Unannounced Finance Inspection Report
3 November 2016

Glencarron

Type of service: Nursing Home
Address: 6 Creamery Road, Crossmaglen BT35 9AD
Tel no: 02830868366
Inspector: Briege Ferris

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Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Glencarron took place on 3 November 2016 from 09:40 to 15:45 hours.

The inspection sought to assess progress with any issues raised during and since the last finance inspection and to determine if the nursing home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

A safe place in the home was available and staff members were familiar with controls in place to safeguard patients' money and valuables. One area for improvement was identified; this related to introducing a written safe record which should be reconciled and signed and dated by two people at least quarterly.

Is care effective?

Controls to ensure patients' money and valuables were safeguarded were found to be in place; however, six areas for improvement were identified during the inspection. These related to: records of patients' property in their rooms; ensuring that errors on income and expenditure records are appropriately dealt with; ensuring that a reconciliation of money and valuables is carried out and recorded by two people at least quarterly; ensuring that records of any treatments provided to patients (for which there is an additional charge) contain the necessary information; notifying each patient or their representative of any increases in fees and ensuring that changes to patients' agreements are agreed in writing.

Is care compassionate?

Significant effort was being made by the home and in particular by the home administrator to ensure that those patients whose money was held in the local credit union had ready access to funds to meet their weekly personal needs. No areas for improvement were identified.

Is the service well led?

Governance and oversight arrangements were found to be in place; however, two areas for improvement were identified during the inspection. These related to ensuring that written authorisation is obtained from each patient or their representative to spend the patient's money on identified goods and services to pre-agreed expenditure limits; and ensuring that the home review its current standard agreement with patients to ensure it contains, as a minimum, the content of DHSSPS Care Standard 2.2. Up to date individual agreements reflecting the specific fees and any financial arrangements should be provided to each of the current patients in the home.

This inspection was underpinned by Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	8

Details of the Quality Improvement Plan (QIP) within this report were discussed with Oonagh Grant, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

1.2 Actions/enforcement taken following the most recent finance inspection

A finance inspection of the home was carried out on behalf of RQIA on 29 September 2008; the findings from this inspection were not brought forward to the inspection on 3 November 2016.

2.0 Service details

Registered organisation/registered person: Glencarron Homes Ltd/Brendan Liddy & Bridget Liddy	**Registered manager:** Oonagh Grant
Person in charge of the home at the time of inspection: Oonagh Grant	**Date manager registered:** 21 December 2011
Categories of care: NH-DE, NH-PH, NH-PH(E), NH-I	**Number of registered places:** 44

3.0 Methods/processes

Prior to inspection the record of notifiable incidents reported to RQIA in the last 12 months was reviewed; this established that none of these incidents related to services users' 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: Oonagh Grant, the registered manager; Shane Liddy; Brenda Magill; the home's administrator and the home's activities co-ordinator/hairdresser. A poster detailing that the inspection was taking place was positioned at the entrance to the home, however no relatives or visitors chose to meet with the inspector.

The following records were examined during the inspection:

- The home's welcome pack for new patients
- Training record for the home administrator (Protection of Vulnerable Adults)
- Policies addressing: Accounting and financial control arrangements; Management of patient property and finances and Guidance for the secure management of patient property
- A sample of income, expenditure and reconciliation records
- A sample of receipts for hairdressing and podiatry services facilitated in the home
- Five patients' care files
- Six patients' finance files - "credit union files"
- Three records of patients' property in their rooms

4.1 Review of requirements and recommendations from the most recent inspection dated 21 July 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector. This QIP will be validated by the pharmacy inspector at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last finance inspection

As noted above, a finance inspection of the home was carried out on behalf of RQIA on 29 September 2008; the findings from this inspection were not brought forward to the inspection on 3 November 2016.

4.3 Is care safe?

The home had a full time administrator and evidence was reviewed which confirmed that she had received training on the Protection of Vulnerable Adults (POVA). The administrator was familiar with the controls in place to safeguard patients' money and valuables in the home.

During discussion, the registered manager confirmed that there were no current, suspected, alleged or actual incidents of financial abuse, nor were there any financial-related restrictive practices in place for any patient.

The home had a safe place available for the deposit of cash or valuables belonging to patients; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection, cash and valuables belonging to patients were deposited with the home for safekeeping. The home had a written record of cash held (discussed in section 4.4 below); however, there was no written safe contents record in respect to the valuables being held.

A recommendation was made to introduce a written safe record, which should be reconciled, signed and dated by two people on at least a quarterly basis.

Areas for improvement

One area for improvement was identified during the inspection in relation to introducing a written safe record.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

Discussion with the registered manager and the home administrator established that no representatives of the home were acting as nominated appointee for any patient in the home, nor was the home in direct receipt of the personal monies of any patient in the home.

The home was, however, supporting a small number of patients with their individual credit union accounts. Arrangements were in place such that the home would liaise with the local credit union on a weekly basis to ensure that those patients had enough money at their disposal to pay for any additional goods or services over and above the weekly fee. The home administrator advised that money for the patients was deposited in their respective credit union accounts either by a family member or representative or otherwise by the HSC trust (from the individual patients' monies managed by the HSC trust on behalf of each patient). The home administrator explained how a representative of the credit union would visit the home on a weekly basis with the monies requested for the patients and this would be signed over to the patient or deposited with the home for safekeeping on the patient's behalf. Records to evidence this process in action were maintained by the home.

Discussion established that for other patients in the home, family representatives were involved in supporting the patients with their money. Family representatives would deposit an amount of money with the home for payment of the hairdresser or other sundry items. Records detailing income and expenditure incurred on behalf of patients were maintained in a ledger book entitled "Patients accounts ledger". The book had been in use for some time and it was observed to be in poor condition in places. The book had been spiral-bound, therefore in order to insert additional pages into the book for a patient, the entire contents would need to be taken apart and rebound. The book evidenced that in a number of cases this had not been done; instead, additional pages had been stapled to the existing pages in the book, which had weakened the pages bound in the book.

The inspector highlighted that the records were required to be maintained for at least six years from the date of the last entry; given the condition of the book, the records were at risk of becoming detached from the book. Advice and alternative methods of maintaining the records were discussed during feedback with the registered manager.

A sample of the records of income and expenditure incurred on behalf of patients were reviewed. It was noted that entries in the ledger followed a standard ledger format and entries were consistently signed by two people.

It was noted, however, that there was inconsistency in the way errors were dealt with in the ledger book. While some errors in the cash columns had been appropriately dealt with (one line drawn through the entry, and initialled), in a significant number of cases, errors had been scribbled out, making the original entry illegible. The inspector noted that staff making entries in the records must be advised on to how to appropriately record entries in a financial ledger and to how to deal with mistakes.

A recommendation was made in respect of this finding.

A review of a sample of the income and expenditure records identified that the ledgers had most recently been reconciled to the cash held the day before the unannounced inspection. However, the reconciliation prior to 2 November 2016 was carried out seven months previously. The importance of ensuring that records of money and valuables held by the home are reconciled and signed and dated at least quarterly was emphasised.

A recommendation was made in respect of this finding.

Hairdressing, private podiatry and beautician services were being facilitated within the home. At least two hairdressers provided services within the home and discussion established that a number of payment arrangements were in place. The inspector spoke with one of the hairdressers (also the activities therapist within the home). The hairdresser/activities therapist noted that some patients are capable of handling their own money and paid her directly, she noted that a receipt was always provided to the patient and she kept the duplicate; these were also the arrangements where a family member was paying her directly for treating a patient.

She noted that in most cases, money was deposited with the home for safekeeping in order to pay for hairdressing or other goods or services. She explained that receipts were provided to the office so that these could be held in the individual patients' records.

A sample of hairdressing receipts were reviewed (for both hairdressers). It was noted that in both cases, while most of the required information for treatment records had been recorded, some items were absent. The same was also true for treatments by a private podiatrist who visited the home. The inspector highlighted that the necessary information to consistently record was detailed in DHSSPS Care Standard 14.13.

A recommendation was made in respect of this finding.

A sample of the record of patients' property (within their rooms) was reviewed. From a sample of four records, all four patients had a "personal belongings on admission/discharge" form; however the record for one patient was blank. The inspector noted that this patient's financial records included a receipt for the purchase of an item of electrical equipment for their room which they had paid for personally; this item should have been recorded in the patient's property record accordingly.

A requirement was made to ensure that every patient had a record of the furniture and personal possessions which they have brought into their room.

The remaining patients in the sample had a completed record on their file, however there was some inconsistency evidenced within these records. While the template itself required the signatures of two people, a number of the records had been signed only by one person; there was no evidence that the records had been checked at least quarterly (as required by DHSSPS Care Standard 14.26).

A recommendation was made to ensure that additions or disposals from patients' property records are signed and date by two people; reconciliations of patients' property should be carried out at least quarterly.

Discussion with the registered manager and a review of the records evidenced that only those patients funding their places privately were notified of any increases in fees payable. The inspector noted that irrespective of how a patient's place was funded, patients or their representatives must be notified of any changes to their agreement (including the fees and financial arrangements) and that the changes(s) should be agreed in writing.

A recommendation was made to ensure that each patient or their representative is given written notice of all changes to the agreement and these are agreed in writing. There is further discussion about individual patient agreements in section 4.6 below.

Areas for improvement

Six areas for improvement were identified during the inspection. These related to records of patients' property in their rooms; ensuring that errors on income and expenditure records are appropriately dealt with; ensuring that a reconciliation of money and valuables is carried out and recorded by two people at least quarterly; ensuring that records of any treatments provided to patients (for which there is an additional charge) contain the necessary information; notifying each patient or their representative of any increases in fees and ensuring that changes to patients agreement are agreed in writing accordingly.

Number of requirements	1	Number of recommendations	5

4.5 Is care compassionate?

The day to day arrangements in place to support patients were discussed with the registered manager and the home administrator. The home administrator described specific examples of how the home supported a range of patients with their money and she did so with clarity and empathy. Significant effort was being made by the home and in particular by the home administrator to ensure that that those patients whose money was held in the local credit union had ready access to funds to meet their weekly personal needs.

There was evidence of on-going liaison with credit union representatives to ensure that cash was available for those patients, and records were available to evidence the receipt of money either by individual patients or by the home to be held in the safe place until the patient required it. Records evidenced that the receipt of money was signed into the records held by two people (one representative from the home and the other being the credit union representative). The home administrator maintained clear, detailed records to substantiate the withdrawals from the patients' credit union accounts.

Discussion with the registered manager established that arrangements to safeguard a patient's money were discussed with the patient or their representative at the time of admission to the home.

Arrangements for patients to access their money outside of normal office hours were discussed with the registered manager. The registered manager was able to clearly explain that the nurse in charge had access to the safe place in the home and there was therefore access at any time for patients to money which had been deposited with the home for safekeeping.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The home had a number of written policies and procedures in place to guide practice in the area of safeguarding patients' money and valuables. There was a clear organisational structure within the home; discussion established that those involved in supporting patients with their money on a daily basis were familiar with their roles and responsibilities in relation to safeguarding patients' money and valuables.

A review of a sample of five care files and six "credit union" (finance) files evidenced that there were no personal monies authorisation records in place between each patient and home. The personal monies authorisation provides the home with written authority to spend a patient's money on identified goods and services on the patient's behalf. Discussion with the registered manager during feedback also confirmed that these were not in place.

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

A review of a sample of four patients' files identified that each of the four patients had a signed page on their file which had been laminated. The page comprised the sentence "I have read the conditions of admission, I understand and accept them." The pages reviewed on the patients' files were dated either August or September 2015. The registered manager confirmed that agreements with patients had not been updated over time (that is, to reflect annual regional changes to fees which are normally increased in April each year). A recommendation has been made previously under section 4.4 in respect of this finding.

Initial discussions with the registered manager established that this was only part of the patient agreement which was retained by the home; the remainder of the document was provided to the patient or their representative.

The inspector noted, however, that the content of the agreement provided to the sampled patients could not be evidenced as the home had not retained a full copy of the agreement as provided to each patient. The inspector advised the registered manager that it was prudent for the home to retain a full copy of each patient's signed agreement. The inspector noted that from a brief overview of the home's current form of agreement with patients, there appeared to be a number of components absent from the agreement. These included, for instance, the person by whom fees were payable and how the home would be paid, and the costs of any additional services facilitated within the home (such as hairdressing etc.).

It was highlighted that any financial arrangement in place between the home and an individual patient must also be included in that patient's individual agreement with the home. Earlier discussions had confirmed that a number of financial arrangements were in place which must be reflected in each patient's agreement accordingly.

A recommendation was made to ensure that the home review its current form of agreement with patients to ensure that it contains the content of DHSSPS Minimum Standard 2.2.

Up to date individual agreements reflecting the specific fees and financial arrangements for each patient should be provided to each of the current patients or their representatives.

Areas for improvement

Two areas for improvement were identified during the inspection. These related to ensuring that written authorisation is obtained from each patient or their representative to spend the patient's money (on identified goods and services) to pre-agreed expenditure limits; and ensuring that the home review its current form of agreement with patients to ensure that it contains the content of DHSSPS Minimum Standard 2.2. Up to date individual agreements reflecting the specific fees and financial arrangements for each patient should be provided to each of the current patients or their representatives.

Number of requirements	0	Number of recommendations	2

5.0 Quality improvement plan

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

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

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the RQIA office for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be completed by:** 4 November 2016	The registered provider must ensure that a record of furniture and personal possessions brought by a patient into the room occupied by them is maintained.
	Response by registered provider detailing the actions taken: Each Care Assistant is allocated to one or two residents It is their responsibility to update patient inventory at least monthly. families have been advised to notify Staff of all incomming items in order that they are added to a newly devised inventory list. Inventories will be audited quarterly to monitor record keeping and safe guard against loss.

Recommendations

Recommendation 1 **Ref:** Standard 14.9 **Stated:** First time **To be completed by:** 17 November 2016	The registered provider should ensure that a written safe record is introduced to record any money or valuables held within the safe place for safekeeping on behalf of a patient. (Records of monies or valuables held should be reconciled and signed and dated by two people at least quarterly).
	Response by registered provider detailing the actions taken: Records are currently reconciled and signed by two staff however some shortfalls have been identified. This process is now more secure with reconciliation dates clearly highlighted on both ledger & desk diary.

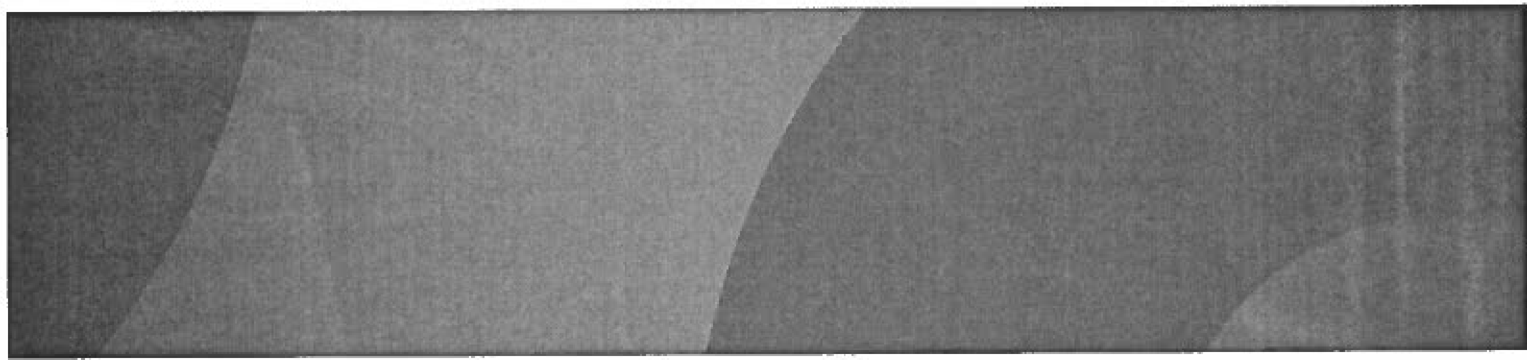
Recommendation 2 **Ref:** Standard 14.11 **Stated:** First time	The registered provider should ensure that records made on behalf of residents are legible and mistakes appropriately dealt with on the face of the ledger (i.e. a clear line crossed through the incorrect entry with an amendment on the line below and initialled by the member of staff recording the entry). Correcting fluid is never used to amend records.
To be completed by: 4 November 2016	**Response by registered provider detailing the actions taken:** Staff have been advised of the correct method of recording credits and debits. A new ledger has been commenced. The existing ledger does not reflect the use of correcting fluid
Recommendation 3 **Ref:** Standard 14.25 **Stated:** First time	The registered provider should ensure that a reconciliation of money and valuables held and accounts managed on behalf of residents is carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.
To be completed by: 3 February 2017 and at least quarterly thereafter	**Response by registered provider detailing the actions taken:** Processes have been put in place to ensure that patient accounts are reconciled and co signed at least quarterly.

Recommendation 4 **Ref:** Standard 14.13 **Stated:** First time **To be completed by:** 4 November 2016	The registered provider should ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the resident or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each resident.
	Response by registered provider detailing the actions taken: Processes have been established to record & verify transactions between patient and relevant provider. Individual ledgers for external Service providers have been developed and will accomodate the above information required.
Recommendation 5 **Ref:** Standard 14.26 **Stated:** First time **To be completed by:** 3 December 2016 and at least quarterly thereafter	The registered provider should 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.
	Response by registered provider detailing the actions taken: As documented in Requirement 1.

Recommendation 6 **Ref:** Standard 2.6 **Stated:** First time **To be completed by:** 4 November 2016	The registered provider should ensure that the resident or their representative and (in the case of trust-managed residents) the Trust (in accordance with local arrangements) are given written notice of all changes to the agreement and these are agreed in writing. Where the resident is unable to sign or chooses not to, this is recorded. **Response by registered provider detailing the actions taken:** In future all changes will be notified in writing to relevant individuals and/or bodies
Recommendation 7 **Ref:** Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 3 December 2016	The registered provider should ensure that where a home is responsible for managing a resident's finances, the arrangements and records to be kept are specified in the individual agreement. Written authorisation is obtained from each resident or their representative to spend the resident'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. **Response by registered provider detailing the actions taken:** Arrangements for financial safe keeping are as follows 1 - Individual financial agreements in place 2 - Board financial agreements in place 3 - Written authorisations for pre agreed expenditure in place 4. Trust representative informed of their duty of care in this matter

Recommendation 8 **Ref:** Standard 2.2 **Stated:** First time **To be completed by:** 3 December 2016	The registered provider should ensure that the home's current form of agreement with patients is reviewed to ensure that it contains the content of DHSSPS Minimum Standard 2.2. Up to date individual agreements reflecting the specific fees and financial arrangements for each patient should be provided to each of the current patients or their representatives.
	Response by registered provider detailing the actions taken: Minimum Standard 2.2 is acknowledged in patient agreement 5.4 'Patients right to control their own money will be facilitated'. All financial implications are broadly outlined in patient agreement and where necessary will be elicited in a Patient Specific financial care plan.

Name of registered manager/person completing QIP	Oonagh Grant		
Signature of registered manager/person completing QIP		Date completed	16/12/16
Name of registered provider approving QIP			
Signature of registered provider approving QIP	Bridget Liddy	Date approved	19/12/16
Name of RQIA inspector assessing response			
Signature of RQIA inspector assessing response		Date approved	03/01/17



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Assurance, Challenge and Improvement in Health and Social Care