The Regulation and Quality Improvement Authority

Unannounced Finance Inspection Report
29 November 2018

The Glebe Care Centre

Type of Service: Nursing Home
Address: 12 Glebe Road, Carnmoney, Newtownabbey, BT36 6UW
Tel No: 028 9084 8212
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 38 beds that provides care for older patients or those with a physical disability other than sensory impairment.

3.0 Service details

Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd Responsible Individual(s): Christopher Walsh	Registered Manager: Geraldine Boyce
Person in charge at the time of inspection: Geraldine Boyce	**Date manager registered:** 28 June 2012
Categories of care: NH-I, NH-PH	**Number of registered places:** 38

4.0 Inspection summary

An unannounced inspection took place on 29 November 2018 from 10.45 to 14.15 hours.

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

There were examples of good practice found in relation to:

- the availability of a safe place to enable patients to deposit money or valuables for safekeeping
- the existence of a separate patient bank account and comfort fund bank account
- records of income, expenditure were available including supporting documents
- mechanisms were available to obtain feedback from patients and their representatives
- the home administrator confirmed she was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures, and
- there were mechanisms in place to ensure that patients experienced equality of opportunity.

Areas requiring improvement were identified in relation to:

- ensuring that patients' personal property records are reconciled and signed and dated by two people at least quarterly
- ensuring that treatment records are signed by the person providing the treatment and countersigned by a member of staff to verify that the treatment as detailed has been delivered and
- ensuring that patients or their representatives are advised of the up to date fee arrangements which constitute a change to each patients' individual written agreement with the home. Individual written agreements should be kept up to date with any change to the patient's agreement agreed in writing by the patient or their representative.

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	4

Details of the Quality Improvement Plan (QIP) were provided to the responsible person and the registered manager of the home at the conclusion of the inspection. 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 reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with the home administrator and subsequently, the registered manager and the responsible individual. A poster was provided for display in a prominent position in the home detailing that the inspection was taking place, however no relatives or visitors chose to meet with the inspector.

The inspector provided to the home administrator 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:

- A sample of income, expenditure and reconciliation records (records of checks performed)
- A sample of bank statements in respect of the patients' pooled bank account
- A sample of comfort fund records
- A sample of written financial policies and procedures
- A sample of patients' personal property (in their rooms)
- A sample of charges to patients or their representatives for care and accommodation
- The service user guide
- A sample of patients' individual written agreements and
- A sample of treatment records for services facilitated within the home for which there is an additional charge to patients

The findings of the inspection were shared with the responsible individual and 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 03 October 2018

The most recent inspection of the home was unannounced medicines management inspection.

6.2 Review of areas for improvement from the last finance inspection dated 27 May 2014

A finance inspection of the home was carried out on 27 May 2014; the findings from which were not brought forward to the inspection on 29 November 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 registered manager confirmed that adult safeguarding training was mandatory for all staff in the home including administrative staff.

Discussions 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.

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, cash was being held for patients, one item belonging to a patient was being held within the safe place, this was an empty purse. The registered manager reported that the home used a book to record any such items; however this could not be located before the end of the inspection. Advice was provided to ensure that should the safe record not be located, a written record should be made of any items held within the safe place with the record signed and dated by two people at least quarterly.

Areas of good practice

There were examples of good practice found for example, in relation to the availability of a safe place to enable patients to deposit money or valuables for safekeeping.

Areas for improvement

No areas for improvement were identified as part of 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.

Discussion with the registered manager established that no person associated with the home was acting as appointee for any patient. Discussions with the registered manager established that for the majority of patients, monies for their personal expenditure or to pay for additional goods and services not covered by the weekly fee were deposited with the home by family members.

Records of income and expenditure were available for patients, including supporting documents e.g.: a lodgement receipt or an expenditure receipt. A sample of transactions was chosen to ascertain whether the supporting documents were available within the records, and for the sample chosen, these were found to be in place. Evidence was in place identifying that those depositing monies routinely received a receipt which was signed by two people.

As noted above, records of income and expenditure were available detailing that reconciliations, signed by two members of staff were available in the home. However it was noted that the most recent record of reconciliation available in the home signed by two people was dated 20 April 2018. The responsible individual provided a record which detailed that a balance of monies on hand had been recorded in October 2018; however, this did not constitute a comprehensive reconciliation.

An area for improvement was identified to ensure that records of patients' monies are reconciled and signed and dated by two people at least quarterly.

A patients' pooled bank account was in place to administer patients' monies. The account was named appropriately and records were available to evidence that the account was reconciled and signed and dated by two people on a monthly basis. The account had also been reconciled by two people most recently in April 2018 and therefore the area for improvement identified above also relates to the patients' bank account.

Hairdressing, chiropody and barbering treatments were being facilitated within the home and a sample of these treatment records was reviewed. Each record within the sample reviewed evidenced that neither the persons providing the treatment nor a representative of the home had signed the records to verify that the treatments had been delivered. Treatment records should be maintained in the manner as set out within standard 14.13 of the Care Standards for Nursing Homes (2015).

Ensuring that all treatment records are maintained in this manner was identified as an area for improvement.

The inspector discussed with the registered manager how patients' property (within their rooms) was recorded and requested to see a sample of the property records maintained. The registered manager provided the records for three patients and it was noted that each record was signed and dated by two people. However the records reviewed were dated between 2014 and 2016 and no evidence was presented to identify that they had been updated since the original record had been made.

The inspector highlighted that these records should be updated/reconciled on a quarterly basis by a member of staff and countersigned by a senior member of staff as per standard 14.26 of the Care Standards for Nursing homes, 2015. The responsible individual provided evidence that the a new template for capturing a quarterly check of the items recorded for patients had been provided to the home for completion, however the template had not been implemented at the date of the inspection.

Ensuring that these records are updated for all patients was identified as an area for improvement.

The home administrator confirmed that the home operated a comfort fund and a policy and procedure was in place to administer the fund. A separate bank account, which was appropriately named, was also in place.

The cash and banking records in respect of the fund had been reconciled and signed and dated by two people most recently in April 2018. As noted above, an area for improvement has been made to ensure that reconciliations are signed by two people and recorded at least quarterly.

The home administrator confirmed that the home did not operate a transport scheme.

Areas of good practice

There were examples of good practice found in relation to the existence of a separate patient bank account and comfort fund bank account; and records of income and expenditure were available including supporting documents.

Areas for improvement

Three areas for improvement were identified during the inspection in relation to ensuring that patients' personal property records are reconciled and signed and dated by two people at least quarterly; ensuring that treatment records are in place and detail the information set out within standard 14.13 of the Care Standards for Nursing Homes (2015) and ensuring that a reconciliation of patients' personal monies, the comfort fund and any related bank accounts are carried out 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.

Discussion with the home administrator established that arrangements to appropriately support patients with their money would be discussed with the patient or their representative at the time of the patient's admission to the home.

Discussion with the registered manager established that the home had a range of methods in place to encourage feedback from patients or their representatives in respect of any issue. She noted that day to day ongoing verbal feedback was the key mechanism for engaging with patients and families.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. This established that there were arrangements in place to ensure that the individual needs and wishes of patients could be met in this regard.

Areas of good practice

There were examples of good practice found in respect of the arrangements in place to support individual patients discussed during the inspection and mechanisms to obtain feedback and views from 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 service user guide provided a range of information for new patients including what services are covered for the weekly fee and those services attracting an additional charge.

Policies and procedures were discussed with the registered manager. The responsible individual provided evidence that a number of the policies held on file which were outside of the three year time period had in fact been reviewed in 2017, however the files had not been updated with the revised versions. Updated written policies and procedures were in place to guide financial practices in the home, including the administration of the patients' comfort fund, handling residents' monies and personal property, the patient's agreement, and managing lost or missing items.

Discussion with the home administrator established that she was aware of the home's policy on complaints management and whistleblowing.

Individual patient agreements were discussed with the registered manager and a sample of three patients' finance files were requested for review. This review established that each patient had a signed written agreement on their files which were dated between 2014 and 2016. However there was no evidence on the patients' files to identify that the patient's agreement had been updated subsequently, as is required. It was noted that there should be evidence that each patient or their representative has been advised of any changes to their original written agreement, with the change agreed in writing with the patient or their representative.

An area for improvement was identified to ensure that patients or their representatives are advised of the up to date fee arrangements which constitute a change to each patients' individual written agreement with the home. Individual written agreements should be kept up to date with any change to the patient's agreement agreed in writing by the patient or their representative.

Each patient's finance file also contained a personal monies authorisation detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services.

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

Areas of good practice

There were examples of good practice found: the home administrator confirmed that she was familiar with the home complaint's process and process for escalating any concerns under the home's whistleblowing procedures. The home's service user guide contained a range of information for a new patient, there were arrangements in place to ensure patients experienced equality of opportunity and each patient's file selected contained an individual written agreement and personal monies expenditure authorisation form.

Areas for improvement

One area for improvement was identified as part of the inspection in relation to ensuring that each patient's agreement is updated to reflect any changes with the update shared for signature by the patient or their representative.

	Regulations	Standards
Total number of areas for improvement	0	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 the responsible individual and the registered manager of the home, at the conclusion 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 DHSSPS 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 DHSSPS Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 30 November 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 patient or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each patient. Ref: 6.5
	Response by registered person detailing the actions taken: All treatment records and goods provided for the Residents will be signed by the Nurse in Charge
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 29 December 2018	The registered person shall ensure that an inventory of property belonging to each patient 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 audit of all residents property has been undertaken and records have been signed by 2 staff members and countersigned by the Nurse in Charge
Area for improvement 3 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 29 December 2018	The registered person shall ensure that a reconciliation of patients' personal monies, the comfort fund and any related bank accounts are carried out and signed and dated by two people at least quarterly. Ref: 6.5
	Response by registered person detailing the actions taken: A reconcilliation of all personal monies ,comfort fund and all related bank accounts will be carried out quarterly

Area for improvement 4 Ref: Standard 2.8 Stated: First time To be completed by: 15 January 2019	The registered person shall ensure that patients or their representatives are advised of the up to date fee arrangements which constitute a change to each patients' individual written agreement with the home. Individual written agreements should be kept up to date with any change to the patient's agreement agreed in writing by the patient or their representative. Ref: 6.7
	Response by registered person detailing the actions taken: Records are currently being updated to ensure all representatives are aware of any changes

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

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