Commission for Social Care Inspection

Making Social Care Better for People

Inspecting for better lives

Random inspection report

Care homes for older people

Name:	Weir Hotel The
Address:	24 The Weir Hessle East Yorkshire HU13 0RU

The quality rating for this care home is:	two star good service
The rating was made on:	

A quality rating is our assessment of how well a care home, agency or scheme is meeting the needs of the people who use it. We give a quality rating following a full assessment of the service. We call this a 'key' inspection.

This is a report of a **random inspection** of this care home. A random inspection is a short, focussed inspection. Details of how to get other inspection reports for this care home, including the last key inspection report, can be found on the last page of this report.

Lead inspector:	**Date:**							
Diane Wilkinson	2	0	0	2	2	0	0	9

Information about the care home

Name of care home:	Weir Hotel The
Address:	24 The Weir Hessle East Yorkshire HU13 0RU
Telephone number:	01482643120
Fax number:	01482649282
Email address:	
Provider web address:	

Name of registered provider(s):	Hessle Properties Limited
Type of registration:	care home
Number of places registered:	31

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
dementia	31	0
old age, not falling within any other category	0	31

Conditions of registration:
The registered person may provide the following category of service only: Care Home only Code PC To service users of the following gender: Either Whose primary care needs on admission to the Home are within the following categories: Old Age, not falling within any other category, Code OP - maximum number of places 31 Dementia - Code DE, maximum number of places 31
The maximum number of service users who can be accommodated is: 31

Date of last inspection								

Brief description of the care home
The Weir Hotel is a care home that is situated close to the town centre of Hessle, in the East Riding of Yorkshire. It is registered to care for and accommodate 31 older people, including those with dementia related conditions. The home comprises a large semi-detached building that has four floors with a new single storey extension to the rear. There is a lounge, a dining room and a conservatory on two floors that creates a quiet

Brief description of the care home
area for residents to spend their time. To the rear of the premises is a pleasant garden that is accessible to wheelchair users with assistance. There is easy access to shops, churches, public houses, coffee shops and bus/train services, and there is a small forecourt for parking at the front of the property.

What we found:

We examined the care records for a resident that had been admitted to the home since the last key inspection. The manager told us that they had visited this person at their previous address (another care home) to complete a full care needs assessment. However, this could not be found on the day of this site visit. We noted that there is a care plan in place that records basic details such as the names of the care coordinator and next of kin, the reason for the admission and a health profile, including details of the medication prescribed. The care plan included risk assessments, one on moving and handling and another that was more specific to the individual needs of the resident. This recorded the residents tendency to wander and also recorded the action to be taken by staff i.e. to ensure fire exits remain shut and the gate locked. Because the resident was unable to agree to the information recorded in their care plan, a family member had signed to acknowledge their agreement to the care plan. Daily entries were recorded on diary sheets to record the care provided; these were quite basic, such as the persons food and fluid intake and sleep pattern.

Information about the person's health care needs was included in the care plan, including the details of any contact with health care professionals i.e. the chiropodist, the district nurse and the optician. The care plan included special dietary information that had been obtained at the previous care home; the manager said that the person had previously had a poor appetite but that this had improved since she was admitted to The Weir Hotel. We were told that a dietician had visited the home and was satisfied that the resident no longer required a special diet. However, this was not recorded. There was a weight chart in place to assist with nutritional screening.

We were concerned to read in daily diary entries of an incident that had happened a few days earlier involving this resident and another resident. A male resident had attacked this resident, leaving red marks around her neck. We asked the manager what action had been taken following this incident and we were told that staff had been asked to observe both residents at all times, and the male resident had been seated in a different area of the home so that they had minimal contact with each other; this course of action had been successful to date. However, the manager had not completed a safeguarding alert and forwarded it to the local authority, which is the course of action that should have been taken. The manager contacted the local authority whilst we were at the home and we later telephoned the local authority, who confirmed that a safeguarding alert had been received in respect of this incident. The manager told us that both residents had dementia and neither had any recollection of the incident following the event. We were told that the manager has undertaken the manager's awareness training on safeguarding adults and that she is due to attend again in March 2009, and that this training was undertaken by most care staff in January 2007.

We examined the medication records for the person being case tracked and noted that there were no gaps in recording on medication administration records. At the last key inspection staff were advised to record the strength of the medication being returned to the pharmacist. The medication returns book could not be found on the day of this site visit so we could not check this information. The senior carer on duty told us that there is a photograph of each resident in medication records to assist with

identification.

The care plan that we examined recorded that the resident would like to have their hair done every week but did not include information about the person's life history, previous lifestyle or interests so there was no information for staff to use when interacting with the resident to enhance their well being. The key worker for the person being case tracked recorded that they spent time walking around the home with the resident as 'one to one' time. This resident's care plan recorded that they spent their whole day walking around the home so this did not seem like a suitable activity for the key worker and resident.

The manager told us that they now employ an activities coordinator on four days per week, from 9.30 am until 1.30 pm. They arrange group activities and also spend one to one time with residents who do not like group sessions. The manager told us that the activities coordinator keeps a separate diary of activities undertaken each day but does not keep a record of who has joined in which activities, and this information is not recorded in individual care plans. We were also told that the activities coordinator does not spend any time with the resident being case tracked.

Training records evidenced that most staff attended training on infection control in either July or November 2007 and the manager told us that all chemicals are now purchased in individual packages so they are labelled correctly to meet the Control of Substances Hazardous to Health (COSHH) regulations.

We viewed the laundry facilities on the day of this site visit. Although these were untidy, walls and floors were made of materials that could easily be kept clean and they were seen to be clean on the day of this site visit. We noted that there was a small basket for storing each persons clothes following laundering and the manager said that this helped in ensuring that only a residents own clothes are returned to them. The manager also said that they had received no complaints about laundry since the last key inspection.

Some progress has been made on redecoration. The basement has been redecorated and new lighting has been fitted and this is now a light and bright area of the home. Two doors in the main entrance hall have been badly damaged by the use of wheelchairs and should be repaired or replaced. This gives a poor first impression of the home, which is well decorated in all other areas. The registered provider has arranged for a qualified person to assess the suitability of the premises for use by the current client group and a report has been produced; this information is now retained at the home.

We saw the staff rota for the week and noted that there is a separate rota for day staff and night staff. The rota does not record the role of each staff member and the hours worked by the registered manager and by ancillary staff continue to not be recorded.

We examined the recruitment records for a new member of staff. These included an application form that recorded the persons employment history and a criminal conviction declaration. Two written references and a Protection of Vulnerable Adults (POVA) first check had been obtained prior to the person commencing work. New staff receive a copy of the Induction programme provided by the local authority and start to work on this from their first day at the home. They also shadow existing staff as part

of the induction process.

On both occasions that the inspector has visited the home, the registered provider has been present undertaking maintenance work. Although the registered person visits the home on a regular basis they do not undertake unannounced visits as required by Regulation 26 of the Care Homes Regulations 2001, and no visits are recorded.

We received information from the Fire Officer about improvements that were required following their visit to the home in August 2008. The manager told us that all work had now been completed. This included a review of the home's fire risk assessment.

We noted that staff at the home send us notifications when there is a death at the home but that we are not notified of accidents or incidents. We checked the accident book and gave advice to the manager on some accidents recorded that should have been notified to the Commission, i.e. when medical intervention is sought.

We discussed the home's quality assurance system with the manager. She told us that the activities coordinator completes satisfaction surveys with residents. The manager said that she checks all returned surveys and takes any necessary action, but the information is not collated or published, and is not used to formulate an annual development plan. However, some changes have been made to the menu as a result of suggestions from residents.

What the care home does well:

Details of any input from health care professionals is recorded in care plans, along with information to support nutritional screening.

An activities coordinator has now been employed at the home; they arrange group activities and spend one to one time with residents.

Staff do not commence work at the home until all safety checks are in place. This ensures that only staff that are suitable to work with vulnerable people are employed.

Staff undertake induction training and shadow existing staff as part of their induction to the home and before they start to work unsupervised. This protects residents from the risk of harm.

Some progress has been made on redecoration and most areas of the home are bright and well decorated.

What they could do better:

There must be a copy of the initial care needs assessment included with all care planning documentation to ensure that a person's assessed needs are being met.

There is little information in care plans about a person's life history, previous lifestyle or interests. This provides staff with a lack of information about the whole person and does not result in a holistic care package.

Activities undertaken by the activities coordinator, any trips out of the home and any

visits from family and friends should be recorded in a person's care plan so that there is a full picture of the care provided by staff at the home.

The manager must make appropriate referrals to the local authority under safeguarding adults protocols when an incident occurs at the home. This is needed to protect residents from the risk of harm.

The Commission are notified of deaths but are not notified of accidents or incidents involving residents as required by regulation. This is needed so that accidents and incidents at the home can be monitored.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details set out on page 2.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These requirements were set at the last inspection. They may not have been looked at during this inspection, as a random inspection is short and focussed. The registered person must take the necessary action to comply with these requirements within the timescales set.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	3	14	The care needs assessment undertaken by staff should be included in the person's care plan. This information should be used to develop an individual plan of care. This is needed to ensure that care plans are based on the assessed needs of the individual concerned.	20/03/2009
2	18	13	Any incidents or allegations of abuse must be referred to the local authority under safeguarding protocols. This is needed to protect residents from the risk of harm.	20/03/2009
3	37	37	The Commission must be notified of any accidents or incidents involving residents. This is to ensure that appropriate people are notified of events concerning residents and to allow for care provision to be monitored.	20/03/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No.	Refer to Standard	Good Practice Recommendations
1	7	The care plan should include more information about a resident such as their life history, previous lifestyle and interests so that a holistic care plan can be developed. Daily recording and one to one time spent by key workers should then reflect this.
2	9	It is good practice to ensure all medications returned to the pharmacist have the strength of the drug recorded.
3	12	Activities undertaken by the activities coordinator, any trips out and any visitors seen should be recorded in a person's care plan so that a full picture of their care is recorded.
4	19	The doors in the entrance hall are badly damaged and should be repaired or replaced.
5	27	The staff rota should record the role of each staff member and should include the hours worked by the registered manager and ancillary staff.
6	33	The registered provider should make unannounced visits to the home and these visits should be recorded and information retained at the home.
7	33	The outcome of quality surveys should be published and results should be used to devise an annual development plan.

Reader Information

Document Purpose:	Inspection Report
Author:	CSCI
Audience:	General Public
Further copies from:	0870 240 7535 (telephone order line)

Our duty to regulate social care services is set out in the Care Standards Act 2000. Copies of the National Minimum Standards –Care Homes for Older People can be found at www.dh.gov.uk or got from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

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Textphone: 0845 015 2255 or 0191 233 3588

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