



The Regulation and
Quality Improvement
Authority

Camphill
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Unannounced Finance Inspection of Camphill

28 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced finance inspection took place on 28 July 2015 from 09:55 to 13:30. A poster detailing that the inspection was taking place that day was positioned at the entrance to the home.

Overall on the day of the inspection, we found care to be compassionate; the safety and effectiveness of care were found to be good, however there are some areas identified for improvement. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report. This inspection was underpinned by the Nursing Homes Regulations (Northern Ireland) 2005.

On the day of inspection, we met with the registered manager and the business support administrator; no relatives or visitors chose to meet with us during the inspection. We would like to thank those who participated in the inspection for their co-operation.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	1

The details of the QIP within this report were discussed with Ms Joy McKay, the registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care/Maureen Royston	Registered Manager: Ms Joy McKay
Person in Charge of the Home at the Time of Inspection: Ms Joy McKay	Date Manager Registered: 4 June 2015
Categories of Care: NH-MP(E), NH-I, NH-PH, NH-PH(E), NH-DE	Number of Registered Places: 72
Number of Patients Accommodated on the Day of Inspection: 55	Weekly Tariff at Time of Inspection: £593.00 - £637.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following theme has been met:

Inspection Theme: Patients' finances and property are appropriately managed and safeguarded

Statement 1

The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Statement 2

Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Statement 3

A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained

Statement 4

Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with the registered manager and business support administrator
- Review of records
- Evaluation and Feedback

Prior to inspection the following records were analysed:

- Records of incidents notified to RQIA in the last twelve months

The following records were reviewed during the inspection:

- The patient guide
- The home's policies in respect of patients' personal allowance monies and valuables
- The home's other cash floats and sundry funds policy (including "residents' social fund")
- The home's current standard agreement with patients
- Four patient finance files
- Five signed patient agreements
- Most recent Northern HSC trust payment remittance
- Confirmation of correct fees charged to three patients for care/accommodation
- Personal allowance expenditure authorisations (1 signed, 3 not signed)
- Income/lodgements and expenditure, including comfort fund records
- Hairdressing and podiatry treatment receipts

- Records of items deposited for safekeeping with the home
- Four records of patients' personal property/inventory

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an announced estates inspection on 21 July 2015, the findings from which will be reported on separately.

5.2 Review of Requirements and Recommendations from the last Finance Inspection

There has been no previous RQIA inspection of the service.

5.3 Statement 1 - The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Is Care Safe?

The home has a "service user" guide, a copy of which was provided to us during the inspection. We noted that the guide included information for patients on the general terms and conditions of residency, and an appendix detailing financial information.

We noted that the home have a standard written agreement and amendment forms to update the standard agreement as the weekly fee changes over time. We asked to see a sample of finance files for patients in the home. On reviewing a sample of four files, we noted that three of four patients had a signed agreement on file which reflected the up to date fee arrangements for those patients on the day of inspection. The fourth patient had a signed agreement on file, however this was dated 2013 and reflected the fee arrangements in place at that time. On reviewing the remainder of the file, we noted that there was correspondence to the patient's representative and that effort was being made to contact representatives repeatedly about other finance-related matters.

We noted on reviewing the fourth patient's file that there was no written evidence to establish that the home had provided an updated agreement in 2014 or 2015. We discussed this with the registered manager and the business support administrator who explained that there were difficulties in getting documents signed by some family members. We accepted this, but noted that there must be written evidence on each relevant patient's file to confirm that the home have attempted to follow up on these matters. Copy documents sent for signature must be maintained along with the dates and details of follow up by the home.

A requirement has been made in respect of this finding.

We noted that the Care Standards for Nursing Homes (April 2015) included a number of additional components in each patient's agreement which did not appear in previously. We recommended that the registered manager engage with other Four Seasons Health Care colleagues in respect of reviewing the FSHC standard agreement which must contain all of these components as a minimum.

A recommendation has been made in respect of this finding.

Is Care Effective?

We queried whether there was any involvement by the home in supporting individual patients with their money; the registered manager advised that there was no involvement by the home in this regard and that families are highly involved in supporting patients in the home.

We noted that the home has a number of policies and procedures in place addressing controls in place to safeguard patients' money and valuables.

Is Care Compassionate?

We noted that written notifications of increases in fees in response to changes in regional fee rates had provided to patients or their representatives. It was noted that all increases in fees must be reflected in a patient's agreement with the home.

Discussions with the registered manager established that on the day of inspection, the home was not supporting any individual patient to manage their money.

Areas for Improvement

Overall on the day of inspection, we found care to be effective and compassionate. The safety and of care was found to be good, however there was one area identified for improvement; this related to following up on having individual written agreements with patients signed by patient representatives.

Number of Requirements	1	Number Recommendations:	1
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5.4 Statement 2 - Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Is Care Safe?

A review of the records identified that copies of the HSC trust payment remittances are available confirming the weekly fee for each patient in the home. There is an identified number of patients in the home who contribute their weekly care fees in full or part, directly to the home. For all other patients, the home is paid directly by the relevant HSC trust. A review of a sample of charges established that the correct amounts were being charged by the home.

The home is in receipt of the personal allowance monies for an identified number of patients in home from the Northern HSC trust. Copies of payment remittances are retained and payments made to the personal allowance bank account managed by the home form part of the monthly bank reconciliation. We reviewed the files for the identified patients and noted that they had signed personal monies authorisations in place from their Appointee.

For all other patients, family representatives deposit money with the home for safekeeping in order to pay for additional goods and services not covered by the weekly fee (such as for hairdressing, toiletries or other sundries).

A review of the records identified that the home provides a receipt to anyone depositing cash. We reviewed a sample of receipts and noted that receipts are routinely signed by two people.

We noted that records of income and expenditure are maintained on personal allowance account statements detailing transactions for individual patients. There are weekly transaction sheets signed by two people, there was also evidence that the business support administrator had audited the records. A pooled bank account is in place to hold personal monies belonging to patients; the bank account is named appropriately. We noted that there were weekly and monthly cash and bank reconciliations carried out which were signed and dated by two people.

We sampled a number of transactions from the records and were able to trace these entries to the corresponding records to substantiate each transaction, such as a receipt for a cash lodgement or hairdressing or shop receipt.

A review of the records identified that a hairdresser visit the home to provide services to patients. Treatment records were reviewed a sample of which established that while they were signed by either the hairdresser or the podiatrist, they were not routinely signed by a representative of the home to verify that the patient has received the service detailed and incurred the associated cost.

A requirement has been made in respect of this finding.

A review of the records established that that the home operates a fund for the benefit of the patients in the home. We noted that records relating to income and expenditure for the fund were maintained and that entries were routinely double signed and that a weekly and monthly reconciliation of the comfort fund monies was recorded, signed and dated by two people, good practice was observed.

We noted that a bank account was in place for the administration of the fund and that the account was named appropriately. We reviewed a sample of records for expenditure undertaken from the fund and noted that the expenditure appeared consistent with the home's policy addressing the "resident social fund".

Is Care Effective?

The registered manager confirmed that no representative of the home was acting as nominated appointee for any patient. As noted above, discussions established that the home receives money from family representatives and from the Northern HSC Trust for an identified number of patients. A review of a sample of four patients' records established that a signed personal allowance authorisation was in place for one of four patient, two other authorisations were on file but had not be signed the family representative and a fourth patient did not have an authorisation on file. We discussed these findings and the registered manager and business support administrator noted that it was difficult to obtain a signature from some family representatives and attempts had been made. We noted however that the home's effort to follow up on these matters was not apparent from the files reviewed. We noted that the home must ensure that any contact with family representatives to follow up on getting documents signed must be recorded on the file including the dates that documents are posted.

A requirement has been made in respect of these findings.

Is Care Compassionate?

We queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the registered manager confirmed that none of the patients had any known assessed needs or restrictions.

Areas for Improvement

Overall on the day of inspection, we found care to be safe and compassionate. The effectiveness of care was found to be good, however there were two areas identified for improvement; these were in relation to countersigning records of hairdressing and podiatry treatments and ensuring that signed personal allowance authorisations are followed up and documented.

Number of Requirements	2	Number Recommendations:	0
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5.5 Statement 3 - A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained

Is Care Safe?

A safe place exists within the home to enable patients to deposit cash or valuables. We viewed the location of the safe place and were satisfied with the controls around the persons with access.

We viewed the contents of the safe places and established that on the day of inspection, cash balances for a number of patients and the comfort fund monies as well as a number of non-cash items were being held within the safe place for safekeeping. On the day of inspection, the cash balance held did not agree to the records held, the cash balance was £10.00 short. As the administrator was not in the home on the day of inspection, this anomaly could not be resolved before the end of the inspection. However subsequent correspondence from the home clarified the rationale for the variance and the matter was satisfactorily resolved.

We noted that there was a record of safe contents which was typed and checked on a monthly basis, safe checks were signed and dated by two people.

Is Care Effective?

We queried whether there were any general or specific arrangements in place to support patients with their money. The registered manager explained how the home engages with HSC trust representatives on an ongoing basis, however noted that there were no specific agreed arrangements in place to support any patient at present.

We enquired how patients' property within their rooms was recorded and requested to see a sample of the completed property records for four patients.

We were advised that the property records were contained within the patients' care files and we were provided with the four care files for review. We noted that each patient's file contained a record of property. We noted that each patient's property was recorded on a "schedule of

personal effects” form which was part of the admission process. There was evidence that one of the four records had been updated however, none of the entries on the four records had been signed or dated; these records must be signed and dated by two people.

We discussed these findings with the registered manager and explained that additions or disposals of furniture and personal possessions brought into each patient’s room must be signed and dated by two people and that these records must be updated at least quarterly. We noted that a retrospective record for each patient in the home must be made.

A requirement has been made in respect of this finding.

Is Care Compassionate?

As noted above, there are safe storage arrangements within the home to enable patients to deposit cash or valuables, should they wish to. We enquired as to how patients would know about the safe storage arrangements; the registered manager explained that these matters are often discussed on admission in which case patients and their representatives are advised of where valuables are stored and who has access to the safe place.

We asked about arrangements for patients to access their money from the safe place in the home outside of office hours. The registered manager explained that the needs of the patients in the home are well understood and that there is pre-planning to ensure that patients have what they require to cover the weekend period.

Areas for Improvement

Overall, we found care to be safe and compassionate; the effectiveness of care was found to be good, however there was one area identified for improvement; this was in relation how patients’ property is recorded.

Number of Requirements	1	Number Recommendations:	0
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5.6 Statement 4 - Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

Is Care Safe?

On the day of inspection, the home did not operate a transport scheme for patients.

Is Care Effective?

As noted above, on the day of inspection, the home did not operate a transport scheme for patients, however we discussed options for patients to access other forms of transport and it was clear that arrangements exist in the home to support patients to access private transport and should the need arise.

Is Care Compassionate?

As above, we noted that the home has arrangements to support patients to access other means of transport.

Areas for Improvement

Overall on the day of inspection, we found care to be safe, effective and compassionate. No areas for improvement were noted in respect of Statement 4.

Number of Requirements	0	Number Recommendations:	0
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5.7 Additional Areas Examined

There were no additional areas examined as part of the inspection.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Joy McKay, the registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Care Standards for Nursing Homes (April 2015) etc. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered manager/Registered Person

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to finance.team@rqia.org.uk and assessed by us.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements

Requirement 1

Ref: Regulation
5 (1) (a) (b)

Stated: First time

To be Completed by:
28 September 2015

The registered person must provide ensure that any current patient in the home who does not have an up to date agreement/fees amendment in place is issued with one. Where it is difficult to secure signatures on agreements from patients' representatives, a copy of the agreement sent for signature should be retained on file detailing the date it was sent and any follow up from the home to secure signature.

Response by Registered Person(s)Detailing the Actions Taken:

All Current Patients of Camphill Care Home for which we did not hold an up to date agreement/fees amendment have been issued with same for completion and return. Copies of the agreement/fees amendment sent have been retained on file along with any necessary follow up letters requesting reutrn of same. All letter issued are dated to confirm date that documentation has been requested and date of follow ups. Home will issue letter to to confirm acceptance of terms & conditions as they have received no objections if no further response is received.

Requirement 2

Ref: Regulation
19 (2) Schedule 4 (3)

Stated: First time


To be Completed by:
28 September 2015

The registered person must ensure that that any outstanding personal allowance authorisations are followed up with patients/their representatives. Where it is difficult to secure signatures on personal monies authorisations, a copy should be retained on file detailing the date it was sent and any follow up from the home to secure signature.

Response by Registered Person(s)Detailing the Actions Taken:

All outstanding personal allowance authorisations have been issued to the relevant person etc. for completion and return. Copies of the personal allowance authorisations sent out have been retained on file with letter confirming date sent. All necessary follow up letters have been issued to chase up non return of same and are dated also with copy retained on file. Home will issue final letter to confirm that they understand that the relevant person etc. will be providing all personal effects for resident if no response is received. Should there be any time when the residents needs are not being met by the person responsible for the finances this will be reported by the home to the relevant Care Manager.

<p>Requirement 3</p> <p>Ref: Regulation 19 (2) Schedule 4 (9)</p> <p>Stated: First time</p> <p>To be Completed by: From the date of inspection</p>	<p>The registered person must ensure that treatment records for hairdressing and podiatry services facilitated within the home are also signed by a representative of the home to verify that the patient received the treatment they are being charged for.</p> <p>Response by Registered Person(s)Detailing the Actions Taken: Care staff etc. assisting residents attending hairdressing and podiatry services are signing the appropriate records to confirm that the treatment has been received by the resident.</p>
<p>Requirement 4</p> <p>Ref: Regulation 19(2) Schedule 4 (10)</p> <p>Stated: First time</p> <p>To be Completed by: 23 September 2015</p>	<p>The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by all newly admitted patients. The registered person must also ensure that a retrospective record is made of the furniture and personal possessions owned by existing patients accommodated in the home.</p> <p>All inventory records should be updated on a regular basis. (Care Standards for Nursing Homes, April 2015 require that a reconciliation of these records is recorded at least quarterly).</p> <p>Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry. The registered person should advise staff of the importance of recording inventory details consistently. Items of significant value or those requiring electrical safety testing should be distinctly highlighted on the record for ease of identification.</p> <p>Response by Registered Person(s)Detailing the Actions Taken: All resident property lists in the home are under review for accuracy, to include items of value and electrical items along with Serial Number where applicable. Two staff members will date and sign this document. Any new residents have an inventory completed as part of the admission procedure.</p>
Recommendations	
<p>Recommendation 1</p> <p>Ref: Minimum Standard 2.2</p> <p>Stated: First time</p> <p>To be Completed by: 28 October 2015</p>	<p>It is recommended that the registered manager engage with other Four Seasons Health Care colleagues in respect of reviewing the FSHC standard agreement which must contain all of the components set out in the DHSSPS Minimum Standards.</p> <p>Response by Registered Person(s)Detailing the Actions Taken: FSHC standard agreements are currently under review and will be updated to meet/comply with DHSSPS Minimum Standards. The agreements will be in place for issue with the new April 2016 Uplifted Rates.</p>

Registered Manager Completing QIP	J McKay	Date Completed	26/08/15
Registered Person Approving QIP	Dr Claire Royston	Date Approved	18.09.15
RQIA Inspector Assessing Response		Date Approved	19/09/15

Please complete in full and returned to finance.team@rqia.org.uk from the authorised email address