Unannounced Finance Inspection Report
28 June 2017

Sandringham

Type of Service: Nursing Home
Address: 24 Sandringham Court, Portadown, BT63 5BW
Tel No: 028 38394194
Inspector: Briege Ferris

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 63 beds that provides care for older patients, those with a physical disability or those living with dementia.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual(s):** Maureen Claire Royston	**Registered Manager:** Not applicable
Person in charge at the time of inspection: Tracey Palmer	**Date manager registered:** Not applicable
Categories of care: Nursing Care (NH) I - Old age not falling within any other category PH - Physical disability other than sensory impairment DE – Dementia	**Number of registered places:** 63 comprising: A maximum of 32 in category NH-DE.

4.0 Inspection summary

An unannounced inspection took place on 28 June 2017 from 10.00 to 15.50.

This inspection was underpinned by Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

The inspection assessed progress with any areas for improvement identified since the last finance inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found, for example: a safe place in the home was available and staff members were familiar with controls in place to safeguard service users' money and valuables; controls to ensure service users' money and valuables were safeguarded were in place; the home had a range of methods in place to encourage feedback from patients or their representatives and evidence of governance arrangements were identified.

Areas requiring improvement were identified in relation to: the personal property records of patients; records of treatments to patients facilitated in the home for which there is an additional charge; improving how updating and sharing individual patient agreements and personal monies authorisation documents is managed.

One patient spoken with noted their contentment living in the home and in the way their money was managed. They noted in particular, the enjoyment they received from the beautician treatments facilitated in the home and stated of the person providing the treatments - "she's brilliant".

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	3

Details of the Quality Improvement Plan (QIP) were discussed with Tracey Palmer, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

5.0 How we inspect

Prior to the inspection, the record of notifiable incidents reported to RQIA in the last twelve months was reviewed; this established that none of these incidents related to residents' money or valuables. The record of calls made to RQIA's duty system was also reviewed and this did not identify any relevant issues; the care inspector was contacted prior to the inspection and they confirmed there were no matters to be followed up.

During the inspection, the inspector met with one patient and three staff members (the manager, home administrator and regional business support administrator).

The following records were examined during the inspection:

- Five patients' finance files
- Four patients' signed individual written agreements
- A sample of income, expenditure, banking and reconciliation records
- A sample of service users' social fund records
- The safe record
- A sample of treatment records for services facilitated within the home
- Financial policies and procedures including that in respect of:
    - "Safekeeping of a Person in Care's Valuables"
    - "Management & Recording of Personal Allowances"
    - "Management of Bank Account and Cash Float"
    - "Other Cash Floats & Sundry Funds"
    - "Retention and Disposal of Records"
- Three records of service users' personal property (in their rooms)

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 28 February 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last finance inspection

The home has not previously received an RQIA finance inspection.

6.3 Inspection findings

6.4 Is care safe?

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

The inspector met with the home administrator who was able to clearly describe the home's controls in place to safeguard patients' money and valuables. The manager confirmed that adult safeguarding training was mandatory for staff on an annual basis; the home administrator had completed the training in February 2017.

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

The home had a safe place available for the deposit of cash or valuables belonging to patients; the inspector was satisfied with the location of the safe place and the persons with access. On the day of inspection cash belonging to patients was deposited for safekeeping; no valuables were being held.

A safe record was updated on the day of inspection, this detailed the items contained in the safe place and was signed by the home administrator. It was noted that should any valuables be deposited for safekeeping by patients, the safe record should detail the date the items are deposited and returned (with the signatures of two people) and the safe record should be reconciled by two people at least quarterly.

Areas of good practice

The home had a safe place available for the deposit of money or valuables; access was limited to authorised persons. Staff members spoken to were familiar with controls in place to safeguard service users' money and valuables.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Discussions with the manager and home administrator identified that no representative of the home was acting as nominated appointee for any resident. Discussion and a review of the records identified that the home was in direct receipt of the personal monies from the HSC trust in respect of eight service users.

The home administrator described that for a significant number of patients, family representatives deposited money directly with the home in order to pay for goods or services for which there was an additional charge, such as hairdressing, toiletries, podiatry or other sundries.

The home had a patients' personal allowance bank account which was named appropriately in favour of the patients in the home. Records were available to confirm the amount and timing of the receipt of monies into respective patients' personal allowance balances maintained by the home.

A sample of the records for income and expenditure incurred on behalf of service users was reviewed. It was noted that the home maintained "personal allowance account statements" detailing income and expenditure, together with other records to substantiate each transaction, such as a duplicate receipt for a cash/cheque lodgement or a treatment record (for hairdressing, podiatry or beautician services). The inspector traced a sample of transactions and was able to evidence the relevant documents; for example, a receipt for an item of expenditure or a receipt for a lodgement which had been made to the home. There was evidence that records of personal monies held on behalf of service users were reconciled and signed and dated by two people on a regular basis.

As noted above, hairdressing, podiatry and beautician treatments were being facilitated within the home. A sample of recent treatment records for all three types of service was reviewed.

Hairdressing, podiatry and beautician treatment records were all made on a similar template which was designed to include detail as to: the treatment provided to all of the patients on a particular day and the respective charges; the signature of the person providing the treatment

and the signature of a representative of the home who could verify that the treatments had been provided to those patients detailed.

A sample of five recent hairdressing treatment records evidenced that the names of the patients, the treatments provided and the individual costs had been detailed, however, three of the records had not been signed by the hairdresser and the remaining two records had not been signed by either the hairdresser or a person from the home.

A recent podiatry treatment record evidenced that the podiatrist had signed the record as the person providing the treatments to each patient and they had also signed beside the "staff confirmation" column, the record had therefore not been signed by a member of staff.

A recent beautician treatment record was reviewed and while the person providing the treatments to patients had signed the record, the "staff confirmation" column was again, not completed.

All of the above treatments had been authorised for payment, despite the fact that the treatment records were missing the requisite signatures to verify the treatments had been received by the patients.

This was highlighted as an area for improvement.

The inspector discussed how service users' property (within their rooms) was recorded and requested to see the completed property records for five randomly sampled service users. The manager reported that while she had been advised by staff in the home that the records had been completed recently, they could not be located during the course of the inspection. She noted that she had directed staff to repeat the exercise of recording the items for all of the patients in the home. By the end of the inspection, the records had been completed for only one unit in the home. Three of the five records sampled were available for review; however two records were not in place, as the patients resided in the other unit in the home.

The records which were available included the details of significant items for example; the make, model and approximate size of electrical items had been recorded. The administrator confirmed that two members of staff had carried out the exercise and their names were detailed on the document. The inspector noted however, that only one of the persons who had carried out the exercise had signed the record, the home administrator had countersigned the records. The inspector highlighted that this practice should be reviewed and/or reconsidered as the administrator had not been present to observe that the items were in fact, in the respective patients' rooms.

While the manager advised that the process of recording the furniture and personal possessions belonging to each patient would be completed in the day/s following the inspection, the records were not in place on the day, as is required by the regulations.

This was highlighted as an area for improvement.

The home had a service users' comfort fund. It was noted that income and expenditure records were maintained, which were reconciled and signed and dated by two people on a regular basis. A bank account was in place to administer the fund; this was named appropriately in favour of the patients in the home.

The manager confirmed that the home did not provide transport to service users.

Areas of good practice

There were examples of good practice found in respect of the availability of mechanisms to record income and expenditure on behalf of patients and of the existence of audit mechanisms. Controls to ensure that patients' money and valuables were safeguarded were evidenced.

Areas for improvement

Two areas for improvement were identified during the inspection. These related to ensuring 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 patient or a member of staff of the home signs the treatment record to verify the treatment or goods provided and the associated cost to each patient and to ensuring that each patient has a record of the furniture and personal possessions which they have brought into their rooms.

	Regulations	Standards
Total number of areas for improvement	1	1

6.6 Is care compassionate?

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

The arrangements to support service users with their money on day to day basis were discussed with the manager and the home administrator. Staff described how discussions regarding the arrangements to store money safely in the home or pay fees etc would be discussed with the patient or their representative around the time a service user would be admitted to the home.

Discussion established that the home had a number of methods in place to encourage feedback from families or their representatives in respect of any issue including the home's "quality of life" initiative to provide feedback via iPad computers placed throughout the home. A "residents and representatives" meeting was scheduled and held on the day of the inspection.

Arrangements for service users to access money outside of normal office hours were discussed with the manager and home administrator; this established that there was a contingency arrangement in place to ensure that this could be facilitated.

The inspector spoke to one patient who reported a concern about their personal property; with the consent of the patient, this was relayed to the manager during feedback from the inspection. The manager noted that the patient had also raised the same matter as part of the patients' and relatives meeting held earlier that day and she committed to following up on the patient's concern accordingly.

Areas of good practice

There were examples of good practice identified in relation to listening to and taking account of the views of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

The home had a range of written policies and procedures addressing matters relating to safeguarding money and valuables and record keeping; these were easily accessible by staff. The home's new patient pack encompassing the patient guide included information relating to the payment of fees and the arrangements in place to protect a patient's money and valuables deposited for safekeeping by the home.

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

Discussion was held regarding the individual written agreements in place with patients and a sample of five service user files were selected for review. Four patients had an agreement signed by the patient or their representative, however these did not reflect the up to date terms and conditions e.g.: the current fees payable. Three of the four patient files included an up to date "amendment to terms and conditions" form which detailed the current fee arrangements for the respective patients, however one patient did not have an up to date amendment form on their file.

The "amendment to terms and conditions" forms which were reviewed had not been signed or dated by the patient or their representative, nor had they been signed or dated by a representative of the home. It was therefore impossible to tell if or when they had been shared with the patients or their representatives for signature.

This was discussed with the manager and it was noted that there should be robust evidence that it has given notice of all changes to the agreement to the patient or their representative (or in the case of trust-managed service users, the trust). This was highlighted as an area for improvement under the Care Standards for Nursing Homes (April 2015).

While the four patients discussed above had a signed (albeit out of date) agreement on their files, the fifth patient did not have any signed agreement on their file.

It was therefore impossible to evidence that the patient or their representative had ever been provided with an individual written agreement.

This was also highlighted as an area for improvement.

A review of the five service user files evidenced that the home used documents entitled "Financial assessment Part 3". These documents were used to detail what authority the home had to make purchases of goods or services on behalf of the individual patient.

A sample of five service user files evidenced that only one patient had a "Financial Assessment Part 3" document on their file which had been signed by the patient or their representative to provide the requisite authority. It was noted, however, that the person who had signed the form had not actually completed it by indicating which services they were providing authority for the home to purchase on the patient's behalf. The inspector suggested that the forms be reviewed when they are returned to the home to ensure that arrangements are clarified. The remaining four patients had a blank "Financial assessment Part 3" on their files which had not been signed or dated by either party. It was therefore impossible to tell if or when they had been shared with the patients or their representatives for signature.

This was highlighted as an area for improvement.

Areas of good practice

There were examples of good practice found in respect of governance arrangements regarding how patients' monies were safeguarded in the home; the existence of policies and procedures to guide financial practice in the home and the existence of a written patient agreement and personal monies authorisation template for provision to patients or their representatives.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to ensuring that the patient or their representative is provided with a written individual agreement; ensuring that each patient or their representative (or in the case of trust-managed service users, the trust) is given notice of all changes to the patients' individual agreement with the home and ensuring that written personal monies authorisations detailing the arrangements for handling the personal monies of each patient are shared for signature with each patient or their representative and are kept up to date to reflect any changes.

	Regulations	Standards
Total number of areas for improvement	1	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Tracey Palmer, manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with the Nursing Homes Regulations (Northern Ireland (2005)	
Area for improvement 1 **Ref**: Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be completed by:** 07 July 2017	The registered person shall ensure that a record is maintained of the furniture and personal possessions which each patient has brought into their room. A record should be made for each of the current patients in the home, which should be kept up to date throughout the patient's stay in the home. Ref: 6.5
	Response by registered person detailing the actions taken: Record maintained and in place for all current residents. The file is kept in Administrators Office and updated when new residents are admitted and also when current residents received new personal possessions. This is also reconciled every quarter.
Area for improvement 2 **Ref**: Regulation 5 **Stated:** First time **To be completed by:** 28 August 2017	The registered person shall ensure that each patient is provided with a written agreement which specifies the fees payable by or in respect of the patient for the provision of accommodation and personal care (and except where a single fee is payable for those services, the services to which each fee relates); the method of payment and the person by whom the fees are payable. Ref: 6.7
	Response by registered person detailing the actions taken: This has been reviewed and in place for all current residents and will be monitored by Home Manager
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 29 June 2017	The registered person shall 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. Ref: 6.5
	Response by registered person detailing the actions taken: This has been reviewed and now in place for all service providers and will be monitored by Home Manager

Area for improvement 2 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 28 August 2017	The registered person shall ensure that where any changes to the individual agreement are agreed in writing by the resident or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the resident or their representative is unable to or chooses not to sign the revised agreement, this is recorded. An up to date agreement (or amendment to the agreement document) should be shared for signature with each or the current patients in the home or their representative or HSC trust representative as appropriate. Ref: 6.7
	Response by registered person detailing the actions taken: All residents files contain a copy of the agreements, any that are awaiting return from next of kin have a notice in place and followed up by administrator.
Area for improvement 3 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 28 August 2017	The registered person shall ensure that 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. An up to date personal monies authorisation should be shared for signature with each or the current patients in the home or their representative or HSC trust representative as appropriate. Ref: 6.7
	Response by registered person detailing the actions taken: Authorisations have been updated and in place in the relevant service user files

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews