Unannounced Finance Inspection Report
11 April 2017

Aughnacloy House

Type of Service: Nursing Home
Address: 2 Tandragee Road, Lurgan, Craigavon BT66 8TL
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Briege Ferris

1.0 Summary

An unannounced inspection of Aughnacloy House took place on 11 May 2017 from 10:30 to 15:30 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 for patients to deposit money and valuables and staff members were familiar with controls in place to safeguard patients' money and valuables. However, one area for improvement was identified during the inspection, this related to ensuring that valuables deposited for safekeeping with the home are reconciled to the written record at least quarterly. Reconciliations should be recorded and signed and dated by two people.

Is care effective?

Controls to ensure patients' money and valuables were safeguarded were found to be in place; however two areas for improvement were identified during the inspection. These related to 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; and ensuring that a record is maintained of the furniture and personal possessions brought into the home by all newly admitted patients.

Is care compassionate?

Discussion with staff members evidenced an empathic attitude to ensuring patients' money and valuables were appropriately safeguarded; the home also had a number of ways to obtain feedback from patients. Discussion established that the home actively engaged with other relevant stakeholders (such as the HSC trust) to ensure that patients had access to the money for personal expenditure. No areas for improvement were identified during the inspection.

Is the service well led?

Governance arrangements were found to be in place; however three areas for improvement were identified during the inspection. These related to: ensuring that relevant policies and procedures are comprehensively reviewed and updated accordingly; learning from the finance inspection should be considered as part of this process. All staff directly affected by the policies should be provided with the opportunity to become familiar with the content of the updated policies; ensuring that an up to date individual written agreement is provided to each patient or their representative and ensuring that a personal monies written authorisation is obtained from each patient or their representative to spend the patient's money on identified goods and services to pre-agreed expenditure limits.

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	4

Details of the quality improvement plan (QIP) within this report were discussed with Constance Mitchell, 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 of the home was carried out on 14 May 2009 on behalf of RQIA. The findings from the inspection were not brought forward to the finance inspection on 11 May 2017.

2.0 Service details

Registered organisation/registered person: MD Healthcare Ltd/Lesley Megarity	**Registered manager:** Constance Mitchell
Person in charge of the home at the time of inspection: Constance Mitchell	**Date manager registered:** 12 February 2015
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 71

3.0 Methods/processes

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; the previous inspector to visit the home was also contacted prior to the inspection and they confirmed there were no matters to be followed up.

During the inspection, the inspector met with Constance Mitchell, the registered manager and both administrators. A poster detailing that the inspection was taking place was positioned at the entrance of the home, however no visitors or relatives chose to meet with the inspector.

The following records were examined during the inspection:

- The home's "resident" guide
- A sample of written policies including those in respect of:
  - "Domestic Care, MD Healthcare & Optimum Care Safeguarding Service Users Finance and Belongings" dated May 2014
  - "Practice guidance for safeguarding service users' finance and belongings" dated May 2016
  - "Residents Comfort Fund Policy" dated December 2015
- Four patient finance files
- A sample of patient income and expenditure records
- A sample of records for hairdressing and chiropody services facilitated in the home
- A sample of "usage of personal float money" documents
- A sample of income and expenditure records relating to the patients' comfort fund
- The record of safe contents – "Valuables" book
- One patient's record of personal property (in their rooms)

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 2 February 2017

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 dated 14 May 2009

As noted above, a finance inspection of the home was carried out on 14 May 2009 on behalf of RQIA. The findings from the inspection were not brought forward to the finance inspection on 11 May 2017.

4.3 Is care safe?

The home had two part time administrators, both of whom were present during the inspection. Evidence was reviewed which confirmed that they had both received adult safeguarding training. Both administrators were familiar with the controls in place to safeguard patients' money and valuables in the home; and both could clearly describe these to the inspector.

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 a number of patients was lodged for safekeeping.

The written record of items deposited in the safe place had been made in the "valuables" book. A review of the book identified that entries (both of items deposited and returned to family members) had been signed and dated by two people. Discussions with staff identified that a check of all of the items held would be carried out approximately every six months, however this was not recorded. There was no evidence that the record of items had been reconciled on at least a quarterly basis.

A recommendation was made to ensure that a reconciliation of valuables deposited for safekeeping is carried out, recorded and signed and dated by two people at least quarterly.

Areas for improvement

One area for improvement was identified during the inspection, this related to ensuring that valuables deposited for safekeeping with the home are reconciled to the written record at least quarterly. Reconciliations should be recorded and signed and dated by two people.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

Discussion with the registered manager established that no representatives of the home were acting as nominated appointee for any patient in the room, nor was the home in direct receipt of the personal monies for any patient. Discussion with administrative staff established for a small number of identified patients, requests were made to the HSC trust for an amount of personal money (being safeguarded by the trust) to be sent to the home for the patients' personal expenditure. Staff confirmed that cash (belonging to the home) to the value of the cheque amount was deposited in the patient's separate balances, with the cheque then lodged to the business bank account. Records were in place to substantiate the timing of the requests and the receipt and encashment of cheques received. Staff confirmed that the home did not operate a patients' bank account.

In the majority of cases, the home were in receipt of money from the family/friends of patients in order to pay for additional services facilitated within the home for which there was an additional

charge, such as hairdressing, chiropody or other sundries. Evidence was reviewed which identified that double signed receipts were provided to those making deposits.

A sample of the records of income and expenditure maintained on behalf of patients was reviewed. Clear, detailed records made using a standard financial ledger format were evidenced; entries were routinely signed by two people.

A review of a sample of the records identified that a monthly reconciliation of the money held on behalf of patients was recorded and signed and dated by two people. The inspector traced a sample of transactions recorded in the records and was able to locate the relevant documents; for example, a hairdressing or chiropody treatment record or a receipt for a lodgement which had been made.

As noted above, hairdressing and chiropody treatments were being facilitated within the home. A sample of hairdressing treatment records was reviewed and these were found to be made on a template. The template listed the names of all of the patients and had an additional column alongside each person's name. Completed records evidenced that in this column, the hairdresser routinely completed the initials of the treatment provided and the cost. These records were not signed by the hairdresser. The signature of one of the home administrators was at the bottom and she explained that this was to evidence that the hairdresser had been paid.

A sample of chiropody treatment records detailed the names of the patients and as explained by the home administrators, a tick alongside the names of the people they had treated on a particular day. This record had been signed by the chiropodist.

These findings were discussed with the registered manager and it was highlighted that Standard 14.13 of the Care Standards for Nursing Homes required 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.

A recommendation was made in respect of this finding.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see a sample of the completed property records for four patients. Only one of the four patients' files contained a record of their personal property. The one record which was available had been signed and dated by two people on the day of the patient's admission to the home in 2015. It included the entries "1 painting, 1 pictures, 1 black tv". These findings were discussed with the registered manager and it was highlighted that staff completing the records in future should be guided on the appropriate level of detail to record against items of personal property.

As there were no records of personal property available for three of the four people in the sample, a requirement was made.

The registered person must ensure that a record is maintained of the 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.

The registered manager was reminded that these records should be reconciled at least quarterly, with the record signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.

Discussion established that the home also administered a patients' comfort fund; no bank account was operated for the fund. A written policy and procedure was provided at the end of the inspection (there is further discussion regarding written policies and procedures in section 4.6 of this report). A sample of the records of income and expenditure for the fund was reviewed; these were maintained in a notebook and entries were routinely signed and dated by two people. The most recent "Balance check" had been recorded in April 2017 and this was signed by two people.

During the inspection, staff confirmed that the home did not provide transport to patients.

Areas for improvement

Two areas for improvement were identified during the inspection. These related to: 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 and ensuring that a record is maintained of the 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.

Number of requirements	1	Number of recommendations	1

4.5 Is care compassionate?

Day to day to day arrangements in place to support patients were discussed with both administrators. Each member of staff described specific examples of how the home supported a number of patients with their money. Discussion established that arrangements to safeguard a patients' money would generally be discussed with the patient or their representative prior to or at the time of the patient's admission to the home. Staff described the sensitivities around these discussions with empathy.

From a review of a sample of the finance records, there was evidence of engagement with other professional stakeholders eg: the HSC trust. This included engagement in order to ensure that identified patients had sufficient funds lodged with the home to ensure that they each had access to their money, if required.

Discussion with the registered manager identified that the home had a range of methods in place to encourage feedback from families or their representatives in respect of any issue, including, annual questionnaires and a monthly questionnaire. The registered manager shared a copy of the latter document, which was entitled "Resident's views on care provided".

She explained that about 20% of the patients in the home were sampled each month and care staff carried out the questionnaire with patients. The registered manager reported an example of how feedback from the questionnaire had led to improvements for patients.

It was noted that the questionnaire included twelve questions and it was encouraging that three of these related to the management of patients' money and valuables by the home.

Arrangements for patients to access money outside of normal office hours were discussed with the registered manager. The registered manager explained the contingency arrangement in place in the home to ensure that this could be facilitated, if required.

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?

Discussion was held with both administrators regarding written policies and procedures and their how these supported day to day practice in the home. Both administrators were not familiar with the existence of written policies in respect of the home's responsibilities to safeguard patients' monies and valuables or administer the patients' comfort fund.

During the inspection, the registered manager provided a copy of the "Domestic Care, MD Healthcare & Optimum Care Safeguarding Service Users Finance and Belongings" policy. The policy was noted to be for employees of all of the above entities and as such was generic in nature. Under section five, financial procedures, basic record keeping requirements consistent with the (DHSSPS) Care Standards for Nursing Homes, April 2015 were absent eg: income and expenditure transactions recorded on behalf of patients should be signed and dated by two people and should be reconciled at least quarterly. It was noted that the above policy was dated May 2014 and was therefore due for review in May 2017 at the latest.

During the course of the inspection, two documents were provided by the registered manager. She noted that these had been sent through by a senior colleague for the inspector's attention. These documents were not available in the home on the day. One document was entitled "Finance review – residents funds" which appeared to be a form of audit tool; however the registered manager confirmed that this was not in use in the home.

A second documents was entitled "Practice guidance for safeguarding service users' finance and belongings", this was dated May 2016. This document contained predominantly information on the principles of safeguarding patients' money and valuables and signs of financial abuse and how to escalate concerns. It was noted that section seven, record keeping, lacked sufficient detail; eg: "All transactions must be transparent and evidenced by "good record keeping"; the term "good record keeping" had not been defined. As noted above, policies and procedures for staff in the home should be detailed and in respect of record keeping responsibilities, should be consistent with the requirements of the (DHSSPS) Care Standards for Nursing Homes, April 2015.

In respect of the patients' comfort fund, the administrators were not aware that a policy on the administration of the fund was in place; a copy of the policy was not available in the home on the day. Towards the end of the inspection, a copy of the "Residents Comfort Fund Policy" dated December 2015 was emailed to the registered manager by a colleague.

A recommendation was made to ensure that relevant policies and procedures are comprehensively reviewed and updated accordingly; learning from the finance inspection should be considered as part of this process. All staff directly affected by the policy should be provided with the opportunity to become familiar with the content of the updated policies.

There was a clear organisational structure within the home; this was detailed in the home's statement of purpose. As noted above, discussion established that those involved in supporting patients with their money on a daily basis were familiar with their roles and responsibilities in relation to safeguarding patients' money and valuables.

Both administrators could describe how they would deal with a complaint and discussion evidenced that they were clear about the home's whistleblowing procedures or escalating any concerns.

Individual patient agreements were discussed and a sample of four patients' files was selected for review. None of the four patients had a signed written agreement on their file. Discussion with the administrative staff evidenced that a written agreement was always provided at the time a patient was admitted to the home, however they reported that they did not update any patient's agreement thereafter.

Staff surmised that following the agreement being provided to families, the agreements for the patients sampled may have been returned to the organisation's head office. This was discussed with the registered manager who confirmed that she would contact head office to ensure this had not happened. However, following the inspection, RQIA was not advised that this had in fact, been the case.

Therefore, as discussed with the registered manager on the day of inspection, there was no evidence on the files that patients had been provided with an individual written agreement.

A requirement was made to ensure that an up to date individual written agreement is provided to each patient or their representative. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. The registered person must ensure that all patients written agreements comply with the requirements of Regulation 5 of the Nursing Homes Regulations (NI) 2005 and meet Standard 2.2 of the (DHSSPS) Care Standards for Nursing Homes, April 2015.

Discussion was held regarding written personal monies authorisations between the patient/their representative and the home. These documents are in place to provide the home with authority to use the patients' personal monies to purchase goods and services on their behalf. A review of the four patient files evidenced that three of the four patients had a signed "Usage of personal float money" on their individual file. However one of the four patients did not have this document on their file.

A recommendation was made to ensure that a personal monies written authorisation is obtained from each patient or their representative to spend the patient's money on identified goods and services to pre-agreed expenditure limits. The written authorisation must be retained on the patient's records and updated as required.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to: ensuring that relevant policies and procedures are comprehensively reviewed and updated accordingly;

learning from the finance inspection should be considered as part of this process. All staff directly affected by the policies should be provided with the opportunity to become familiar with the content of the updated policies; ensuring that an up to date individual written agreement is provided to each patient or their representative. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. The registered person must ensure that all patients written agreements comply with the requirements under Regulation 5 of the Nursing Homes Regulations (NI) 2005 and meet Standard 2.2 of the (DHSSPS) Care Standards for Nursing Homes, April 2015 and ensuring that a personal monies written authorisation is obtained from each patient or their representative to spend the patient's money on identified goods and services to pre-agreed expenditure limits. The written authorisation must be retained on the patient's records and 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 Constance Mitchell, 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 finance.team@rqia.org.uk 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:** 11 July 2017	The registered provider must ensure that a record of furniture and personal possessions brought by a patient into the room occupied by them is maintained throughout their stay in the home. Records of furniture and personal possessions belonging to all of the patients in the home must be reviewed and brought up to date.
	Response by registered provider detailing the actions taken: The registered manager will ensure that a record of furniture and personal possessions brought by a new resident into their room is maintained throughout their stay in the home and records of all residents in the home will be reviewed and brought up to date.
Requirement 2 **Ref:** Regulation 5 **Stated:** First/ time **To be completed by:** 11 July 2017	The registered provider must ensure that an up to date individual written agreement is provided to each patient or their representative. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. The registered person must ensure that all patients written agreements comply with the requirements under Regulation 5 of the Nursing Homes Regulations (NI) 2005 and meet Standard 2.2 of the (DHSSPS) Care Standards for Nursing Homes, April 2015.
	Response by registered provider detailing the actions taken: The registered manager will ensure that an up to date written agreement is provided to each resident or their representative and where they are unable to, or choose not to sign the agreement, this will also be recorded. The registered manager will ensure that all residents written agreements comply with the requirements under Regulation 5 of the Nursing Homes Regulations (NI) 2005 and meet Standard 2.2 of the (DHSSPS) Care Standards for Nursing Homes, April 2015.
Recommendations	
Recommendation 1 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 18 May 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 registered manager has ensured that an immediate reconciliation of money and valuables held and accounts managed on behalf of residents, has been carried out, and will be undertaken at least quarterly. The reconciliation will be recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.

Recommendation 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 12 May 2017	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: Where services are facilitated within the home, such as those listed above, the person providing the service and the resident or a member of staff of the home will sign the treatment record or receipt to verify the treatment or goods provided and the associated cost to each resident.
Recommendation 3 **Ref**: Standard 36.1 **Stated:** First time **To be completed by:** 11 July 2017	The registered provider should ensure that relevant policies and procedures are comprehensively reviewed and updated accordingly; learning from the finance inspection should be considered as part of this process. All staff directly affected by the policies should be provided with the opportunity to become familiar with the content of the updated policies.
	Response by registered provider detailing the actions taken: The registered provider and manager will ensure that relevant policies and procedures are comprehensively reviewed and updated accordingly, including learning from the finance inspection. All staff directly affected by the policies will be provided with the opportunity to become familiar with the content of the updated policies.
Recommendation 4 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 11 June 2017	The registered provider should ensure that a detailed written authorisation is obtained from each patient or their representative to spend the patient's money on identified goods and services to pre-agreed expenditure limits. The written authorisation must be retained on the patient's records and updated as required.
	Response by registered provider detailing the actions taken: The registered manager has ensured that a detailed written authorisation has been obtained from each resident or their representative to spend the resident's money on identified goods and services to pre-agreed expenditure limits. The written authorisation will be retained on the resident's records and updated as required.

Please ensure this document is completed in full and returned to finance.team@rqia.org.uk from the authorised email address

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