Unannounced Finance Inspection Report
18 February 2019

Rathmena House Care Home

Type of Service: Nursing Home
Address: 26 Rathmena Gardens, Ballyclare, BT39 9HU
Tel No: 028 9332 2980
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 29 beds which provides care for patients placed under the categories of care detailed in section 3.0 below.

3.0 Service details

Organisation/Registered Provider: MD Healthcare **Responsible Individual(s):** Lesley Catherine Megarity	**Registered Manager:** Joanne Roy
Person in charge at the time of inspection: Joanne Roy	**Date manager registered:** 29/10/2018
Categories of care: Nursing NH-PH - Physical disability other than sensory impairment NH-PH(E) - Physical disability other than sensory impairment over 65 years NH-LD - Learning Disability NH-LD(E) - Learning Disability over 65 years NH-I - Old age not falling within any other category Residential RC-I - Old age not falling within any other category	**Number of registered places:** 29 Not more than four persons in categories NH-LD and NH-LD(E) to be accommodated at any one time.

4.0 Inspection summary

An unannounced inspection took place on 18 February 2019 from 10.15 to 14.20 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 home administrator participated in adult safeguarding training
- records of income, expenditure and reconciliation (checks performed) were available including supporting documents
- arrangements were in place to support patients to manage 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 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 hairdressing and podiatry treatment records are maintained in the manner as set out in standard 14.13 of the Care Standards for Nursing Homes, 2015
- ensuring that the bank account used to administer patients' monies is renamed to clarify that the monies belong to patients and not to the home.

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 and the home administrator 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 registered manager and the home administrator.

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:

- A sample of income, expenditure and reconciliation records (records of checks performed)
- A sample of comfort fund records

- A sample of written policies and procedures
- A sample of patients' personal property records (in their rooms)
- A sample of patients' individual written agreements
- A sample of hairdressing and podiatry treatment records

The findings of the inspection were discussed with the registered manager and the home administrator at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 07 November 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 April 2013

A finance inspection of the home was carried out on 29 April 2013; the findings were not brought forward to the inspection on 18 February 2019.

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; the home administrator had participated in adult safeguarding training in 2018.

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 and valuables were being held for patients.

A written safe contents record "Valuables record" was in place to detail the contents of the safe; this had been reconciled, and signed and dated by two people in January 2019.

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, a written safe contents record was in place and the home administrator participated in adult safeguarding training.

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 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 patients' 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 January 2019 month end.

A pooled patients' bank account was in use to administer patients' personal monies. The name on the bank account did not clearly designate that the monies belonged to patients and not to the business. Ensuring that the name on the bank account is amended accordingly was identified as an area for improvement.

Hairdressing and podiatry treatments were being facilitated within the home and a sample of these treatment records was reviewed. The sampled hairdressing records evidenced that a record was made by the hairdresser which she signed. Separately, the home administrator typed the records of patients who had received treatments; this record was signed by the home administrator and a second member of staff in the home.

Podiatry treatment records were signed by the podiatrist; however, these were not signed by a representative of the home to verify that the treatment had been delivered. Feedback on these findings was provided to the registered manager and an area for improvement was identified to ensure that treatment records are maintained in accordance with standard 14.13 of the Care Standards for Nursing Homes, 2015.

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 for three patients. The registered manager explained that the home were in the process of updating the records and using a new template to record patients' property. The sample of records reviewed identified that one patient had their property recorded on the new template while two patients' records had not yet been updated on the new template.

A review of the records identified that two of the records were signed by two people (as is required) while one was signed by one person in February 2019. The remaining two records were dated August and October 2017 respectively and failed to evidence that they had been reconciled on a quarterly basis as is required by standard 14.26 of the Care Standards for Nursing homes, 2015. This finding 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. No bank account was used to manage the fund; a sum of cash was maintained for expenditure. Records were maintained using a standard financial ledger format. A review of a sample of transactions evidenced that supporting receipts for purchases and deposits were in place.

The registered manager 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 records of income, expenditure and supporting documentation.

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 the name on the bank account used to administer patients' personal monies is amended to detail that the monies belong to patients and not to the home and ensuring that treatment records are maintained as set out within standard 14.13 of the Care Standards for Nursing Homes (2015).

	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 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. This included operating an "open-door" policy, ongoing feedback from patients and relatives and relatives meetings.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager and home administrator. This established that a sum of money was available in a safe place in the home accessible by the nurse in charge so that in the event of a

patient requiring money outside of office hours, this could be facilitated. A record was maintained by the home administrator to evidence that the balance was checked regularly. Good practice was observed.

Areas of good practice

There were examples of good practice found in respect of the mechanisms to obtain feedback and views from patients and their representatives and the contingency arrangements in place to ensure that patients could access money outside of office hours.

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 and associated appendices contained a range of useful information for a new patient including the terms and conditions of a patient's residency in the home, details as to the scale of charges and the costs of any additional services facilitated in the home.

Written policies and procedures were in place to guide financial practices in the home, including the administration of the patients' comfort fund and the management of patients' personal monies and valuables.

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 whistleblowing procedures.

Individual patient agreements were discussed with the home administrator and a sample of three patients' agreements was requested for review. The home administrator provided the files for each patient; this identified that the patients either had an up to date, signed agreement in place or written evidence was in place to confirm that the patients' up to date agreements had been shared with the commissioning health and social care trust for review.

Records authorising the home to spend the patient's personal monies on identified goods and services were in place for all three patients.

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 patients. The registered manager was able to describe the means by which this was achieved in the home.

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, detailed written policies and procedures were in place to guide practices in the home, signed patient agreements were in place or there was evidence these had been shared with HSC trust representatives and there were arrangements in place to ensure patients experienced equality of opportunity.

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 the registered manager and home administrator, at the conclusion of the inspection. The timescales commence from the date of inspection.

The registered provider/registered 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 **Stated:** First time **To be completed by:** 18 March 2019	The registered person shall ensure that the name of the account used to administer patients' personal monies is amended to clearly identify that the monies belong to patients, not the home. Ref: 6.5
	Response by registered person detailing the actions taken: With effect from the 19th March 2019, the bank has now amended this.
Area for improvement 2 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 01 April 2019	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: Procedure has been implemented to ensure that an inventory of property belonging to each resident is maintained throughout the resident's stay in the home.This will be monitored
Area for improvement 3 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 19 February 2019	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: New documention now in place for services facilitated within the home such as hairdressing, which highlights evidence of staff signature to verify any treatment has been provided and includes associated cost to each resident.

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

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