Announced Finance Inspection Report
06 July 2018

Avila

Type of Service: Nursing Home (NH)
Address: 32 Convent Hill, Bessbrook, Newry, BT35 7AW
Tel No: 028 3083 8969
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 49 beds which provides care for older patients and/or those with a dementia, learning disability or physical disability other than sensory impairment.

3.0 Service details

Organisation/Registered Provider: Kilmorey Care Ltd **Responsible Individual:** Cathal O'Neill	**Registered Manager:** Lucille Holt
Person in charge at the time of inspection: Lucille Holt	**Date manager registered:** 17 July 2013
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. LD – Learning disability. LD (E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 49 A maximum of 1 patient shall be accommodated within category NH-LD/LD (E). A maximum of 10 patients in category NH-DE to be accommodated within the Dementia Unit.

4.0 Inspection summary

An announced inspection took place on 06 July 2018 from 11.00 to 13.30 hours. The service received two hours' notice of the inspection.

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 and the availability of a written safe contents record; the existence of expenditure, banking and reconciliation records and supporting documents such and expenditure receipts and treatment records; the availability of up to date patient comfort fund records and related reconciliations; the availability of personal property records maintained for patients' furniture and personal possessions; correct charges for care and accommodation; mechanisms were in place to obtain feedback and views from patients and their representatives; a range of useful information was contained in the patient guide; each patient had a signed individual written agreement in place with the home or there was evidence that agreement to updating each patient's agreement had been sought by the home.

No areas for improvement were identified.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Lucille Holt, registered manager, as part of the inspection process and can be found in the main body of the report.

4.2 Action/enforcement taken following the most recent finance inspection dated 22 April 2013

A finance inspection of the home was carried out on 22 April 2013; however the findings from this inspection were not brought forward to the inspection on 06 July 2018.

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, the clinical lead, the home administrator and the accounts administrator (who is based at the organisation's head office).

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:

- Patients Guide
- The "Avila nursing home safe book"
- A sample of patients' expenditure and bank reconciliation (check) records
- Written policies and procedures including:
  - "Policy on record keeping" dated 2018
  - "Whistleblowing policy" dated 2018
  - "Chaperone/Transport policy" dated 2018
  - "Financial arrangements policy" dated 2018
  - "Complaint policy" dated 2018
- Three records of patients' personal property (in their rooms)
- Three patients' individual written agreements with the home/amendment documents
- A sample of treatment records for chiropody and hairdressing services facilitated within the home
- A sample of charges made to patients for care and accommodation

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 16 April 2018

The most recent inspection of the home was an unannounced care inspection. No areas for improvement were identified following this inspection.

6.2 Review of areas for improvement from the last finance inspection dated 22 April 2013

As noted above, a finance inspection of the home was carried out on 22 April 2013; however the findings from this inspection were not brought forward to the inspection on 06 July 2018.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed that adult safeguarding training was mandatory for all staff in the home. Discussions 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; however as is further described in section 6.5 of this report, it was not the home's policy to hold or manage cash on behalf of any patient.

The inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, valuables were being held on behalf of a number of patients, no cash was on deposit.

A written safe record was in place which had previously been used to record any items deposited for safe keeping with the home, entries in and out of the safe place were routinely signed and dated by two people. A check of the contents of the safe place was recorded as part of the accounts assistant's monthly audit process in the home. Advice was provided by the inspector in terms of explicitly recording the reconciliation (signed and dated by two people) every third month.

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 and the availability of a written safe contents record.

Areas for improvement

No areas for improvement were identified during 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.

The registered manager confirmed that no representative of the home was acting as nominated appointee for any patient (ie: managing a patient's social security benefits on their behalf). The registered manager explained that no personal monies belonging to any patient were received directly by the home. She reported that it was the home's policy to not hold any monies belonging to patients. Rather, the home's practice was to settle the cost of any additional goods or services required by patients, with the cost subsequently billed to patients or their representatives from head office.

During the inspection, the organisation's accounts administrator provided a number of records which related to the expenditure incurred by patients in the home. These were used as the basis on which to raise invoices to patients or their representatives for those amounts.

Records were maintained to detail any additional goods or services used by patients which attracted an additional charge e.g.: newspapers, private transport, toiletries, chiropody and hairdressing treatments and which had been settled by the home on behalf of each patient. Periodically, an invoice reflecting the goods or services received by each patient was processed at head office and sent to the patient or their representative for settlement. Clear, detailed records were maintained by the home/head office in respect of the amount and timing of the various elements of this process.

The home had a patients' bank account which the accounts administrator reported was used to facilitate the receipt of payment for any goods or services purchased on behalf of patients (subsequently billed to each patient or their representative). The bank account was named appropriately to reflect its use. Records were provided which evidenced that a monthly reconciliation of this bank account was carried out and signed and dated by two people.

Hairdressing and chiropody treatments were being facilitated within the home. A sample of treatment records were reviewed and were found to detail the date, the name of the patient, the treatment received (and the cost) the signature of the person delivering the treatment and the signature of a representative of the home to verify that the treatment had been received.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see the property records for three patients. Each record sampled had a detailed record of the patient's personal property on file "property list" which was kept up to date via the

home's computerised care records system. The accounts administrator confirmed that it was the home's practice to reconcile these records on a quarterly basis; the records reviewed had been signed and dated by two people in June 2018.

The home had a "Patient comfort fund". It was noted that income and expenditure records were maintained, which were reconciled, signed and dated by two people on a regular basis. A written policy and procedure was in place to guide the administration of the comfort fund and an appropriately named bank account was in place to administer the funds. Records were in place to confirm that the bank account was also reconciled and signed and dated by two people on a monthly basis.

Discussion established that the home raised an invoice for care fees on a monthly basis. A review of a sample of these charges confirmed that the correct amounts had been raised.

Discussion with the accounts and home administrator established that the home operated a transport scheme for patients, however there was no charge to the patients for the use of this service. A written policy and procedure was in place addressing the use of transport by patient and described under what circumstances a chaperone charge would be levied.

Areas of good practice

There were examples of good practice found in relation to: the existence of expenditure, banking, reconciliation records and supporting documents such and expenditure receipts and treatment records; the availability of up to date patient comfort fund records and related reconciliations; the availability of personal property records maintained for patients' furniture and personal possessions and correct charges for care and accommodation costs had been raised.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Day to day arrangements in place to support patients were discussed with the registered manager. Discussion established that arrangements to safeguard a patient's money would be discussed with the patient or their representative prior to, or at the time of the patient's admission to the home.

Discussion established that the home had a range of methods in place to encourage feedback from families or their representatives in respect of any issue. This included: family meetings; residents' meetings, an annual quality assurance review; regulation 29 monthly monitoring visits by the provider and from time to time, suitably qualified and experienced external visitors and a quarterly quality assurance questionnaire sent from the organisation's head office.

Areas of good practice

There were examples of good practice found in respect of the arrangements in place to support individual patients discussed during the inspection and mechanisms to obtain feedback and views from patient and their representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The patient guide detailed a range of useful information for a prospective patient including general information on fees, arrangements to safeguard patients' property, and reference to a number of home's policy and procedures.

A range of written policies and procedure were in place addressing areas such as the patients' comfort fund, patient property, general record keeping; whistleblowing, and the chaperone/transport scheme and complaints management. Policies were easily accessible by staff.

Individual patient agreements were requested and a sample of three patients was chosen in order to review those in place between the home and each patient or their representative.

On each patient's file was an update detailing the changes to the respective patient's fees and financial arrangements for 2018/2019 year (commencing April 2018). One of these had been returned signed. One of the three patients had a full copy of the original comprehensive agreement between the home and each patient; the remaining two patients did not have a full copy of the agreement on file. Advice was provided during feedback to ensure that a copy of what has been previously shared is retained on file together with evidence of how and when it has been shared for signature by the patient or their representative.

The inspector discussed with the registered manager and clinical lead 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 and clinical lead were able to describe specific examples of the way this was achieved within the home and how this had benefited individual patients, including staff training in human rights and staff receiving a three day induction to the home. Comments were made including that staff must be "respectful of (patients') choices… (We) will facilitate patients' wishes to make them feel more comfortable. The registered manager stated that "you lead by example…these people are beloved to somebody."

Areas of good practice

There were examples of good practice found in respect of: the range of information contained in the patient guide, each patient had a signed individual written agreement in place with the home or there was evidence that agreement to updating each patient's agreement had been sought by the home.

Areas for improvement

No areas for improvement were identified during the inspection. Advice was provided with respect to ensuring that a full copy of the agreement which has been shared with the patient or their representative for signing is retained on each relevant patient's file.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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