Glenview
RQIA ID: 1470
11 Bleary Road
Portadown
Craigavon
BT63 5NE
Tel: 02838350500
Email: manager@glenviewnursinghome.co.uk

Inspector: Briege Ferris
Inspection ID: IN023276

Unannounced Finance Inspection
of
Glenview

8 September 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 announced finance inspection took place on 8 September 2015 from 09:20 to 13:50. A poster detailing that the inspection was taking place that day was positioned at the entrance to the home.

Overall on the day of the inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there are some areas identified for improvement, which 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 Mr Brendan Breen, (the registered person), Mr Cathal Breen (Director of Glenview), Mrs Najla Basketfield, (the registered manager) and Mrs Andrea Breen. No relatives or visitors chose to meet with us during the inspection.

Discussions established that the home had received a financial audit commissioned by the Southern Health and Social Care Trust (SHSCT) in 2015. During the inspection, we were advised that representatives of the home had arranged to meet with the SHSCT later that week in order to formally discuss the audit findings and recommendations.

Given the number of areas for improvement which we identified, we advised the home's representatives that following the inspection, we would be liaising with the SHSCT regarding their findings and recommendations and those from the RQIA inspection.

We would like to thank 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	6	6

The details of the QIP within this report were discussed with Mr Brendan Breen, the registered person, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Glenview/Mr Brendan Breen	**Registered Manager:** Mrs Najla Basketfield
Person in Charge of the Home at the Time of Inspection: Mrs Najla Basketfield	**Date Manager Registered:** 24 August 2015
Categories of Care: NH-PH(E), NH-PH, NH-I, NH-DE	**Number of Registered Places:** 31
Number of Patients Accommodated on the Day of Inspection: 31	**Weekly Tariff at Time of Inspection:** £593.00 – 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 Mr Brendan Breen (registered person), Mr Cathal Breen (Director of Glenview) and Mrs Andrea Breen
- 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 “Residents’ Guide”
- The home’s “Contract Agreement” with patients
- Five patient care files
- Most recent HSC trust payment remittance
- Confirmation of correct fees charged to a sample of patients for care/accommodation
- Income/lodgements and expenditure, including comfort fund records
- Hairdressing treatment receipts
- “Residents’ Property Book”
- 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 announced care inspection on 19 June 2015; 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 “Residents’ Guide”, a copy of which was provided to us for review during the inspection. We noted that the guide included information for patients on the general terms and conditions of residency, and detailed that the home takes responsibility only for those items deposited for safe keeping. Patients are also encouraged to personalise their rooms with items of a sentimental nature, such as pictures.

We requested to view the files of four sampled patients. We noted on reviewing the files, that two patients had a “Contract Agreement” (described below) which had been signed at the time of admission, one patient had a blank “contract agreement” and the remaining patient did not have an agreement on their file.

We requested to see a standard written agreement which would be provided to a newly admitted patient. We were provided with one page entitled “Contract Agreement”. We noted that there were six statements on the page to which the person signing was requested to tick to indicate whether they agreed. We queried whether the document formed part of a more comprehensive document and we were advised that it did not.

We discussed this with those present and noted that the home's agreement must at a minimum, contain all of the components set out within Standard 2.2 of the Care Standards for Nursing Homes (April 2015). We noted that a significant 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 also 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.

Following the inspection, we received email correspondence from the home attaching a draft "patient agreement". We confirmed that we could not approve provider documentation, however appropriate guidance on content was provided.

We noted the good progress regarding the implementation of these documents with patients.

Is Care Effective?

We queried whether there was any direct involvement by the home in supporting individual patients with their money; we were advised that there was no involvement by the home in this regard.

We noted that the home did not have a policy and procedure in place addressing patients' money and valuables.

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?

We obtained confirmation that written notifications of increases in fees had been provided only to those patients paying their fees in full or in part to the home. We noted that each patient in the home or their representative must be advised in writing of an increase in the fee and that the patient's written agreement must be updated to reflect this. We noted that increases in fees are normally implemented in April each year regionally and that as soon as the home is advised of the new regional rates, the home must ensure that all patients are advised as above.

A requirement has been made in respect of this finding.

Areas for Improvement

Overall on the day of inspection, the financial arrangements were found care to be contributing to safe, effective and compassionate care; however there were three areas of improvement identified. These related to providing individual written agreements to all patients which reflect the requirements of Regulation 5 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (2015); ensuring that patients or their

representatives are advised in writing of any changes to fees payable (with changes to the patients' agreements agreed in writing) and the implementation of a policy and procedure on safeguarding patients' money and valuables.

Number of Requirements	**2**	**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 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 established that patients' representatives deposit money with the home for safekeeping in order to pay for additional services not covered by the weekly fee (hairdressing).

A review of the records identified that the home provides a receipt to anyone depositing money. We reviewed a sample of receipts and noted that receipts are routinely signed only by the person receiving the money. We noted that receipts must be signed by two people, ideally the second signature being that of the person depositing the money. We also highlighted that where a patient's representative is unwilling or unable to sign a receipt, two members of staff must sign the receipt.

A requirement has been made in respect of this finding.

We discussed how patient expenditure was recorded on behalf of patients. We were provided with a file labelled "hairdressing". We noted that there was a record of income and expenditure for 26 patients. The records/ledgers detailed the date, money in, money out, the balance and had columns for two signatures. On reviewing a sample of the records we noted that the only expenditure recorded was for hairdressing. We noted that a details column was missing from the ledger template and that only lodgements were signed by two people, withdrawals were routinely signed only by the hairdresser. We also noted that where errors had been made in the records, these had been scribbled out. The correct method of dealing with errors in financial ledgers is to put one line through the error and initial it, and to re-write the entry on the line below. There was no evidence of reconciliation of the records. We noted that a standard financial ledger format must be introduced and adhered to and that reconciliations of patients' money must be carried out, recorded and signed and dated by two people at least quarterly.

A requirement has been made in respect of this finding.

We discussed the operation of the lodgements and withdrawal arrangements in respect of patients' money. We noted that the home act as an intermediary between patients' representatives lodging money and the hairdresser. Discussions established that the home

receives money from family members and provide a receipt (as noted above); the money is then stored in the home until the next visit by the hairdresser who receives the money which has been deposited since her last visit. We were advised that the hairdresser holds the balance of money for future hairdressing treatments, and that the hairdresser signs a weekly sheet to evidence that the patients identified have been treated.

We noted that this arrangement was not common practice or recommended and that the home must introduce an alternative arrangement to facilitate the payment of hairdressing services within the home.

A requirement has been made in respect of this finding.

On reviewing the treatment records (weekly sheet) we noted that only the cost of the treatment (not the treatment itself) was recorded. In addition, we also noted that the representative of the home countersigning these records was a member of administrative staff. We noted that the representative of the home signing the record is signing to verify that the patients identified have received the treatment and that this is usually a member of care staff. Should the administrator wish to sign the treatment record to evidence that the hairdresser has been paid; this would represent a third signature on the record.

A recommendation has been made in respect of this finding.

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”. Those present explained that money is normally raised for the fund from donations to the home from relatives of previous patients or the wider community or internal fundraising. We noted that records relating to income and expenditure were maintained in a book which contained records of income and expenditure dating back to 2005. We noted that entries in the book routinely contained the date, details of the income and expenditure, a receipt number (where applicable) and the running balance; entries in the book were not signed. We noted that this did not reflect a standard financial ledger format and that there was no evidence of reconciliations of these monies being carried out.

A requirement has been made previously in this report regarding the use of a standard financial ledger format to record transactions and the performance of reconciliations to be recorded and signed and dated by two people at least quarterly. This requirement also extends to the comfort fund records.

We reviewed all of the entries in the book and noted that a number of items had been purchased from the comfort fund which should have been paid for by the home. These items included beds, bedding and equipment including hoists, slings, finger pulse oximeters, pressure reducing cushions.

We discussed these matters with the registered person and highlighted our concern about these items being paid from monies intended to be used to provide additional benefit to all of the patients in the home and not to fund items which are the financial responsibility of the home. We noted that we would be liaising with the SHSCT in respect of this matter.

Subsequent correspondence established that as part of the financial audit commissioned by the SHSCT, the trust had also highlighted a number of items purchased from the comfort fund

which should have been paid for by the home. RQIA were informed by the SHSCT that a repayment of monies had been made by the home to comfort fund accordingly.

We noted that the home did not have a policy and procedure addressing the administration of the comfort fund. Discussion with those present identified that the home are engaging with the SHSCT regarding the implementation of robust financial procedures within the home. We noted that the home must have a detailed policy and procedure in place for the administration of the comfort fund.

A recommendation has been made in respect of this finding.

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, such as a purchase receipt. We noted within the sample of records reviewed, that a representative of the home had used a supermarket loyalty card when making purchases of newspapers for patients which are paid for from the comfort fund.

The departmental Minimum Standards highlight that where staff purchase items of behalf of patients, any store loyalty points earned are owned by the patient. Representatives of the home must not benefit from points earned on purchases which are not made from their personal or the business funds.

It is recommended that the registered person ensure that when purchases made from the patients' comfort fund attract store loyalty points, these points belong to the patients not a representative of the home. Staff should be reminded of the importance of not using their own personal store loyalty cards in these circumstances.

A recommendation has been made in respect of this finding.

Is Care Effective?

We were advised that no representative of the home was acting as nominated appointee for any patient. We were also advised that the home did not operate a bank account for the patients jointly nor were any bank accounts operated for individual patients.

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 to provide the home with the necessary written authorisation to purchase goods and services on behalf of each patient were not in place.

We noted that the only expenditure recorded on behalf of patients related to payments for hairdressing services. Discussions established that the SHSCT had recently requested that the home ensure that each receipt for money deposited for safekeeping must detail "deposited for hairdressing" so that the purpose for depositing the money was clear. We accepted this but also noted that having a written personal monies authorisation in place was good practice.

A recommendation has been listed 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; we were advised that none of the patients had any known assessed needs or restrictions.

Areas for Improvement

Overall on the day of inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were seven areas identified for improvement.

Number of Requirements	**3**	**Number Recommendations**:	**4**

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 noted that there are two safe places within the home and we viewed both of these and were satisfied with the controls around the physical location of the safe places and the persons with access.

We viewed the contents of the safe places and established that on the day of inspection, no cash or valuables were deposited for safekeeping by the home.

We noted that while there was no record of money or valuables lodged on the day of inspection, it was best practice to have a safe record/register to detail the contents of the safe place. We noted that these records should be reconciled and signed and dated by two people at least quarterly.

A recommendation has been made in respect of this finding.

Is Care Effective?

We queried whether there were any specific arrangements in place to support patients with their money. The manager explained how the home would engage with HSC trust representatives as and when required, 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 patients. We were provided with the "residents' property book". We noted that there were 14 patient records in the book; discussions established that other patients' property records were archived (post-inspection email correspondence from the home stated that the archived property book containing the records for the other patients had been located).

We noted on reviewing the "residents' property book" that almost all of the records were signed by one person. We highlighted 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.

Following the inspection, we received email correspondence from the home attaching a draft "property register". We confirmed that we could not approve provider documentation, however appropriate guidance on content was provided. Again, we noted the progress made by the home to swiftly address this issue.

Is Care Compassionate?

As noted above, there are safe storage arrangements within the home to enable patients to deposit cash or valuables, should they wish to. The availability of safe storage arrangements is detailed in the residents' guide.

Areas for Improvement

Overall, the financial arrangements were found to be contributing to safe, effective and compassionate care; however there were two areas identified for improvement; these were in relation to introducing a safe record and the way in which patients' property is recorded.

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

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 we discussed options for patients to access other forms of transport. It was clear that arrangements exist in the home to support patients to access alternative transport arrangements for instance for medical/hospital appointments, such as by non-emergency ambulance.

Is Care Compassionate?

As above, we noted that the home has arrangements to support patients to access other means of transport.

Areas for Improvement

Overall on the day of inspection, the financial arrangements were found to be contributing to safe, effective and compassionate care. 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 Mr Brendan Breen, the registered person, 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:** 8 November 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 an 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: Each patient currently accommodated in the home (and their representatives as appropriate) have had agreements provided to them which detail the current fees and financial arrangements. Individual patient agreements have been reveiwed for compliance with requirements under Regulation 5 of the Nursing Homes Regulation (Northern Ireland) 2005 in respect of Management of financial position.The standard 2.2 of the DHSSP Care Standards for Nursing Homes (2015) was addressed within the agreement. A copy of the signed agreement by the patient or their representative and the registered person is retained in the patients records. A record will be made of any patients that choose not to, or are unable to sign the agreement. Where an HSC trust managed patient does not have a family member or friend to act as their representative, the patients individual agreement will be shared with the Trust. We are addressing this with respect to one of our current residents. A residency agreement has been created which complies with relevant regulations. An appendix to the agreement which relates solely to fees has also been created. The residency agreement has been issued to all next of kin for signature. The Fees appendix has also been issued to next of kin and this will be renewed annually to reflect any increases in fees.

Requirement 2 **Ref**: Regulation 5 (2) (a) (b) **Stated:** First time **To be Completed by:** From the date of the next change	The registered person must provide at least 28 days' written notice to each patient or their representative of any increase in the fees payable by or in respect of the patient, or any variation in the method of payment of the fees or the person by whom the fees are payable. The registered person must ensure that any changes to the individual patient's agreement are agreed in writing by the patient or their representative. The patient's individual agreement must be updated accordingly. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded.
	Response by Registered Person(s)Detailing the Actions Taken: As above the fees has been dealt with as a separate appendix to the residency agreement. Any changes to the fees will be notified in writing giving 4 weeks' notice. A new fees appendix will be issued to reflect the changes and signatures from next of kin sought accordingly.
Requirement 3 **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 the receipts which the home provides to any person lodging cash for safekeeping are signed by two people. The receipt should ideally be signed by the person lodging the money; however, if that person is unwilling to or cannot sign, two members of staff must sign the receipt, a copy of which must be retained by the home.
	Response by Registered Person(s)Detailing the Actions Taken: All receipts issued in relation money received on behalf of residents is ideally signed by staff receiving the money and the person handing in the money. If that is not possible then it is signed by 2 members of staff.
Requirement 4 **Ref:** Regulation 19 (2) Schedule 4 (9) **Stated:** First time **To be Completed by:** 22 September 2015	The registered person is required to ensure that a standard ledger format is used to clearly and accurately detail every transaction for individual patients and the patients' comfort fund records. Each transaction should be supported by receipts and signed by two persons. If a receipt is not available, the reason for this should be recorded. Records made on behalf of patients must be legible and any mistakes appropriately dealt with on the face of the ledger i.e. a clear line crossed through the incorrect entry with an amendment on the line below and initialled by the member of staff recording the entry. Reconciliations of the monies/valuables held on behalf of patients in the home must be performed, recorded, signed and dated by two persons at least quarterly.
	Response by Registered Person(s)Detailing the Actions Taken: Separate records are kept of money received on behalf of residents for the various purposes in line with the Personal Monies Authorisation. These records are audited by the manager on a quarterly basis. The records are signed by 2 persons every time there is a transaction or quarterly (which ever happens first) in or out of the comforts fund.

	This is recorded in the comforts fund ledger.
Requirement 5 **Ref:** Regulation 14 (4) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person is required to introduce an alternative arrangement to facilitate the payment of the hairdresser who provides services to patients. If patients or their representatives deposit money with the home for safekeeping, the money must be safeguarded and secured within the home at all times.
	Response by Registered Person(s)Detailing the Actions Taken: The hairdresser money is now retained by office staff and appropriate records kept. The hairdresser issues an invoice for services delivered and the office staff pay as required. The invoice is countersigned to verify that services were delivered as stated.
Requirement 6 **Ref:** Regulation 18 (2) (c) **Stated:** First time **To be Completed by:** From the date of inspection	The registered person must ensure that any future expenditure from the patients' comfort fund is used for the benefit of the body of patients in the home and does not fund any items which should be paid for by the home. The rationale for any purchase made from the comfort fund must be clear. A written policy and procedure for the administration of the patients' comfort fund must be introduced. The policy and procedure should include reference to and inclusion of the patient and/or relative suggestions (if any) in the decision making process for expenditure from the comfort fund and the controls which will exist around record keeping, reconciliation etc.
	Response by Registered Person(s)Detailing the Actions Taken: We have developed a policy on the comforts fund. The records are signed by 2 persons every time there is a transaction or quarterly (which ever happens first) in or out of the comforts fund. This is recorded in the comforts fund ledger.The registered person shall ensure that future expenditure from the Residents comforts fund is used for the benefit of the body of Residents in the Home.
Requirement 7 **Ref:** Regulation 19(2) Schedule 4 (10) **Stated:** First time **To be Completed by:** 20 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: New Patients property records have been devised allowing for ongoing auditing of the property held. New admissions will be using this new format. Existing residents will be moved across onto the new records on a rolling basis. All entries will be double signed and next of kin have been advised that all property brought into the home or removed from the home must be notified to the staff to ensure that our records remain accurate.
Recommendations	
Recommendation 1 **Ref:** Appendix 2 **Stated:** First time	The registered person should ensure that a policy and procedure addressing patients' money and valuables is introduced and implemented. The relevant staff members should be made aware of the contents of the policy and procedure.
To be Completed by: 8 November 2015	**Response by Registered Person(s)Detailing the Actions Taken:** In development and will be completed by 8 November 2015. This will then be introduced, implemented and highlighted to relevant staff members.
Recommendation 2 **Ref**: Standard 35.21 **Stated:** First time	It is recommended that the registered person ensure that the hairdressing treatment record details the treatment provided to each patient. The records should continue to be signed by the hairdresser and should also be signed by a representative of the home who is able to verify that the treatment as detailed has been received by the individual patients.
To be Completed by: From the date of inspection	**Response by Registered Person(s)Detailing the Actions Taken:** The hairdresser now completes an invoice detailing services delivered to residents on a given date and the amount payable. This is countersigned by a member of staff to verify services delivered as invoiced.
Recommendation 3 **Ref**: 14.16 **Stated:** First time	It is recommended that the registered person ensure that when purchases made from the patients' comfort fund attract store loyalty points, these points belong to the patients not a representative of the home. Staff should be reminded of the importance of not using their own personal store loyalty cards in these circumstances.
To be Completed by: From the date of inspection	**Response by Registered Person(s)Detailing the Actions Taken:** Staff responsible for purchasing items on behalf of residents are aware that they cannot get loyalty points for their personal use from these purchases. This is also detailed in Patient's money and valuables policy.

Recommendation 4 **Ref**: Standard 35.21 **Stated:** First time **To be Completed by:** 8 November 2015	It is recommended that the registered person obtain written authorisation from each patient or their representative to spend the personal monies of patients on pre-agreed expenditure. The written authorisation should be retained on the patient's records and updated as required. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded.
	Response by Registered Person(s)Detailing the Actions Taken: A Personal Monies Authorisation form has been created and has been sent out to each next of kin for signature. This form will be renewed annually in line with any rate changes in April each year.
Recommendation 5 **Ref**: 35.21 **Stated:** First time **To be Completed by:** 8 November 2015	It is recommended that the registered person introduce a written "safe book/register" to record any items held within the safe place. This should record anything 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 record should be reconciled and signed and dated by two people at least quarterly.
	Response by Registered Person(s)Detailing the Actions Taken: A contents of safe register has been put in place. This is checked by office staff on a regular basis and audited by the manager each quarter. Any entries into/removals from this register are signed by 2 members of staff.

Registered Manager Completing QIP	Najla Basketfield	**Date Completed**	06.11.15
Registered Person Approving QIP	Cathal Breen in the absence of Brendan Breen	**Date Approved**	06.11.15
RQIA Inspector Assessing Response		**Date Approved**	11/11/2015

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