Unannounced Finance Inspection Report
28 September 2018

Moneymore

Type of Service: Nursing Home (NH)
Address: Cookstown Road, Moneymore, BT45 7QF
Tel No: 028 8674 8118
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 41 beds that provides care for older patients or those with a physical disability other than a sensory impairment.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** Ailish Devlin
Person in charge at the time of inspection: The two Nurses in Charge	**Date manager registered:** 28 December 2017
Categories of care: Nursing Home (NH) I - Old age not falling within any other category PH - Physical disability other than sensory impairment	**Number of registered places:** 41 A maximum of 1 patient in category NH-PH. There shall be a maximum of 2 named residents receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 28 September 2018 from 10.20 to 14.30 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, a written safe record was in place; the existence of a separate patient bank account and comfort fund bank account; records of income, expenditure and reconciliation (checks) were available including supporting documents; arrangements were in place to support patients with their monies; mechanisms were available to obtain feedback from patients and their representatives; 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; detailed written policies and procedures were in place to guide financial practices in the home and there were mechanisms in place to ensure that patients experienced equality of opportunity.

Areas requiring improvement was identified in relation to ensuring that each patient has a written record made of the furniture and personal possessions which they brought to their room; ensuring that patients' personal property records are reconciled and signed and dated by two people at least quarterly; ensuring that chiropody treatment records are countersigned by a member of staff in the home and ensuring that there is evidence that any changes to patients' agreements have been made with the agreement shared by the home with the patient or their representative for signing.

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 provided to both nurses in charge 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 both nurses in charge and the home administrator.

The inspector provided to the nurses in charge 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.

Four patients spoke with the inspector and provided feedback in respect of their dissatisfaction with an aspect of care practice they had experienced the previous evening. This feedback was shared with the nurses in charge at the conclusion of the inspection and with the care inspector for the home following the inspection. One of the patients also noted that they "couldn't praise the nurses… and the kitchen staff enough".

The following records were examined during the inspection:

- A sample of income, expenditure and reconciliation (check) records
- 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 records (in their rooms)
- A sample of patients' individual written agreements
- A sample of patients' "financial assessment" documentation
- 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 both nurses in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 30 June 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP from the inspection was returned and approved by the care inspector. The 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 29 July 2013

A finance inspection of the home was carried out on 29 July 2013; the findings from which were not brought forward to the inspection on 28 September 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 nurses in charge confirmed that adult safeguarding training was mandatory for all staff in the home; the home administrator had participated in adult safeguarding training in July 2018.

Discussions with the nurses in charge 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 and valuables were being held for patients.

A written safe contents record “FSHC Valuables record” was in place to detail the contents of the safe; this had been reconciled and signed and dated by two people in September 2018.

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 and a written safe contents record.

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 nurses in charge and home administrator established that no person associated with the home was acting as appointee for any patient. It was noted that the home was not in direct receipt of the personal monies for any patient. For the majority of patients, monies for patients' 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, the most recent record of reconciliation available in the home was in respect of the August 2018 month-end.

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.

Hairdressing and chiropody treatments were being facilitated within the home and a sample of these treatment records was reviewed. The sampled hairdressing records routinely detailed the information required to be recorded by the care standards. However a sample of chiropody treatment records evidenced that while these were consistently signed by the chiropodist, these were not routinely signed by a representative of the home to evidence that the person had received the treatment.

It was noted that these records are required to be signed by both parties and this was identified as an area for improvement.

The inspector discussed with the home administrator how patients' property (within their rooms) was recorded and requested to see a sample of the property records maintained. The home administrator provided the records for three patients and it was noted that two of the patients had a record of personal property on their files entitled "Schedule of personal effects". One of the records had been signed by two people, as is required, a second record had not been signed; neither of the records were dated. It was noted that these records should be 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. As this evidence was not available, this was identified as an area for improvement.

The third patient's "Schedule of personal effects" record had items detailed however a line had been crossed through this and the word "error" written across the record, this entry had not been signed or dated. The home administrator liaised with care colleagues who confirmed that no other record was in place for this patient. Therefore there was no record of the patient's furniture or personal possessions in place and this 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 for the August 2018 month-end.

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, expenditure and reconciliation were available including supporting documents.

Areas for improvement

Three areas for improvement were identified during the inspection in relation to ensuring that a record is made of each patients' furniture and personal possessions, ensuring that patients' personal property records are reconciled and signed and dated by two people at least quarterly and ensuring that chiropody treatment records are countersigned by a member of staff in the home to verify that the treatment was delivered as recorded.

	Regulations	Standards
Total number of areas for improvement	1	2

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.

Day to day arrangements in place to support patients were discussed with the nurses in charge and the home administrator. They described a range of examples of how the home supported patients with their money. Discussion 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 nurses in charge established that the home had a range of methods in place to encourage feedback from patients or their representatives in respect of any issue. This included an annual questionnaire, regular audits, staff meetings, relative and resident meetings and the "me and my care" documentation on each patient's care records.

Arrangements for patients to access money outside of normal office hours were discussed with the nurses in charge. 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.

Written policies and procedures were in place to guide financial practices in the home. Policies were in place addressing areas of practice including general record keeping, confidentiality, the administration of the patients' comfort fund and the management of patients' personal allowance monies.

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

Individual patient agreements were discussed with the home administrator and a sample of three patients' finance files were requested for review. A review of the information established that each of the three patients sampled had a signed individual written agreement with the home. In addition annual updates to two of three sampled patient records were noted to be on file. These amendment documents detailed the changes to the (regional) fees over time and had been shared for signature with patients or their representatives. However the third patient's file which was sampled did not have the most recent update on file and on discussing this with the home administrator, he noted that this had been an oversight.

Ensuring that each patient's agreement is updated and shared for signature with the patient or their representative was identified as an area for improvement.

A review of the information on file for the three patients whose files were sampled, identified that documents entitled "financial assessment part 3" were in place setting out the express authority granted to the home to spend the patient's money on identified goods and services.

A review of the documents on file for the three patients evidenced that all three patients had this document on file which had been signed by the patient or their representative.

The inspector discussed with the nurses in charge 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 nurse in charge was able to describe examples of the way this was achieved within the home. She noted in particular that patients benefitted from developing a good rapport with families in order to get to know each patient as an individual and to find out for example what activities the patient enjoyed participating in.

Areas of good practice

There were examples of good practice found: 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 and detailed written policies and procedures were in place to guide financial practices in the home and there were arrangements in place to ensure patients experienced equality of opportunity.

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 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 both nurses in charge 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be completed by:** 09 November 2018	The registered person shall ensure that a record is maintained of the furniture and personal possessions which each brings bring into their room. Ref: 6.5
	Response by registered person detailing the actions taken: Registered Manager has discussed with Registered Nurses the requirement to have a record of furniture and personal possessions brought in by the Resident or their next of kin to the bedroom in which they occupy. This will be monitored by Registered Manager.
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:** 29 September 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: Registered Manager has discussed with Registered Nurses and Administrator the importance of signing off the treatment record and or the receipt to verify that the service was received and cost is referred to resident account.
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 09 November 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: Registered Manager has discussed with Registered Nurses the importance of Residents inventory of their property should be maintained throughout their stay in the Home. Registered Nurses to oversee that Key workers reconcile each Residents inventory record

	quarterly and that the record is signed by the key worker and countersigned by a Registered Nurse and or Registered Manager.
Area for improvement 3 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 09 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: 6.7
	Response by registered person detailing the actions taken: Registered Manager has discussed with Administrator that any change to a Resident agreement is agreed in writing by the Resident and or their representative. A record should also be made when a Resident or representative is unable to sign or chooses not to sign the revised change.

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

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