Dungannon
RQIA ID: 1468
100 Killyman Road
Dungannon
BT71 6DQ

Inspector: Briege Ferris
Inspection ID: IN023746

Tel: 02887753034
Email: dungannon@fshc.co.uk

Announced Follow-up Finance Inspection of Dungannon

27 October 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An announced follow up finance inspection took place on 27 October 2015 from 10:00 to 14:00. A poster detailing that the inspection was taking place was positioned at the entrance to the home.

On the day of inspection, the position of manager was vacant; it was noted that day to day management support was being by Mrs Patricia Graham, registered manager of another facility within Four Seasons Health Care. Feedback from the inspection was provided to Mrs Graham accordingly. During the inspection, we also met with the home's administrator; no relatives or visitors chose to meet with us during the inspection.

This inspection was carried out to review progress with actions detailed in the Quality Improvement Plan (QIP) from the previous finance inspection on 18 June 2015. While progress in addressing a number of actions has been identified, a number of areas for improvement are stated for the second time in the 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	4	1

The details of the QIP within this report were discussed with Mrs Patricia Graham, 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/Maureen Claire Royston	**Registered Manager:** Manager's post vacant
Person in Charge of the Home at the Time of Inspection: Rochelle Conde (Nurse in Charge)	**Date Manager Registered:** Manager's post vacant
Categories of Care: NH-LD, NH-LD(E)	**Number of Registered Places:** 36
Number of Patients Accommodated on the Day of Inspection: 36	**Weekly Tariff at Time of Inspection:** £593.00 - £1,638.70

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 Mrs Patricia Graham and the home administrator
- Review of records
- Evaluation and Feedback.

Prior to inspection the following records were analysed:

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

The following records were reviewed during the inspection:

- Four patient finance files
- Three written agreements
- A sample of comfort fund records
- A sample of hairdressing, aromatherapy, and foot massage treatment records
- A record of safe contents reconciliations
- Four records of patients' furniture and personal possessions
- A sample of transport journey records

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 7 October 2015, the findings from which will be reported on separately. We were not required to follow up on any matters arising from the previous inspection.

5.2 Review of Requirements and Recommendations from the Finance Inspection on 18 June 2015

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 19 (2) (b)	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.	**Met**
	Action taken as confirmed during the inspection: All of the records which were requested as part of the inspection were provided by the home's administrator.	
Requirement 2 **Ref**: Regulation 5 (1) (a) (b)	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 details the minimum components of the agreement. A copy of the agreement signed 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.	**Not Met**

	Action taken as confirmed during the inspection: We selected a sample of four finance files for review in order to view the written agreements in place with individual patients. The first two files reviewed contained a signed agreement which pre-dated the date of the last finance inspection (18 June 2015). We noted that these agreements were signed in May 2015. (At the time of the previous finance inspection, signed agreements could not be located in the home). While the correct weekly fee was recorded on these agreements, we noted that the words "as per Trust invoice" had been written on both agreements. We highlighted in the inspection feedback that the name of the payee and the method of payment must be detailed on each patient's agreement. We noted that in subsequent updated agreements with these patients, these details must be included. On reviewing the remaining two finance files, we noted that neither of these patients had an up to date, signed agreement on their file. One patient had an agreement on file which was signed in 2013; the second patient did not have a signed agreement on their file. There was no written evidence on either patient's file to demonstrate that updated agreements had been sent to the patients' representatives. We discussed these findings during inspection feedback at which time, the administrator provided a copy of a letter which were informed had been sent to the representative of one of the patients in question. The letter was dated 8 July 2015 and enclosed an updated agreement. We queried why the letter was not on the patient's file and the administrator informed us that it had been removed so that it could be reviewed as part of the inspection. The administrator left the feedback to attempt to locate an equivalent letter to the patient with no agreement on their file, however the administrator returned to advise that such a letter could not be located. The administrator also advised that the patient in question did not have a family representative who could sign an agreement. We	

	clarified that if that was the case, the patient's agreement should be shared with their HSC trust care manager. This arrangement was also clearly detailed in the actions in the QIP from the inspection of 18 June 2015. We highlighted that the patient who did not have any agreement in place with the home (and for whom there was no written evidence that any attempt had been made by the home to secure a signed agreement) was a patient for whom a representative of the registered person had been acting as nominated Appointee (i.e.: managing the patient's social security benefits). We noted that given this patient had a financial arrangement in place with the home, it was especially important for them to have a detailed agreement in place with the home to clarify the arrangements in place to support the patient. In summary, within a sample of four files, two patients did not have a signed agreement on their file, in addition, correspondence to evidence that the home had attempted to obtain a signed agreement was either not on the patients' files or could not be located. This requirement is therefore stated for the second time.	
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. 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.	**Met**

	Action taken as confirmed during the inspection: There had been no change to regional fee rates since the previous finance inspection on 18 June 2015; compliance with the above requirement will therefore be assessed on a subsequent finance inspection of the home. This requirement is noted as met at present, until such times as compliance can be assessed.	
Requirement 4 **Ref**: Regulation 19(2) Schedule 4 (3)	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.	**Not Met**
	Action taken as confirmed during the inspection: The home has a "financial assessment part 3" document which is used to obtain written authority from a patient or their representative for the home to make purchases of goods and services from patients' personal monies held by the home. We sampled the finance files for four patients and noted that none of the four patients had a "financial assessment part 3" document on their file which had been signed by the patient or their representative. The home is required to ensure that any patient who does not have a signed personal monies expenditure authorisation on their file is provided	

	with one and that there must be written evidence on the patient's file to demonstrate the home has followed up on documents which have not been returned. This requirement is therefore stated for the second time.	
Requirement 5 **Ref**: Regulation 22 (3)	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.	
	Action taken as confirmed during the inspection: The home's administrator advised that since the previous finance inspection on 18 June 2015, the Appointee arrangement between the home and the identified patient had been relinquished and the commissioning HSC trust had taken over this responsibility. We reviewed the patient's file for any evidence of relevant correspondence with the commissioning trust or the Social Security Agency in this regard; however, no such correspondence was evidenced on the patient's file. During feedback; the administrator advised that there may be an email to the commissioning HSC trust regarding the change in arrangements; the administrator left the feedback to attempt to find the correspondence, however returned to advise that it could not be located. We noted that there was therefore no written evidence on the patient's file which would identify that the home had engaged with the Social Security Agency and the commissioning HSC trust regarding the proposed change in Appointee arrangements for the identified patient. During feedback from the inspection, we highlighted the importance of being able to evidence that	**Not Met**

	matters have been appropriately addressed. As we were advised by the home that the Appointee arrangements for the patient have been relinquished, a requirement is made for the registered person to evidence in the patient's records that there has been engagement with the HSC trust and other relevant stakeholders regarding the change in this arrangement. Written confirmation of the new arrangements in place to support the identified patient must be available in the patient's records. A requirement has been made in respect of this finding.	
Requirement 6 **Ref**: Regulation 19(2) Schedule 4 (9)	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.	**Met**
	Action taken as confirmed during the inspection: We were advised by the home's administrator that there had been no visits by retailers since the last finance inspection on 18 June 2015. The administrator noted that it was likely a retailer would visit before Christmas, at which point the controls above would be adhered to. Compliance with this requirement will therefore be reviewed at a subsequent finance inspection of the home. This requirement is noted as met at present, until such times as compliance can be assessed.	
Requirement 7 **Ref**: Regulation 19(2) Schedule 4 (9)	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.	**Met**
	Action taken as confirmed during the inspection: We reviewed a sample of the records for complimentary therapy and noted that the controls as outlined above were consistently being adhered to.	

	We also reviewed the records for foot massage treatments provided to the patients. We noted that the cost of the treatments varied according to the number of people treated on a given day. We discussed this matter with the administrator who advised that the person providing the treatment receives a fixed amount for each visit irrespective of how many people are treated on that occasion. We discussed this during feedback and noted that this would not reflect normal charging practices and noted that the home should review this charging mechanism for appropriateness. A recommendation has been made in respect of this finding.	
Requirement 8 **Ref**: Regulation 19(2) Schedule 4 (9)	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.	**Partially Met**
	Action taken as confirmed during the inspection: The home had developed a template to record hairdressing treatments. The home administrator also provided the hairdressing book in which staff record the names of the patients to be treated. We were advised that the treatment record is completed following the day's treatments. We reviewed a sample of completed hairdressing treatment records. We noted that a high proportion of the records made since the last inspection had not been signed by a member of staff to verify that the patient had received the treatment. This requirement is therefore stated for the second time.	

Requirement 9 **Ref**: Regulation 19(2) Schedule 4 (9)	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.	**Met**
	Action taken as confirmed during the inspection: We reviewed the records of reconciliations of the safe place. We noted that reconciliations had been recorded on 13 July 2015, 13 August 2015 and 3 September 2015; reconciliations had been signed and dated by two people. The home administrator noted that the only change to the record had been the addition of a set of keys formally retained by a member of home management.	
Requirement 10 **Ref**: Regulation 19(2) Schedule 4 (10)	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.	**Met**
	Action taken as confirmed during the inspection: We requested to see the property records for a sample of four patients and we were provided with the care files for the selected patients.	

	We noted that all four patients had a "Schedule of personal effects" document on their care files. We noted that each of the four records had been signed or initialled by two persons; there was also evidence that records had been updated recently. Care Standards for Nursing Homes (2015) require that these records are updated at least quarterly, compliance with this will be assessed in a future finance inspection of the home.	
Requirement 11 **Ref**: Regulation 19(2) Schedule 4 (17)	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.	**Met**
	Action taken as confirmed during the inspection: We reviewed a sample of the transport journey records and noted that records were being maintained as detailed above.	

5.3 Additional Areas Examined

There were no additional areas examined as part of the inspection.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Patricia Graham, 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 5 (1) (a) (b) **Stated:** Second time **To be Completed by:** 28 November 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: Individual agreements re-issued to all clients representatives, family members or trust staff where applicable. Dates diarised for return and follow up planned if not returned.
Requirement 2 **Ref**: Regulation 19(2) Schedule 4 (3) **Stated:** Second time **To be Completed by:** 28 November 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: As above personal expenditure forms re-issued to families and clients representatives for signature to specify and allow monies to be spent on clients account.

Requirement 3 **Ref**: Regulation 19(2) Schedule 4 (3) **Stated:** Second time **To be Completed by:** 10 November 2015	The registered person must ensure that within the identified patient's records, there is evidence to demonstrate engagement with the relevant organisations (including the Social Security Agency and the HSC Trust) regarding the change in the Appointee arrangements. When received, written confirmation of the new arrangements in place to support the identified patient must be retained in their records.
	Response by Registered Person(s)Detailing the Actions Taken: Correspondance forwarded to the relevant trust to return written confirmation. follow up phone calls also made, assurance given by trust that appropriate paperwork will be sent to the home by end of the month.
Requirement 4 **Ref**: Regulation 19(2) Schedule 4 (9) **Stated:** Second 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: proper paperwork now in place and 2 signatures for any transactions completed
Recommendations	
Recommendation 1 **Ref**: Standard 14.13 **Stated:** First time **To be Completed by:** 28 November 2015	It is recommended that the registered person review the appropriateness of the charging structure for foot massage treatments facilitated within the home. The home should engage with patient representatives and HSC Trust representatives as appropriate.
	Response by Registered Person(s)Detailing the Actions Taken: foot massage is now being charged per person and no longer by the hour. a rate of £6 per resident is the current rate agreed by the provider.

Registered Manager Completing QIP	Pat Graham	**Date Completed**	24/11/15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	24.11.15
RQIA Inspector Assessing Response		**Date Approved**	26/11/2015

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