Unannounced Finance Inspection Report
10 August 2017

St Francis

Type of Service: Nursing Home
Address: 71 Charles Street, Portadown, BT62 4BD
Tel No: 0283835 0970
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 25 beds that provides care for older people or those with a physical disability (other than sensory impairment).

3.0 Service details

Organisation/Registered Provider: Mary Bernadette Breen	**Registered Manager:** Laura Lavery (Manager; awaiting application)
Person in charge at the time of inspection: Romegan Uy (Nurse in Charge)	**Date manager registered:** Laura Lavery – awaiting application "registration pending"
Categories of care: Nursing Home (NH) PH – Physical disability other than sensory impairment I – Old age not falling within any other category	**Number of registered places:** 25 comprising: 1 - NH-PH 24 - NH-I

4.0 Inspection summary

An unannounced inspection took place on 10 August 2017 from 09.30 to 14.00 hours.

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, staff could clearly describe the controls in place to safeguard patients' money and valuables and there were methods in place to encourage feedback from patients or their representatives.

Areas requiring improvement were identified in relation to each service user's record of furniture and personal possessions (in their rooms); records of income and expenditure; hairdressing treatment records, patient agreements (and personal monies authorisations) and written policies and procedures.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	6

Details of the Quality Improvement Plan (QIP) were discussed with Romegen Uy, the nurse in charge, as part of the inspection process. The timescales for completion commence from the date of 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 service 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; 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 the nurse in charge and the home administrator; the home manager was not on duty during the inspection.

The following records were examined during the inspection:

- The Patient Guide and associated appendices
- Three patients' finance files
- One patient's individual written agreement with the home
- A sample of income and expenditure records maintained on behalf of patients
- The safe record- "Contents of Safe Register"
- A sample of treatment records in respect of hairdressing services facilitated in the home
- A sample of charges to patients or their representatives for care and accommodation
- One patient's record of personal property in their room
- A range of written policies and procedures including those in respect of:
    - "Policy on Planning and Record Keeping" dated July 2013
    - "Safeguarding and Protecting Patients' Money and Valuables" dated July 2013
    - "Financial Policy" dated August 2014

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 01 June 2017

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

6.2 Review of areas for improvement from the last finance inspection dated 24 June 2009

A finance inspection of the home was carried out on behalf of RQIA on 24 June 2009; the findings from this inspection were not brought forward to the inspection on 10 August 2017.

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 service users' money and valuables. She advised that she had worked in the home for a short time and that mandatory training formed part of her induction in the home. She advised that she had completed adult safeguarding training on 01 August 2017.

Discussions established 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 service user; this was confirmed by the manager following the inspection.

The home had a safe place available for the deposit of cash or valuables belonging to service users; the inspector was satisfied with the location of the safe place and the persons with access. However during the course of the inspection, it was identified that money (including patients' money deposited for safekeeping) was not held within the safe place but was stored elsewhere in one of the home's offices. The inspector noted that while the office was locked while not occupied, it was inadvisable to hold money in a location otherwise than the designated safe place.

As the home administrator had access to the money and the safe place, the inspector requested that any patient monies be moved to the designated safe place within the home and this was completed during the inspection.

It was noted that in future, any patients' monies are held within the designated safe place in the home. This was identified as an area for improvement.

On the day of inspection, money belonging to a number of patients was deposited for safekeeping; no valuables were being held.

A safe record was available detailing the contents of the safe "Contents of Safe Register"; any valuables deposited for safekeeping or withdrawn previously had been signed and dated by two people.

There is discussion on the reconciliation of patients' money in section 6.5 of this report.

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

One area for improvement was identified during the inspection, this related to ensuring that any patients' monies are held within the designated safe place in the home. This was identified as an area for improvement.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

Discussions established that that no representative of the home was acting as nominated appointee for any patient (ie: managing and receiving social security benefits on a patient's behalf). Discussions also established that the home was not in direct receipt of the personal monies for any patient via a HSC trust or other representative e.g.: a Solicitor.

The home administrator explained that the only money managed by the home on behalf of patients was that which was deposited with the home for the sole purpose of hairdressing (and more infrequently, private chiropody) services facilitated within the home. Double-signed receipts were available detailing the deposit of monies by family representatives for these purposes.

Records of income and expenditure were maintained for each patient for whom the home held money. These detailed (for each transaction) the date, whether the transaction related to a deposit or a withdrawal, the running balance and space for the signatures of two people to be recorded. A review of a sample of these records established that only one signature was routinely recorded against each transaction. It was noted that in accordance with the home's template and that Care Standards for Nursing Homes (2015), transactions should be signed by two people.

This was identified as an area for improvement.

A review of a sample of the income and expenditure records failed to identify that any reconciliation of the monies had been carried out. The home administrator advised that the money was checked prior to the hairdresser's visits, however it was noted that this did not constitute a reconciliation which should be carried out and be signed and dated by two people.

This was identified as an area for improvement.

As noted above, hairdressing treatments were being facilitated within the home and a sample of recent records was reviewed. Treatment records identified the patients treated on the stated day, the treatment provided and the cost. The treatment records reviewed were routinely signed and dated by both the hairdresser and a representative of the home to verify that the treatment had been received by the patient. A column was in place on the records to record whether any money was available to facilitate the treatment that day. Against each person's name was the balance of monies deposited for safekeeping for them.

It was noted that it was unnecessary to provide this level of detail on the hairdressing treatment record and that patients' right to confidentiality in regard to how much money they had deposited with the home should not be unnecessarily shared. It was noted that it was sufficient to record a tick symbol or by recording "yes" in the appropriate column.

This was identified as an area for improvement.

The home administrator advised that private chiropody treatments were infrequent and while a sum of money had been deposited to pay for a treatment for one patient, the treatment had not yet taken place.

The inspector discussed how patients' property (within their rooms) was recorded and requested to see the completed property records for three patients. A file was produced and the home administrator noted that having reviewed the file, only one patient's property record of the three could be located. The inspector reviewed this record and noted that it was dated, (July 2017) however it had not been signed.

The inspector noted that each patient is required to have a record of the furniture and personal possessions which they have brought with them to the home. These records should be reconciled on at least a quarterly basis, with the records signed by two people.

This was identified as an area for improvement.

A sample of charges made to patients or their representatives for care and accommodation was reviewed and it was noted that the correct amounts had been charged by the home.

Discussions also established that the home did not operate a bank account for any patient (individually or pooled) nor did the home operate a transport scheme.

Areas of good practice

There were examples of good practice found for example, in respect of controls in place to record income and expenditure and treatments facilitated in the home for which there was an additional charge and in relation to records maintained of charges made to patients or their representatives for care and accommodation.

Areas for improvement

Four areas for improvement were identified during the inspection. These related to: maintaining each patient's record of furniture and personal possessions and ensuring that these records are reconciled and signed and dated by two people at least quarterly; maintaining records of patients' monies using a standard financial ledger format; carrying out a quarterly reconciliation of patients' money and valuables and ensuring that treatment records are maintained in a way which does not unnecessarily detail the amount of money held for each patient.

	Regulations	Standards
Total number of areas for improvement	1	4

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 patients with their money on day to day basis were discussed with the nurse in charge and the home administrator. Discussions identified that 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 patient is admitted to the home.

Discussion established that the home had a number of methods in place to encourage feedback from patients or their representatives in respect of any issue.

Arrangements for patients to access money outside of normal office hours were discussed with the home administrator. She explained that as the money deposited with the home for safekeeping was used only for the purpose of paying the hairdresser, patients would not routinely ask for their money for another purpose; however she explained that the home would make any necessary arrangements to facilitate this.

Areas of good practice

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

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 patients in order to deliver safe, effective and compassionate care.

The home's "patient guide" encompassed a range of information for a new patient including that in respect of the general arrangements regarding fees, and the safeguarding of patients' money and valuables in the home.

A range of written policies and procedures were reviewed including those addressing record keeping and safeguarding patients' monies; however, it was noted that a number of these policies were outside of the timescales for review (three years). A sample of policies reviewed were dated July 2013 and one policy was dated August 2014 and was therefore due for review before the end of August 2017.

The review and updating of policies was identified as an area for improvement.

Discussion with the home administrator 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 copy of a blank agreement was provided for review. It was noted that the agreement included a number of appendices addressing the payment of a third party top up, a personal monies authorisation document and an appendix detailing the current fees and the current costs for additional services facilitated in the home (hairdressing, podiatry etc). This appendix required the signature of the relative of the patient. However it was noted that this appendix should make clear in respect of each individual patient, who is paying the fee/how the home are receiving the fee and by what method. This should be amended in the appendices from the date of the next change (likely to be April 2018).

This was identified as an area for improvement.

Three patients were sampled in order to review the agreements in place with the home. Each patient had a finance file and a review of each file evidenced that only one patient had a signed agreement on their file. The remaining two patients did not have a signed agreement on their files, however they had a copy of a letter dated April 2017 sent from the home to the patient's next of kin describing that the agreement and personal monies authorisation was enclosed for signature; a copy of the agreements enclosed were not on each patient's file.

It was encouraging to note that the letters had been sent to relatives so promptly following the regional uplift in fees. However it was not clear what, if any, efforts had been made to pursue the return of the signed agreements for the two patients sampled. A review of the home's policy file identified that there was no policy on patient agreements as is required by the care standards. It was noted that the home should develop such a policy and the arrangements for evidencing the efforts which have been taken to secure a signed agreement with the patient or their representative and what the home's policy will be in attempting to have agreements returned.

This was identified as an area for improvement.

As noted above, discussion established that the home provided a personal monies authorisation document to patients or their representatives for signature. This document provides the home with authority, in particular, to spend the service user's money on identified goods and services.

The sample of three patient files referred to above evidenced that one patient had a signed personal monies authorisation on their file (the patient whose agreement was on file). The remaining two patients did not have signed personal monies authorisation on their file. Again it was noted that the home should have a procedure to follow in the event of the non-return of these documents in the same manner as the return of individual patient agreements.

Areas of good practice

There were examples of good practice found for example, in respect of the availability of a written agreement with several appendices detailing financial arrangements and evidence that letters advising of a change in fees had been sent to relatives so promptly following the regional uplift in fees in April 2017.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to ensuring that the relevant policies are reviewed and updated; ensuring that (from the date of the next change) the appendix detailing current fees is individualised to reflect for each patient, from whom the home receives payment of the fee in whole or part, and by which method(s) the home is paid; and ensuring that the home develops a policy and procedure which addresses what efforts will be taken to secure a signed agreement with the patient or their representative and how the home will evidence this.

	Regulations	Standards
Total number of areas for improvement	0	3

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Romegen Uy, the nurse in charge, 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 to Agencies.Team@rqia.org.uk 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:** 24 September 2017	The registered person shall ensure that a record of the furniture and personal possessions brought by each patient into their room is maintained. Patients' inventory records are reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.5
	Response by registered person detailing the actions taken: Residents property is documented in the property book and the staff member has signed same.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 11 August 2017	The registered person shall ensure that any patients' monies are held within the designated safe place in the home. Ref: 6.4
	Response by registered person detailing the actions taken: All money relating to the Residents is kept in a locked safe.
Area for improvement 2 **Ref**: Standard 14.10 **Stated:** First time **To be completed by:** 11 August 2017	The registered person shall ensure that a standard financial ledger format is used to clearly and accurately detail transactions for patients. The format captures the following information each time an entry is made on the ledger: the date; a description of the entry; whether the entry is a lodgement or withdrawal; the amount; the running balance of the patient's cash total held; and the signatures of two persons able to verify the entry on the ledger. Ref: 6.5
	Response by registered person detailing the actions taken: Two signatories verify entries on the ledger in place after inspection.

Area for improvement 3 **Ref**: Standard 14.25 **Stated:** First time **To be completed by:** 10 September 2017	The registered person shall ensure that a reconciliation of money and valuables held and accounts managed on behalf of patients 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. Ref: 6.5
	Response by registered person detailing the actions taken: Reconciliation of all money etc to be carried out on a quarterly basis.
Area for improvement 4 **Ref**: Standard 5.8 **Stated:** First time **To be completed by:** 11 August 2017	The registered person shall ensure that the balance of monies held on behalf of patients is not included on any treatment records maintained by the home. If it is necessary to confirm that money is available in order to facilitate the treatment, this should be denoted by a tick symbol or by recording "yes" in the appropriate column. Ref: 6.5
	Response by registered person detailing the actions taken: New ledger completed one week after inspection in place for next hairdressing date.
Area for improvement 5 **Ref**: Standard 36.4 **Stated:** First time **To be completed by:** 24 September 2017	The registered person shall ensure that policies and procedures are subject to a three yearly review at a minimum (and more frequently if required), and the registered person ratifies any revision to (or the introduction of new) policies and procedures. Ref: 6.7
	Response by registered person detailing the actions taken: All policies and procedures reviewed on 3 yearly basis.
Area for improvement 6 **Ref**: Standard 2 **Stated:** First time **To be completed by:** From the date of the next change in fees	The registered person shall ensure that any the appendix to each individual patient's agreement details who is paying the fee/how the home are receiving the fee (or each part of the fee as appropriate) and by what method(s) is the home paid. This should be amended in the appendices from the date of the next change in fees. Ref: 6.7
	All appendices are amended from the date of the next change in fees.

Area for improvement 7 **Ref**: Standard 36.1 **Stated:** First time **To be completed by:** 24 September 2017	The registered person shall ensure that a policy and procedure (on patient agreements) is developed which should address the arrangements for evidencing what efforts have been taken to secure a signed individual agreement with the patient or their representative and what the home's policy will be in attempting to have agreements returned. Ref: 6.7
	Response by registered person detailing the actions taken: Policy and procedure in place to ensure patient agreements are returned in a timely manner.

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

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