Unannounced Finance Follow Up Inspection Report 13 December 2018

Ladyhill Private Nursing Home

Type of Service: Nursing Home
Address: 40 Creevery Road, Antrim, BT41 2LQ
Tel No: 028 9446 6905
Inspectors: Briege Ferris (Finance) and Amanda Jackson (Senior 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 service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Ladyhill is a nursing home with 31 beds that provides care for patients with a learning disability. On the day of inspection, 22 patients were residing in the home.

3.0 Service details

Organisation/Registered Provider: Town and Country Care Homes Limited **Responsible Individual:** Marina Lupari	**Registered Manager:** See below
Person in charge at the time of inspection: Marina Lupari	**Date manager registered:** Marina Lupari – Acting
Categories of care: NH- Nursing Home LD - Learning Disability LD(E)- Learning disability – over 65 years	**Number of registered places:** 31

4.0 Inspection summary

An unannounced inspection took place on 13 December 2018 from 10.00 to 17.45

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes (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.

The following areas were examined during the inspection:

- Income, expenditure, banking and property records
- Patient Agreements and personal monies authorisation documents
- Physical security and safe contents

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities and enhance safe financial practices.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Marina Lupari, responsible individual, 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 26 October 2017

Other than those actions detailed in the QIP, no further actions were required to be taken following the most recent inspection on 26 October 2017.

5.0 How we inspect

Prior to the inspection, the record of notifiable incidents reported to RQIA since the last inspection 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 inspectors met with the responsible individual and the two members of business support staff. A poster was provided for display in a prominent position in the home detailing the inspection was taking place, no relatives or visitors requested to meet with the inspectors.

The finance inspector provided to the business support 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.

Areas for improvement identified at the last finance inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The following records were examined:

- A sample of patients' income, expenditure and banking records, including supporting documents
- A sample of records detailing treatments provided to patients for which there is an additional charge
- Evidence of the reconciliation of service users' monies and valuables
- A sample of patients' personal property records
- A sample of patients' individual written agreements
- A sample of written financial policies and procedures and standard operating procedures
- 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 provided to the responsible individual at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 06 December 2018

The most recent inspection of the home was an unannounced care inspection. The QIP from the inspection 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 26 October 2017

Areas for improvement from the last finance inspection		
Action required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 19 (3) (b) **Stated:** Second time **To be completed by:** 27 October 2017	The registered person shall ensure that the records referred to in paragraphs (1) and (2) of regulation 19 are at all times available for inspection in the home. Ref: 6.7	**Met**
	Action taken as confirmed during the inspection: During the course of the inspection, a broad sample of records was requested for review; records were available and were provided to the inspectors.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall ensure that the safe place in the home is appropriately secured. Ref: 6.4	**Met**
	Action taken as confirmed during the inspection: The inspectors reviewed the safe place in the home and were satisfied with the location of the safe place and access arrangements. A sample of patients' cash records was reviewed and these agreed to the cash balances in hand.	

Area for improvement 2 **Ref**: Standard 14.9 **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall arrange to review the reason why the cash record for the identified patient was not updated and implement measures to ensure that records are kept up to date. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: The cash ledger for the identified patient was provided for review and this identified that the patient's cash ledger had been updated accordingly.	
Area for improvement 3 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the patient or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each patient. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: A sample of treatment records were reviewed which identified that a template was in use to record hairdressing and chiropody treatment records. Advice was provided to the responsible person in respect of amending the template to provide more space for signatures to be recorded.	
Area for improvement 4 **Ref**: Standard 14.26 **Stated:** Second time **To be completed by:** 26 November 2017	The registered person shall ensure that an inventory of property belonging to each patient 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	**Met**
	Action taken as confirmed during the inspection: A sample of patients' inventory records were reviewed which identified that patients had a template in place to record the personal property in their rooms. Records identified	

	that records had consistently been subject to a quarterly check.	
Area for improvement 5 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 26 November 2017	The registered person shall ensure that any changes to the individual agreement are agreed in writing by the patient or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded. Ref: 6.7	**Met**
	Action taken as confirmed during the inspection: A sample of records were reviewed which identified that a number of patients had a signed agreement in place with the home (which included the costs of pre-agreed expenditure). Where patient records did not include a signed written agreement, evidence was presented by the responsible individual that identified that the home had shared patients' agreements with patients' representatives including representatives of the commissioning trusts.	
Area for improvement 6 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 26 November 2017	The registered person shall ensure that the arrangements for managing a patient's finances are specified in the patient's individual agreement. Written authorisation is obtained from each patient or their representative to spend the patient's personal monies to pre-agreed expenditure limits. The written authorisation must be retained on the patient's records and updated as required. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the patient is managed by a HSC Trust and does not have a family member or friend to act as their representative, the authorisation about their personal monies must be shared with the HSC Trust care manager. Ref: 6.7	**Met**
	Action taken as confirmed during the inspection:	

	As noted above, a sample of records were reviewed which identified that a number of patients had a signed agreement in place with the home (which included a personal monies authorisation template). Where patient records did not include a signed written agreement and personal monies authorisation, evidence was presented by the responsible individual that identified that the home had shared patients' agreements with patients' representatives including representatives of the commissioning trusts.	

6.3 Inspection findings

6.3.1 Income, expenditure, banking and property records

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.

The responsible individual confirmed that the home was not acting as appointee for any patient in the home. Inspectors were advised that the commissioning trusts or family members were acting in this capacity for patients in the home.

A sample of income and expenditure records for ten 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.

An extensive sample of expense transactions was reviewed to ensure that the receipts were in place to support the entries on the ledgers. In all but one case, the supporting purchase receipts for expenditure were available within the records. One receipt for the purchase of clothing to the value of £50 could not be located, RQIA were advised that the receipt had been misplaced. Several expense receipts included items purchased for more than one patient and inconsistency was observed in respect of clearly detailing on communal receipts which items were purchased in respect of which patients.

Within the sample of ledgers reviewed it was observed that some transactions were recorded out of chronological order; one patient's records identified that an entry had been recorded including the balance, while the next entry on the ledger predated the entry above.

The sample of the ledgers records also reflected that in a number of instances, the exact cost of the expense had been recorded, rather than the withdrawal of monies and the return of any change. This method was not in keeping with best practice in recording income and expenditure transactions; however these entries were noted to be in the minority of the transactions on the sample of ledgers reviewed.

The patients' ledgers evidenced that there were monies returned from shopping for patients' birthday and Easter shopping expenditure; however there was no corresponding withdrawal in advance of the shopping trip. A review of the records and discussion with the responsible person established that monies for this expenditure were paid from the patients' pooled bank account to designated staff members with the change (in cash) returned from the shopping trip into each individual patient's cash balance. It was also noted that on one patient's ledger, a cheque lodgement had been recorded on their cash ledger.

Feedback was provided to the responsible person to ensure that bank transactions are not mixed with cash transactions recorded on the cash ledger. It was clarified that only cash related transactions should appear on the cash book/ledger for each patient. The responsible individual noted that the HSC trust were aware of the mechanism for facilitating seasonal expenditure for patients in the home ie: the transfer of patients' monies from the patients' bank account to designated staff members' accounts.

Ensuring that there are accurate and up to date records maintained of patients' income and expenditure was identified as an area for improvement in respect of the above findings.

A number of the ledgers evidenced that amendments had been made to entries on the ledgers, which had not been dealt with in accordance with the Care Standards for Nursing Homes (2015). Errors on the ledgers were routinely crossed through with the balance over-written; the amendments had not been initialled. The responsible person was advised to ensure that corrections are dealt with appropriately ie: a clear line drawn through the error with an amendment on the line below and any amendment initialled by the person making the entry.

An area for improvement was made to ensure that errors on the ledgers are dealt with in the appropriate manner in future.

A review of the ledger for one patient identified an entry relating to the purchase of clothing. The receipt for this purchase was reviewed and it was noted that the staff member had used a personal store loyalty card when making the purchase. An area for improvement was identified to ensure that staff members are reminded that it is prohibited that they use personal store loyalty cards to earn points when making purchases on behalf of patients.

Discussion established that the home operated a bank account for patients' monies. The responsible person provided evidence which detailed that bank account had a generic name and did not clearly detail that the money within the account belonged to patients. Advice was provided to the responsible person to contact the bank and ask for this to be amended to a more appropriate account name.

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 as well as individual electronic records detailing the overall monthly income and expenditure. 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.

Advice was provided to the responsible person to review the layout of the template to ensure that there is sufficient space for those completing the template to sign their names. It was also suggested that a sample of signatures be introduced and held on file to identify those making entries in the income and expenditure/treatment records.

A sample of the personal property records were reviewed for patients detailing those items in their rooms which belonged to them. Records had been signed and reflected that a quarterly check of the records had been carried out.

Transport records were in place detailing the miles travelled by patients and the member(s) of staff accompanying staff. The responsible person clarified 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 (there is further discussion about patient agreements in section 6.3.2 of this report).

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 were traced and this identified that the calculations were arithmetically correct, however other records had not been completed to calculate the miles travelled and the subsequent costs to those patients travelling (only the start and end mileage had been calculated). This was discussed with the responsible individual and advice was provided to ensure that there was consistency in the approach to recording journeys.

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.

6.3.2 Patient Agreements and personal monies authorisation documents

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 records were reviewed which identified that a number of patients had a signed agreement in place with the home (which included the costs of pre-agreed expenditure). Where patient records did not include a signed written agreement, evidence was presented by the responsible individual 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.

Included within the sample of agreements was a patient's agreement which had been signed by the patient's representative, however the transport agreement section had not been completed to indicate whether the patient or their representative were choosing to opt in or opt out of the scheme.

The inspectors noted that the home should ensure that where agreements are signed, they are checked to ensure that patients or their representatives have completed the forms. It was also noted that no representative of the home had signed or dated the patient's agreement on behalf of the home.

6.3.3 Physical security and safe contents

The home had a safe place available for the deposit of cash or valuables belonging to patients; the inspectors were satisfied with the location of the safe place and the persons with access. On the day of inspection, cash belonging to a number of patients was lodged for safekeeping; no valuables were on deposit. A sample of the cash balances secured on behalf of patients agreed to the records held.

Areas of good practice

A safe place available for the deposit of cash or valuables belonging to patients and a sample of records agreed to the cash balances in hand.

Areas for improvement

No areas for improvement were identified during 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 Marina Lupari, responsible person, as part of the inspection process.

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, 2015.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPS Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 14.9 **Stated:** First time **To be completed by:** 14 December 2018	The registered person shall ensure that accurate and up to date records of income and expenditure are maintained for patients. Transactions should be recorded in the correct chronological order, with the amount of the withdrawal of monies and any change recorded on the ledger (not the amount of the expense). Communal receipts should clearly detail which patients purchased which items and only cash related transactions should appear on the cash book/ledger for each patient. Ref: 6.3.1
	Response by registered person detailing the actions taken: The Registered Person shall ensure that accurate and up to date records of income and expenditure are maintained for residents. New audit templates have been created and are lead by the Business Support Manager to ensure all records are accurate and up to date. A memo has gone out to remind staff of the operational guidelines in regards to management of residents monies. Communal receipts will clearly detail which residents purchased which items and only cash related transactions will appear on the cash book/ledger for each residents.New templates have been created to clearly detail communcal receipts.
Area for improvement 2 **Ref**: Standard 14.11 **Stated:** First time **To be completed by:** 14 December 2018	The registered person shall ensure that records made on behalf of patients are legible and mistakes appropriately dealt with on the face of the ledger (ie 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). Correcting fluid is never used to amend records. Ref: 6.3.1
	Response by registered person detailing the actions taken: The Registered Person shall ensure that records made on behalf of the patients are legible and mistakes are appropriately dealt with on the face of the ledger. A new audit template has been created and is lead by Business Support Manager to ensure mistakes are appropriately dealt with.
Area for improvement 3 **Ref**: Standard 14.16 **Stated:** First time **To be completed by:** 14 December 2018	The registered person shall ensure that where staff purchase items on behalf of patients, any store loyalty points earned are owned by the patient and this is documented on the receipt. Where a patient is not a member of a loyalty scheme, staff do not benefit from the transaction by using their personal loyalty cards. Receipts for such purchases are returned to the patient for their own records Ref: 6.3.1

	Response by registered person detailing the actions taken: The Registered Person shall ensure that where staff purchase items on behalf of residents, any store lotaly points eared are owed by the resident and this is documented on the receipt. Staff will not benefit from the transaction by using their personal loyalty cards. A memo has gone out to remind staff of the operational guidelines in regards to management of residents monies.

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

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