Unannounced Finance Inspection Report
31 July 2018

Rylands

Type of Service: Nursing Home
Address: 11 Doagh Road, Kells, Ballymena, BT42 3LZ
Tel No: 028 2589 2411
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 45 beds that provides care for older patients or those living with a physical disability other than sensory impairment or those patients with a learning disability.

3.0 Service details

Organisation/Registered Provider: Rylands **Responsible Individuals:** Trevor Duncan Karen Duncan	**Registered Manager:** Valerie Rutherford
Person in charge at the time of inspection: Valerie Rutherford	**Date manager registered:** 24 March 2014
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. LD – Learning Disability.	**Number of registered places:** 45 A maximum of 2 patients in category NH-LD.

4.0 Inspection summary

An unannounced inspection took place on 31 July 2018 from 10.10 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 and a safe record was in place which was checked on a monthly basis
- a sample of expenditure transactions recorded agreed to the supporting evidence (such as a treatment record) and to the subsequent invoices raised for those expenses to patients or their representatives
- there were mechanisms to listen to and take account of the views of patients and their representatives in respect of any issue
- the patients guide contained a range of information for new patients
- 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
- each patient record selected as part of the sample contained a signed written agreement with the home or evidence that an up to date agreement had been shared for signature and not returned.

Areas requiring improvement were identified in relation to:

- ensuring that treatment records are signed by the person providing the treatment and by a member of staff who is in a position to verify that the patient received the treatment
- ensuring that each patient's record of their furniture and personal possessions is kept up to date. This record is signed and dated by a staff member and senior member of staff at least quarterly. Records are required to ensure that the patients' comfort fund bank account is checked, signed and dated by two people at least quarterly.

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	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 20 May 2013

A finance inspection was carried out on 20 May 2013; the findings from which were not brought forward to the inspection on 31 July 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. The care inspector who visited the home most recently was also contacted prior to the inspection, they confirmed there were no matters to be followed up from that inspection.

During the inspection, the inspector met with the registered manager 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 patients guide
- Three patients' individual written agreements with the home
- The safe contents record
- A sample of income and expenditure and reconciliation (check) records maintained on behalf of patients
- A sample of patient comfort fund records
- A sample of treatment records in respect of hairdressing and chiropody treatments facilitated in the home
- Three patients' records of furniture and personal possessions (in their rooms)
- A sample of charges to patients/their representatives for care and accommodation costs
- A sample of written policies and procedures including:
    - "Whistle blowing" March 2017
    - "Safeguarding of residents money & valuables" January 2017
    - "Residents comfort fund" March 2017

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 15 May 2018

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 20 May 2013

As noted above, a finance inspection was carried out on 20 May 2013; the findings from which were not brought forward to the inspection on 31 July 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 and the home administrator who confirmed that adult safeguarding training was mandatory for all staff members. The home administrator confirmed that she had most recently received this training in 2017.

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, a number of valuables were being secured within the safe place. Cash belonging to a number of patients was deposited for safekeeping; discussions established that this was money which was not used routinely for patient's personal expenditure. In most cases; balances were held for patients who had been admitted with a sum of money on their person. The home administrator described how the home paid for the costs of any additional goods or services required by individual patients, with the cost subsequently billed to patients or their representatives. This process is further described in section 6.5 of this report.

A written safe record was in place which was checked against the contents of the safe. These records were signed and dated by two staff members every month. A trace of several valuables and cash balances for patients identified that these agreed to the records held.

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; access was limited to authorised persons and a written safe record was in place which was checked on a monthly basis.

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 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. The home administrator described how the home paid for the cost of additional services (mainly hairdressing and chiropody) with the cost subsequently billed to the patients or their representatives for settlement. A sample of records were reviewed which demonstrated this process in action. Clear, detailed records were in place to identify the goods or services which patients had received, the related costs and the respective invoices on which these costs had been detailed. A sample of expenses recorded on the invoices was traced to establish whether the appropriate supporting evidence was in place. For the sample of expenses reviewed, this evidence was available.

As noted in section 6.4 above, cash and valuables belonging to a number of patients was deposited for safekeeping in the safe within the home. Clear records were in place to detail that the cash and the items had been checked against the records routinely, on a monthly basis, with the balance signed and dated by two people.

Hairdressing and private chiropody treatments were being facilitated within the home and a sample of recent treatment records was reviewed. Routinely, the hairdressing treatment records detailed the majority of the information required by the Care Standards for Nursing Homes (2015) however the records reviewed were not signed by the hairdresser, as is required. A review of chiropody treatment records identified that a retrospective invoice was provided, detailing the names of the patients who had been treated on a given day. Discussion was held with the registered manager and the home administrator in respect of ensuring that a contemporaneous record is made which includes the details as set out within the above standard.

An area for improvement was identified to ensure that treatment records include all of the details as required by the Care Standards.

The inspector discussed with the home administrator how patients' property (within their rooms) was recorded and was informed that each patient had a record. A sample of three patients' records was chosen and their files provided. Each patient sampled had a record in place; however these evidenced weaknesses in the record keeping; only one of the three records was signed by two people, as is required. Two of the three records were dated August 2017 and February 2016 respectively and there was no evidence presented to suggest that they had been reviewed and updated subsequently.

Records of patients' property should be checked on at least a quarterly basis, with the records signed by a staff member and countersigned by a senior member of staff.

This was identified as an area for improvement.

A record of charges to patients or their representatives for care and accommodation fees was available for review by the inspector and a sample of charges reviewed identified that the correct amounts had been charged.

A patients' comfort fund was in place and a bank account was in place to manage the fund. Receipts were available to evidence how the money had been spent; no cash was held in respect of the fund. There was evidence that a quarterly check of the bank account had been performed by the home administrator, however it was highlighted that any bank accounts managed on behalf of patients should be reconciled and signed and dated by two people.

This was identified as an area for improvement.

Discussions with the registered manager established that the home did not operate a transport scheme.

Areas of good practice

There were examples of good practice found in relation to expenditure transactions recorded in respect of goods or services required by patients which are not covered by the weekly fee. A sample of transactions could be traced in support of this process. A sample of charges to patients or their representatives for care and accommodation agreed to that which should be charged.

Areas for improvement

Three areas for improvement were identified during the inspection in relation to ensuring that treatment records are signed by the person providing the treatment and a member of staff who

is in a position to verify the patient received the treatment. Records in respect of patients' furniture and personal possessions are required to be kept up to date, signed and dated by a staff member and senior member of staff at least quarterly; and ensuring that the patients' comfort fund bank account is checked and signed and dated by two people at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	3

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 day to day basis were discussed with the registered manager and the home administrator. As noted above, monies held for patients were not used for routine expenditure, rather in most cases, cash had been brought to the home at the time the patient was admitted and had been on deposit ever since.

Discussions with the home administrator established that arrangements to pay fees and settle invoices for goods or services paid initially by 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 quality assurance questionnaire, relatives' meetings, "residents" meetings, and feedback on a day to day basis.

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 information for a new patient including the organisational structure of the home; the home's terms and conditions of residency including the current scale of charges and a copy of the home's complaints procedure.

Written policies were reviewed including those in respect of whistleblowing, safeguarding patients' monies and valuables and the administration of the patients' comfort fund. Policies 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 was held with the home administrator regarding the individual written agreements in place with patients and the home. A sample of three patients' individual written agreements was reviewed which established that each patient had an agreement on their file; these were dated between 2013 and 2018 ie: the respective dates of admission of the patients. There was evidence available to identify that on an annual basis, updates to the agreements (namely because of regional changes in fees) had been shared with the patients or their representatives for signature. One of the amendment documents had been returned signed, the remaining two amendment documents had not yet been returned by the respective patients or their representatives.

Review of a sample of the records identified that authorisation documents were in place whereby patients or their representatives had consented to treatments by the hairdresser and the private podiatrist and for the annual cost of toiletries (should the patient or their representative wish to opt-in to this arrangement). A schedule was in place on the patient files reviewed to detail a quarterly administrative check of the individual patient's file. These checks covered whether the appropriate documentation was in place on the file, whether invoices for costs previously paid for by the home on behalf of the patient had been recouped and how and when to follow up on any outstanding documentation not yet returned by patients or their representatives.

Areas of good practice

There were examples of good practice found in relation to the information contained in the patient guide; the home administrator's knowledge in relation to responding to a complaint or escalating a concern under the home's whistleblowing procedures. Patients records selected as part of the sample had a signed written agreement with the home and evidence that agreements had been updated to reflect any changes, with the updated agreements shared for signature.

Areas for improvement

No areas for improvement were identified as part of 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 Valerie Rutherford, 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 Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 14 August 2018 and at least quarterly thereafter	The registered person shall ensure that a reconciliation of…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: AnThe Resident's Comfort Fund is reconciled quarterly, signed by the Administrator and countersigned by the Nurse manager or Director.
Area for improvement 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 01 August 2018	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 resident 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 resident. Ref: 6.5
	Response by registered person detailing the actions taken: A system is in place that when a service is carried out within the home for a resident eg private podiatry or hairdressing, that the service is signed for by the person providing the service and that this is verified by the Nurse in Charge of the home that the service has been carried out.
Area for improvement 3 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 11 September 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: An inventory of property detailing personal items that are of value to the resident is insitu. This will be reconciled at least quarterly and will be signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

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

The Regulation and Quality Improvement Authority

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