The Regulation and Quality Improvement Authority

Unannounced Finance Inspection Report
11 September 2018

Cairnhill

Type of Service: Nursing Home
Address: 39 Rathfriland Road, Newry, BT34 1JZ
Tel No: 0283026 8112
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 22 beds which provides care for patients with a learning disability.

3.0 Service details

Organisation/Registered Provider: Cairnhill Home 'A' Ltd Responsible Individual(s): Charles Anthony Digney	Registered Manager: James Digney
Person in charge at the time of inspection: The nurse in charge	**Date manager registered:** 01/04/2005
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 22

4.0 Inspection summary

An unannounced inspection took place on 11 September 2018 from 11.00 to 13.45 hours.

This inspection was underpinned by Nursing Homes Regulations (Northern Ireland) 2005 and the 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.

Evidence of good practice was found in respect of:

- a safe place was available for the deposit of money or valuables
- a sample of income, expenditure and transactions recorded agreed to the supporting evidence (such as an expenditure receipt)
- records of regular reconciliations (checks) of patients' cash and the pooled bank account were in place
- there were mechanisms to listen to and take account of the views of patients and their representatives in respect of any issue
- the home administrator with key responsibility for the oversight of patients' monies was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's whistleblowing procedures
- the nurse in charge was able to describe specific examples of how patients experienced equality of opportunity.

Areas requiring improvement were identified in relation to:

- ensuring that administrative staff who have an input into managing patients' monies and valuables receive adult safeguarding training;
- ensuring that each patient's record of their furniture and personal possessions is kept up to date. This record is signed and dated by a staff member and senior member of staff at least quarterly;
- ensuring that each patient or their representative is provided with an individual written agreement detailing the terms and conditions of the residency in the home;

- ensuring that the content of the generic written patient agreement is consistent with the required content as set out with standard 2.2 of the care standards for nursing homes (2015); and
- ensuring that written personal expenditure authorisation forms are in place for all patients for whom the home engages in purchases of goods or services.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	4

Details of the Quality Improvement Plan (QIP) were shared with the registered manager following the inspection. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent finance inspection dated 30 March 2015

A finance inspection was carried out on 30 March 2015; the findings from which were not brought forward to the inspection on 10 September 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 also reviewed and this did not identify any relevant issues.

During the inspection, the inspector met with the nurse in charge and two members of administrative staff based at head office. A poster was displayed detailing that the inspection was taking place, however no relatives or visitors chose to meet with the inspector.

The inspector provided to the nurse in charge 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:

- The "Resident guide"
- A sample generic written patient agreement
- A sample of income and expenditure and reconciliation (check) records maintained on behalf of patients

- A sample of pooled patients' bank account records
- Three patients' records of furniture and personal possessions (in their rooms)
- A sample of written policies and procedures including:
    - "Whistleblowing policy" reviewed July 2018
    - "Management of residents personal belongings- missing items" reviewed July 2018
    - "Handling of residents finances" reviewed July 2018
    - "Management of records and information" reviewed July 2018

The findings of the inspection were shared with the registered manager following the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 25 October 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.

6.2 Review of areas for improvement from the last finance inspection dated 17 October 2013

As noted above, a finance inspection was carried out on 30 March 2015; the findings from which were not brought forward to the inspection on 11 September 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 inspector met with the nurse in charge and one administrator at the home and subsequently with the second administrator at the registered provider's office at a separate address. One administrator had received adult safeguarding training in March 2018; however the second administrator (hereafter referred to as the home administrator) had not received adult safeguarding training. It was noted that all (administrative) staff who have an input into managing patients' finances should participate in adult safeguarding training.

This was identified as an area for improvement.

The nurse in charge 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. On the day of inspection, no cash or valuables were being secured within the safe place.

Areas of good practice

There were examples of good practice found in respect of a safe place available for the deposit of money or valuables and access was limited to authorised persons.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that staff who have an input into managing patients' finances participate in adult safeguarding training.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Discussions with the home administrator established that a representative of the home was acting as appointee for one identified patient (i.e.: managing a patient's social security benefits on their behalf). The official documentation in respect of this appointment was available.

The home administrator also confirmed that the home was in direct receipt of the personal monies for several patients. In these cases, monies were received from the HSC trust and from families in the minority of cases. Records existed to detail the amount and timing of these receipts.

Records of income and expenditure, which followed a standard financial ledger format, were maintained in the home and evidenced that reconciliations were being carried out and recorded by two people at least quarterly. A pooled bank account was in place to administer patients' monies and this was appropriately named. Records were in place to evidence that the account was reconciled on a weekly basis with the signatures of two people recorded.

A sample of expenditure transactions was chosen to ascertain whether the relevant supporting evidence was available; this review established that the relevant evidence was in place.

Hairdressing treatments were being facilitated within the home and a sample of recent treatment records was reviewed. Routinely, the records detailed the information required by the Care Standards for Nursing Homes (2015).

The inspector discussed with the nurse in charge how patients' property (within their rooms) was recorded and was informed that each patient had a property record. A book containing the records was provided for review and this evidenced that each patient had a record in the book. The records which were sampled for the patients were dated September 2018, February 2017 and December 2016. Discussion with the nurse in charge established that these records were

made on each patient being admitted to the home. Subsequent contact with the registered manager following the inspection established that additional patient property records were also maintained and the records for two of the patients who records were dated February 2017 and December 2016 were requested. This was to ascertain had the records been subject to a quarterly reconciliation, as is required. The requested records evidenced that the records had been updated and signed by two people in March 2018 and November 2017 respectively.

As noted above, records of patients' property should be checked on at least a quarterly basis, with the records signed by a staff member and countersigned by a senior member of staff.

This was identified as an area for improvement.

Discussions with the nurse in charge established that the home did not operate a transport scheme or a patients' comfort fund.

Areas of good practice

There were examples of good practice found in relation to income, expenditure and reconciliation records, and the availability of supporting documents; the availability of official appointee documents for the identified patient; and the information recorded on hairdressing treatment records which were sampled.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that records in respect of patients' furniture and personal possessions are reconciled and signed and dated by a staff member and senior member of staff at least quarterly.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

The arrangements to support patients with their money on day to day basis were discussed with the nurse in charge. These discussions established that the home had measures in place to be flexible and respond to the individual needs and preferences of patients.

Discussions with the nurse in charge established that arrangements to pay fees and handle safeguard patients' monies in the home, would be discussed with the patient or their representative at the time a patient was admitted to the home.

The nurse in charge confirmed that the home had a number of methods in place to encourage feedback from families or their representatives in respect of any issue. This included "residents" meetings and ongoing day to feedback including the receipt of thank you cards which were displayed in the home.

Areas of good practice

There were examples of good practice identified in relation to listening to and taking account of the views of patients 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 patients in order to deliver safe, effective and compassionate care.

Written policies were reviewed addressing areas in respect of whistleblowing, management of patients' personal belongings and finance and the management of records. Policies had been reviewed within the last three years.

Discussion with the home administrator established that she was confident on how to deal with the receipt of a complaint or escalate any concerns under the home's existing whistleblowing procedures.

Discussion was held with the nurse in charge and subsequently the home administrator regarding individual written patient agreements. These discussions established that the home had a generic agreement template in place however agreements were not in place with patients at the date of inspection. The inspector was informed that it was proposed these would be drafted and shared at the time of each individual patient's HSC trust care management review. The inspector noted that agreements should already be in place with patients (from the date of admission) and that providing these to patients or their representatives should not be delayed any further.

Ensuring that each patient is provided with an up to date, personalised written agreement setting out the terms and conditions of their residency in the home was identified as an area for improvement.

The home's generic patient agreement template was reviewed and it was noted that the front page referred to the content of the agreement (which was based on the required content per the Care Standards for Nursing Homes 2015). On further review, the agreement itself did not reflect the list of contents detailed on the front page. It was highlighted that the content of the agreement ought to include as a minimum, the details set out within standard 2.2 of the Care Standards for Nursing Homes.

An area for improvement was listed to ensure that the home's generic template is reviewed and updated accordingly before sharing agreements with patients or their representatives.

Discussion with the nurse in charge established that there were no personal monies authorisation documents for patients.

These documents provide the home with authority to make purchases of (types of) identified goods and services from each patient's personal monies. Ensuring that these are on file for all relevant patients was identified as an area for improvement.

The inspector discussed with the nurse in charge 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 residents. The nurse in charge was able to describe examples of the way this was achieved.

Areas of good practice

There were examples of good practice found in relation to: the home administrator's knowledge in relation to responding to a complaint or escalating a concern under the home's whistleblowing procedures; written policies and procedures were available and the nurse in charge was able to describe specific examples of how patients experienced equality of opportunity.

Areas for improvement

Three areas for improvement were identified as part of the inspection. These related to ensuring that each patient is provided with an individual, personalised written agreement; ensuring that the home's generic patient agreement template is reviewed to ensure it is consistent with standard 2.2 of the Care Standards for Nursing Homes, 2015 and ensuring that personal monies authorisation documents are in place for all relevant patients.

	Regulations	Standards
Total number of areas for improvement	1	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were shared with James Digney, registered manager, following the inspection. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home.

The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 5.(1) (a) (b) **Stated:** First time **To be completed by:** 22 October 2018	The registered person shall ensure that each patient or their representative is provided with an individual written agreement detailing the terms and conditions of their stay in the home. Ref: 6.7 **Response by registered person detailing the actions taken:** Individual written agreements shall be posted to each residents next of kin.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 13.11 **Stated:** First time **To be completed by:** 10 December 2018	The registered person shall ensure that any any member of administrative staff who has input into patients' finances receives adult safeguarding training. Ref: 6.4 **Response by registered person detailing the actions taken:** Mentioned staff member has now received Adult Safeguarding Training.
Area for improvement 2 **Ref**: Standard 14.10 **Stated:** First time **To be completed by:** 22 October 2018	The registered person shall ensure that an inventory of property belonging to each resident is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.5 **Response by registered person detailing the actions taken:** The inventory of residents property shall now be reconciled quarterly.
Area for improvement 3 **Ref**: Standard 2.2 **Stated:** First time **To be completed by:** 22 October 2018	The registered person shall ensure that the home's generic patient agreement template is reviewed to ensure it is consistent with the content of the standard listed. Ref: 6.7 **Response by registered person detailing the actions taken:** The mentioned document has been ammended.

<table>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 14.6, 14.7

Stated: First time

To be completed by:
22 October 2018</td><td>The registered person shall ensure that written authorisation is obtained from each resident or their representative to spend the patient’s personal monies to pre-agreed expenditure limits.
The written authorisation must be retained on the resident’s records and updated as required. Where the resident or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the resident 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.

Ref: 6.7</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Written authorisation shall be sought from residents representatives to spend personal monies.</td></tr>
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Please ensure this document is completed in full and returned via Web Portal

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