspection, both cash and other items belonging to patients were deposited for safekeeping. We traced a sample of the cash balances to the cash in hand and noted that these agreed.

There was no written record available of the non-cash items being held in the safe place. We noted that the home did not have a safe record in place to record the contents of the safe place which had been deposited for safekeeping. We highlighted the importance of ensuring this was introduced and reconciled at least quarterly in order that a clear audit trail of movements into and out of the safe place was available.

A recommendation was made in respect of this finding.

Is Care Effective?

We enquired how patients' property within their rooms was recorded and requested to see a sample of the completed property records for four patients. The registered manager provided the records for four patients which we had selected. We noted that each patient had a template in place to record property in their rooms. Three of the records had been signed by one person and one record had been signed by two people; only three of the four records were dated.

We highlighted that any additions or disposals from patients' property records must be signed and dated by two people and that the Care Standards for Nursing Homes (2015) require that these records of patients' property in their rooms are updated at least quarterly and are signed and dated by two people.

We noted that the home must review and update these records for every patient in the home and ensure that they were kept up to date.

A recommendation has been made in respect of this finding.

Is Care Compassionate?

There were safe storage arrangements within the home to enable patients to deposit cash or valuables, should they wish to. We enquired as to how patients would know about the safe storage arrangements; the registered manager explained that during the pre-assessment process, before a person is admitted to the home, the arrangements for a prospective patient to bring any important items to the home is explained. The registered manager noted that the arrangements for the safekeeping of any money or valuables belonging to the patient are also explained, and the right of the patient to hold onto their own money while in the home is also emphasised.

Arrangements for patients to access their money from the safe place in the home outside of office hours were discussed. The registered manager explained that, at the present time, the needs of patients were such that access to their money during office hours was currently sufficient to meet their needs.

Areas for Improvement

Overall, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were two areas identified for improvement; these related to introducing a safe record and to improving the way in which patients' property was recorded.

Number of Requirements	**0**	**Number Recommendations**:	**2**

5.6 Statement 4 - Arrangements for providing transport to patients were transparent and agreed in writing with the patient/their representative

Is Care Safe, Effective and Compassionate?

On the day of inspection, the home did not operate a transport scheme for patients.

Areas for Improvement

No areas for improvement were identified in respect of Statement 4.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.7 Additional Areas Examined

There were no additional areas examined as part of the inspection.

6. Quality Improvement Plan

The issues identified during this inspection were detailed in the QIP. Details of this QIP were discussed with Mrs Jocelyn Leyson-Bagood, the registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered manager/Registered Person

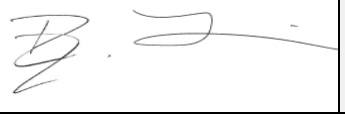
The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to finance.team@rqia.org.uk and assessed by us.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 19 (2) (b) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that the records referred to in paragraphs (1) and (2) – are at all times available for inspection in the home by any person authorised by the Regulation and Quality Improvement Authority to enter and inspect the nursing home. **Response by Registered Person(s)Detailing the Actions Taken:** All records are available for inspection.
Recommendations	
Recommendation 1 **Ref**: Standard 2.2 **Stated:** First time **To be Completed by:** 31 March 2016	The registered person should ensure that the content of the home's standard agreement is compared with Standard 2.2of the DHSSPS Minimum Standards to ensure that all of the required components are included. The home's agreement should be updated as necessary prior to issuing updated agreements to all patients in 2016. **Response by Registered Person(s)Detailing the Actions Taken:** Following the recent inspection the Residents' Agreement form is been reviewed and necessary components on the standard of agreement is also been included.
Recommendation 2 **Ref**: Minimum Standard 2.8 **Stated:** First time **To be Completed by:** From the date of the next change	The registered person should ensure that any changes to the individual agreement are agreed in writing by the patient or their representative. The individual agreement should be updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded. **Response by Registered Person(s)Detailing the Actions Taken:** An up to date Residents Agreement form is to be given to all residents/representative for this coming coming April 2016.Any changes are to be noted and recorded in each residents file. .
Recommendation 3 **Ref**: Minimum Standard 14.11 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person should ensure that records made on behalf of residents are legible and mistakes appropriately dealt with on the face of the ledger (i.e. a clear line crossed through the incorrect entry with an amendment on the line below and initialled by the member of staff recording the entry). Correcting fluid should never used to amend records. **Response by Registered Person(s)Detailing the Actions Taken:** All staff are made aware of the proper recording and a detailed legible records should be maintained at all times. Correcting fluids was never

	been used.
Recommendation 4 **Ref**: Standard 14.25 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person should ensure that a reconciliation of money and valuables held and accounts managed on behalf of patients is carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.
	Response by Registered Person(s)Detailing the Actions Taken: An evidence record will be maintained during reconcillations of money and valuables in behalf of residents.The quarterly audits will be sign by staff member and counter sign by the manager.
Recommendation 5 **Ref**: Standard 14.13 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person 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 patient or a member of staff of the home signs the treatment record or receipt to verify the treatment and the associated cost to each patient.
	Response by Registered Person(s)Detailing the Actions Taken: A treatment record or receipts were signed by staff member and the person providing the service are already inplaced.
Recommendation 6 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be Completed by:** 6 February 2016	The registered person should ensure that written authorisation is obtained from each patient or their representative to spend the patient's monies on pre-agreed expenditure. The written authorisation must be retained on the patient's records and updated as required. Where the patient or their representative is unable to, or chooses not to sign the authorisation, this must be recorded. Where a patient is managed by a HSC trust and does not have a family member or friend to act as their representative, the authorisation about their personal monies must be shared with the HSC trust care manager.
	Response by Registered Person(s)Detailing the Actions Taken: A written authorisation letter is obtained from each resident/family member/representative to spend the residents monies on pre-agreed expenditure are retained in each individual file.In the event the resident will not chooses or unable to sign the authorisation it will be recorded in residents care plan.
Recommendation 7 **Ref**: Standard 14.9, 14.25 **Stated:** First time **To be Completed by:** 6 February 2016 and at least quarterly thereafter	The registered person should ensure that there is a record of any money or valuables (including bank cards and gift cards) handed over by the resident for safekeeping (this record is signed and dated by the resident and the member of staff on receipt and return of the items). A reconciliation of money and valuables held and accounts managed on behalf of resident is carried out at least quarterly. The reconciliation is recorded and signed and dated by the staff member undertaking the reconciliation and countersigned by a senior member of staff.

	Response by Registered Person(s)Detailing the Actions Taken: The valubles handed by the residents/representative for safekeeping such as money, bankcards,giftcards are recorded and signed and dated by the member of staff on receipt and return of items. A records will be maintained for reconcilliation of money and valuables held in behalf of the resident.A quarterly checks of reconcillations will be carried out by the staff member undertaking the reconciliation signed and dated as well as countersigned by a senior member of staff
Recommendation 8 **Ref**: Standard 14.26 **Stated:** First/Second/Third time **To be Completed by:** **DD Month Year**	The registered person should ensure that an inventory of property belonging to each resident is maintained throughout their stay in the home. The inventory record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.
	Response by Registered Person(s)Detailing the Actions Taken: An inventory of residents property brought to the home upon admission was recorded and maintained in each residents file. All staff are made aware that inventory record must be signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.

Registered Manager Completing QIP	Jocelyn Bagood	**Date Completed**	24/4/16
Registered Person Approving QIP	Chris Arnold	**Date Approved**	24/2/15
RQIA Inspector Assessing Response		**Date Approved**	24/02/2016

Please ensure this document was completed in full and returned to finance.team@rqia.org.uk from the authorised email address