Unannounced Finance Inspection Report
19 January 2018

Chester

Type of Service: Nursing Home
Address: 27 – 29 Chester Avenue, Whitehead, BT38 9QQ
Tel No: 028 9335 3060
Inspector: Briege Ferris

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

1.0 What we look for

2.0 Profile of service

This is a nursing home with 43 beds that provides care for patients with a dementia, or learning disability or physical disability other than sensory impairment or older patients with a mental disorder excluding learning disability or dementia.

3.0 Service details

Registered organisation/registered person: Chester Homes Ltd/Colin Nimmon	**Registered manager:** Gillian Dowds
Person in charge of the home at the time of inspection: Gillian Dowds	**Date manager registered:** 24 July 2014
Categories of care: Residential Care (RC) LD - Learning Disability MP(E) - Mental disorder excluding learning disability or dementia – over 65 years DE - Dementia Nursing Care (NH) PH - Physical disability other than sensory impairment DE - Dementia	**Number of registered places:** 43 comprising - 39 Nursing & 4 Residential. A maximum of 10 persons in category NH-PH. The home is also approved to provide care on a day basis to 3 persons.

4.0 Inspection summary

An unannounced inspection took place on 19 January 2018 from 10.00 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: the registered manager confirmed that adult safeguarding training was mandatory for staff; a sample of income and expenditure records identified that transactions were routinely signed by two people, and supporting evidence was available; income and expenditure records had been reconciled at least quarterly; detailed personal property records were in place for patients; hairdressing and podiatry treatment records were in place; the home had methods to obtain feedback from patientsand arrangements were in place to ensure that patients had access to their monies; each patient sampled had a signed, up to date agreement in place with the home and relevant patients had a signed “Finance authorisation slip” document in place.

Areas requiring improvement were identified: these related to ensuring that entries in patients’ income and expenditure records detail the amount of a withdrawal and the return of any change, not the cost of the purchase; that patient agreements provide a consistent level of detail in regards to the payment of fees; ensuring that a policy and procedure is in place addressing the management of records and information and ensuring that the complaints and whistleblowing policies are updated as these were outside the three year time period for review.

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

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	4

Details of the Quality Improvement Plan (QIP) were discussed with Gillian Dowds, 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.

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; the most recent inspector to visit the home was also contacted prior to the inspection.

The inspector met with the registered manager and subsequently, the area manager. Feedback from the inspection was provided to the registered manager.

The following records were examined during the inspection:

- The Patient Guide
- Written policies and procedures including:
    - "Clients – additional services" dated February 2016
    - "Policy for handling monies held in the home on behalf of clients" reviewed February 2016
    - "Accepting gifts/client & staff comfort funds"dated August 2016
    - "Whistleblowing" dated March 2012
    - "Residents Complaints (Expression of Dissatisfaction Procedure) dated April 2012
- Document entitled "Financial audit training for all staff who handle monies"
- A sample of patients' income, expenditure and reconciliation records
- A sample of treatment records for services facilitated within the home which attract an additional charge
- Four records of patients' personal property (in their rooms)
- A sample of charges to patients for care and accommodation fees
- Four written individual patient agreements
- Two written personal monies authorisations "Finance authorisation slips"

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 03 January 2018

The most recent inspection of the home was an unannounced medicines management inspection. The QIP from the inspection, which is due to be returned to RQIA by 16 February 2018, will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last financeinspection

The home has not previously received an RQIA finance inspection.

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 adult safeguarding training was mandatory for all staff on an annual basis. Records provided for review included a document entitled “Financial audit training for all staff who handle monies”. This detailed the controls in place in the home to safeguard patients’ monies and valuables and had been signed by the registered manager and staff members to confirm that it had been read and understood.

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

A safe place was available in the home for the deposit of money and valuables. Cash balances were being held for two patients, no valuables were being held. A record was in place detailing the deposit of any items for safekeeping and to record the payment of fees by cash or cheque. Entries in the record were signed and dated by two people.

Areas of good practice

The home had a safe place available for the deposit of money or valuables; access was limited to authorised persons.

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 with the registered manager identified that no representative of the home was acting as nominated appointee for any patient. The home was not in direct receipt of the personal allowance monies from a Health and Social Care (HSC) trust or any other appointed representative, such as a Solicitor.

The registered manager reported that it was not the home's policy to hold patients' cash in the home, rather, the cost of any additional goods or services were billed to patients' representatives on a monthly basis. She noted that at the time of the inspection, by exception, there were balances of cash held for two patients. The registered manager could clearly explain the rationale for this in light of each patient's individual circumstances. Receipt books were available to record the deposit of any monies on behalf of patients or pay fees for care and accommodation to the home. Entries were signed by either one or two people and advice was provided to the registered manager in respect of capturing two signatures on receipt books, as this acts as a protection both for patients and staff members receiving cash.

A review of a sample of the income and expenditure records for the two patients for whom money was held identified that transactions had consistently been signed and dated by two people. There was clear evidence that the records had been reconciled to the monies held at least quarterly; reconciliations had been signed and dated by two people.

A sample of transactions was selected to identify whether the supporting evidence for the transaction was in place e.g.: a deposit or expenditure receipt; in each case the supporting evidence was available.

However, a review of the records identified that staff had routinely recorded the actual cost of any goods (such as toiletries or newspapers) rather than recording the withdrawal of the monies to pay for the goods and the return of any change from the purchase. It was highlighted that the actual cost of the goods (the difference between the withdrawal amount and the return of any change)would be evident from the related expenditure receipts.

Ensuring that income and expenditure records are completed using a standard financial ledger format was identified as an area for improvement.

Hairdressing and podiatry treatments were being facilitated within the home. A sample of recent treatment records for these services was reviewed. Hairdressing treatment records detailed the information required by the Care Standards for Nursing Homes (2015), including the signature of the hairdresser and a person from the home to verify the treatment had taken place. Podiatry treatment records also reflected the majority of these details; however, the actual cost of a treatment was not always detailed on each treatment day record. Advice was provided to the registered manager to ensure that the actual cost is consistently recorded on each treatment record.

The inspector queried with the registered manager how patients' property (within their rooms) was recorded and was advised that each patient had a written record, which was kept up to

date. Four patients' names were selected from a list and a review of the records provided established that each of the four patients had a written property record in place.

The property records were detailed and had been signed and dated by two people, as is best practice. In addition, there was clear evidence that the records had been updated; each patient's record identified that they had been updated in November 2017. Where no new items had been brought into the patient's rooms this had been clearly recorded.

The registered manager confirmed that the home operated a patients' comfort fund, however she noted that records in respect of the fund were held at head office. She reported that comfort fund monies were not held in the home; she advised that should the home wish to spend any monies previously deposited, a request would be made to head office to release the money for the identified expenditure. A written policy and procedure was in place in respect of the administration of the comfort fund.

The registered manager provided a detailed schedule which set out the current weekly fees payable in respect of each patient. A copy of the most up to date HSC trust payment remittances were requested from head office and reviewed. A sample of charges made to patients for care and accommodation established that the correct charges had been made.

The registered manager confirmed that the home did not provide transport to patients. The area manager confirmed that the home had a bank account in place in respect of patients in the home which she noted was managed at head office. She confirmed that there were no monies belonging to patients held in the account, the only monies held for patients in Chester were the two cash balances held in the home on the day of the inspection.

Areas of good practice

A sample of income and expenditure records identified that transactions were routinely signed by two people, and supporting evidence was available; income and expenditure records had been reconciled at least quarterly;detailed personal property records were in place for patients and hairdressing and podiatry treatment records were in place.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that income and expenditure records are completed using a standard financial ledger format.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients 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. She described how discussions regarding the arrangements to store money safely in the home or pay fees would be held with the patient or their family around the time of admission to the home.

Discussion with the registered manager established that the home used methods such as "patient satisfaction forms" and questionnaires to obtain feedback from patients and their representatives, as well as day to day discussions with patients.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. Discussion established that the home had suitable arrangements in place to ensure that the individual needs of patients were met in this regard.

Areas of good practice

There were examples of good practice identified in relation to obtaining feedback from patients and arrangements to ensure that patientshad access to their monies.

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.

A copy of the patient guide was provided for review and this was noted to include a range of information for a newly admitted patient. The guide also included general information about the payment of fees and that the home could facilitate the deposit of valuables should the need arise. The guide also included a sample patient agreement which included appendices in respect of the payment of fees, a list of additional services for which there was a charge and arrangements to record patients' personal property.

Written policies and procedures were easily accessible and the registered manager provided copies of written policies and procedures for review during the inspection. A review of the policies provided identified that there was no policy addressing the management of records and information.

This was confirmed by the area manager during the inspection.

Ensuring that the policies and procedures for all operational areas of the home are in accordance with statutory requirements was identified as an area for improvement. Several policies and procedures were reviewed addressing the management of patients' monies, valuables and the management of the patients' comfort fund and any gifts or donations made to the home. It was noted that these policies had been reviewed in 2016. However a review of the Whistleblowing" policy and the "Residents Complaints (Expression of Dissatisfaction Procedure) identified that these were dated March and April 2012 respectively and therefore were outside the three year time period for review.

This was identified as an area for improvement.

Discussion with the registered manager established that patient agreements were held on a safe-stick which was evidenced as being held securely within the home's safe place. A sample of four patients were chosen to review the agreements in place with the home and these were printed from the safe-stick by the registered manager.

A review of the agreements identified that each patient's agreement was up to date and reflected the correct total weekly fee payable; each agreement reviewed had been signed and dated by a representative of the home and each patient's representative.The cost of additional services (such as hairdressing and podiatry) was also clearly detailed within the agreements reviewed.

Each agreement included an appendix setting out the weekly fee (which included a third party top up charge) and space for the detail of the person(s) paying the fee and the method(s) of payment to be recorded. The agreements for two patients set out with detail, the weekly fee and the separate amounts payable by each person, contributing to the total cost per week, together with the respective methods of payment. This was noted to the registered manager to reflect the level of detail required and was identified as good practice.

However, a review of the remaining agreements sampled identified that while the total cost per week was detailed, the equivalent level of detail included within other agreements reviewed had not been consistently applied. The detail in respect of third party topup elements of the total fee payable or nursing contributions from the HSC trust was not clearly detailed.

Ensuring that individual patient agreements consistently include the required level of detail in respect of the payment of fees was identified as an area for improvement.

Discussion with the registered manager established that the home used documents entitled "Finance authorisation slips" which detailed authority for the home to hold monies and make purchases of goods and services on behalf of the patient.

As noted in section 6.5 above, balances of cash were being held for two patients and the registered manager could clearly explain the rationale for this in light of each patient's individual circumstances. "Finance authorisation slip" documents were in place for each patient and were signed by the patient or their representative. The registered manager provided another version of the "Finance authorisation slip" which had been updated in December 2017. She noted that this provided more detail on the authority given to the home to hold or spend a patient's money and she advised that this would be implemented for the two patients for whom money was being held in the home.

Areas of good practice

The patient guide contained a range of information for new patients; each patient sampled had a signed, up to date agreement in place with the home and relevant patients had a signed "Finance authorisation slip" document in place.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to ensuring that patient agreements provide a consistent level of detail in regards to the payment of fees; introducing a policy and procedure addressing the management of records and information and ensuring that the complaints and whistleblowing policies are updated as these were outside the three year time period for review.

	Regulations	Standards
Total number of areas for improvement	0	3

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Gillian Dowds, registered manager, 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/to RQIA office for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.10 **Stated:** First time **To be completed by:**20 January 2018	The registered person shall ensure thata standard financial ledger format is used to clearly and accurately detail transactions for patients. The format captures the following information each time an entry is made on the ledger: the date; a description of the entry; whether the entry is a lodgement or withdrawal; the amount; the running balance of the patient's cash total held; and the signatures of two persons able to verify the entry on the ledger. Ref: 6.5
	Response by registered person detailing the actions taken: The financial ledger is now formatted as above and now includes the withdrawal and lodgement in each
Area for improvement 2 **Ref**: Standard 2.2 **Stated:** First time **To be completed by:**From the date of the next change in fees payable	The registered person shall ensure that there is a consistent level of detail provided within each patient's agreement with respect of the fees payable for each patient (including any nursing contribution or third party top up included in the weekly fee). Ref: 6.5
	Response by registered person detailing the actions taken: All agreements/schedules and new contracts are to be issued in April and will reflect the above and adhere to the required format.
Area for improvement 3 **Ref**: Standard 36.1 **Stated:** First time **To be completed by:** 19 March 2018	The registered person shall ensure that the policies and procedures for all operational areas of the home are in accordance with statutory requirements and there is a process of systematic audit in place to ensure compliance with policies and procedures. Ref: 6.7
	Response by registered person detailing the actions taken: All policies and procedures are currently in the process of being updated and will be reviewed regularly to ensure compliance

Area for improvement 4 **Ref**: Standard 36.4 **Stated:** First time **To be completed by:**19 March 2018	The registered person shall ensure policies and procedures are subject to a three yearly review at a minimum (and more frequently if required), and the registered person ratifies any revision to (or the introduction of new) policies and procedures. Ref: 6.7
	Response by registered person detailing the actions taken: All policy manuals are currently being updated to ensure all have been reviewed within 3 year period.

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

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