

Finance Inspection Report

20 June 2016



Clairville

Type of Service: Residential Care Home
Address: 62 Bann Road, Rasharkin, BT44 8SZ
Tel No: 0282954 1139
Inspector: Briege Ferris

1.0 Summary

An unannounced inspection of Clairville took place on 20 June 2016 from 09:45 hours to 14:00 hours. The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Controls in place to protect residents' money and valuables were found to be in place; no requirements or recommendations were made.

Is care effective?

Systems were found to be in place to record money received and spent on behalf of residents, however four areas for improvement were identified during the inspection. These were in relation to: ensuring that records of income and expenditure for residents follow a standard financial ledger format; ensuring that a reconciliation of residents' money and valuables is carried out and recorded at least quarterly; reviewing and updating the records of residents' furniture and personal possessions in their rooms and ensuring that the records of treatments provided to residents which attract an additional cost contain the required information and are signed by both the person providing the treatment and a representative of the home.

Is care compassionate?

Discussion with staff evidenced that staff were aware of measures in place to protect residents' money and ensure that residents had access to their money if they wished; no requirements or recommendations were made.

Is the service well led?

Discussion with the registered manager and the senior charge nurse evidenced that governance and oversight arrangements were in place. However, one area for improvement was identified during the inspection in relation to ensuring that records are at all times available for inspection in the home by any person authorised by the Regulation and Improvement Authority to enter and inspect the residential care home.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards, August 2011.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Veronica Reid, 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.

1.2 Actions/enforcement taken following the most recent finance inspection

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

2.0 Service details

Registered organisation/registered person: Clairville/Veronica Reid	Registered manager: Veronica Reid
Person in charge of the home at the time of inspection: Roisin McGowan (Senior Charge Nurse)	Date manager registered: 1 April 2005
Categories of care: RC-PH, RC-DE, RC-I, RC-MP(E), RC-PH(E)	Number of registered places: 17

3.0 Methods/processes

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 services users' money or valuables. The record of calls made to RQIA's duty system was also reviewed and this did not identify any relevant issues. Contact was also made with the inspector who had most recently visited the home.

On the day, the inspector met with the senior charge nurse and two residents. A poster detailing that the inspection was taking place was positioned at the entrance to the home, however no relatives or visitors chose to meet with the inspector. The registered manager was not in the home on day of inspection, however she was contacted by telephone following the inspection in order for the inspector to provide feedback from the day.

The following records were examined during the inspection:

- Five resident care records
- Three resident care reviews
- Six duplicate receipt books
- A sample of receipts for hairdressing services facilitated in the home
- "Clairville R Home Monies, Valuables, Property for Safekeeping" book
- Financial Policy "Accounting and financial control arrangements"
- Six records of residents' property within "Clairville property book"

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 June 2016

The most recent inspection of the home was an unannounced care inspection. The care inspector was contacted prior to the inspection and confirmed there were no matters to be followed up.

4.2 Review of requirements and recommendations from the last finance inspection dated 10/08/08

The most recent finance inspection of the home was carried out on 10 August 2008 on behalf of RQIA. The findings from this inspection were not brought forward as part of the inspection on 20 June 2016.

4.3 Is care safe?

The nurse in charge confirmed that the home did not have a dedicated administrator and that the registered manager took primary responsibility for matters relating to residents' money and the associated records. However, she was able to clearly explain the arrangements in place at the home for nursing staff to receive money from families in order to pay for hairdressing.

The nurse in charge confirmed that protection of vulnerable adults (POVA) training was mandatory for all staff in the home.

The home’s policy file was readily accessible by the nurse in charge, and a review of its contents established that the home had a number of policies addressing residents’ money and valuables. These included policies addressing residents bringing their own furniture to the home, complaints handling and accounting and financial controls arrangements. The latter policy was not dated; however the registered manager confirmed that policies were reviewed every year.

During discussion, 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 resident. The home had a safe place available for the deposit of cash or valuables belonging to residents; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, there were a number of cash balances held for individual residents, no valuables were being held.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0
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4.4 Is care effective?

During the course of the inspection, a sample of records relating to residents’ money and valuables was reviewed. Individual duplicate receipt books were in place for each resident whose representative had at some point, deposited money with the home on the identified resident’s behalf. A book entitled “Clairville R Home Monies, Valuables, Property for Safekeeping” was also in place which contained records of items signed into and out of the safe place, alongside entries detailing money deposited and used on behalf of identified residents; entries were routinely signed by only one person.

In addition, the nurse in charge provided the inspector with a number of envelopes held within the safe place which contained cash balances for residents as well as numerous unfilled receipts. From a review of these and discussion with the nurse in charge, the system appeared to be such that residents’ representatives would lodge cash in an envelope to be spent on hairdressing/podiatry/toiletries as requested; the amount within the envelope would be written on the envelope with a statement as to which resident and what purpose the money was for. Insufficient evidence was available on inspection to confirm that a receipt was issued to each person making the deposit, although some duplicate receipts detailing lodgements were evidenced.

The inspector noted that receipts for services or goods provided were inserted into envelopes along with any remaining cash balance. In this way, envelopes were acting as both a record of the income and expenditure and a ‘purse’ system.

No additional records of income and expenditure were evidenced beyond those discussed above.

A recommendation was made for clear income and expenditure records utilising a standard financial format to be introduced for each resident. This 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 a withdrawal, the amount; the running balance of the resident's cash total held and the signatures of two persons to verify the entry in the ledger.

The record should reflect the amount of a withdrawal and the return of change (if any), not the amount of money spent, as receipts should be available to verify this. If a receipt is not available for expenditure, the record should be annotated to reflect this. Records made on behalf of residents must be legible and any 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. Correction fluid must not be used on residents' income and expenditure records.

A review of the records also established that there was no evidence of any reconciliations of money and valuables carried out and recorded by the home.

A recommendation was made to ensure that a reconciliation of money (and valuables) held on behalf of residents is carried out at least quarterly. The reconciliation should be recorded and signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Discussion established that the home did not provide transport to residents; the nurse in charge advised that transport to medical appointments etc. was provided for by the ambulance service or by residents' family members.

Discussion with the registered manager established that no representative of the home was acting as nominated appointee for any resident, nor were any personal monies belonging to resident being directly received by the home (other than via deposits by residents' representatives).

The "Clairville property book" was reviewed which contained entries dating from 1994 to the present (the nurse in charge confirmed that no additional property records were held for residents). Given the age of the book, it was noted to be in poor condition and some pages had become detached from the binding and were not secured.

Each of six residents (sampled at random), had a written record of their property contained in the book; however there was no evidence that any of the records had been updated. Significant inconsistency was evidenced across the records: four of six records had been dated (with the date of admission), two had not been dated; one record had been signed by three people (including the resident); two had been signed by two people and two had been signed by one person.

In addition, the inspector noted that a sample of records evidenced entries such as "1 TV" and "1 Radio". It was highlighted that the level of detail required for descriptions of items (e.g. make/model/size) should be communicated to relevant staff by management. The inspector discussed this with the registered manager and highlighted that residents' property must be recorded in a consistent manner by staff with the signatures of (at least) two people recorded. The inspector also noted that property records should be kept up to date on an ongoing basis.

A recommendation was made to ensure that every a record of the furniture and personal possessions belonging to each resident is reviewed and brought up to date.

The "Clairville property book" should no longer be used, but should be retained in line with the home's records retention policy.

A review of a sample of records identified that a hairdresser and podiatrist routinely visited the home to provide services to residents; these services attracted an additional cost payable by the resident or their representative and individual receipts written in a duplicate receipt book were evidenced. Receipts routinely detailed the name of the resident, the date, the service provided, and the associated cost. A sample of records evidenced that receipts were not signed by either the hairdresser or a representative of the home, but would normally read “paid, thank you”.

A review of a sample of podiatry receipts identified that routinely, the details recorded were the name of the resident, the date, the cost and the signature of the podiatrist.

A recommendation was made to ensure that treatment records detail the name of the resident, the date, the service provided and the cost and the signature of both the person providing the service and a representative of the home who can verify that the detailed service has been provided.

Areas for improvement

Four areas for improvement were identified during the inspection. These were in relation to: ensuring that records of income and expenditure for residents follow a standard financial ledger format; ensuring that a reconciliation of residents’ money and valuables is carried out and recorded at least quarterly; reviewing and updating the records of residents’ furniture and personal possessions in their rooms and ensuring that the records of treatments provided to residents (which attract an additional cost) contain the required information and are signed by both the person providing the treatment and a representative of the home.

Number of requirements	0	Number of recommendations:	4
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4.5 Is care compassionate?

The inspector discussed the day to day arrangements in place in the home to support residents. The nurse in charge noted that there were no particular financial arrangements in place for residents which she was aware of; following the inspection the registered manager also confirmed this.

As part of the inspection, we spoke with two residents, both of whom confirmed that they were happy with the respective arrangements in place regarding their money. They also confirmed that they knew how to raise any concerns with the home.

As noted above, the home had a written complaints policy which was easily accessible. A review of the entries in the complaints book from 2006 onwards evidenced that no complaints had been received in relation to the management of residents’ money and valuables; no complaints had been recorded in the book since 2014. During discussion, the nurse in charge confirmed that there were no current suspected, alleged or actual incidents of financial abuse; this was also confirmed by the registered manager.

Discussion established that the home had arrangements in place to ensure that residents had access to their money outside of normal office hours.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0
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4.6 Is the service well led?

There was a clear organisational structure within the home and discussion with the nurse in charge established that she was familiar with her role and responsibilities in relation to safeguarding residents' money and valuables and escalating any relevant matter.

Early in the inspection, it was established that all of the records required as part of the inspection were not available. The nurse in charge stated that the requested records may be at the home of the registered manager. The inspector noted that this was not appropriate and that such records were required to be kept in the home for the purposes of inspection.

A requirement was made to ensure that records are at all times available for inspection in the home by any person authorised by the Regulation and Improvement Authority to enter and inspect the nursing home.

As there was no access to residents' financial files/agreements on the day of inspection; it was not possible for the inspector to evidence whether individual written agreements were in place between residents and the home.

A review of a sample of three residents' most recent care reviews evidenced an effective working relationship between the home and the HSC trust regarding arrangements in place to ensure appropriate arrangements were in place to safeguard individual residents' money.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that records are at all times available for inspection in the home by any person authorised by the Regulation and Improvement Authority to enter and inspect the nursing home.

Number of requirements	1	Number of recommendations:	0
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5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Veronica Reid, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider/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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Residential Care Homes Minimum Standards (August 2011). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered provider will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to **RQIA's office** and assessed by the inspector.

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 registered person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
<p>Requirement 1</p> <p>Ref: Regulation 19 (2) (b)</p> <p>Stated: First time</p> <p>To be completed by: 1 July 2016</p>	<p>The registered person must ensure that records are at all times available for inspection in the home by any person authorised by the Regulation and Improvement Authority to enter and inspect the nursing <i>residents</i> home.</p> <hr/> <p>Response by registered person detailing the actions taken:</p> <p><i>Records that were held in "office" in Manager's home are now in place in the residential Home.</i></p>
Recommendations	
<p>Recommendation 1</p> <p>Ref: Standard 15.7</p> <p>Stated: First time</p> <p>To be completed by: 1 July 2016</p>	<p>The registered person should 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. Where the resident or their representative is unable to sign or chooses not to sign, two members of staff sign the record.</p> <hr/> <p>Response by registered provider detailing the actions taken:</p> <p><i>Financial ledger is now in place in the residential Home.</i></p> <div style="border: 2px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p style="text-align: center; margin: 0;">REGULATION AND QUALITY</p> <p style="text-align: center; color: red; margin: 0;">02 JUL 2016</p> <p style="text-align: center; margin: 0;">IMPROVEMENT AUTHORITY</p> </div>

<p>Recommendation 2</p> <p>Ref: Standard 15.12</p> <p>Stated: First time</p> <p>To be completed by: 1 July 2016</p>	<p>The registered person should ensure that a reconciliation of money (and valuables) held on behalf of residents is carried out at least quarterly. The reconciliation should be recorded and signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.</p>
<p>Recommendation 3</p> <p>Ref: Standard 8.7</p> <p>Stated: First time</p> <p>To be completed by: 20 July 2016</p>	<p>Response by registered provider detailing the actions taken:</p> <p><i>This Recommendation is in place.</i></p> <p>Response by registered provider detailing the actions taken:</p> <p><i>Recommendation is in place.</i></p>

<p>Recommendation 4</p> <p>Ref: Standard 15.7</p> <p>Stated: First time</p> <p>To be completed by: 1 July 2016</p>	<p>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 resident or a member of staff of the home should sign the record or receipt to verify the service or goods provided and the associated cost to each resident.</p>
	<p>Response by registered person detailing the actions taken:</p> <p><i>Recommendation is in place within the home.</i></p>

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Registered manager completing QIP	<i>V Reid</i>	Date completed	<i>29/7/16</i>
Registered person approving QIP		Date approved	
RQIA inspector assessing response	<i>[Signature]</i>	Date approved	<i>03/08/16</i>

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The Regulation and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9051 7500

Fax 028 9051 7501

Email info@rqia.org.uk

Web www.rqia.org.uk

 @RQIANews