Unannounced Finance Inspection Report
3 October 2018

Drummaul House

Type of Service: Nursing Home
Address: 41 New Street, Randalstown, BT41 3AF
Tel No: 028 9447 3958
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 43 beds which provides care for older patients or those with a physical disability other than sensory impairment.

3.0 Service details

Organisation/Registered Provider: Hutchinson Homes Ltd **Responsible Individual(s):** Naomi Carey	**Registered Manager:** Maria Bothwell
Person in charge at the time of inspection: Maria Bothwell	**Date manager registered:** 1 April 2005
Categories of care: NH- Nursing Home I - Old age not falling within any other category PH - Physical disability other than sensory impairment	**Number of registered places:** 43 The home is approved to provide care on a day care basis only to 2 persons. There shall be a maximum of 3 named residents receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 3 October 2018 from 10.50 to 14.30 hours.

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 in respect of:

- A safe place was available for the deposit of money or valuables; access was limited to authorised persons.
- A sample of income and expenditure transactions recorded agreed to the supporting evidence (such as a treatment record).
- There were mechanisms to listen to and take account of the views of patients and their representatives in respect of any issue.
- The home administrator was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures.
- Written policies and procedures easily accessible.
- The registered manager was able to describe specific examples of how patients experienced equality of opportunity.

Areas requiring improvement were identified in relation to:

- Ensuring that reconciliations i.e.: checks of cash and valuables deposited for safekeeping on behalf of patients are checked and recorded on at least a quarterly basis.
- Ensuring that each patient's record of their furniture and personal possessions is kept up to date. This record should be signed and dated by a staff member and senior member of staff at least quarterly.
- Ensuring that where there is any change to a patient's written agreement with the home, the agreement is updated and the change shared with the patient or their representative for signature and agreement.
- Ensuring that written patient agreements (or copies) are available within the home.

One patient who was spoken with expressed how satisfied they were with the current arrangements and complimented the staff, (in particular the registered manager) about the support they received to manage and safeguard their money. The patient noted that they had "no complaints whatsoever" and that they were "very happy". Speaking generally about their time since being admitted to the home, and they improvements in their wellbeing, the patient noted "these people brought me up".

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	1	3

Details of the Quality Improvement Plan (QIP) were discussed with the registered manager as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent finance inspection dated 02 December 2013

A finance inspection was carried out on 2 December 2013; the findings from which were not brought forward to the inspection on 3 October 2018.

5.0 How we inspect

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

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

The inspector provided to the registered manager written information explaining the role of RQIA, the inspection process, the name of the inspector and the date of the inspection. It was requested that this information be displayed in a prominent position in the home so that relatives or visitors who had not been present during the inspection could contact the relevant inspector should they wish to discuss any matter or provide any feedback about their experience of the home.

The following records were examined during the inspection:

- The patient guide.
- Three patients' individual written agreements with the home.
- A sample of charges to patients or their representatives for care and accommodation.
- A sample of income, expenditure and checks maintained/carried out on behalf of patients.
- A sample of treatment records in respect of hairdressing and podiatry treatments facilitated in the home.
- Three patients' records of furniture and personal possessions (in their rooms).
- A sample of written policies and procedures including:
    - "Whistleblowing" December 2016
    - "Residents' money and valuables" March 2017
    - "Complaints investigations" October 2016

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 11 September 2018

The most recent inspection of the home was an unannounced medicines management inspection. No further actions were required to be taken following the most recent inspection on 11 September 2018.

6.2 Review of areas for improvement from the last finance inspection dated 2 December 2013

As noted above, a finance inspection was carried out on 2 December 2013; the findings from which were not brought forward to the inspection on 3 October 2018.

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 inspector met with the registered manager who confirmed that adult safeguarding training was mandatory for all staff members. The home administrator had most recently received this training in February 2018.

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. On the day of inspection, cash and a number of valuables were being secured within the safe place.

A written record of the items safeguarded within the safe place was available, records were available which evidenced that the items were checked and signed and dated by two staff members. However the most recent check of the safe record to the contents had been recorded on 27 June 2018, therefore outside the required three month period. It was highlighted that a check of the safe contents to the written record should be performed and recorded by two people at least quarterly. This was identified as an area for improvement. (There is further reference to checking patients' cash balances in section 6.5 of this report).

Areas of good practice

There were examples of good practice found in respect of a safe place available for the deposit of money or valuables and access was limited to authorised persons.

Areas for improvement

One area for improvement was identified during the inspection, in relation to ensuring that a check of the safe contents is performed and recorded by two people at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

Discussions with the registered manager and home administrator established that no representative of the home was acting as appointee for any patient (ie: managing a patient's social security benefits on their behalf). These discussions also established that the home was not in direct receipt of the personal monies for any patient.

Routinely the cost of additional services not covered by the weekly fee ie: hairdressing and podiatry were added to the monthly invoice for care and accommodation fees charged to patients or their representatives. On the day of inspection, cash balances for four patients were being held and it was noted that patients spent the cash held as they wished. No purchases were being made by the home on behalf of any patient.

For one patient, their family provided monies to the home which was routinely signed out to the patient for them to spend as they wished. This patient was in the home on the day of inspection and agreed to speak with the inspector in private about these arrangements. This patient expressed how satisfied they were with the current arrangements and complimented the staff, in particular the registered manager about the support they received to manage and safeguard their money. The patient noted that they had "no complaints whatsoever" and that they were "very happy". Speaking generally about their time since being admitted to the home, and the improvements in their wellbeing, the patient noted "these people brought me up".

Income and expenditure records were maintained for any patient for whom the home handled cash as described above. A review of the records identified that the records were made using a standard financial ledger format and transactions were routinely signed by two people. A sample of transactions was chosen to ascertain whether the relevant supporting evidence was available; this review established that the relevant evidence was in place.

A review of the records identified that the most recent check of the cash balances per the income and expenditure records had been performed on 11 April 2018. This was therefore outside of the required period for reviewing and checking the balance in hand to the income and expenditure records ie: at least every three months. An area for improvement has been listed under section 6.4 of this report; cash balances held for patients should also be checked at least quarterly.

Hairdressing and private podiatry treatments were being facilitated within the home and a sample of recent treatment records was reviewed. Routinely, these records detailed all of the information required by the Care Standards for Nursing Homes (2015). The cost of these treatments was added to the monthly invoices for care and accommodation fees and a sample of charges made agreed to a sample of treatment records reviewed.

A sample of charges for care and accommodation made to patients or their representatives was also reviewed and these agreed to the information detailed in the trust payment remittance for the patients in question.

The inspector discussed with the registered manager how patients' property (within their rooms) was recorded and was informed that each patient had a record detailed within the "property book". Three patients' names were chosen and the book containing the records was reviewed.

Each of the three patients had a record in place which had been signed and dated by two people. However, these records are required to be checked and signed and dated by two people at least quarterly. Each of the records reviewed had been checked on 11 April 2018 and should therefore have been checked and countersigned on 11 July 2018 at the latest.

Ensuring that records of patients' property are checked on at least a quarterly basis, with the records signed by a staff member and countersigned by a senior member of staff was identified as an area for improvement.

Discussions with the registered manager established that the home did not operate a transport scheme or a patients' comfort fund.

Areas of good practice

There were examples of good practice found in relation to: maintaining income and expenditure transactions and a sample of transactions could be traced in support of this process; a sample of charges made for care and accommodation were correct and hairdressing and podiatry treatment records detailed the required information.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that records of patients' property are checked on at least a quarterly basis, with the record signed and dated by two people.

	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 registered manager and the home administrator. These discussions established that the home had measures in place to be flexible to respond to the individual needs and preferences of patients. This was borne out in the discussions held with one patient, as described in section 6.5 above.

Discussions with the home administrator established that arrangements to pay fees and safeguard patients' monies in the home, would be discussed with the patient or their representative at the time a patient was admitted to the home.

Discussion with the registered manager established that the home had a number of methods in place to encourage feedback from families or their representatives in respect of any issue. This included a yearly satisfaction questionnaire, resident meetings, relative meetings, annual trust care reviews and day to day feedback from patients and their representatives.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of patients in order to deliver safe, effective and compassionate care.

The patient guide contained a range of information for a new patient and detailed arrangements for safeguarding monies, valuables, general information about fees and accessing services for which there was an additional fee e.g.: hairdressing.

Written policies were reviewed including those in respect of whistleblowing, complaints investigations and patients' money and valuables. Polices were easily accessible by staff and had been reviewed within the last three years.

Discussion with the home administrator established that she was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's existing whistleblowing procedures.

Discussion with the registered manager established that patient agreements were not held in the home, these were held in a sister home nearby. There was no rationale for this being the case, however it was noted that the administrator for both homes was based in the sister home. The inspector highlighted that each patient's written agreement with the home (or a copy) should be accessible within the home itself. The registered manager reported during the inspection, that having spoken to the home administrator, arrangements would be made to ensure that a copy of the patient agreements was available within the home.

Ensuring that patient agreements are held within the home was identified as an area for improvement.

The inspector was invited to meet with the home administrator at her office in the sister home nearby for discussion and to review the agreements.

The home administrator provided files for three patients whose records were chosen at random. Each of the files was provided and it was noted that each patient had a signed detailed written agreement in place with the home. The files in two of the three cases also evidenced that annual updates to the patients' agreements had been detailed and these changes had been agreed in writing by the respective patients or their representatives. Good practice was observed in respect of the detail reflected in the agreements and the annual updates.

However, a review of the third patient's records established that the most up to date agreement/amendment to the agreement reflected the fees for the 2015/16 year. There was no evidence on file that the patient or their representative had been provided with an update for signature in the 2016/17, 2017/18 or 2018/19 years. The home administrator noted that the patient's relative resided overseas and the agreement may have been emailed by the finance manager for the group of homes. Contact was made with the finance manager following the inspection, who confirmed that the most recent update had been posted to the patient's representative. However as noted above, no records were on file to evidence this and no additional evidence was presented following the inspection. In the days following the inspection, the finance manager confirmed that the patient's updated agreement had now been posted to their representative and that the patient's file would reflect this position.

Ensuring that there is evidence that each patient or their representative had been provided with an up to date written agreement or amendment to written agreement for signature and agreement was identified as an area for improvement.

The inspector discussed with the registered manager the arrangements in place in the home to ensure that patients experienced equality of opportunity and that staff members were aware of equality legislation whilst recognising and responding to the diverse needs of residents. The registered manager was able to describe specific examples of the way this was achieved.

Some of the areas of equality awareness identified during the inspection included: comprehensive pre-admission assessments and annual staff training on the care standards. The registered manager noted that consideration was currently being given to specific human rights/equality training for staff.

Areas of good practice

There were examples of good practice found in relation to: the home administrator's knowledge in relation to responding to a complaint or escalating a concern under the home's whistleblowing procedures; patient records selected as part of the sample had a signed written agreement with the home (albeit these required updating); written policies and procedures easily accessible; and the registered manager was able to describe specific examples of how patients experienced equality of opportunity.

Areas for improvement

Two areas for improvement were identified as part of the inspection. These related to ensuring that there is evidence that each patient or their representative had been provided with an up to date written agreement and ensuring that patient agreements are held within the home.

	Regulations	Standards
Total number of areas for improvement	1	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Maria Bothwell, registered manager, at the close of the inspection. The timescales commence from the date of inspection.

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

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home.

The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005 and the 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 The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 (2) Schedule 4 (3) **Stated:** First time **To be completed by:** 3 November 2018	The registered person shall ensure that a record of all accounts relating to the home, including a record of patient's fees and financial arrangements that are handled by the nursing home and a record of persons working at the home acting as the appointee or agent of a patient are kept in the home. This relates to ensuring that written patient agreements are accessible within the home. Ref: 6.7
	Response by registered person detailing the actions taken: The written patient agreements are now retained in Drummaul.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 17 October 2018	The registered person shall ensure that a reconciliation (check) of money and valuables held and accounts managed on behalf of residents 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: Reconciliation of residents money and valuables will be carried out quarterly, signed by the manager and countersigned by another staff member.
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 3 November 2018	The registered person shall ensure that an inventory of property belonging to each resident is maintained throughout their stay in the home. The inventory record 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
	Response by registered person detailing the actions taken: A property inventory will be maintained for each resident and reconciled quarterly by 2 senior staff.

Area for improvement 3 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 3 November 2018	The registered person shall ensure that any changes to the individual agreement are agreed in writing by the resident or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the resident or their representative is unable to or chooses not to sign the revised agreement, this is recorded. Ref: 2.8
	Response by registered person detailing the actions taken: Individual patient agreements will be sent to the residents and or their representatives so that any changes e.g. increases in charges payable can be agreed in writing. Records are being kept for those who are unable to or choose not to sign the updated agreement.

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

The Regulation and Quality Improvement Authority

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