The Regulation and Quality Improvement Authority

Unannounced Finance Inspection Report
25 January 2017

Ashgrove

Type of Service: Nursing Home
Address: 55 Belfast Road, Newry BT34 1QA
Tel no: 02830269110
Inspector: Briege Ferris

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Ashgrove took place on 25 January 2017 from 10:35 to 15:10 hours.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care, and if the service was well led.

Is care safe?

A safe place in the home was available and staff members were familiar with controls in place to safeguard patients' money and valuables; no areas for improvement were identified.

Is care effective?

Controls to ensure patients' money and valuables were safeguarded were in place however four areas for improvement were identified during the inspection. These related to: ensuring that records of patients' valuables are reconciled and recorded by two people at least quarterly; ensuring 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; ensuring that each patient has a record of the furniture and personal possessions which they have brought into their room; and ensuring that patients' records of their furniture and personal possessions are kept up to date and are reconciled by two people at least quarterly.

Is care compassionate?

The home had a range of methods in place to encourage feedback from families or their representatives. The welcome pack contained information for new patients on fees and funding-related matters. The home administrator spoke about the patients with empathy; no areas for improvement were identified during the inspection.

Is the service well led?

A number of indicators of governance arrangements were evidenced; however three areas for improvement were identified during the inspection. These related to ensuring that each patient or their representative is provided with a written agreement, setting out the terms and conditions of residency; ensuring that any change to a patient's agreement (including the weekly fee or other financial arrangements are agreed in writing with the patient or their representative; and ensuring that that written authorisation is obtained from each patient or their representative to spend the patient's money to pre-agreed expenditure limits. The written authorisation including the arrangement for managing or handling patients' personal allowance monies should be clearly detailed for each patient and should be updated as required.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the (DHSSPS) Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	5

Details of the quality improvement plan (QIP) within this report were discussed with Jolly Joseph, 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.

1.2 Actions/enforcement taken following the most recent finance inspection

A finance inspection was carried out on 1 October 2010 on behalf of RQIA; the findings were not brought forward to the inspection on 25 January 2017.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/Maureen Claire Royston	**Registered manager:** Jolly Joseph
Person in charge of the home at the time of inspection: Jolly Joseph	**Date manager registered:** 17 August 2016
Categories of care: NH-DE	**Number of registered places:** 52

3.0 Methods/processes

Prior to the inspection, the record of notifiable incidents reported to RQIA in the last twelve months was reviewed; this identified that no incidents in relation to patients' money or valuables had been reported.

During the inspection, the inspector met with Jolly Joseph, registered manager; the home's administrator and the regional business support administrator. A poster detailing that the inspection was taking place was positioned at the entrance of the home, however no relatives or visitors chose to meet with the inspector.

The following records were examined during the inspection:

- The home's welcome pack for new patients
- Confirmation that the home administrator had received training on the Protection of Vulnerable Adults
- A sample of the home's policies addressing safeguarding patients' money and valuables
- A sample of income, expenditure, banking and reconciliation records
- The record of entries in the safe record
- A sample of records for hairdressing and podiatry services facilitated in the home
- A sample of charges made to patients or their representatives (for care and accommodation)
- A sample of patient social fund records
- Seven patient finance files
- Four records of patients' personal property (in their rooms)

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 June 2016

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.

4.2 Review of requirements and recommendations from the last finance inspection

As noted above, a finance inspection was carried out on 1 October 2010 on behalf of RQIA; the findings were not brought forward to the inspection on 25 January 2017.

4.3 Is care safe?

The home had one full time administrator and evidence was reviewed which confirmed that she had received training on the Protection of Vulnerable Adults (POVA). The administrator was able to describe the home's controls in place to safeguard patients' money and valuables in the home.

During discussion, 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; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, cash and valuables belonging to patients was lodged with the home for safekeeping.

The home had a written safe contents record; this evidenced that the entries recording any deposit or removal of items had been signed by two people. There is comment on the home's arrangements to reconcile these records in section 4.4 of the report.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

Arrangements in place for the home to receive the personal monies of any patient directly were discussed. Discussion established that no representative of the home was acting as nominated appointee for any patient. However, discussion and a review of the records evidenced that the home was in direct receipt of the personal monies for four patients either from the HSC trust or a Solicitor. The home had a patients' personal allowance bank account which was named appropriately in favour of the patients in the home. Records were available to confirm the amount and timing of the receipt of monies into respective patients' personal allowance balances clearly maintained by the home.

Discussion with the home administrator established that the home was also in receipt of money lodged by family members to pay for goods or services for which there is an additional charge, mainly hairdressing, podiatry, or other sundries.

A sample of the records for income and expenditure incurred on behalf of patients was reviewed. It was noted that the home maintained "personal allowance account statements" detailing income and expenditure, together with other records to substantiate each transaction, such as a duplicate receipt for a cash/cheque lodgement or a hairdressing treatment record. The inspector traced a sample of transactions and was able to evidence the relevant documents; for example, a receipt for an item of expenditure or a receipt for a lodgement which had been made to the home. There was evidence that records of personal monies held on behalf of patients were reconciled and signed and dated by two people on a monthly basis.

A review of the home's safe contents records however failed to evidence that the safe contents check had been reconciled. During the inspection, the business support administrator arranged to check the valuables to the safe contents record to ensure the record was up to date.

It was noted that the safe contents should be carried out and signed and dated by two people at least quarterly.

A recommendation was made for the first reconciliation this to be carried out before the end of the week in which the inspection took place.

As outlined above, hairdressing and podiatry treatments were being facilitated within the home and records were in place to evidence the patients treated on any given day and the cost of the respective treatments. The information detailed on treatment records (as required by DHSSPS Minimum Standard 14.13) was being consistently recorded for hairdressing treatments; however this was not the case for podiatry treatments.

A recommendation was made to ensure that where any service is facilitated within the home, 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.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see the completed property records for five randomly sampled patients. The administrators liaised with care colleagues in the home and provided the records for the sampled patients.

Records for the five sampled patients were obtained; one of these records was blank. This evidenced that there was no record of any furniture and personal possessions which the patient had brought into their room.

A requirement was made to ensure that a record of furniture and personal possessions brought by each patient into their room is maintained. A review of the four remaining records evidenced that none of the records had been signed or dated by staff; there was also limited evidence that the records had been updated.

A recommendation was made to ensure that the home reviews each patient's record of furniture and personal possessions and that these are brought up to date. Each patient's record should be kept up to date and be reconciled by two people at least quarterly.

The home had a patients' comfort fund, a written policy and procedure existed to guide the administration of the fund. It was noted that income and expenditure records were maintained, which were reconciled and signed and dated by two people every month.

The home administrator confirmed that the home did not provide transport to patients.

Areas for improvement

Four areas for improvement were identified during the inspection. These related to: ensuring that records of patients' valuables are reconciled and recorded by two people at least quarterly; ensuring 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; ensuring that each patient has a record of the furniture and personal possessions which they have brought into their room; and ensuring that patients' records of their furniture and personal possessions are kept up to date and are reconciled by two people at least quarterly.

Number of requirements	1	**Number of recommendations**	3

4.5 Is care compassionate?

Day to day to day arrangements in place to support patients was discussed with the home administrator. She described how she may speak with a patient or their representative around the time a patient would be admitted to the home to explain the home's arrangements to safeguard money and valuables or to discuss the payment of fees etc. Seven patients' finance files were reviewed and it was clear from this sample that the home administrator had contacted family and other representatives to advise if balances were running low for patients and to ask representatives to top up the balance accordingly. This therefore enabled patients to have money at their disposal to pay for any goods or services they desired.

Discussion established that the home had a number of methods in place to encourage feedback from families or their representatives in respect of any issue. The welcome pack contained information on fees and funding-related matters.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager and home administrator; this established that there was a contingency arrangement in place to ensure that this could be facilitated.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The home had a range of written policies and procedures addressing matters relating to safeguarding money and valuables, record keeping requirements and other relevant issues such as complaints and whistleblowing. Discussion with the home administrator also established that they were clear on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures.

Discussion was held regarding the individual written agreements in place with patients and a sample of seven patient files were selected for review. A review of the files identified that five of the seven patients had a signed agreement on their files; two patients did not have a signed agreement in place.

These findings were discussed with the registered manager and it was noted that there must be evidence available on each patient's file to demonstrate that each patient or their representative has been provided with an individual written agreement.

A requirement was made in respect of this finding.

Of the five patients who had a signed agreement on their file, one patient's agreement reflected the current terms and conditions in respect of the patient's residency in the home (the patient had been admitted in 2016). The remaining four patients' agreements did not detail of the current terms and conditions of the patients' residency in the home e.g.: one agreement was undated, while three agreements were dated 2013.

It was highlighted that any change to a patient's agreement (including the weekly fee or other financial arrangements) should be agreed in writing with the patient or their representative.

A recommendation was made in respect of this finding.

A review of the seven patient files evidenced that the home used documents entitled "Financial assessment Part 1, 2 and 3". These documents were used to detail the home's assessment of whether the patient could manage their own money (Part 1), what arrangements were in place regarding the management of the patient's personal allowance money (Part 2) and what authority the home had to make purchases of goods or services on behalf of the patient (Part 3).

A sample of seven patient files evidenced that four financial assessment Part 3 documents were in place which had been signed by the patient or their representative, while three were not in place. Two patients did not have financial assessment Part two in place; the personal money for these two patients was being received directly by the home either from a HSC trust or from a Solicitor.

The inspector noted that it was important to ensure that these documents were in place for all patients, irrespective of how their monies were being managed.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to ensuring that each patient or their representative is provided with a written agreement, setting out the terms and conditions of residency; ensuring that any change to a patient's agreement (including the weekly fee or other financial arrangements are agreed in writing with the patient or their representative; and ensuring that that written authorisation is obtained from each patient or their representative to spend the patient's money to pre-agreed expenditure limits. The written authorisation including the arrangement for managing or handling patients' personal allowance monies should be clearly detailed for each patient and should be updated as required.

Number of requirements	1	Number of recommendations	2

5.0 Quality improvement plan

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

The registered provider/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 provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to **the web portal** for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref**: Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be completed by:** 25 March 2017	The registered provider must ensure that the home maintains a record of furniture and personal possessions brought by each patient into their room. **Response by registered provider detailing the actions taken:** There is is now a record in place with each resident's personal property details. This will now be updated and signed on a quartley basis..
Requirement 2 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time **To be completed by:** 26 January 2017	The registered provider must ensure that each patient is provided with a written agreement, setting out the terms and conditions, by not later than the day they become a patient and in the case of unplanned admissions, within five days of admission. **Response by registered provider detailing the actions taken:** All written agreements are now in place. There is a system in place to ensure new admissions have an agreement in place on the day of admission or within 5 days if the admission is an emergency This will be monitored by the Home Manager.
Recommendations	
Recommendation 1 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 27 January 2017 and at least quarterly thereafter	The registered provider should ensure that a reconciliation of money and valuables held and accounts managed on behalf of patients 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. **Response by registered provider detailing the actions taken:** The Home Administrator carries out a reconciliation of money and valuables each month and this is checked and signed by the Home Manager on the day.

Recommendation 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 26 January 2017	The registered provider should 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. **Response by registered provider detailing the actions taken:** There are systems is in place to record any services provided in the home and this is signed by both the provider fo the service and a staff member.
Recommendation 3 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 25 March 2017	The registered provider should ensure that each patient's record of furniture and personal possessions which they have brought into their room is reviewed and brought up to date. Each patient's record should be kept up to date and be reconciled by two people at least quarterly. The record should be signed by the staff member undertaking the reconciliation and be countersigned by a senior member of staff. **Response by registered provider detailing the actions taken:** There is a record of each patients property in place, this will be reviewed when any changes occur and each record will be reviewed quaterly by a staff member and counter signed by the senior member of staff.
Recommendation 4 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 25 February 2017	The registered provider should ensure that any changes to the individual agreement are agreed in writing by the patient or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded. **Response by registered provider detailing the actions taken:** The Home administrator has approached the patient/their representative for completion of their individual agreemets as per the recommendation. Where residents or their reprexentatives are unable or chosing not to sign this is recorded in the residnets file.
Recommendation 5 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 25 February 2017	The registered provider should ensure that where a home is responsible for managing a patient's finances, the arrangements and records to be kept are specified in the individual agreement. Written authorisation is obtained from each patient or their representative to spend the patient's personal monies to pre-agreed expenditure limits. The written authorisation must be retained on the patient's records and updated as required. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the patient is managed by a HSC Trust and does not have a family member or friend to act as their representative, the authorisation about their personal monies must be shared with the HSC Trust care manager.

	Response by registered provider detailing the actions taken: The home has a specified system in place as per company policy. Following the inspection any patient that has the Trust as their representative, documents have been sent out to be signed and still waiting for the confirmation.

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