Announced Finance Inspection Report
25 January 2018

Three Islands

Type of Service: Nursing Home
Address: 62-66 Main Street, Toomebridge, BT41 3NJ
Tel no: 028 7965 0650
Inspector: Briege Ferris

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 40 beds that provides care for patients with a learning disability.

3.0 Service details

Registered organisation/registered person: D McAteer & A McAteer	**Registered manager:** David Joseph McAteer
Person in charge of the home at the time of inspection: Biriu Kuriakose	**Date manager registered:** 07 May 2009
Categories of care: NH-LD, NH-LD (E)	**Number of registered places:** 40

4.0 Inspection summary

An announced inspection took place on 25 January 2018 from 10.00 to 16.10 hours. The registered manager was provided with less than 24 hours' notice of the inspection.

This inspection was underpinned by Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

The inspection assessed progress with any areas for improvement identified since the last finance inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found for example: a safe place in the home was available; staff could clearly describe the controls in place to safeguard patients' money and valuables; records were available relating to monies received and used on behalf of patients; receipts were available for expenditure; official documents were available in respect of appointee arrangements; records of charges for transport services agreed to journey records maintained; policies and procedures were available and up to date and a sample of records identified that each patient had an up to date individual written agreement with the home.

Areas requiring improvement were identified in relation to signing each entry in each patient's income and expenditure records and ensuring that these records and bank accounts are reconciled and signed and dated by two people at least quarterly.

One patient who was spoken with noted that they were satisfied with the current arrangements in place to support them with managing their monies. The patient noted that "I love it here", "I'm happy enough".

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Anne McAteer, responsible individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent finance inspection dated 04 -08 January 2013

Other than those actions detailed in the QIP, no further actions were required to be taken following the most recent inspection on 04 - 08 January 2013.

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 no incidents relating to patients' money or valuables had been reported. The previous inspector who had visited the home was also contacted; they confirmed there were no matters to be followed up.

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 responsible individual, registered manager, the home administrator and one patient. A poster was displayed detailing that the inspection was taking place, however no relatives or visitors chose to meet with the inspector.

The following records were examined during the inspection:

- The Patients' Guide
- Four patients' finance files
- Four patients' individual written agreements with the home
- A sample of income and expenditure records maintained on behalf of patients
- A sample of records in respect of hairdressing and podiatry treatments facilitated in the home
- A sample of patients' comfort fund records
- A sample of records of patients' furniture and personal possessions
- The record of safe contents
- Written policies and procedures including:
    - "Accounting and Financial Control Arrangements policy incorporating the provision of an individual written agreement" October 2015
    - "Policy on receipting and recording patients expenditure" October 2015
    - "Transport and Mobility policy" March 2015
    - "Policy on patients' money or valuables going missing from the home" August 2015
    - "Patient comfort funds" February 2016
    - "Gifts and Endowments Policy" February 2016
    - "Record keeping" August 2017

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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 30 October 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last finance inspection dated 04 January 2013

Areas for improvement from the last finance inspection		
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, and the Nursing Homes Regulations (NI) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 5 (1) (a) (b)	The registered person must provide individual written agreements to any new patient or their representative not later than the day of admission. A copy of the signed agreement by the patient or their representative and the registered person must be retained in the patients records. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. The registered person must provide individual agreements to each patient or their representative currently accommodated in the home. A copy of the signed agreement by the patient of 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. The registered person must ensure that all patient written agreements comply with requirements under Regulation 5 of the	**Met**

	Nursing Homes Regulations Northern Ireland 2005 and Standard 4 of the DHSSPS Minimum Standards for Nursing Homes 2008. The registered person must share a copy of the homes individual patient agreement with each of the relevant trust care managers.	
	Action taken as confirmed during the inspection: The inspector confirmed that evidence was available which confirmed that patients or their representatives had been provided with individual written agreements.	
Area for improvement 2 **Ref**: Regulation 5 (2) (a) (b)	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 and/or the person by whom the fees are payable. The registered person must ensure that any changes to the individual patients agreement are agreed in writing by the patient or their representative. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded.	**Met**
	Action taken as confirmed during the inspection: The inspector confirmed that there was evidence individual patients or their representatives had been informed of any increase in the fees payable.	
Area for improvement 3 **Ref**: Regulation 19 (2) Schedule 4 (10)	The registered person must ensure that from 24 January 2013, 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.	**Met**

	Action taken as confirmed during the inspection: The inspector reviewed evidence which confirmed that records of individual patients' furniture and personal possessions were in place.	
Area for improvement 4 **Ref**: Regulation 18 (2) (c)	The registered person must ensure that any items of furniture, bedding, and other furnishings (including curtains and floor coverings) and equipment suitable to the needs of the patients and screens are provided and paid for by the home. If a patient or their representative wish to purchase specific items from the patients personal monies which include any of the items identified above, the registered person must ensure that the patients records provide evidence of discussion and agreement with the patient or their representative and the care manager.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed a sampled of records which confirmed that these records were in place for patients.	
Area for improvement 5 **Ref**: Regulation 27 (2) (d) & (4) (d) (i)	The registered person must ensure that any work necessary to keep the nursing home clean and reasonably decorated is provided and paid for by the home The registered person must ensure that any equipment or expense necessary to take adequate precautions against the risk of fire is paid for by the home.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed a sample of records which confirmed that patients had not paid for the cost of the above.	
Area for improvement 6 **Ref**: Regulation 19 (2) Schedule 4 (3)	The registered person is required to obtain written authorisation to open and manage a bank account on behalf of any new patient admitted to the home. The registered person must also ensure that written authorisation is obtained retrospectively for any other patient in the home for whom written authorisation to open	**Met**

	and manage a bank account does not exist. The registered person must confirm in writing to RQIA that the relevant authorisations have been obtained regarding patients bank accounts and are available within individual patient records. Where a representative of the home is acting as an "agent" for a patient, and that patients social security benefits are paid into an account and managed by the home. The registered person must ensure that written authorisation for this arrangement is retained in the patient's records.	
	Action taken as confirmed during the inspection: A sample of records confirmed that this evidence was in place for the patients reviewed.	
Area for improvement 7 **Ref**: Regulation 19 (2) Schedule 4 (3)	The registered person must have written evidence to confirm that they have been authorised by a patient or their representative or care management to approach the Social Security Agency to act as "nominated appointee" for the individual patient. The evidence must be available in the patient's records. The registered person must have documentary evidence in place from the Social Security Agency to confirm those persons working in the home acting as an appointee or agent of a patient. The registered person must ensure that the individual patient's agreement with the home accurately reflects these arrangements and records to be retained. The registered person is therefore required to ensure that written confirmation of the details of any representative of the home nominated as appointee of any patient is obtained from the Social Security Agency and retained on the patient's files. These details including the records to be kept should also be reflected within the relevant patient's agreements with the home. The registered person is therefore required to ensure that written authorisation is obtained	**Met**

	to act as agent for any relevant patient at the home and that this authorisation is retained on the patient's file. The arrangements for acting as agent should also be reflected in the patient's individual agreement with the home.	
	Action taken as confirmed during the inspection: A sample of records confirmed that this evidence was in place for the patients reviewed.	
Area for improvement 8 **Ref**: Regulation 19 (2) Schedule 4 (9)	The registered person must ensure that written authorisation is obtained from each patient or their representative to spend the personal allowance of monies of patients on pre-agreed expenditure. The written authorisation must be retained on the patients records.	**Met**
	Action taken as confirmed during the inspection: A sample of records confirmed that this evidence was in place for the patients reviewed.	
Area for improvement 9 **Ref**: Regulation 12 (1) (a) (b) (c) (2) (a) (b)	The registered person must ensure that appropriate aids or equipment necessary to meet each patient's individual needs are provided and paid for by the home and not from patients individual monies. The registered person must ensure that all aids and equipment used in or for the person of the home are properly maintained and any costs of repair are paid for by the home and not taken from patient's individual monies.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed a sample of records which confirmed that patients had not paid for the cost of the above.	
Area for improvement 10 **Ref**: Regulation 19 (2) Schedule 4 (9)	The registered person is required to ensure that two signatures are logged against every transaction recorded on behalf of the patients at the home.	**Partially met**
	Action taken as confirmed during the inspection: The inspector reviewed a sample of income	

	and expenditure records which established that each page of each patient's individual records were signed and dated by two people; however each individual transaction had not been signed. This was identified as an area for improvement under the Care Standards for Nursing Homes (2015).	
Area for improvement 11 **Ref**: Regulation 19 (2) Schedule 4 (9)	The registered person must ensure that any expenditure paid from patient's comfort fund is used for the benefit of the body of patients at the home and does not fund any items which should be paid for by the home. The registered person must liaise with the relevant trust/care manager to arrange a re-assessment of any patient in the home for whom the comfort fund has been used for expenditure for that patient due to a lack of personal monies. The patient's records should provide evidence of any liaison with the trust/care manager and the outcomes of any re-assessment. The homes policy and procedure for the comfort fund must be reviewed to ensure that the fund is managed appropriately and any expenditure is only for the benefit of the body of patients in the home. The policy and procedure should include reference to and inclusion of the patient and/or relative forum in the decision making process for expenditure from the comfort fund. A copy of the revised comfort fund policy and procedure should be forwarded to RQIA and each of the relevant trusts.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of records identified that this evidence was in place.	
Area for improvement 12 **Ref**: Regulation 19 (2) Schedule 4 (17)	The registered person was informed that the existing system for charging patients for transport services must cease immediately. The registered person must introduce a new system for charging patient for transport services which reflects the actual usage of the transport services provided to individual patients. The system should be clearly indicated within the homes revised transport	**Met**

	policy and procedures. The registered person must ensure that a transport agreement is in place between the home and each patient or their representative. A copy of the agreement signed by the patient or their representative and the registered person must be retained in the patient's records. The registered person must amend the homes policy on the provision of transport services to patients and ensure that it incorporates the new procedures. The homes revised transport policy and procedures should evidence consultation and agreement with the relevant Health and Social Care Trusts involved with the patients accommodated in the home. A copy of the homes proposed transport policy and procedure must be forwarded to RQIA.	
	Action taken as confirmed during the inspection: The inspector reviewed a sample of records which identified that this matter had been addressed.	
Action required to ensure compliance with Nursing Homes Minimum Standards 2008		**Validation of compliance**
Area for improvement 1 **Ref**: 25.16	It is recommended that the registered person ensure that the amount of cash from the comfort fund which is physically held at the home is kept to a minimum. Comfort fund monies should be lodged to the designated bank account should the level of cash go above an acceptable level (to be established by the registered person).	**Met**
	Action taken as confirmed during the inspection: The inspector confirmed that there was evidence this matter had been addressed.	

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 home administrator was able to clearly describe the home's controls in place to safeguard patients' money and valuables. She advised that she had completed adult safeguarding training in May 2016.

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

The home had a safe place available for the deposit of cash or valuables belonging to patients; the inspector was satisfied with the location of the safe place and the persons with access.

On the day of inspection no money belonging to patients was deposited for safekeeping, valuables belonging to one patient were deposited for safekeeping. A written safe contents record was available; entries had been signed and dated by two people. It was good to note that the record had reconciled to the safe contents on a monthly basis.

Areas of good practice

The home had a safe place available for the deposit of money or valuables; access was limited to authorised persons. Staff members spoken to were familiar with controls in place to safeguard patients' money and valuables.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Discussions established that a representative of the home was acting as nominated appointee for three patients (i.e: managing and receiving social security benefits on a patient's behalf). The responsible individual reported that she had requested that the WHSCT (Western Health and Social Care Trust) take over appointeeship for the three patients concerned; however, as at the date of the inspection, this had not been progressed by the trust. The responsible individual noted that she planned to follow up the matter with the WHSCT accordingly.

However, discussions established that the home was in direct receipt of the personal monies for six patients. In each case, clear records existed to detail the amount and timing of monies received on behalf of patients. The home administrator explained that for the remaining patients in the home, any expenditure was settled by the home initially and subsequently billed to patients' representatives as appropriate.

Records of income and expenditure were maintained on behalf of patients for whom cash was held or a bank account was managed. A review of a sample of these records established that transactions had been recorded meticulously and each page of each patient's income and expenditure records had been signed and dated by two people. However, the sample reviewed identified that individual transactions were not signed by two persons.

This was identified as an area for improvement.

A sample of transactions was traced in order to establish whether the appropriate supporting evidence was in place (for instance, evidence detailing the receipt of monies or a purchase receipt for expenditure). This identified that the supporting documents were in place for the sample chosen.

Discussions established that bank accounts were in place for six patients and discussions established the rationale for the respective arrangements which were in place. A review of a sample of statements for each patient identified that the names on the bank accounts reflected the individual names of the patients. The patients' individual written agreements with the home also included an appendix which clearly detailed the arrangements in respect of banking transactions to be carried out on behalf of patients. In case patient's case, the necessary authority had been provided by the patient or their representative, as set out in the appendices reviewed.

A review of the bank statements identified that individual entries had been ticked, which the home administrator confirmed as recording that the entry had been agreed. However, reconciliations of the accounts managed by the home had not been recorded and signed by two people. In addition, while each month, patients' records of income and expenditure had been ruled off on a monthly basis, a reconciliation signed and dated by two people had not been recorded.

These findings were identified as an area for improvement.

Hairdressing and podiatry treatments were being facilitated within the home and a sample of recent records was reviewed. Treatment records relating to the above services included almost all of the relevant details as required by the Care Standards for Nursing Homes (2015). Hairdressing and private podiatry services had a single charge and these two respective costs were not included in the standard treatment record template. Advice was provided to the home administrator to include these details from the date of the inspection.

Patients' property (within their rooms) was discussed and a sample of four patients was selected to review the records in place. Each patient had a "Record of items owned by the patient" record. In each case, each entry in the record had been signed and dated by two people. There was evidence that the records had been reconciled and signed and dated by two people at least quarterly.

The home operated a patients' comfort fund and records of income and expenditure were maintained. A bank account was in place to manage the fund; the bank account was

appropriately named in favour of the patients. A written policy and procedure was in place to guide the administration of the fund.

The home operated a transport scheme and a written policy and procedure was in place in respect of its operation. Discussion and a review of the records established that up to date details of the operation of the scheme are shared with the HSC trust on an annual basis. A review of a sample of charges to patients identified that these agreed to the related journey records.

Areas of good practice

There were examples of good practice found for example, records were available relating to monies received and used on behalf of patients; receipts were available for expenditure; official documents were available in respect of appointee arrangements and records of charges for transport services agreed to journey records maintained.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that income and expenditure records as maintained by the home and bank accounts managed by the home on behalf of patients are reconciled and signed and dated by two people at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The arrangements to support patients with their money on a day to day basis were discussed with the responsible individual, the registered manager and the home administrator.

Discussions identified how the home had individualised arrangements in place to meet the specific needs of individual patients regarding how they were supported to manage their money.

It was noted that arrangements to support patients with their money would be discussed with the patient or their representative prior to, and at the time of a patient's admission to the home.

The home had a number of methods in place to encourage feedback from patients or their representatives in respect of any issue, including: an annual questionnaire; the relatives' forum which meets every Sunday; the patients' forum which meets every month and day to day feedback from patients or their representatives.

Arrangements for patients to access money outside of normal office hours were discussed. Staff could clearly describe the arrangements which would be in place to meet the individual needs of patients living in the home.

The inspector met with one patient who noted that they were satisfied with the current arrangements in place to support them with managing their money. The patient noted that "I love it here", "I'm happy enough".

The patient noted that they knew the staff members to speak with should they wish the current arrangements to change or if they wanted to make any compliments or complaints.

Areas of good practice

There were examples of good practice identified in relation to listening to and taking account of the views of patients.

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 home's patient guide included a range of information for a new patient including general arrangements in the home regarding fees, financial arrangements and additional charges payable for services not included in the weekly fee.

Written policies and procedures were available and were easily accessible by staff. The sample of policies and procedures reviewed were dated within the last three years. Discussion with the home administrator established that she was clear on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures.

A sample of four patient files was chosen to review the individual written agreements in place with patients. A review of a sample of four patient files identified that each patient had a signed, up to date written agreement on their file setting out the terms and conditions of their residency in the home and any specific financial arrangement(s) in place to support them.

Each patient's agreement contained several appendices requesting authority to aspects of the various financial arrangements in place; one appendix set out the arrangements for personal allowance expenditure. For each of the four patient's agreements reviewed, this appendix had been completed as appropriate.

Areas of good practice

There were examples of good practice found for example, in respect of the availability of written policies and procedures, and signed individual written agreements.

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 Anne McAteer, the responsible individual, 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 Care Standards for Nursing Homes (April 2015).

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with DHSSPS Care Standards for Nursing Homes (April 2015).

Area for improvement 1 **Ref**: Standard 14.9 **Stated:** First time **To be completed by:** 26 January 2018	The registered person shall ensure that all allowances and income received on behalf of the patient and of the distribution of this money to the patient or their representative (with each transaction signed and dated by the patient and a member of staff); and receipted amounts of expenditure on behalf of the patient (with each transaction signed and dated by the patient and a member of staff). Receipts are held with the records. Ref: 6.5
	Response by registered person detailing the actions taken: At present we record each transaction, with receipts obtained and two signatures to verify.We also sign and date a completed ledger sheet with two signatures, Going forward, in line with the standard, we will ensure each transaction is signed and dated to enhance our current practice of just signing the completed ledger page.
Area for improvement 2 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 02 February 2018 and at least quarterly thereafter	The registered person shall ensure 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. Ref: 6.5
	Response by registered person detailing the actions taken: At present we reconcile the money and valuables held and accounts managed on behalf of patients monthly. We keep a bank balance sheet for the small number of bank accounts, signed and dated with two signatures. We will amend our practice to include signing each bank statement individually in line with the current standard.

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

The Regulation and Quality Improvement Authority

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