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Unannounced Finance Inspection of Dungannon

18 June 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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Summary of Inspection

An unannounced finance inspection took place on 18 June 2015 from 10:05 to 16:30. Overall on the day of the inspection the safety, effectiveness and compassion of care were found to be good, however there are some areas identified for improvement. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report. This inspection was underpinned by the Nursing Homes Regulations (Northern Ireland) 2005.

1.1 Actions/Enforcement Taken Following the Last Inspection

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

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	11	0

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

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care	**Registered Manager:** Mrs Yvonne Diamond
Person in Charge of the Home at the Time of Inspection: Ms Susy San (Nurse in Charge)	**Date Manager Registered:** 30 January 2015
Categories of Care: NH-LD, NH-LD(E)	**Number of Registered Places:** 36
Number of Patients accommodated on the day of Inspection: 31	**Weekly Tariff at Time of Inspection:** £593 - £1285.20

3. Inspection Focus

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

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

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

Statement 2
Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Statement 3
A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained

Statement 4
Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

4. Methods/Process

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

- Discussion with the nurse in charge and the home's administrator
- Examination of records
- Review of records
- Evaluation and Feedback

During the inspection we met with the home's administrator, the nurse in charge and spoke to one patient. The registered manager and deputy manager were not in the home on the day of inspection.

Prior to inspection the following records were analysed:

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

The following records were examined during the inspection:

- The patient guide
- The home's policy on:
    - Management and recording of personal allowances
    - Personal allowance spending

- Three signed patient agreements
- One signed personal allowance expenditure authorisation
- Income/lodgements and expenditure including comfort fund records
- Cash and bank Reconciliations
- Safe contents reconciliations
- Four records of patients' personal property/inventory
- A sample of journey records for the home's minibus
- Record of the home administrator's safeguarding of vulnerable adults training

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection on 5 March 2015; the completed Quality Improvement Plan was returned and approved by us.

5.2 Review of Requirements and Recommendations from the last Finance Inspection

A finance inspection of the home was undertaken on RQIA's behalf on 14 June 2010.

Previous Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 4 (1)	A formal contract should be signed between Four Seasons Healthcare and the trusts responsible for placing patients. Copies of these contracts should be retained at the home.	**Met**
	Action taken as confirmed during the inspection: We confirmed that signed contracts between the organisation and commissioning trusts are held at the organisations head office and are accessible by home management when required.	
Previous Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 15	Action should be taken to reduce the level of account balances held for patients. Excess funds should be identified for those patients whose affairs are managed by the Office of Care and Protection and these funds sent to the Official Solicitor.	**Met**
	Action taken as confirmed during the inspection: We confirmed that excess balances of money held for a number of patients are transferred to the Office of Care and Protection as required.	

Recommendation 2 **Ref**: Standard 15	Management should review cash holding limits for the home and set these at an appropriate level to meet day to day needs. _____ **Action taken as confirmed during the inspection**: We noted from discussion with the registered manager that this issue had been addressed by the home.	**Met**
Recommendation 3 **Ref:** **Standard 15.7**	Shop receipts for purchases made on behalf of patients should be signed by care staff. _____ **Action taken as confirmed during the inspection**: We noted that this arrangement was in place in the home.	**Met**

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

Is Care Safe?

We were provided with a copy of Four Seasons' patient guide (for use throughout Northern Ireland) and also with a copy of the home's own brochure and associated appendices. We noted that the guide contained information for patients on: fees (in general); charging for additional services (including an appendix detailing the current charges for services within Dungannon); the management of patients' personal monies and insurance.

We queried whether there were any individual financial arrangements in place with individual patients in the home; the administrator described how a number of patients are able to manage different amounts of money depending on their needs. Two patients with individual arrangements in place were described, together with the day to day arrangements in place in the home to support these patients to manage their money.

We noted that the home have a standard written agreement, an individual copy of which is provided to each newly admitted patient. We asked to see both a copy of an up to date agreement and agreements which are already in place with a sample of patients in the home.

The administrator advised us that updated agreements had been sent to the patients' representatives and that a number of these had been returned already. However when we asked to see those agreements which had been returned, the administrator could not find them. She advised us that the agreements had been kept together so that when they were all returned they would be filed away into each patient's file.

Following the inspection, we discussed this with the registered manager, who was not in the home on the day of inspection. We highlighted that the regulations require that these records are at all times available for inspection by RQIA.

A requirement is made in respect of this finding.

Subsequent to the inspection, a copy of the most recent agreement between the home and one patient was faxed to us. On reviewing the fees section of the agreement, we noted that it simply stated the weekly fee with the reference "as per trust invoice". We note that we reviewed the fee arrangements for the same patient on inspection; the HSC trust are contributing an to the patient's weekly fee, however the patient is also personally contributing to the payment of the weekly fee; these details were not reflected in the agreement.

In order to comply with Regulation 5 (1) of the Nursing Homes Regulations (Northern Ireland) 2005, a patient's agreement must clearly state the weekly fee, the person(s) by whom the fees are payable and the respective methods of payment.

It is noted that the DHSSPS Care Standards for Nursing Homes 2015 are now in effect. Standard 2.2 of the Care Standards for Nursing Homes (2015) requires that a number of additional areas are included in the home's individual agreement with patients.

On comparing the home's standard form of agreement with patients to Standard 2.2 of the Care Standards for Nursing Homes (2015), we noted that a number of elements were absent. The registered person will be required to carry out their own comparison of these documents and update agreements for each patient in the home.

A requirement has been made in respect of these findings.

Is Care Effective?

We queried there was any involvement by the home in supporting individual patients with their money; the administrator advised that an identified number of patients are capable of managing defined amounts of money. The administrator explained how an identified number of patients come to the home's office and request their money. We spoke with one patient who described this process and how they are very satisfied with the arrangement and that they know what to do if they become dissatisfied with the arrangement.

We noted that the home has a number of policies and procedures in place addressing the management and safeguarding of patients' money. We queried whether the home's administrator had received training in the protection of vulnerable adults (POVA); evidence of same was provided to us on inspection.

Is Care Compassionate?

Given the absence of up to date agreements for all patients sampled, there was no evidence that patients had been informed in writing of increases in the fees payable over time.

A requirement is made in respect of this finding.

Discussions with the home's administrator established that on the day of inspection, the home were supporting a number of patients with their money and had processes in place to ensure that patients had access to their money as required.

Areas for Improvement

Overall on the day of inspection, we found care to be effective. The safety and and compassion of care were found to be good, however there were three areas identified for improvement; these were in relation to providing up to date individual written agreements to all patients, obtaining written agreement of any change to a patient's individual agreement and ensuring that records are available for inspection at all times.

Number of Requirements	**3**	**Number Recommendations**:	**0**

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

Is Care Safe?

A review of the records identified that copies of the HSC trust payment remittances are available confirming the weekly fee for each patient in the home and the amount to be contributed by each patient, where relevant.

We reviewed the records relating to amounts charged to a selection of sample of patients contributing to their fees and were satisfied that the correct amounts were being charged by the home.

We noted that the home had a number of written policies and procedures to guide practice in respect of safeguarding patients' money and valuables.

Discussion with the registered manager established that patients' representatives lodge money with the home in order to pay for additional goods and services not covered by the weekly fee (such as hairdressing, private podiatry or other sundries). The personal allowance monies for an identified number of patients is sent to the home from either a HSC trust organisation or a person who has been legally appointed to manage the affairs of the patient in question. For any person lodging money in person, the home provides a receipt to which is routinely signed by two people.

A review of the documentation evidenced that the home has a pooled bank account used exclusively for the safekeeping of patients' personal monies which are received by the home for expenditure on the patients' behalf such as hairdressing, toiletries etc.

As noted above, balances of patient monies held for safekeeping by the home (whether in cash or in the personal allowance bank account managed by the home) are reconciled on a regular basis.

We reviewed a sample of the records for expenditure incurred on behalf of four patients such as that in respect of hairdressing and podiatry services. We noted that the home maintain "personal allowance account statements" detailing income and expenditure. We sampled a number of transactions from the records and were able to trace these entries to the corresponding records to substantiate each transaction, such as copy receipt for cash lodgement or the hairdresser's treatment record for a treatment recorded on the statement.

We reviewed a sample of the records for hairdressing services facilitated within the home and noted that records were recorded in a book. The details routinely recorded were the date and the first name of the patients; each patient had a tick against their name. We noted that these records did not include all of the necessary details, such as the price of the respective treatments received or the signature of the hairdresser and a member of staff who could verify the person had been treated.

A requirement has been made in respect of this finding.

We also reviewed the records of treatments provided by a complimentary therapist who is facilitated within the home. These records had Four Seasons Healthcare at the top of the page and detailed the number of sessions each person had received and the respective costs. This record had not been signed by the complimentary therapist or a member of staff in the home. It detailed the total amount due to the therapist and the relevant cheque number used to pay her. We noted that there must be a treatment record for each day that treatments are provided to patients so that the therapist can sign the record and a member of staff can verify the patient has been received the treatment detailed that day.

A requirement has been made in respect of these findings.

On reviewing a sample of the records for income and expenditure we noted that a retailer visits the home to sell clothing to patients. We reviewed a sample of the records from this retailer which detailed the date, the name of the patient, the type of item and individual price and total amount payable. This record was not signed by the retailer or by a representative of the home. In future all those providing goods for sale to patients must provide an invoice which includes all of the required details.

A requirement has been made in respect of these findings.

Discussion with the administrator established that the home operates a comfort fund for the benefit of the patients in the home and which is normally funded from donations from patients' relatives and internal fundraising. We reviewed a sample of the records relating to the comfort fund and noted that a ledger entitled "cash withdrawn from comfort fund" is maintained detailing income and expenditure as well as records detailing the specifics of deposits made to the fund and receipts for expenditure from the fund. There is also a bank account in place to manage the comfort fund monies, the account is named in favour of patients in the home.

The home has a written policy and procedure in place for the administration of the comfort fund.

Is Care Effective?

The administrator advised that a representative of the home was acting as nominated appointee for one patient on the day of inspection, although she noted that appointeeship was in the process of being transferred.

We reviewed the file of the patient for whom a representative of the home is acting as nominated appointee. We noted that there was no written confirmation from the Social Security Agency detailing the name and date of appointment of the nominated appointee. We noted that this information is required to be on the patient's file. Furthermore, the arrangements for this appointment and the records to be kept must also be detailed in the patient's agreement.

A requirement has been made in respect of this finding.

On reviewing the identified patient's file, we noted that the patient did not have a current or previous individual written agreement on their file, a requirement has previously been made in respect of this finding.

As noted above, discussions with the administrator also established that the home receives money for safekeeping on behalf of patients from family representatives, the commissioning HSC trusts and others legally appointed.

We reviewed four patients' files and noted that only one patient had written authorisation from their representative providing authority for the home to spend the patient's personal monies on identified goods and services. The remaining three files reviewed did not have a written authorisation in place.

A requirement has been made in respect of these findings.

Is Care Compassionate?

We queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the home's administrator advised that she was not aware of any. The administrator described how certain patients can independently manage different amounts of money. One patient spoken with was happy with the arrangement in place to them to obtain a certain amount of their money from the office on a regular basis.

Areas for Improvement

Overall on the day of inspection, we found care to be compassionate. The safety and effectiveness of care were found to be good, however there were five areas identified for improvement.

Number of Requirements	**5**	**Number Recommendations**:	**0**

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

Is Care Safe?

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

We viewed the content of the safe place and established that on the day of inspection, cash and valuables were deposited for safekeeping.

We were provided with the most up to date safe record, we noted that this was dated 19/05/2014, therefore more than one year prior to the date of inspection. The record of items in the safe place did not agree with the actual items held; the administrator explained that certain

items had been collected by a patient's representative; however there was no written record available to confirm this.

We highlighted that these records are required to be updated at least every three months and that the home's internal policies require that they are reconciled every month.

A requirement is made in respect of this finding.

Is Care Effective?

We queried whether there were any general or specific arrangements in place to support patients with their money. As noted above, discussions with the administrator established that the home has direct involvement in supporting one patient and indirect involvement in supporting a number of other patients in the home. The costs of any additional services such as hairdressing are paid for from monies lodged with the home by representatives of the patients, including the HSC trusts and legally appointed representatives.

We requested the inventory/property records for four patients and were informed that these were retained in the patients' care files. A review of the files established that all four patients had a property record on their file.

We noted that all four records had been made on a pre-printed template entitled "Schedule of personal effects". The records contained almost exclusively clothing, with the exception of one patient, whose radio and TV had been recorded. We noted that none of the records were signed or dated making it impossible to tell when the record had been made or by whom. There was also no evidence of the records being updated.

A requirement has been made in respect of these findings.

Is Care Compassionate?

As noted above, a safe place exists within the home to enable patients to deposit cash or valuables should they wish to. We asked about arrangements for patients to access their money from the safe place in the home outside of office hours (when the key holder) may not be in the home. The administrator explained that the home has a small amount of money held in a second safe place in the home which can only be accessed by senior care staff. We noted that records exist to detail an amount of money transferred from the office to the second safe place. We spoke with the nurse in charge of the home on the day of inspection who showed us the second safe place and noted the persons with access were kept to a minimum. The nurse in charge explained the purpose of the small float of money, used for instance when a patient requires a taxi at the weekend. Receipts detailing how the money is spent are returned to the home office to form part of the weekly cash reconciliation process.

Patients therefore have access to funds at the weekend, should this be required.

Areas for Improvement

Overall on the day of inspection, we found care to be compassionate. The safety and effectiveness of care were found to be good, however there were two areas identified for

improvement; these was in relation to updating the safe record in the home and the recording of patients' personal property.

Number of Requirements	2	Number Recommendations:	0

5.6 Statement 4 - Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

Is Care Safe?

The home operates a minibus to provide transport to patients. As a result of a trust investigation (which at the time of the inspection had not been concluded) charges to patients were not being made. The administrator advised us that no charges were to be made until agreement had been reached with the commissioning trust regarding future arrangements for providing transport to patients.

The home has a written policy in respect of the use of transport for patients.

Is Care Effective?

As noted above, the home has a written policy and procedure addressing transport provision for patients. The administrator explained that the records of journeys taken by patients continued to be made, despite charges not being levied by the home. We requested to see the journey records. On reviewing the records, we noted that a template was in use to record the detail of journeys, however this was not been appropriately completed. The minibus mileage at the start and the end of the journey was not being recorded, only the miles travelled. There was also no way to tell who had completed the record only the names of the patients who had travelled was required on the template. From the sample of records provided, we also noted that when staff had fully completed the page, rather than taking a new sheet, staff continued to write outside of the area for recording details. We noted that these findings indicated a need to improve the way journey records were made.

A requirement is made in respect of this finding.

Is Care Compassionate?

The home has an agreement in place which allows for patients or their representatives to agree to use the transport provided by the home at the cost stated or alternatively patients are free to access other forms of transport. We noted on the day of inspection that a number of patients in the home access private taxis to meet their transport needs.

Areas for Improvement

Overall on the day of inspection, we found care to be safe and compassionate. The effectiveness of care was found to be good, however there was one area identified for improvement; this was in relation to the recording of journeys taken by patients on transport provided by the home.

Number of Requirements	1	Number Recommendations:	0

5.7 Additional Areas Examined

There were no other additional areas examined.

6 Quality Improvement Plan

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

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

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

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

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

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

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 19 (2) (b) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that records are at all times available for inspection in the home by any person authorised to enter and inspect the home. **Response by Registered Person(s)Detailing the Actions Taken:** Strategies in place to ensure accurate storage of records to make them available for inspection, BSA and home manager will check this periodically.
Requirement 2 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time **To be Completed by:** 30 July 2015	The registered person must provide individual agreements to each patient currently accommodated in the home (or their representative) which detail the current fees and financial arrangements in place in respect to the individual patient. Individual patient agreements must be reviewed for compliance with requirements under Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and must meet Standard 2.2 of the DHSSPS Care Standards for Nursing Homes (2015), which detail the minimum components of the agreement. A copy of the signed agreement by the patient or their representative and the registered person must be retained in the patient's records. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where a HSC trust-managed patient does not have a family member or friend to act as their representative, the patient's individual agreement should be shared with the HSC trust care manager. **Response by Registered Person(s)Detailing the Actions Taken:** Terms and Agreements were sent to all NOK prior to the date of the inspection, some had been returned signed, those which have not been returned were sent again on 08.07.15. For those with no NOK, home manager discussed with care manager and records kept to evidence this. Terms and Conditions are stored in the residents file, which will be checked by the BSA and Home Manager periodically.
Requirement 3 **Ref**: Regulation 5 (2) (a) (b)	The registered person must provide at least 28 days written notice to each patient or their representative of any increase in the fees payable by or in respect of the patient, or any variation in the method of payment of the fees or the person by whom the fees are payable.

Stated: First time **To be Completed by:** From the date of the next change	The registered person must ensure that any changes to the individual patient's agreement are agreed in writing by the patient or their representative. The patient's individual agreement must be updated accordingly. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded.
	Response by Registered Person(s)Detailing the Actions Taken: Terms and Agreements were sent to all NOK prior to the date of the inspection, some had been returned signed, those which have not been returned were sent again on 08.07.15. For those with no NOK, home manager discussed with care manager and records kept to evidence this. Terms and Conditions are stored in the residents file, which will be checked by the BSA and Home Manager periodically.
Requirement 4 **Ref:** Regulation 19(2) Schedule 4 (3) **Stated:** First time **To be Completed by:** 30 July 2015	The registered person must ensure that written authorisation is obtained from each patient or their representative to spend the personal monies of patients on pre-agreed expenditure. The written authorisation must be retained on the patient's records and updated as required. The registered person must ensure that where any representative of a patient (including care manager or next of kin) have signed a document for the home on behalf of the patient, the representative's name and relationship to the patient are clearly stated on the document. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where a HSC trust-managed patient does not have a family member or friend to act as their representative, the patient's personal monies authorisation should be shared with the HSC trust care manager.
	Response by Registered Person(s)Detailing the Actions Taken: Pre agreed expenditure were sent to all NOK prior to the date of the inspection, some had been returned signed, those which have not been returned were sent again on 08.07.15. For those with no NOK, home manager discussed with care manager and records kept to evidence this. Pre agreed expenditure are stored in the residents file, which will be checked by the BSA and Home Manager periodically For one of purchases home manager will gain aggreement from NOK and Care manager prior to spending and records will be kept to evidence this.
Requirement 5 **Ref:** Regulation 22 (3) **Stated:** First time **To be Completed by:** 30 July 2015	The registered person must request written confirmation from the Social Security Agency of the details of the nominated Appointee for the one patient identified during the inspection. Once received, this confirmation must be retained on the patient's file. In addition, the details of the appointment and the records to be kept in respect of this appointment must be reflected in the individual patient's agreement which should be signed by the patient or their representative.

	Response by Registered Person(s)Detailing the Actions Taken: Home has contacted providing Trust to take over apponitee ship at beginning of year, awaiting paperwork to confirm same. Home has followed up with Trust who advised they will forward paperwork
Requirement 6 **Ref:** Regulation 19(2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that any visiting retailer to the home signs the receipt left with the home. A representative of the home must also sign the receipt to verify that a patient has received the items detailed on the receipt provided. **Response by Registered Person(s)Detailing the Actions Taken:** Strategies in place to ensure for all future visiting retailers a signed reciept will be left by the retailer which will also be signed by a member of staff.
Requirement 7 **Ref:** Regulation 19(2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that the treatment records for any complimentary therapy facilitated in the home are signed by the person providing the treatment and a representative of the home to verify the treatment has taken place. There must be a countersigned treatment record for every treatment day. **Response by Registered Person(s)Detailing the Actions Taken:** New weekly payment sheets have been introduced which include the name and signature of person delivering the treatment, staff signature, Residents name, therapy given and cost.
Requirement 8 **Ref:** Regulation 19(2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that treatment records from the hairdresser facilitated within the home include the following details as a minimum: the date; name of the patient; treatment provided and the associated cost; the signature of the hairdresser and the signature of a member of staff in the home who can verify that the person received the treatment detailed on the record. **Response by Registered Person(s)Detailing the Actions Taken**: New weekly payment sheets have been introduced which include the name and signature of person delivering the service, staff signature, Residents name, service given and cost.

Requirement 9 **Ref:** Regulation 19(2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that a reconciliation of the safe place is carried out, recorded and signed and dated by two people at least quarterly. Where items are returned to a patient or their representative, the record should be updated with the date the item(s) were returned and include two signatures to verify the return of the items. _____ **Response by Registered Person(s)Detailing the Actions Taken**: A safe reconciliation will be carried out at the beginning of each month by two staff members, usually the Home Manager and Home Administrator, this will be checked by BSA.
Requirement 10 **Ref:** Regulation 19(2) Schedule 4 (10) **Stated:** First time **To be Completed by:** 30 July 2015	The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by all newly admitted patients. The registered person must also ensure that a retrospective record is made of the furniture and personal possessions owned by existing patients accommodated in the home. All inventory records should be updated on a regular basis. (Care Standards for Nursing Homes, April 2015 require that a reconciliation of these records is recorded at least quarterly). Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry. The registered person should advise staff of the importance of recording inventory details consistently. Items of significant value or those requiring electrical safety testing should be distinctly highlighted on the record for ease of identification. _____ **Response by Registered Person(s)Detailing the Actions Taken:** Care staff have been advised of this and staff supervision held in this area to include signing by two staff and dating, home manager and deputy manager have started to include in care plan audits
Requirement 11 **Ref**: Regulation 19(2) Schedule 4 (17) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that journey records for patients travelling on the home's minibus are legible, kept up to date and recorded on the appropriate templates. All of the necessary details must be recorded on the journey records. _____ **Response by Registered Person(s)Detailing the Actions Taken**: Staff supervision for care staff and those who drive the bus in relation to recoding of journeys and ensuring records are legible and recorded on correct template. Home Manager and BSA will continue to check accuracy.

Registered Manager Completing QIP	Yvonne Diamond	**Date Completed**	24.07.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	31.07.15
RQIA Inspector Assessing Response	Briege Ferris	**Date Approved**	18/08/15

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

Please provide any additional comments or observations you may wish to make below: