



The **Regulation** and
Quality Improvement
Authority

Inspector: Briege Ferris
Inspection ID: IN022902

Ladyhill Lodge
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**Finance Inspection
of
Ladyhill Lodge**

12 June 2015 & 7 July 2015

The Regulation and Quality Improvement Authority
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Summary of Inspection

A finance inspection took place on 12 June 2015 from 10:05 to 14:10 and was continued on 7 July 2015 from 11:15 to 15:15. A poster detailing that the inspection was taking place was positioned at the entrance to the home on each visit.

Overall on the day of the inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care; however, there are 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 visited the home on 12 June 2015 and were informed by the acting manager that Mr and Mrs McGoldrick were out of the country. The acting manager provided us with all of the information to which she had access; however, this was not sufficient to enable the inspection to be completed on that day.

We arranged to carry out a further visit to the home on 7 July 2015. On this occasion, we met with Mrs Mary McGoldrick, the responsible individual and Mr Ian McGoldrick, Director of the Adarra Developments Limited.

No relatives or visitors chose to meet with us during either of the inspection visits.

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. While improvements in practice have been noted, there remain a number of areas in which the home has failed to demonstrate consistent compliance with the Regulations. Details of these matters are outlined in the following sections of the report and the number of times they have been stated is detailed in the appended Quality Improvement Plan.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	9	3

The details of the QIP within this report were discussed with Mrs Mary McGoldrick, the responsible individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Adarra Developments Ltd/Mary McGoldrick	Registered Manager: Valerie Reynolds
Person in Charge of the Home at the Time of Inspection: Ms Lisa Davison (Acting Manager) (on both visits)	Date Manager Registered: 16 January 2015
Categories of Care: NH-LD, NH-LD(E)	Number of Registered Places: 31
Number of Patients Accommodated on the Day of Inspection: 28	Weekly Tariff at Time of Inspection: £593.00 - £1,203.00

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 are 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 Mrs Mary McGoldrick the responsible individual, Mr Ian McGoldrick, director of Adarra Developments Limited and the acting manager, Ms Lisa Davison
- Examination of records
- 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

The following records were examined during the inspection:

- The patients' guide
- The home's policy on:
 - Safeguarding vulnerable adults
 - Resident monies
 - Transport
- Two signed patient agreements
- One signed personal allowance contract
- A sample of income/lodgements and expenditure records
- A sample of Banking records (Residents' monies)
- A sample of charges to patients/their representatives for care and accommodation
- A sample of hairdressing and podiatry records
- Cash Reconciliations
- Two records of patients' personal property/inventory

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection on 27 November 2014; the completed Quality Improvement Plan was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Previous Finance Inspection

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 Ref: Regulation 19 (2) Schedule 4 (9)	The registered person is required to ensure that records of patient expenditure are clearly and accurately recorded; that records are entered in patient ledgers contemporaneously and that each entry is signed and dated by two persons.	Met
	Action taken as confirmed during the inspection: We reviewed a sample of these records which record day to day expenditure such as that on hairdressing and toiletries. We noted that entries were up to date and routinely signed by two people.	

Requirement 2 Ref: Regulation 19 (2) Schedule 4 (9)	The registered person is required to ensure that the amount of monies held on behalf of patients is regularly reconciled (at least on a quarterly basis) and that a record of the reconciliation is made in writing and signed and dated by two persons.	Not Met
	Action taken as confirmed during the inspection: We reviewed the records of reconciliations of patients' money. We noted that while reconciliations of patients' monies had been carried out, they had not been performed and recorded at least quarterly. This matter has been highlighted on the last three inspections 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?

We were provided with a copy of the home's patient guide on the day of inspection. We noted that the guide included relevant information on: patients bringing personal property into the home; the availability of a locked cabinet in the patient's room and the availability of a safe place in the home's office for the deposit of valuable items. We also noted that the guide details that each newly admitted patient or their representative is provided with a user agreement setting out the terms of residency.

We selected a sample of four patient agreements for review. On reviewing the sample of four patients' files, we noted the following: two patients had a signed individual agreement on file which had been signed in 2012 and 2013 respectively; one patient had an unsigned agreement on file (which reflected fees rates correct as at 2013); one patient did not have an agreement on file.

We discussed these findings with Mr and Mrs McGoldrick; we noted that the agreements which were on file were out of date and other patients sampled did not have a signed agreement. Mrs McGoldrick produced correspondence from the Northern HSC Trust detailing fee rates payable in respect of patients for the financial year April 2015- March 2016 which was dated June 2015. Mr McGoldrick explained that he hadn't issued the contracts for this year yet. We highlighted that this would not explain why updated patient agreements for 2014 to 2015 were not on file for patients.

We noted that the DHSSPS Care Standards for Nursing Homes 2015 were now in effect and that Standard 2.2 of the Care Standards for Nursing Homes (2015) requires a number of additional areas to be included in the home's individual agreement with patients.

An individual agreement which meets the requirements of Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and the requirements of the DHSSPS minimum standards is required to be provided to each patient or their representative and kept up to date in line with any changes.

A requirement has been made in respect of these findings.

Is Care Effective?

Previous inspections of the home had established that the home had involvement in supporting a number of patients in the home with their money, for example a representative of the home is acting as nominated appointee for a number of patients in the home. However as noted above, a review of a sample of patient files identified that all patients in the home did not have a signed individual agreement in place which must include detail of any financial arrangement in place with the home (such as Appointeeship). The requirement for the home to provide each patient in the home with an up to date agreement and to update each agreement over time has been made above.

We noted that the home had a number of written policies and procedures to guide practice in respect of safeguarding patients' money and valuables. We highlighted that the home's "Resident Money Policy" was six sentences in length and this represented an overly brief explanation of the processes in place to safeguard patients' money and valuables.

A recommendation has been made in respect of this finding.

Is Care Compassionate?

Given the findings above, it was established that all patients or their representatives had not been informed in writing of any of increases in the fees payable over time which must be reflected in each patient's individual agreement with the home.

A requirement has been made in respect of this finding.

Areas for Improvement

Overall on the day of inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were two areas identified for improvement; these were in relation to providing up to date individual written agreements to all patients and providing written notice of any changes to the patient's agreement and updating each agreement over time.

Number of Requirements	2	Number Recommendations:	1
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5.4 Statement 2 - Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Is Care Safe?

A review of the records identified that copies of the HSC trust payment remittances are available confirming the weekly fee for each patient in the home and the amount to be contributed by each patient, where relevant.

The home is in receipt of the social security benefits for an identified number of patients. We noted that the home maintain a clear schedule of the separate benefits received on behalf of each patient which ensures that the correct benefits have been received for the individual patient. In addition, there is a detailed method of ensuring that the portion of patient benefits which are owed to home by way of the patients' contributions is transferred over to the home and clear records exist to substantiate the amount and the timing of these transfers.

We reviewed the records relating to amounts charged to a selection of sample of patients contributing to their fees and were satisfied that the correct amounts were being charged by the home.

The home is in receipt of personal allowance monies for an identified number of patients in the home. These monies are received either from the relevant HSC trust or from the Office of Care and Protection. Detailed records are maintained to substantiate the receipt of these monies which are held in a bank account not associated with the running of the home.

In addition, a number of patients' representatives lodge money with the home in order to pay for additional goods and services not covered by the weekly fee (such as hairdressing services, or other sundries). A review of the records identified that the home provide a receipt to anyone lodging money, however these receipts are not routinely signed by two people.

A requirement has been made in respect of this finding.

We reviewed a sample of the records of patient expenditure recorded on behalf of patients and noted that records were clear and entries routinely signed by two people. We sampled a number of transactions from the records and were able to trace these entries to the corresponding records to substantiate each transaction, such as a purchase receipt or a hairdressing treatment receipt.

The home uses a hairdresser who is available to everyone in the home. As noted above, we reviewed a sample of the receipts for hairdressing treatments provided by the hairdresser and noted that individual receipts were provided for each patient treated. However, we noted that these receipts did not detail the treatment provided, nor were they signed and dated by two people. We noted that these receipts must be signed by both the hairdresser and a representative of the home who can verify that the patient has received the service detailed and incurred the associated cost. .

We noted that we had raised this matter on previous inspections of the home.

A requirement has been made in respect of this finding.

A review of the records established that a written record of reconciliations of monies held on behalf of patients had been carried out. While reconciliations are expected to be carried out and recorded at least quarterly, a review of the reconciliation dates established gaps of up to five months between reconciliations. While progress in ensuring reconciliations are carried out, and signed and dated by two people is noted, we highlighted that it was disappointing to note that reconciliations were not carried out on at least a quarterly basis; in particular as this matter has been raised on inspection of the home on other occasions. We noted that there must be sustained commitment to ensure that reconciliations are carried out and recorded at least every quarter. We noted that there should be a mechanism of ensuring that this control remains on the agenda and does not get overlooked for an extended period of time.

A recommendation has been made in respect of this finding.

As noted above, the home operates a pooled bank account used exclusively for the safekeeping of patients' personal monies which are received by the home for expenditure on the patients' behalf. The account is named appropriately in favour of the patients in the home.

A separate bank account operated by the home is used to manage DLA mobility monies received on behalf of patients in the home; this account is also named appropriately. Charges for transport services are made to this account on the basis of journeys taken by patients in the home. Further discussion on transport services provided by the home is included in the later section of the report.

Mr McGoldrick confirmed that the home did not operate a comfort fund for patients.

Is Care Effective?

Discussions established that on the day of inspection, a representative of the home was acting as nominated appointee for an identified number of patients. A review of a sample of four patient files established that formal confirmation of the appointment of the representative of the home was held on three of the four files.

A requirement has been made in respect of this finding.

A review of a sample of four patients' files established that a personal allowance authorisation to provide the home with the necessary written authorisation to purchase goods and services on behalf of each patient was present on one file.

A requirement has been made in respect of this finding.

Is Care Compassionate?

Mr and Mrs McGoldrick described how the annual care review provides an opportunity to discuss financial matters generally and that there is a good working relationship with HSC trust representatives and the Office of Care and Protection.

We queried how patients would be able to access their money outside of normal working hours and we were informed that the home's petty cash is accessible by the nurse in charge should any patient require money. Mrs McGoldrick also advised that she and Mr McGoldrick are available. This indicated to us that there are good contingency arrangements in place for patients to access their money outside of normal working hours.

We queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the responsible individual 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 were found to be contributing to safe, effective and compassionate care; however there were four areas identified for improvement; these were in relation to countersigning receipts for the deposit of cash, hairdressing treatment records, obtaining personal monies authorisations and obtaining official Appointee details.

Number of Requirements	4	Number Recommendations:	1
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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 are maintained

Is Care Safe?

A safe place exists within the home to enable patients to deposit cash or valuables. We reviewed the safe place within the home and were satisfied with the controls around the physical location of the safe place and the persons with access.

We viewed the content of the safe place and established that on the day of inspection, no valuables belonging to patients were lodged for safekeeping. Cash balances were held for patients in respect of personal allowance monies. We undertook a count of a sample of the cash balances and noted that these agreed to the records held by the home.

We noted that there is no safe record in place in the home, we highlighted that a written "safe book/register" must introduced to record all items held within the safe place.

A requirement has been made in respect of this finding.

Is Care Effective?

We requested the inventory/property records for four patients. A review of the files established that only three of the four patients had a property record on their file. Records in place two patients were completed and reflected items of furniture or personal possessions owned by the patient. One of those three patients had a record on their file which was blank. We discussed these findings with the responsible individual; we were informed that the patient with the blank template did not have any items. We noted that it was good that the template was on the file should any item need to be recorded for the patient.

The fourth patient did not have a record on their file; we were informed that the patient also did not have any items to record. We highlighted that this was inconsistent practice from earlier discussions and we noted that if a blank template had been put on one patient's file, all other patients should have a template in place whether blank or not.

A recommendation has been made in respect of this finding.

Is Care Compassionate?

A safe place exists within the home to enable patients or their representatives to deposit cash or valuables. As noted above, we queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the responsible individual confirmed that none of the patients had any known assessed needs or restrictions.

Areas for Improvement

Overall on the day of inspection, financial arrangements were found to be contributing to safe effective and compassionate care; however there were two areas identified for improvement; these related to the introduction of a safe book/register and the recording of patients' personal property.

Number of Requirements	2	Number Recommendations:	0
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5.6 Statement 4 - Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

Is Care Safe?

The home has a minibus which is used to provide transport services to patients. Patients have the option of opting out of using transport services provided by the home. Discussions established that journeys are mainly undertaken for medical appointments.

The home has a written policy regarding transport provision to patients, which details the arrangements for recording journeys taken by patients and for subsequently charging patients; the details of the charges per mile are also outlined.

Discussions established that there is not a separate transport agreement between the home and those patients choosing to avail of the home's transport; the option to agree to the terms of transport services provided by the home is set out as part of the individual patient agreement which exists between the home and each patient (where one is in place).

As noted above, we reviewed a sample of the agreements for patients and noted that of the sample of files selected, signed agreements were either out of date or absent. A requirement has been made above for up to date agreements to be provided to each patient in the home or their representative and that individual agreements are kept up to date with any changes agreed in writing by the patient or their representative.

Is Care Effective?

The home's policy on transport provision to patients states that "each month the passenger miles for each patient is multiplied by the rate per mile, charged to the patient's account and the payment transferred to the home's account". A review of the records for transport charges established that the records only went up to January 2015, therefore at the time of inspection; charges to patients were six months behind. We discussed this with Mr and Mrs McGoldrick and discussions established that the administration of these records had simply fallen behind.

A requirement has been made in respect of these findings.

Is Care Compassionate?

The home's policy and procedure on transport details arrangements for appropriate personnel to accompany patients to ensure their needs are appropriately met. Patients have the ability of opt out of using the transport services provided by the home.

Areas for Improvement

Overall on the day of inspection, we found care to be safe and compassionate. The effectiveness of care was found to be good, however there was one area identified for improvement; this was in relation to keeping up to date records of charges to patients for transport services.

Number of Requirements	1	Number Recommendations:	0
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5.7 Additional Areas Examined

As noted above, we visited the home initially on 12 June 2015, however it was not possible to obtain all of the required information as the correct personnel were not available to provide details or access to documents and a further visit to the home on 7 July 2015 was necessary.

We note that the Nursing Homes Regulations (Northern Ireland) 2005 state that records must be at all times available for inspection in the home.

A requirement has been made in respect of this finding.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Mary McGoldrick, the responsible individual, 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, 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 within this report do not absolve the registered person/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 person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
<p>Requirement 1</p> <p>Ref: Regulation 5 (1) (a) (b)</p> <p>Stated: Second time</p> <p>To be Completed by: 7 September 2015</p>	<p>The registered person must provide individual agreements to each patient currently accommodated in the home (or their representative) which detail the current fees and financial arrangements in place in respect to the individual patient.</p> <p>Individual patient agreements must be reviewed for compliance with requirements under Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and must meet <u>Standard 2.2</u> of the DHSSPS Care Standards for Nursing Homes (2015), which detail the minimum components of the agreement.</p> <p>A copy of the signed agreement by the patient or their representative and the registered person must be retained in the patient's records. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded.</p> <p>Where an HSC trust-managed patient does not have a family member or friend to act as their representative, the patient's individual agreement should be shared with the HSC trust care manager.</p> <hr/> <p>Response by Registered Person(s) Detailing the Actions Taken: Individual agreements were reviewed and provided via post to all patient representatives. At the time of writing, none have been returned.</p>
<p>Requirement 2</p> <p>Ref: Regulation 5 (2) (a) (b)</p> <p>Stated: Second time</p> <p>To be Completed by: From the date of the next change</p>	<p>The registered person must provide at least 28 days written notice to each patient or their representative of any increase in the fees payable by or in respect of the patient, or any variation in the method of payment of the fees or the person by whom the fees are payable.</p> <p>The registered person must ensure that any changes to the individual patient's agreement are agreed in writing by the patient or their representative. The patient's individual agreement must be updated accordingly.</p> <p>Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded.</p> <hr/> <p>Response by Registered Person(s) Detailing the Actions Taken: The current fees payable have been included in the letters accompanying the individual agreements as per requirement 1.</p>

<p>Requirement 3</p> <p>Ref: Regulation 19(2) Schedule 4 (9)</p> <p>Stated: First time</p> <p>To be Completed by: From the date of inspection</p>	<p>The registered person must ensure that the treatment records for podiatry services facilitated in the home also include the signature of a representative of the home to verify the treatment has taken place.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: A new system has been introduced for all external patient services such as podiatry, hairdresser, beauty etc. This new system now includes more detail on the service provided and a staff signature to verify the service was received.</p>
<p>Requirement 4</p> <p>Ref: Regulation 19(2) Schedule 4 (10)</p> <p>Stated: First time</p> <p>To be Completed by: 14 July 2015</p>	<p>The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by all newly admitted patients. The registered person must also ensure that a retrospective record is made of the furniture and personal possessions owned by existing patients accommodated in the home.</p> <p>All inventory records should be updated on a regular basis. (<u>Care Standards for Nursing Homes, April 2015 require that a reconciliation of these records is recorded at least quarterly</u>).</p> <p>Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry. The registered person should advise staff of the importance of recording inventory details consistently. Items of significant value or those requiring electrical safety testing should be distinctly highlighted on the record for ease of identification.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: A review of all patient properties is taking place, individual inventories are being completed and retrospectively reconciled and updated.</p>
<p>Requirement 5</p> <p>Ref: Regulation 19(2) Schedule 4 (3)</p> <p>Stated: Second time</p> <p>To be Completed by: 7 September 2015</p>	<p>The registered person must ensure that written authorisation is obtained from each patient or their representative to spend the personal monies of patients on pre-agreed expenditure. The written authorisation must be retained on the patient's records and updated as required.</p> <p>The registered person must ensure that where any representative of a patient (including care manager or next of kin) have signed a document for the home on behalf of the patient, the representative's name and relationship to the patient are clearly stated on the document.</p> <p>Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where an HSC trust-managed patient does not have a family member or friend to act as their representative, the patient's personal monies authorisation should be shared with the HSC trust care manager.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: Each patient's representative has been written to and authority for the use of personal monies has been requested via a return addressed</p>

	permission letter. We are awaiting returned forms.
Requirement 6 Ref: Regulation 22 (3) Stated: Third time To be Completed by: 7 September 2015	<p>The registered person must request written confirmation from the Social Security Agency of the name of the appointee and the date they were approved by the Social Security Agency. This request must be made for any patient for whom written confirmation has not already been sought and once received must be placed on the individual patients' files. The registered person must ensure that the individual patients' agreements with the home accurately reflect these arrangements and the records to be retained</p> <p>Response by Registered Person(s) Detailing the Actions Taken: Written request has been sent to the social security agency for form BF57</p>
Requirement 7 Ref: Regulation 18 (2) (l) Stated: First time To be Completed by: 7 August 2015	<p>The registered person is required to ensure that a written "safe book/register" is introduced to record any items held within the safe place. This should record anything held within the safe place including items deposited for safekeeping on behalf of patients. Should any item be deposited for safekeeping, the record should reflect the date items were deposited and should be signed by two persons. Where items are returned to the patient or their representative, the record should be updated with the date the item(s) were returned and include two signatures to verify the return of the items.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: A safe book has been introduced</p>
Requirement 8 Ref: Regulation 19 (2) (a) Stated: First time To be Completed by: From the date of inspection	<p>The registered person is required to ensure that records of charges to patients for transport services provided by the home are kept up to date.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: These records were last reconciled on the 6th October 2015 and will continue to be kept up to date.</p>
Requirement 9 Ref: Regulation 19 (3) (b) Stated: First time To be Completed by: From the date of inspection	<p>The registered person must ensure that the records referred to in paragraphs (1) and (2) – (b) 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.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: New manager is now fully au-fait with procedures in this regard.</p>

Recommendations			
Recommendation 1 Ref: Standard 35.21 Stated: First time To be Completed by: 7 August 2015	It is recommended that the registered person arrange to expand the current policy and procedure on "resident monies".		
	Response by Registered Person(s)Detailing the Actions Taken: Registered person is currently reviewing and expanding the current policy and procedure on resident monies.		
Recommendation 2 Ref: Standard 14.25 Stated: First time To be Completed by: From the date of inspection	It is recommended 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: Reconciliation of monies is up to date, last reconciled on 1 st september 2015 due to be reviewed again by December 2015.		
Recommendation 3 Ref: Standard 14.26 Stated: First time To be Completed by: 21 August 2015	The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by all newly admitted patients. The registered person must also ensure that a retrospective record is made of the furniture and personal possessions owned by existing patients accommodated in the home.		
	All inventory records should be updated on a regular basis. (<u>Care Standards for Nursing Homes, April 2015 require that a reconciliation of these records is recorded at least quarterly</u>). Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry. The registered person should advise staff of the importance of recording inventory details consistently. Items of significant value or those requiring electrical safety testing should be distinctly highlighted on the record for ease of identification.		
	Response by Registered Person(s)Detailing the Actions Taken: As per requirement 4. A template is now available as part of the admission pack for new residents to be completed immediately following admission.		
Registered Manager Completing QIP		Lisa Davison	Date Completed 09/10/15
Registered Person Approving QIP		Mary McGoldrick	Date Approved 09/10/15
RQIA Inspector Assessing Response			Date Approved 12/10/2015