Unannounced Finance Inspection Report
27 June 2018

Tudordale

Type of Service: Nursing Home (NH)
Address: 294 Holywood Road, Belfast, BT4 1SG
Tel No: 028 9065 1336
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 45 beds that provides care for patients with a dementia.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** Rosalind Morrison
Person in charge at the time of inspection: Georgeta Rotaru (Deputy manager)	**Date manager registered:** 03 January 2018
Categories of care: Nursing Home (NH) DE – Dementia	**Number of registered places:** 45

4.0 Inspection summary

An unannounced inspection took place on 27 June 2018 from 10.00 to 14.10 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; 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 and detailed written policies and procedures were in place to guide financial practices in the home.

Areas requiring improvement were identified in relation to ensuring that: a written safe record is introduced which should be reconciled and signed and dated by two people at least every quarter; treatment records or additional services facilitated within the home are signed by a representative of the home to verify that the treatment has been provided to the patient; patients' personal property records are reconciled and signed and dated by two people at least quarterly; any change to a patient's agreement including fees and financial arrangements is agreed in writing by the patient or their representative and that personal monies authorisation documents are in place for all relevant patients.

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	5

Details of the Quality Improvement Plan (QIP) were shared with the registered manager following 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 deputy manager and the home administrator.

The inspector provided to the deputy 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' 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 following the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 February 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 21 March 2013

A finance inspection of the home was carried out on 21 March 2013; the findings from which were not brought forward to the inspection on 27 June 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 deputy manager confirmed that adult safeguarding training was mandatory for all staff in the home; the home administrator had participated in adult safeguarding training in 2017.

Discussions with the deputy 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.

However, the home had no written safe record in place to record and check the contents of the safe place.

Ensuring that a written safe record is introduced which is reconciled and dated by two people at least quarterly was identified as an area for improvement.

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.

Areas for improvement

One area for improvement was identified as part of the inspection in relation to the introduction of a written safe record.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Discussion with the deputy 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 31 May 2018, (these were routinely completed at each 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, barbering and chiropody treatments were being facilitated within the home and a sample of these treatment records was reviewed. Records detailed the majority of the information to be recorded by the care standards. However, within the sample it was identified that records were not consistently signed by a member of staff to confirm that the treatments detailed had been received by the patients.

This was identified as an area for improvement.

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 three 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. Only one of the three records had been dated and all three records were unsigned.

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. On the basis of the records available in the home, the bank account had most recently been reconciled in May 2018.

The deputy 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

Two areas for improvement were identified during the inspection. These related to ensuring that treatment records or additional services facilitated within the home are signed by a representative of the home to verify that the treatment has been provided to the patient and 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	2

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 deputy 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 deputy 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 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 home administrator. 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, whistleblowing, confidentiality, and the management of patients' personal allowance monies.

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 whistleblowing procedures.

Individual patient agreements were discussed with the home administrator and a sample of patients' agreements was requested for review. A review of the information established that each of the three patients sampled had a signed individual written agreement with the home. However, the agreements (or updates to the original signed agreements) were dated either 2017 or 2016 and therefore did not reflect the update to date terms and conditions in respect of the patients' residency in the home. The regional uplift in fees is effective from April each year and therefore agreements were not up to date to reflect 2018/2019 fee arrangements for the selected patients.

An area for improvement was identified to ensure that each patient is provided with an up to date written agreement and which is kept up to date to reflect all changes (which should be agreed in writing with the patient or their representative).

A review of the documents on file for the three patients whose files were sampled, identified that documents entitled "financial assessment part 1, 2 and 3" were in place setting out the funding arrangements for the patient, (1) the control of the patient's personal allowance monies (2) and any express authority granted to the home to spend the patient's money on identified goods and services (3).

A review of the documents on file for the three patients evidenced that this area required improvement. Two of the three patients had part 1 on their file; all three patients had signed parts 2 and 3 on their files (however included within this sample were documents dated 2005, 2006 or which were not completed).

The registered person should ensure that where the home manage the personal money of any patient or make any purchases of goods or services on behalf of a patient, that there is written authority to do so, which should be signed by the patient or their representative. These documents should be kept up to date to reflect any changes in how a patient's money is managed (or otherwise) by the home.

This was identified as an area for improvement.

The inspector discussed with the deputy 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 residents. The deputy manager was able to describe examples of the way this was achieved within the home. She noted that training was provided for staff in this regard and that patient-centred care was critical to ensure that the wishes of individual patients were known and respected.

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.

Areas for improvement

Two areas for improvement were identified as part of the inspection. These related to ensuring that any change to a patient's agreement including fees and financial arrangements are agreed in writing by the patient or their representative and ensuring that personal monies authorisation documents are in place for all relevant patients.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were shared with Rosalind Morrison, registered manager, following 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 1 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 27 July 2018	The registered person shall ensure that a written safe record is in place to record the contents of the safe place. The safe contents should be reconciled to the record and be signed and dated by two people at least every quarter. Ref: 6.4
	Response by registered person detailing the actions taken: A written safe record is in place recording the contents of the safe, two people sign the record when the contents are reconciled quarterly.
Area for improvement 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 28 June 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 patient or a member of staff of the home signs the treatment record or receipt to verify the treatment of goods provided and the associated cost to each patients. Ref: 6.5
	Response by registered person detailing the actions taken: The receipts are signed by the service provider and the Home Administrator or a member of staff in order to verify the goods/service provided and cost to each patient.
Area for improvement 3 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 10 August 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: An inventory of the property of each patient is currently being maintained throughout their stay and reconciled at least quarterly, the record is signed by a staff member and countersigned by a senior member of staff.

Area for improvement 4 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 10 August 2018	The registered person shall ensure that each patient is given written notice of all changes to the agreement and these are agreed in writing by the patient or their representative. Where the patient or their representative is unable to sign or chooses not to sign, this is recorded. Ref: 6.7
	Response by registered person detailing the actions taken: The appropriate letter of notice of all changes to the agreement is issued and agreed in writing by the patient's representative, where it is not signed or going to be signed this will also be recorded.
Area for improvement 5 **Ref**: Standard 14.6,14.7 **Stated:** First time **To be completed by:** 10 August 2018	The registered person shall ensure that where the home manage the personal money of any patient or make any purchases of goods or services on behalf of a patient, that there is written authority to do so. Ref: 6.7
	Response by registered person detailing the actions taken: We will ensure that in the event that we manage personal allowance of any patient and make purchases of goods that we will have written authority to do so.

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

The Regulation and Quality Improvement Authority

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