Corkhill Care Centre
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Inspector: Briege Ferris
Inspection ID: IN023265

Uannounced Finance Inspection
of
Corkhill Care Centre

16 July 2015

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

1. Summary of Inspection

An unannounced finance inspection took place on 16 July 2015 from 09:30 to 16:30. A poster detailing that the inspection was taking place that day was positioned at the entrance to the home.

Overall on the day of inspection we found care to be compassionate; the safety and effectiveness of care were found to be good; however, there are some areas identified for improvement. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report. This inspection was underpinned by the Nursing Homes Regulations (Northern Ireland) 2005.

On the day of inspection, we met with the registered manager, the administrator, the activities co-ordinator and the clinical lead; no relatives or visitors chose to meet with us during the inspection. We would like to thank all those who participated in the inspection for their co-operation.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5	3

The details of the QIP within this report were discussed with Mrs Una McTaggart, the registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Persons: Corkhill Care Centre/Thomas Potts and Margaret Potts	**Registered Manager:** Mrs Una McTaggart
Person in Charge of the Home at the Time of Inspection: Mrs Una McTaggart	**Date Manager Registered:** 24 September 2014
Categories of Care: RC-I, RC-PH, NH-LD, NH-LD(E), RC-DE, NH-DE, NH-I, NH-PH	**Number of Registered Places:** 48
Number of Patients accommodated on the day of Inspection: 46	**Weekly Tariff at Time of Inspection:** £470.00 - £637.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following theme has been met:

Inspection Theme: Patients' finances and property are appropriately managed and safeguarded

Statement 1
The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Statement 2
Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Statement 3
A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained

Statement 4
Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with the registered manager and other members of staff
- Review of records
- Evaluation and Feedback

Prior to inspection the following records were analysed:

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

The following records were reviewed during the inspection:

- The patient guide
- The home's "Resident's Money" policy
- The home's "Comforts Funds" policy
- The home's transport policy
- The home's current standard agreement with patients
- Four signed patient agreements
- Copy invoices raised for care fees
- Personal allowance expenditure authorisations
- Income/lodgements and expenditure, including comfort fund records
- Hairdressing treatment receipts
- Records of items deposited for safekeeping with the home
- Four records of patients' personal property/inventory
- The administrator's completion of Protection of Vulnerable Adults Training record

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection on 1 December 2014; the completed Quality Improvement Plan was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last Finance Inspection

There has been no previous RQIA inspection of the service.

5.3 Statement 1 - The home maintains complete and up to date records in respect of the terms and conditions of the provision of accommodation and personal care

Is Care Safe?

The home has a patient guide, a copy of which was provided to us for review during the inspection. We noted that the guide contained information for patients on the opportunity for each patient to personalise their rooms should they wish. We also noted that the arrangements for patients to store items in the small lockable cupboard in their rooms were detailed in the patient guide.

We noted that the home have a standard written agreement, an individual copy of which is provided to each newly admitted patient. We asked to see both a copy of an up to date agreement and agreements which are already in place with a sample of patients in the home.

We reviewed a sample of four written agreements, all of which had been signed by a representative of the home and the patient or their representative. Each of the four agreements

stated the correct weekly fee, but the agreements did not detail the specific financial arrangements in place for the individual patients. While each patient's weekly fee was the same, there were a number of different financial arrangements in place, for instance one patient sampled was contributing part of their social security benefits to the payment of their weekly fee and this was not reflected in their individual agreement.

We requested to see an up to date agreement, the type of which would be provided to a newly admitted patient. On comparing the home's standard form of agreement with patients to Standard 2.2 of the Care Standards for Nursing Homes (April 2015), we noted that a number of components were absent from the home's agreement and that updated agreements must be provided to each patient which contain all of the necessary components as set out in Standard 2.2.

We clarified that in order to comply with Regulation 5 (1) of the Nursing Care Homes Regulations (Northern Ireland) 2005; a patient's agreement must clearly state the weekly fee, the person(s) by whom the fees are payable and the respective methods of payment.

A requirement has been made in respect of these findings.

Is Care Effective?

We queried whether there was any involvement by the home in supporting individual patients with their money; the registered manager and administrator stated that there was no involvement by the home in this regard and that families are highly involved in supporting patients in the home.

We noted that the home has a policy and procedure in place addressing patients' money which details the controls in place to safeguard money and valuables belonging to patients. We noted that this policy was due to be updated in June 2015 and that it currently did not fully reflect the Care Standards for Nursing Homes which were issued in April 2015.

A recommendation has been made in respect of this finding.

We noted that there was written confirmation in place identifying that the home's administrator had received training in the protection of vulnerable adults.

Is Care Compassionate?

There was evidence to establish that the home had updated agreements with patients regularly in response to changes in regional fee rates and that there was an attempt to give as much notification of these changes in fees as is possible.

Discussions with the registered manager and administrator established that on the day of inspection, the home was not supporting any individual patient to manage their money.

Areas for Improvement

Overall on the day of inspection, we found care to be effective and compassionate. The safety of care was found to be good, however there was one area identified for improvement; this

related to providing individual written agreements to all patients which detail the specific financial arrangements in place for each patient.

Number of Requirements	**1**	**Number Recommendations**:	**1**

5.4 Statement 2 - Arrangements for receiving and spending patients' monies on their behalf are transparent, have been authorised and the appropriate records are maintained

Is Care Safe?

A review of the records identified that copies of the Health and Social Care (HSC) trust payment remittances are available confirming the weekly fee for each patient in the home. There is an identified number of patients in the home who contribute their weekly care fees in full or part, directly to the home. For all other patients, the home is paid directly by the relevant HSC trust. A review of a sample of charges established that the correct amounts were being charged by the home.

The home is not directly in receipt of any personal allowance monies belonging to patients in the home. However, discussion with the registered manager and the administrator established that patients' representatives deposit money with the home for safekeeping in order to pay for additional goods and services not covered by the weekly fee (such as for hairdressing, toiletries or newspapers).

A review of the records identified that the home provides a receipt to anyone depositing money, however receipts are routinely signed by the person receiving the money, receipts must be signed by two people.

A requirement has been made in respect of this finding.

We discussed how patient expenditure was recorded on behalf of patients. The administrator explained that records are made on individual ledgers for patients. We reviewed a sample of these records and noted that records were routinely signed by two people and were up to date, good practice was observed.

We sampled a number of transactions from the records and were able to trace these entries to the corresponding records to substantiate each transaction, such as a receipt for a cash lodgement or a hairdressing treatment record. We noted that there was written evidence of a reconciliation of the records however these were only signed by one person.

A requirement has been made in respect of this finding.

We reviewed a sample of the records for hairdressing services facilitated within the home. We noted that the hairdresser routinely visits the home twice a week and that a record is left with the home detailing those patients treated on both days (small individual receipts were also provided for the individual files of each patient). The first record detailed the name of the patient, the initials of the treatment provided and the cost. This record is signed by the hairdresser and a member of staff at the home (not the administrator). We noted that a record should be provided for each treatment day and that the full name of the treatment should be detailed on the record.

A recommendation has been made in respect of this finding.

We provided guidance on how best to capture treatments by the hairdresser or anyone providing services to patients in the home by using a template, which would avoid doubling up on the recording process.

Discussions established that the home operates a fund for the benefit of the patients in the home; this is referred to in the home as the “comfort fund”. We were advised that the home’s activities therapist is the key member of staff in the home with regard to the operation of the activity fund. We spoke with the activities therapist who was in the home on the day of inspection. We noted that she had a passionate and creative approach which was revealed through her explanation of how money is raised for the fund and in turn, how this is used to improve the experience of patients living in the home.

We queried what records existed for the administration of the fund. We were provided with a book for review which detailed records of income and expenditure from 1997. We noted that entries in the book were routinely double signed and that a reconciliation of the comfort fund monies had been record, signed and dated by two people, good practice was observed.

We noted that a credit union account was in place to administer the comfort fund monies. We noted that these records were safely stored in the home’s safe place. We queried the name on the account, as the most recent statement reflected that the account was in the personal name of a representative of the home; previously other account statements referenced the residents’ comfort fund in the account name.

We requested that the registered manager provide clarification on this post-inspection to establish what name the account was actually in. Subsequent contact with the home established that the home had made contact with the Credit Union to obtain clarification. Written confirmation from the Credit Union was provided to us detailing that an account with the said Credit Union must be held in the personal name of an individual, not a group. However, it was also confirmed that the named individual was not a signatory to the account and therefore does not have access to the comfort fund monies.

We reviewed a sample of records for expenditure undertaken from the fund and were able to trace the selected entries to other records to substantiate the transactions. We noted that within the records of expenditure, there was an entry detailing that a hoist had been purchased from the comfort fund monies in May 2014. We noted that this is a piece of medical equipment used to transfer patients from one place to another. We noted that items such as this should not be purchased from the fund as they should normally be purchased by the home. We discussed this with the registered manager and the administrator and noted that there was a note in the records detailing that in a relatives meeting held at the home in 2014, relatives of patients had requested the home make this purchase. Notwithstanding this, the home are required to purchase all equipment necessary to meet the patients’ needs and we required that the cost of the item must be repaid from the home to the patient comfort fund.

Following the inspection, the home provided us with a copy of the relevant minute which confirmed the content of the discussion held with the registered manager on inspection. In addition, written confirmation was provided to us detailing that the identified amount had been repaid to the balance of comfort monies.

We noted that the home had a policy and procedure addressing the comfort fund which was general in nature; we provided some guidance on how this might be tailored to reflect the home's individual practices.

Is Care Effective?

The registered manager confirmed that no representative of the home was acting as nominated appointee for any patient. As noted above, discussions established that the home receives money from family representatives. A review of a sample of patients' records established that personal allowance authorisations were in place to provide the home with the necessary written authorisation to purchase goods and services on behalf of each patient. We noted that there was reference within the standard authorisation template to "repairs". It was not clear exactly what repairs were being referred to; we discussed this with the administrator who noted that it might be in relation to clothing alterations. We noted that the wording should be reviewed to ensure that patients or their representatives are clear on what authority is being provided for.

A recommendation has been made in respect of this finding.

Is Care Compassionate?

We queried whether any patient had a specific assessed need in respect of their money or any agreed restrictions; the registered manager confirmed that none of the patients had any known assessed needs or restrictions.

Areas for Improvement

Overall on the day of inspection, we found care to be effective and compassionate. The safety of care was found to be good, however there were two areas identified for improvement; these were in relation to double signing receipts for money deposited for safekeeping and countersigning reconciliations of money and valuables.

Number of Requirements	**2**	**Number Recommendations**:	**2**

5.5 Statement 3 - A safe place is provided within the home premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained

Is Care Safe?

A safe place exists within the home to enable patients to deposit cash or valuables. We reviewed the safe place within the home and were satisfied with the controls around the physical location of the safe place and the persons with access.

We viewed the content of the safe place and established that on the day of inspection, cash balances and a number of items were held for patients which had been deposited for safekeeping by the home.

We noted that there was a record of "safe contents" which was recorded on one page and detailed the date the identified items deposited for safekeeping had been received. One entry detailed the description of the item, while a second record did not provide a description of the

item. We noted that each entry had been signed by only one person, not two. We noted that a written safe register of all the items in the safe place including those belonging to the patients and the home must be introduced. Any item deposited to or withdrawn from the safe place must be signed and dated by two people. We noted that the home had a "contents of the safe check list" in place which had been dated every month and ticked as completed. We discussed this with the registered manager and administrator and noted that these reconciliations must be signed and dated by two people.

A requirement has been made in respect of this finding.

Is Care Effective?

We queried whether there were any general or specific arrangements in place to support patients with their money. The registered manager explained how the home engages with HSC trust representatives on an ongoing basis, however noted that there were no specific agreed arrangements in place to support any patient at present.

We enquired how patients' property within their rooms was recorded and requested to see a sample of the completed property records for four patients.

The registered manager explained that the home had introduced a computerised system to record care records etc. and that staff were in the process of transferring over hard copy property records to the computerised system and that any newly admitted patients would only have computerised records. The records for the four randomly sampled patients were provided. Two patients' records were on the computerised system from which a print-out was provided and two patients' records were handwritten records. There was significant inconsistency in the records provided. We noted that staff had made efforts to record important details such as "flat screen TV", "1 grey radio", however one record was signed by two people the other handwritten record was not signed or dated.

We explained that additions or disposals of furniture and personal possessions brought into each patient's room must be signed and dated by two people and that these records must be updated at least quarterly. We noted that a retrospective record for each patient in the home must be made.

A requirement has been made in respect of this finding.

Is Care Compassionate?

A safe place exists within the home to enable patients to deposit cash or valuables should they wish to. We enquired as to how patients would know about the safe storage arrangements; the registered manager explained that the existence of the safe place in the home is advised to patients and their families on admission. We also noted that the availability of safe storage facilities in each patient's room is detailed in the home's brochure, a copy of which is provided to the patient/their representative on admission to the home.

We asked about arrangements for patients to access their money from the safe place in the home outside of office hours (when the key holder may not be in the home). The registered manager explained that the proprietor lives nearby and is frequently in the home; therefore access to the safe place in the home for patients is possible outside of normal office hours.

The registered manager and administrator explained that currently, the needs of the patients are effectively met from access to their money during office hours.

Areas for Improvement

Overall, on the day of inspection, we found care to be compassionate, the safety and effectiveness of care were found to be good, however there were two areas identified for improvement; these were in relation to the safe register and its reconciliation and to the recording of patients' property in their rooms.

Number of Requirements	**2**	**Number Recommendations**:	**0**

5.6 Statement 4 - Arrangements for providing transport to patients are transparent and agreed in writing with the patient/their representative

Is Care Safe?

On the day of inspection, the home did not operate a transport scheme for patients.

Is Care Effective?

As noted above, on the day of inspection, the home did not operate a transport scheme for patients, however a transport policy exists which details how the home supports patients to access other forms of transport, in particular in respect of medical/hospital appointments.

Is Care Compassionate?

The registered manager and administrator described the home's arrangements to support patients to access other means of transport, as detailed in the home's policy and procedure.

Areas for Improvement

Overall on the day of inspection, we found care to be safe, effective and compassionate. No areas for improvement were noted in respect of Statement 4.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.7 Additional Areas Examined

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

6 Quality Improvement Plan

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

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of

the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered manager/Registered Person

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to finance.team@rqia.org.uk and assessed by us.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time **To be Completed by:** 16 October 2015	The registered person must provide individual agreements to each patient currently accommodated in the home (or their representative) which detail the current fees and financial arrangements in place in respect to the individual patient. Individual patient agreements must be reviewed for compliance with requirements under Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and must meet Standard 2.2 of the DHSSPS Care Standards for Nursing Homes (2015), which detail the minimum components of the agreement. A copy of the signed agreement by the patient or their representative and the registered person must be retained in the patient's records. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where a HSC trust-managed patient does not have a family member or friend to act as their representative, the patient's individual agreement should be shared with the HSC trust care manager.
	Response by Registered Person(s)Detailing the Actions Taken: The individual patient agreements have been reviewed and amended to comply with requirements under Regulaton 5 of the Nursing Homes Regulations 2005 and Standard 2.2 of the DHSSPS Care Standards for Nurisng Homes. All new admissions will receive the amended contract.
Requirement 2 **Ref**: Regulation 19 (2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that the receipt provided by the home recording cash handed over for safekeeping is signed by both the person lodging the cash and by a representative of the home.
	Response by Registered Person(s)Detailing the Actions Taken: All receipts provided by the home recording all cash transactions from the date of the inspection are now signed by both the person lodging the cash and by a representative of the home.

Requirement 3 **Ref**: Regulation 19 (2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that written reconciliations of the monies/valuables held on behalf of patients in the home are performed, recorded, signed and dated by two persons at least quarterly.
	Response by Registered Person(s)Detailing the Actions Taken: As and from the date of the inspection all written reconciliations of monies/valuables held on behalf of patients within the home are performed, recorded, signed and dated by two persons at least quarterly.
Requirement 4 **Ref:** Regulation 19 (2) Schedule 4 (9) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person is required to ensure that a written safe register is introduced to record any items held within the safe place. This should record all items held within the safe place including items deposited for safekeeping on behalf of patients. Should any item be deposited for safekeeping, the record should reflect the date items were deposited and should be signed by two persons. Where items are returned to the patient or their representative, the record should be updated with the date the item(s) were returned and include two signatures to verify the return of the items. The safe contents reconciliations must be performed, recorded and signed and dated by two people (at least quarterly).
	Response by Registered Person(s)Detailing the Actions Taken: A written safe register has been introduced to record any items held in the safe detailing the date items were deposited and signed by two persons and also a section detailing the date items were returned to the patient/representive and a section detailing two signatures to verify the return of the items. All safe contents reconciliations are now performed, recorded, signed and dated by two people quarterly.
Requirement 5 **Ref:** Regulation 19(2) Schedule 4 (10) **Stated:** First time **To be Completed by:** 16 October 2015	The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by all newly admitted patients. The registered person must also ensure that a retrospective record is made of the furniture and personal possessions owned by existing patients accommodated in the home. All inventory records should be updated on a regular basis. Care Standards for Nursing Homes, April 2015 require that a reconciliation of these records is recorded at least quarterly). Any entry, whether an addition or disposal, must be dated and signed by two members of staff at the time of the entry. The registered person should advise staff of the importance of recording inventory details consistently. Items of significant value or those requiring electrical safety testing should be distinctly highlighted on the record for ease of identification.

	Response by Registered Person(s)Detailing the Actions Taken: All personal possessions and furniture brought into the home by new residents are recorded by two staff, dated, signed and documented in residents property file. All staff are made aware of the importance of recording inventory details consistently. Items of significant value or requiring electrical safety are underlined/highlighted so easily identified. All entries whether an addition or a disposal will be recorded and dated by two members of staff. An up to date inventory is currently underway for our existing residents and is being recorded which should be fully complete by 16 October 2015. Inventory records will be updated. Family and next of kin are advised as per Resident Guide to make the Home aware of any new items brought in or taken away so inventory updates and reconciliations can be recorded by two staff, dated and signed. These amendments will be added to the individual property list. Otherwise we assume all listed property on the inventory remains unchanged and will be carried forward. Annual checks will be carried out to ensure the accuracy of ongoing records and reconciliations. Key workers will be assigned to this and staff nurses/senior care assistants will oversee this procedure.
Recommendations	
Recommendation 1 **Ref**: Minimum Standard 36 (1) **Stated:** First time **To be Completed by:** 16 September 2015	It is recommended that the home update Policy F3 "Policy for Resident's Money". The policy was due for review in June 2015 and does not reflect the updated Care Standards for Nursing Homes (2015). **Response by Registered Person(s)Detailing the Actions Taken:** F3 "Policy for Resident's money is currently being reviewed to reflect the updated Care Standards for Nursing Homes (2015) and should be completed and in operation by requested completion date.
Recommendation 2 **Ref**: Minimum Standard 35.21 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person should ensure that one record of hairdressing is made for each day the hairdresser is in the home. Records should be legible and provide sufficient space for all of the relevant details to be recorded. Recording the initials of treatments should be avoided, full details should be provided. **Response by Registered Person(s)Detailing the Actions Taken:** As and from the date of inspection a new hairdressing template has been introduced detaling name of resident, details of each treatment, date treatment carried out, reference number, signature of hairdresser, signature of staff member. This record is completed each day the hairdresser visits the home.

Recommendation 3 **Ref**: Minimum Standard 35.21 **Stated:** First time **To be Completed by:** From the date of inspection	It is recommended that the home review the wording of the personal monies authorisation form to ensure that there are no misunderstandings as to what authority is being provided for.
	Response by Registered Person(s)Detailing the Actions Taken: As and from the date of inspection the wording of the personal monies authorisation form has been reviewed and clearly states what items personal allowance money can be used for.

Registered Manager Completing QIP	Una McTaggart	**Date Completed**	08/09/15
Registered Person Approving QIP	Margaret Potts	**Date Approved**	08/09/15
RQIA Inspector Assessing Response		**Date Approved**	11/09/2015

Please complete in full and returned to finance.team@rqia.org.uk from the authorised email address