Unannounced Finance Inspection Report
20 February 2019

Daisyhill Private Nursing Home

Type of Service: Nursing Home
Address: 50a Ahoghill Road, Randalstown, BT41 3DG
Tel No: 02894479955
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 servicefrom 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 25 beds that provides care for patients with a learning disability.

3.0 Service details

Organisation/Registered Provider: Town & Country Homes Limited **Responsible Individual(s):** Marina Lupari	**Registered Manager:** Marina Lupari
Person in charge at the time of inspection: Lisa Davison	**Date manager registered:** 07 November 2018
Categories of care: Nursing LD – Learning Disability LD (E) – Learning Disability over 65 years	**Number of registered places:** 25

4.0 Inspection summary

An unannounced inspection took place on 20 February 2019 from 10.45 to 14.35 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 for example:

- the availability of a safe place to enable patients to deposit money or valuables for safekeeping
- a written safe record was in place
- the business support manager had participated in adult safeguarding training
- records of income, expenditure and reconciliations (checks performed) were in place
- hairdressing and podiatry treatment records were in place
- mechanisms were available to obtain feedback from patients and their representatives
- the business support manager confirmed she was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures, and
- there were mechanisms in place to ensure that patients experienced equality of opportunity.

Areas requiring improvement were identified in relation to:

- ensuring that each patient's record of furniture and personal possessions is reconciled by two people at least quarterly and
- ensuring that that the identified patient's written agreement with the home is updated to reflect the appointee details.

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.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with the registered manager and the business support manager at the conclusion of the inspection. The timescales for completion commence from the date of inspection.

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

5.0 How we inspect

Prior to the inspection, the record of notifiable incidents reported to RQIA in the last twelve months was reviewed; this established that none of these incidents related to patients' money or valuables. The record of calls made to RQIA's duty system was reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with the registered manager and the business support manager. A poster was provided for display in a prominent position in the home 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:

- The safe contents record
- A sample of patients' income, expenditure and reconciliation records (records of checks performed)
- A sample of written financial policies and procedures
- A sample of patients' personal property (in their rooms)
- The resident guide
- A sample of patients' individual written agreements
- A sample of hairdressing and podiatry treatment records
- A sample of patients' banking records
- A sample of patients' transport records
- A sample of the records of charges for care and accommodation costs
- Correspondence with Health and Social Care (HSC) trust representatives seeking clarification on the management of patients' finances or authorisation to make purchases

The findings of the inspection were discussed with the registered manager and the business support manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 22 October 2018

The most recent inspection of the home was an unannounced care inspection.

6.2 Review of areas for improvement from the last financeinspection dated 20 July 2015

A finance inspection of the home was carried out on 20 July 2015; the findings were not brought forward to the inspection on 20 February 2019.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed that adult safeguarding training was mandatory for all staff in the home including administrative staff. The business support manager confirmed she had participated in this training in 2018.

Discussions with the registered manager established that there were no current suspected, alleged or actual incidents of financial abuse, nor were there any finance-related restrictive practices in place for any patient.

The home had a safe place available for the deposit of cash or valuables belonging to patients; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, cash and valuables were being held for patients. A written safe record was in place which detailed the dates which items had been deposited into the safe place. The items had been deposited less than three months preceding the date of the inspection and hence a quarterly check of the items was not yet due.

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, a written safe record was in place and the business support manager had participated in adult safeguarding training.

Areas for improvement

No areas for improvement were identified as part of the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Discussion with the business support manager established that the responsible individual was acting as appointee for one patient. Official evidence was in place confirming that name of the appointee and the date they were appointed to act in that capacity for the identified patient. A review of the individual written agreement for the patient identified that the appointee details were not recorded in their agreement.

An area for improvement was identified to ensure that the name of the appointee, the date they were approved to act in that capacity by the social security agency and the records to be held in respect of the appointment are clearly detailed within the identified patient's individual written agreement.

The monies for an identified patient for whom the responsible person was acting as appointee were received directly by the home. Clear, detailed records existed to identify the amount and timing of these receipts and the transfer of any monies owed to the patient once their share of their care costs had been paid to the home. 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 patients' representatives. Receipts were in place to record the deposit of cash; these were routinely signed by two people.

A sample of income and expenditure records for patients was reviewed; these were entitled "Town and Country care homes Ltd Residents Safe account record 2018_2019". A review of the ledgers identified that transactions were routinely signed by two people and the ledgers evidenced that monthly checks of the balances had been carried out, signed and dated by two people.

Discussion established that the home operated a bank account for patients' monies which was appropriately named in favour of the patients in the home. The home maintained electronic records of the income and expenditure received and spent on behalf of patients. A schedule was maintained of the activity through the account which had been reviewed and detailed individual transactions to ensure clarity with regards to the individual postings to the bank account. In addition, an electronic overview of the current balances available to each patient was maintained. Evidence was presented which identified that the patients' bank account was reconciled and signed and dated by two people on a monthly basis.

Hairdressing and podiatry treatments were being facilitated within the home and a sample of these treatment records was reviewed. The sampled records routinely detailed the information required, including the signature of the person delivering the treatment and the signature of a member of staff to verify that the identified patients had received the treatment detailed.
The inspector discussed with the business support manager how patients' property (within their rooms) was recorded and requested to see a sample of the property records maintained for

three patients. The records established that they were subject to a quarterly check which had been performed in each case in January 2019; the next check was due in April 2019. A review of the records established that these were signed by only one person, as opposed to two which is required by the Care Standards for Nursing Homes, 2015.

An area for improvement was listed to ensure that the quarterly check of patients' property is signed and dated by one staff member and countersigned by a senior member of staff.

Transport records were in place detailing the miles travelled by patients and the member(s) of staff accompanying staff. The business support manager confirmed that at the time of the inspection, staff costs were not being charged to patients for journeys as this issue was currently being discussed and agreed with the commissioning trust(s). The arrangements for the provision of transport services to patients were detailed in each patient's "individual financial care plan" which was appended to the patient's individual written agreement with the home.

At the time of the inspection, transport was being charged at a rate of £0.46/mile divided equally by the number of patients travelling on the same journey. A sample of the journey records was traced and this identified the process for calculating the costs of journeys to patients; these were recorded in a timely manner using the home's computerised system.

A written transport policy and procedure was in place dated October 2018, this included details as to the principles of the transport scheme, the costs associated with the scheme and the basis for charging, the current cost per mile, record keeping arrangements and copies of the templates used to record journeys.

A review of a sample of charges to patients or their representatives identified that the correct charges had been raised in respect of care and accommodation costs. The business support manager confirmed that the home did not operate a comfort fund.

Areas of good practice

There were examples of good practice found for example, in relation to the existence of income, expenditure and reconciliation records and supporting documentation; in relation to an appropriately named bank account to administer patients' monies and a sample of charges to patients or their representatives for care and accommodation were correct.

Areas for improvement

Two areas for improvement were identified during the inspection. These related to ensuring that the name of the appointee, the date they were approved to act in that capacity by the social security agency and the records to be held in respect of the appointment are clearly detailed within the identified patient's individual written agreement and ensuring that the quarterly check of patients' property is signed by two people.

	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.

Discussion with the business support manager 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 and were kept under review if patients' needschanged.

Discussion with the registered manager established that the home had a range of methods in place to encourage feedback from patients or their representatives in respect of any issue. These included getting feedback from patients' families, residents' meetings and the regulation 29 monthly monitoring visits.

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.

The resident guide provided a range of information for new patients including the general terms and conditions of residency in the home, and the current scale of charges.

The home had a range of written policies and procedures and standard operating procedures to guide financial practices in the home. These addressed areas including: the management of patients' monies, property and valuables, banking, transport provision and records management. Policies and standard operating procedures were dated between November 2017 and November 2018.

Discussion with the business support manager established that she was familiar with the home process regarding the receipt of a complaint and knew how to escalate any concerns under the home's whistleblowing procedures.

The home had a generic patient agreement template which detailed the charges payable for care and accommodation and which included several appendices. The appendices included

the costs of pre-agreed expenditure including e.g. hairdressing, podiatry, and transport and an individual financial care plan setting out the personalised financial arrangements for the patient.

A sample of three patients' records was reviewed; this established that one patient's agreement was signed by their representative, while the remaining two patients' agreements had not been signed by the patients' representatives. Where patient records did not include a signed written agreement, evidence was presented by the business support manager that identified that the home had shared patients' agreements with the patients' representative(s) for review and signature.

This included email correspondence to the commissioning trust in respect of obtaining signatures on patient agreements (where the trust were acting as appointee for a patient) and copy minutes from a meeting with the Northern Health and Social Care Trust (NHSCT) in April 2018, in which the issue of having patient agreements signed was also discussed. The minute detailed that the NHSCT do not sign patient agreements on behalf of any patient which they have placed in the home, but noted that when required, the trust would confirm they would not sign the agreement on behalf of a patient.

The business support manager also provided a schedule which detailed the dates of patients' care management review meetings including information regarding when the patients' agreements had been provided for signature (including to the health and social care trust).

In respect of the identified patient (for whom the responsible individual was acting as appointee); their individual written agreement detailed that the responsible individual had signed the patient's agreement as appointee. However, the responsible individual had also signed on behalf of the home. Feedback was provided to the registered manager and business support manager at the conclusion of the inspection to ensure that there is evidence in place that the identified patient's agreement is shared with their HSC trust care manager and secondly that the responsible individual does not in future, sign both on behalf of the home and the patient.

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 patients. The registered manager was able to describe examples of how this was achieved within the home.

Areas of good practice

There were examples of good practice found: the business support manager confirmed that she was familiar with the home complaints process and the process for escalating any concerns under the home's whistleblowing procedures. The home's resident guide contained a range of information for a new patient, each patient had an individual written agreement in place with the home which was either signed by their representative or, the home had evidence in place detailing the efforts the home had made in attempting to secure signatures on the agreements.

Areas for improvement

No areas for improvement were identified as part of the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the registered manager and the business support manager, at the conclusion of the inspection. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes (April 2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered providershould 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 Care Standards for Nursing Homes (2015)

Area for improvement 1 **Ref**: Standard 14.20 **Stated:** First time **To be completed by:** 01 May 2019	The registered person shall ensure thatthe name of the appointee, the date they were approved to act in that capacity by the social security agency and the records to be held in respect of the appointment are clearly detailed within the identified patient's individual written agreement. Ref: 6.5
	Response by registered person detailing the actions taken: The Service User agreement has been amended for the one resident concerned.
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 30 April 2019 (the next 1/4ly check)	The registered person shall ensure that records of patients' furniture and personal possessions which they have brought to their rooms are reconciled and signed and dated by a staff member and countersigned by a senior member of staff at least quarterly. Ref: 6.5
	Response by registered person detailing the actions taken: An audit is in place to ensure that all records of residents's furniture and personal possessions are countersigned by a senior member of staff at least quarterly

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

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
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews