The Regulation and Quality Improvement Authority

Unannounced Finance Inspection Report
25 September 2018

Victoria

Type of Service: Nursing Home
Address: 22-24 Windsor Park, Belfast, BT9 6FR
Tel No: 028 9066 8437
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 33 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: Victoria Responsible Individuals: Robert and Helen Lynas	Registered manager: Helen Chambers
Person in charge at the time of inspection: Helen Chambers	Date manager registered: 20 November 2008
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: 33 There shall be a maximum of 1 named resident receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 25 September 2018 from 11.00 to 13.00 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
- 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
- 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 (and balance checks) on behalf of patients (in particular that two signatures are recorded against each transaction);

- 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 and
- ensuring that each patient is provided with an individual written agreement setting out the terms and conditions of their residency in the home.

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	2

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 21 February 2013

A finance inspection was carried out on 21 February 2013; the findings from which were not brought forward to the inspection on 25 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:

- The home's statement of purpose and service user guide
- A sample of income and expenditure and reconciliation (check) records maintained on behalf of patients
- Three patients' records of furniture and personal possessions (in their rooms)
- A record of the charges being made to one patient
- A sample of written policies and procedures including:
    - "Staff whistle blowing" reviewed February 2018
    - "Record keeping – communication & nursing care" dated June 2016
    - "Policy in relation to clients finances" contained within the service user guide

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 19 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 21 February 2013

As noted above, a finance inspection was carried out on 21 February 2013; the findings from which were not brought forward to the inspection on 25 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 received this training in March 2018.

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 was being held for four patients. The registered manager reported that two items belonging to a patient had been deposited in the safe place the previous day. The inspector verified that these items were secured within the safe place and the details of the deposit written on an envelope. Advice was provided to the registered manager and administrator that these items deposited the previous day should be recorded on a formal safe register/record which should be checked at least every quarter to the contents of the safe place and be signed by two people.

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.

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 for patients to spend independently. It was established that the home did not make any purchases of goods or services on behalf of patients. The registered manager confirmed that the cost of private podiatry and wheelchair taxis was met by the home. The registered manager noted that a member of staff provided hairdressing treatments to the patients when required.

Records were in place to record the receipt of monies deposited by family members on the above basis. On the day of inspection, records were in place for four patients for whom monies were routinely held. A review of the records evidenced that a template was being used to detail the receipt of monies and signing out of monies, the template had columns in a standard financial ledger format. However, all of the columns in the template were not routinely completed; only one signature was being recorded against each transaction. Equally, checks of the balances on deposit which were being carried out approximately every two weeks were being signed only by the administrator.

It was noted in feedback that these records should be signed and dated by two people (as should the reconciliations which were also being recorded by one person). This was identified as an area for improvement.

The inspector discussed with the home administrator how patients' property (within their rooms) was recorded and was informed that each patient had a record on their care files. The files were provided for review and it was noted that each patient had a form of property record on

their file, albeit that these had been recorded in different formats for the patient records selected as part of the sample.

One patient's record had been made on plain paper and had not been signed, although it had been dated March 2018, there was no evidence of any subsequent update to the record. A second patient's record had been made on a template entitled "Inventory of service user's property". This record had been signed by one person and was dated February 2011; there was no evidence that it had been subsequently updated. The final patient's record which was sampled was entitled "Client's inventory" and ran to three pages. The first page was signed and dated November 2015; again there was limited evidence available to confirm that the record had been updated.

These findings were provided to the registered manager at the conclusion of the inspection and it was highlighted that 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.

Discussions with the registered manager established that the home did not operate a transport scheme or a patients' comfort fund.

Areas of good practice

There were examples of good practice found in relation to the availability of income and expenditure transactions recorded and the frequency of balance checks performed.

Areas for improvement

Two areas for improvement were identified during the inspection in relation to ensuring that two signatures are recorded against every transaction in the patients' income, expenditure and reconciliation records (ie: a standard financial ledger format) and ensuring that 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.

	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.

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 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 an annual quality assurance questionnaire and the operation of 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 in place including those in respect of whistleblowing, record keeping and managing patients' monies. 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 registered manager regarding the individual written agreements in place with patients and the home and a sample of three patient agreements were requested. However the registered manager reported that patient agreements were not in place as they had not been updated in several years. She noted that "old agreements" may be in the home's archive storage however no agreements were produced for review by the inspector. There was therefore no evidence presented that patients or their representatives had been provided with an individual written agreement setting out the terms and conditions of the residency in the home as is required under the Nursing homes regulations (Northern Ireland) 2005.

Ensuring that each patient is provided with an up to date written agreement was identified as an area for improvement.

The inspector was provided with a copy of the home's statement of purpose which included a generic patient agreement. A cursory review of this document established that it did not in its current form include all of the information set out within standard 2.2 of the Care Standards for Nursing Homes (2015) which sets out the minimum content of a patient agreement.
The inspector signposted the registered manager to this standard to ensure that the home's generic template would be compared with this standard and updated as necessary prior to sharing written agreements with patients.

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 such as comprehensive pre-admission assessments and individualised care plans setting out the needs, wishes and preferences of each patient.

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, written policies and procedures to guide financial practices in the home were easily accessible and had been reviewed within the last three years and the registered manager was able to describe specific examples of how patients experienced equality of opportunity.

Areas for improvement

One area for improvement was identified as part of the inspection in relation to ensuring that each patient is provided with an up to date written agreement.

	Regulations	Standards
Total number of areas for improvement	1	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 Helen Chambers, 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time **To be completed by:** 25 October 2018	The registered person shall ensure that each patient is 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: written agreements now being rolled out to clients or their representatives.
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:** 26 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: format now as required. Imbedded into practice 5/10/18
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 25 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: working through all client inventories.This wil be completed and signed. Evidence available from 25/10/18

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

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Assurance, Challenge and Improvement in Health and Social Care