The Regulation and Quality Improvement Authority

Finance Inspection Report
30 August 2016

Seapatrick

Type of service: Nursing Home
Address: 80 Lurgan Road, Seapatrick, Banbridge BT32 4LY
Tel No: 02840628289
Inspector: Briege Ferris

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Seapatrick took place on 30 August 2016 from 10.35 to 14.30 hours.

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

Is care safe?

Evidence was obtained which confirmed that the home administrator had recently completed training in the protection of vulnerable adults. Controls in place to protect patients' money and valuables were described by the administrator and a review of sample of records evidenced these in practice; no areas for improvement were identified.

Is care effective?

Systems were found to be in place to effectively record monies received and spent on behalf of patients; however four areas for improvement was identified during the inspection. These related to: engaging with the HSC trust care manager for an identified patient regarding a bank account in the patient's name; informing the HSC trust at least annually of the amount of money or valuables held for any patient assessed as incapable of managing their financial affairs; ensuring that staff do not use personal loyalty cards when making purchases on behalf of patients and ensuring that records of patients' property in their rooms are brought up to date and maintained in line with DHSSPS minimum standards.

Is care compassionate?

There was evidence in a sample of files reviewed, that patients were involved to make decisions affecting their care, including arrangements to support them with their money. The administrator spoke in a caring and compassionate manner about how the patients in the home were supported with their money and valuables.

One recommendation was made for the home to ensure that there are appropriate contingency arrangements in place to ensure that patients have access to money at all times.

Is the service well led?

A review of a sample of records evidenced that governance and oversight arrangements were in place in the home; however, two areas for improvement were identified in respect of this domain. These related to ensuring that each service user is provided with an individual written agreement and ensuring that personal monies authorisations are in place for each service user for whom the home purchases goods and services on the service user's behalf.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	7

Details of the Quality Improvement Plan (QIP) within this report were discussed with Edel McCaughley, registered 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.

1.2 Actions/enforcement taken following the most recent finance inspection

A finance inspection of the home was carried out in 2010 on behalf of RQIA. The findings from this inspection were not brought forward to the inspection on 30 August 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/Maureen Claire Royston	**Registered manager:** Edel McCaughley
Person in charge of the home at the time of inspection: Edel McCaughley	**Date manager registered:** 18 March 2015
Categories of care: NH-MP(E), NH-I, NH-DE, NH-PH	**Number of registered places:** 60

3.0 Methods/processes

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 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. Contact was also made with the inspector who had most recently visited the home.

On the day, the inspector met with the registered manager and the home administrator. 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:

- Training record (Protection of Vulnerable Adults) for the home administrator
- A sample of HSC Trust payment remittances
- A sample of financial policies and procedures
- A sample of charges being made for care and accommodation costs
- A sample of income, expenditure and reconciliation records
- A sample of records for hairdressing and podiatry services facilitated in the home
- A sample of resident social fund records
- Five patient finance files
- Four records of patients' property within their rooms

4.0 The inspection

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

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.

4.2 Review of requirements and recommendations from the last finance inspection dated 22 June 2010

A finance inspection of the home was carried out in 2010 on behalf of RQIA. The findings from this inspection were not brought forward to the inspection on 30 August 2016.

4.3 Is care safe?

Evidence was provided which confirmed that the home administrator had recently received training on the Protection of Vulnerable Adults (POVA); it was noted that this training was mandatory for all staff on a regular basis. The administrator who was in the home on the day had worked in the home for some time and was fulfilling the role of home administrator on a temporary basis.

The home administrator confidently described controls to safeguard patients' money and valuables. She noted that she felt supported by colleagues and she confirmed that she had no unmet training needs at that time.

During discussion, the registered 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 and valuables belonging to patients were lodged with the home for safekeeping. The most recent safe contents reconciliation record was provided; the record had been checked routinely on a monthly basis by two people.

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

Discussion with the registered manager confirmed that no representative of the home was acting as nominated appointee for any patient in the home. There was evidence that staff in the home engaged with a number of stakeholders to ensure that arrangements for receiving and safeguarding service users' monies were transparent and agreed to.

In reviewing one patient's file, it was noted that a bank statements relating to an account in the patient's personal name were being retained by the home on the patient's finance file. The inspector reviewed a sample of the bank statements and did not identify any significant movement in the account balance over time. However it was unclear what arrangements were in place to ensure that the patient's money was appropriately safeguarded in the bank account. The inspector discussed this matter with the registered manager who agreed to contact the patient's HSC trust care manager as a priority.

A recommendation was made in respect of this finding.

Evidence on another patient's file confirmed that the patient was incapable of managing their financial affairs and a legal representative had been appointed by the court accordingly. The inspector advised the registered manager that if a patient has been assessed as incapable, the amount of money or valuables the home held on their behalf, must be notified to the HSC trust on at least an annual basis. A review of the patient's file provided no evidence that this had been occurring.

A recommendation was made in respect of this finding.

The home also received money from family representatives which is deposited with the home in order to pay for additional goods and services which attract a fee, such as hairdressing, personal toiletries etc.

The inspector reviewed a sample of the records for income and expenditure incurred on behalf of patients (such as that in respect of hairdressing and podiatry). The inspector noted that the home maintain clear records on "personal allowance account statements" detailing income and expenditure, together with other records to substantiate each transaction, such as a receipt for cash/cheque lodgement or hairdressing or podiatry treatment record. The inspector traced a sample of transactions and was able to evidence the documents relating to these transactions. There was evidence that records of personal monies held on behalf of patients were reconciled and signed and dated by two people on a monthly basis.

On reviewing a sample of the records it was evidenced that a representative of the home had used a personal loyalty card when making purchases of toiletries on behalf of a group of patients, this was not noted to have happened routinely.

However, a recommendation was made to ensure that staff members are reminded not to use their personal loyalty cards to benefit from purchases made on behalf of patients.

As noted above, hairdressing and podiatry treatments were being facilitated within the home. Records were in place to evidence the patients treated on any given day and the cost of the respective treatments. A review of a sample of the treatment records evidenced that records contained all of the relevant information including the names of the patients treated and the respective costs; records were consistently signed by the person providing the treatment and a representative of the home to verify that the treatments as detailed, had been provided.

The home had a number of written policies and procedures addressing matters relating to safeguarding money and valuables, record keeping requirements and other relevant issues such as complaints and whistleblowing. It was noted that these policies had been reviewed and updated recently.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see a sample of the completed property records for four patients. Each patient sampled had a record made on a "Schedule of personal effects form"; only one of the four records had been signed and dated by two people; the remaining three records had not been signed or dated. There was limited evidence to identify that the records had been updated.

A recommendation was made to ensure that records of inventory for the home's current patients are reviewed and brought up to date accordingly.

It was noted that the home also had a residents' comfort fund, a written policy and procedure existed to guide the administration of the fund. It was noted that income and expenditure records were maintained which were reconciled and signed and dated by two people every month.

It was confirmed that the home did not provide transport to patients. The home administrator described scenarios whereby a number of patients were supported to leave the home with the help of family members.

Areas for improvement

Four areas for improvement were identified during the inspection. These related to engaging with the HSC trust care manager for an identified patient regarding a bank account in the patient's name; informing the HSC trust at least annually of the amount of money or valuables held for any patient assessed as incapable of managing their financial affairs; ensuring that staff do not use personal loyalty cards when making purchases on behalf of patients and ensuring that records of patients' property in their rooms are brought up to date and maintained in line with DHSSPS minimum standards in future.

Number of requirements	**0**	**Number of recommendations**:	**4**

4.5 Is care compassionate?

A sample of fees raised by the home for care and accommodation costs was reviewed and these evidenced that the correct amounts were being charged by the home.

Day to day to day arrangements in place to support patients were discussed with the administrator who was able to describe specific examples of how the home supported a range of patients with their money. Discussion also established how arrangements to safeguard patients' money were discussed with their patient or their representative at the time of admission.

A review of the records established that the home had a range of methods in place to encourage feedback from families or their representatives in respect of any issue; these were discussed with the registered manager and included the home's "Quality of Life Programme".

The welcome pack for new patients and their families also contained a range of information for a new patient including clear information on fees and funding-related matters.

Arrangements for patients to access their money outside of normal office hours were discussed with the registered manager. She noted that at present, access to the safe place within the home was available during normal office hours. She confirmed that there was no access outside of these times.

A recommendation was made for the home to confirm its arrangements which ensure that patients have access to money at all times.

Areas for improvement

One area for improvement was identified during the inspection in relation to ensuring that patients have access to money at all times.

Number of requirements:	0	Number of recommendations:	1

4.6 Is the service well led?

Oversight and governance arrangements for safeguarding patients' money were found to be in place and operating effectively. Regular audits of money were recorded and signed and dated by two people; as noted above, a trace of a random sample of transactions evidenced that records were available to substantiate the entries in each patient's personal monies account statement.

As referred to above, the home had a range of detailed 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 familiar with their roles and responsibilities in relation to safeguarding patients' money and valuables.

The inspector requested a list of the current patients in the home which was provided by the administrator; from this list the inspector selected a sample of five finance files for review. Four of the five patients had a written agreement on their file, signed and dated by the service user or their representative, and which reflected the up to date terms and conditions, including current fees.

The remaining patient did not have an up to date agreement on file reflecting the current terms and conditions. The home administrator and registered manager both provided an explanation as to reason for this, describing the difficulties experienced in obtaining signatures from the patient's representative in this case.

The inspector noted that where difficulties were encountered in securing signatures from service users or their representatives, the home should ensure that robust records are available to evidence how the home has attempted to secure a signature on each service user's updated agreement.

A recommendation was made in respect of this finding.

A review of a sample of the five patients' finance files evidenced that four patients sampled had a signed personal expenditure authorisation in place with the home, granting the home authority to spend personal monies lodged with the home on specific goods or services. One patient did not have a signed authorisation on file, it was noted that this was the identified patient who also did not have a written agreement in place with the home, as described above.

A recommendation was made to ensure that each patient for whom the home purchase goods or services on their behalf, has a personal monies authorisation on file.

Areas for improvement

Two areas for improvement were identified during the inspection. These related to: ensuring that each patient or their representative is provided with an up to date agreement and ensuring that personal monies authorisations are in place for patients for whom the home engages in transactions for goods and services.

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 Edel McCaughley, 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 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 the 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 Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions 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 finance.team@rqia.org.uk 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	
Recommendations	
Recommendation 1 **Ref**: 13.1 **Stated:** First time **To be completed by:** 13 September 2016	The registered provider should confirm that the identified patient's HSC trust care manager has been contacted regarding the bank statements received by the home in the patient's name.
	Response by registered provider detailing the actions taken: The care manager for the identified patient has been informed about the patient's bank account and the current balance being held there. Arrangements are now in place to ensure the care manager will be kept updated each time we receive a copy of the patient's bank statements.
Recommendation 2 **Ref**: Standard 14.18 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that if a resident has been assessed as incapable of managing their own affairs and a designated next of kin has been appointed, the amount of money or valuables held by the home on their behalf is reported in writing by the Registered Manager to the referring Trust and designated next of kin at least annually, or as specified in the individual agreement.
	Response by registered provider detailing the actions taken: Any resident currently incapable of managing their own financial affairs will have an annual statement of their account provided to their appointed next of kin and their care manager.
Recommendation 3 **Ref**: Standard 14.16 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that where staff members purchase items on behalf of patients, any store loyalty points earned are owned by the resident and this is documented on the receipt. Where a patient is not a member of a loyalty scheme, staff do not benefit from the transaction by using their personal loyalty cards. Receipts for such purchases are returned to the patient for their own records.
	Response by registered provider detailing the actions taken: All purchases on behalf of residents are made using the resident's own money or petty cash money which is repaid upon presentation of a receipt, a copy of which is placed in the resident's records. Store loyalty cards are not to be used for any resident purchases.
Recommendation 4 **Ref**: Standard 14.26 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that an inventory of property belonging to each patient 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. Inventory records for each patient should be brought up to date.
	Response by registered provider detailing the actions taken: All residents have a record of their personal effects made on admission which is updated on a 3 monthly basis. This had previously been discussed at a staff meeting (18.07.16) prior to the Financial Inspection

	and was in the process of being implemented when the Inspection was being completed.
Recommendation 5 **Ref**: Standard 14.5 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should confirm the home's arrangements to ensure that patients have access to money at all times.
	Response by registered provider detailing the actions taken: The care home has an account with the local taxi firm so that staff can book taxi's for patient use (e.g. hospital appointments) which the taxi firm will then bill the home for. Any resident who is going out at the weekend will usually be by prior arrangement and staff will ensure that sufficient money will be left with the nurse in charge to cover expenses. Any additional expenses which may be incurred will be repaid on production of a receipt and a copy of this kept in the resident's file.
Recommendation 6 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that any changes to the (patient's) individual agreement are agreed in writing by the patient or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded.
	Response by registered provider detailing the actions taken: All residents have a signed agreement in place which is reviewed annually to reflect any changes in tariffs or charges which may be payable. If the patient's representative does not return or sign the agreement within a specified time frame (usually 1 month of issue) then a letter is sent reminding them to return the documents. A copy of this letter is retained in the resident's file. If the patient's representative does not sign or return the agreement then the care manager is notified and, if appropriate, they sign the agreement.
Recommendation 7 **Ref**: Standard 14.6, 14.7 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that written authorisation is obtained from each patient or their representative to spend the patient's personal monies to pre-agreed expenditure limits. The written authorisation must be retained on the resident's records and updated as required. Where the resident or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the resident is managed by a HSC Trust and does not have a family member or friend to act as their representative, the authorisation about their personal monies must be shared with the HSC Trust care manager.
	Response by registered provider detailing the actions taken: All residents have a third party agreement in place in which it is specified what expenditures the care home is able to make on behalf of the resident. These expenditures usually cover hairdressing, podiatry and occassionally toiletries. If the patient's representative does not return or sign the agreement

	within a specified time frame (usually 1 month of issue) then a letter is sent reminding them to return the documents. A copy of this letter is retained in the resident's file. If the patient's representative does not sign or return the agreement then the care manager is notified and, if appropriate, they sign the agreement.

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

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