Care Quality Commission

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:	07/07/2009

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 review of the service. We call this review a 'key' inspection.

This is a report of a **random inspection** of this care home. A random inspection is a short, focussed review of the service. 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	6	0	7	2	0	1	0

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
Name of registered manager (if applicable)	
Linda Josephine Ferriby	
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 maximum number of service users who can be accommodated is: 31
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

Date of last inspection	0	7	0	7	2	0	0	9

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 that is built over two floors that creates a quiet area where residents can 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. Information about the home is available from the registered manager in the statement of purpose and service user's guide.

What we found:

We visited the home to look at information raised as part of a safeguarding investigation sent to the local authority, and additional information received from them following their initial enquiries. We did not look at outstanding requirements or recommendations that were made in the last key inspection report.

We looked at the following outcome areas:

Health and Personal Care:

We looked at care plans for four people living at the home. There are care plans in place but these are not personalised and they lack the specific information needed by staff to enable them to provide the care needed. For example, they may record 'assistance with personal care' but this needs to be expanded to include information about what this entails, for example, whether the person need help with washing, dressing and undressing, if they can put some clothes on themselves but need help with others and if they like to choose their own clothes. When care plans record that people need assistance with bathing, this should record whether people need help in and out of the bath, whether they like to be in the bathroom alone or accompanied, whether they can wash themselves and dry themselves etc.

We did see that two of the four people had a patient passport in place; this is a document that people can take to the hospital with them to inform staff of their individual support needs. One of these people had a record in their care plan that clearly stated that they were allergic to penicillin. However, the section of the patient passport that asked if there were any allergies was blank. The patient passport recorded, 'memory problems - unable to walk or stand' and 'I need help with all aspects of care' but more detail would have been helpful.

Each care plan is accompanied by a brief risk assessment but, again, these lacked detail. We did not see risk assessments for some areas where we would have expected to see them, such as specific risk assessments on nutrition (such as the MUST nutritional tool), pressure care (such as the Waterlow assessment) and moving and handling, including the risk of falls. We did see some information in care plans about nutritional screening but only part of the document had been used and no risk level had been identified. We noted that people are weighed on a regular basis as part of nutritional screening.

Some areas identified as a risk on the form in use were not dated so it was not possible to ascertain when the risk had been assessed. Some areas of risk had 'cancelled' written across them but with no explanation of why this decision had been made.

One person was receiving 'end of life' care and daily records evidenced that they were having difficulty with eating and drinking. Although this information was referred to in daily records, there was no food and fluid intake chart and no output chart in use. Daily records did evidence that this person had been 'turned' every two hours to assist with pressure area care but there was no risk assessment in place to record this decision.

One person's care plan recorded that they were not weight bearing but that they did not

like to use the hoist. A decision had been made that this person would be assisted with moving and handling via the use of a lifting belt and three carers. This decision had been agreed by the person's daughter but no advice had been sought from health care professionals about the safety aspects of these transfers; this leaves both the person concerned and staff at risk of harm. The same person had a risk assessment that recorded that they have 'cot sides' - this equipment should now be referred to as bed rails and the guidance issued by the Medicines and Health Care Regulatory Agency (MHRA) must be used. There was no evidence that the risk assessment met these guidelines and that the equipment was checked on a regular basis for safety as advised in the guidelines. This leaves people who use bed rails at risk of harm.

When a care package is commissioned by the local authority, assessment information had been obtained from them and this information is used to begin to formulate an individual plan of care. We saw that two of the care plans we checked included information about an annual review that had been arranged by the local authority to check that the care provided by the home was still appropriate; in both instances, the outcome was that the care plan in place met the care needs of the person concerned. We did not see any evidence that people who are privately funded have an annual review that is arranged by the home.

Although some care plans record a monthly review of the care plan and risk assessment, most of these recorded, 'Care plan and RA reviewed - no change'. In some instances these entries were made over long periods of time and it seems unlikely that there would be no change to a person's care needs over such a time span.

An allegation was made as part of the safeguarding alert that people were not able to see GP's and other health care professionals as required. Daily records and medical appointment records evidenced that people are supported to see district nurses, GP's and other health care professionals as and when needed and/or requested. We did not see any information that led us to believe that people needed or had requested medical attention and this had been refused or ignored.

We saw that each person had a form in their care plan called 'Resident's health profile and medical information'. This was a useful record of the medication prescribed for each person, the reason the medication had been prescribed and details of any possible side effects; this is good practice, as it assists staff to understand the reason why people have been prescribed their medication and which side effects to look out for, which assists with maintaining people's health care needs.

There has recently been an allegation about the handling of medication at the home and, at our request, the registered provider undertook an investigation of this and other allegations. A further allegation about mishandling of medication was included in the most recent safeguarding alert. We were told that, since the initial allegation was made, the registered manager had been monitoring the medication systems in place at the home; no evidence of this was seen on the day of this site visit.

We looked at the medication systems at the home. Although there were some practices that were acceptable, we found several areas of concern; medication is not stored safely and the records for the administration and disposal of medicines were not to an acceptable standard.

We saw that there is a medication policy held within the medication file and that staff had signed to confirm that they had read and understood it. The manager of their sister home was present on the day of our site visit and she told us that staff who have responsibility for the administration of medication undertake two courses on the safe handling of medicines, i.e. a short course from a pharmacist and a distance learning course.

Medication is stored in a medication trolley within a locked room. However, the trolley is not secured to the wall to ensure the security of medicines held within it. Additionally, the room is used for the storage of other items including files. Consequently, people may need to gain access to these items and this has the potential to compromise the security of the medicines held in the room.

We also saw that medicines were stored in a filing cabinet in this room. The filing cabinet was not locked; it contained medicines that were in blister packs that were labelled with the individuals prescription, as well as a small number of loose tablets that were not easily identifiable and would not be able to be traced should they go missing. We were told that these were spare tablets and medicines awaiting return to the pharmacy.

We looked at the records for the disposal of medicines that are no longer required. These were of a poor quality and did not record all of the medicines that we would have expected to be returned to the pharmacy. We 'case tracked' one person whose name had been raised as part of the safeguarding investigation. This person had sadly died and their medication records immediately prior to this could not be found. The person's care records indicated that they had not taken their prescribed medication for the last four days of their life yet there was no medication in their name recorded on the returns book for that month. We saw that records for the disposal of medicines were not completed on a monthly basis as we would have expected. We saw a record for the 26th December 2009 to the 10th January 2010 and then not until the 20th May 2010 and the 7th July 2010.

We saw a yellow tub that was used for the disposal of medicines. This contained an extremely large amount of loose tablets that were easily accessible. No clear record of this was kept and it would be difficult to identify if any medicines were missing.

We looked at the medication administration record (MAR) charts for the people who live at the home. We saw that some of the records, but not all, held a photograph of the person concerned and an information sheet. This photograph assists staff to identify the person that they are administering the medicine to and helps to reduce the possibility of errors occuring. These should be held with all individual medication records.

We saw that medicines received into the home are 'checked in' by the deputy manager. A record is made on MAR charts of the amount of medication received. It would be good practice for a second person to countersign this record to verify that the information recorded is correct.

In most instances medication was signed for at the time it was administered but we saw some examples when this was not the case. For example, one medicine that was administered by the district nurse was not cross referenced on the MAR chart to verify that it had been administered.

We saw that one person having respite care at the home had not had their medication for

the previous four days. The explanation given at the time was that the home had 'run out' of these medicines. We were concerned that this could have a detrimental affect on the person's health and raised this with the manager of the sister home, who acted to make sure that this person's medication was obtained. We were later told that some of this medication was in fact 'in stock', yet it had not been administered.

Another person had a packet of antibiotics that were labelled with instructions for two tablets to be taken each day for one week, with a total of 14 tablets being issued. This course should have been completed the previous week. However, the antibiotics were not recorded on the person's MAR chart and only seven had been removed from the packaging. This led us to believe that this person had not received their prescribed course of medication, resulting in their health needs not being fully met.

We saw that MAR charts were not always kept up to date and that on more than one occasion a person's medication was written on two separate sheets. Although it was only signed for once on each occasion of administration, this creates a risk of the medicine being administered twice, with the potential for harm to the individual. Some records for the administration of 'as required' medication were accurate but others were not. Some were left blank and others recorded an 'O' when they had not been administered. This code was used whatever the reason for not giving medication and there was no written explanation for the non administration of these medicines.

We noted that, at times, old MAR charts were not removed from the file and were simply folder over. The details on these had not been fully completed and there was no record to indicate that they were no longer in use. This has the potential for confusion when administering people's medicines.

We spoke to a visitor to the home and someone who lives at the home and both, when asked, expressed no concerns about the administration of medication.

Complaints and Protection:

We did not assess these standards on the day of our site visit to the home. However, the safeguarding adults team informed us that they had identified some incidents in one person's care plan that should have been referred to them under safeguarding protocols. We checked our records to see if we had been sent a Regulation 37 notification for the same incidents and no information had been received. The Care Quality Commission must be notified of any incidents that affect the well being or safety of people living at the home and the safeguarding adults team of the local authority must be notified of any allegations or incidents of abuse. Failure to do so leaves people living at the home at risk of harm.

Environment:

We did not detect any unpleasant odours at the time of this site visit to the home.

Staffing:

An allegation was made as part of the current safeguarding investigation that staff at the home have training certificates in place for training that they have not actually undertaken. We checked the training and development plan on display in the home and

some individual staff records. All evidenced that staff have regular refresher training on core health and safety topics.

The manager of the sister home is responsible for all training at the two homes and she told us that new staff have in-depth training but long-term staff have refresher training days. These take place in the training room at their sister home and several topics are covered in one day. Staff are paid for each days training they attend and we were told that this has proved to be more successful then staff having to attend separate training events. We had no reason to believe that staff were not attending for the training events recorded in staff files and on the training and development plan.

The manager told us that they do not always issue a training certificate and we advised that this would be good practice. Retaining attendance sheets is another way of confirming that training has taken place.

We were told that most training is provided in-house, using DVD's, questionnaires and demonstrations. However, moving and handling and medication training is provided by an external trainer. All core training is undertaken on an annual basis. For example, all but four staff have undertaken training on safeguarding adults from abuse this year.

What the care home does well:

Each person has a care plan in place and this includes details of the medication prescribed to them, the reason that the medication has been prescribed and any possible side effects.

People are weighed on a regular basis as part of nutritional screening.

There were no unpleasant odours detected at the home on the day of this site visit.

Staff have regular training updates; this results in a staff group who have the skills and knowledge needed to care for people living at the home.

Staff have signed to record that they have read the medication policies and procedures at the home and understood them.

What they could do better:

Care plans are not detailed and some care planning information is not kept up to date. This could result in people not receiving the care they need.

Risk assessments are very brief and are not in place for some areas where a risk has been identified, for example, the use of bed rails, pressure care and nutrition.

Monitoring charts are not being used for identified areas of risk, for example, food and fluid intake and 'turn' charts.

Appropriate advice is not sought to support decision making, for example, decisions have been made about moving and handling that may not be safe and bed rails are being used without appropriate risk assessments/consultation being evidenced.

Medication procedures and practices are not robust. Our main concerns are:

- storage of medication, including the lack of security and other things being stored in the medication cupboard
- poor record keeping
- people not getting the medication they require
- used medication not being accounted for.

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 are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
1	29	19	Two written references must be in place prior to someone commencing work at the home. This is to ensure that only people who are safe to work with vulnerable people are employed.	30/08/2009

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, 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	7	13	Care plans must be supported by robust risk assessments. This is needed so that any identified risks can be minimised and care can be provided in the safest possible way.	31/08/2010
2	7	15	Care plans must be kept under review and updated appropriately. This is needed to ensure that staff always have current information available to them.	31/08/2010
3	7	15	Care plans must include sufficient detail to enable staff to provide the care that is needed. Staff can only provide individualised care if they are provided with sufficient detail about the person concerned.	31/08/2010
4	9	13	Medicines within the home must be stored securely and	13/08/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, 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
			safely. This includes all prescribed medicines including medicines awaiting return to the pharmacy for disposal. This is to ensure that only people who have responsibility for this task can access medication.	
5	9	13	Unused medication must be returned to the Pharmacy and there must be evidence of this transaction. This is to ensure that unused medication is not kept on the premises, as this places people at risk of harm.	13/08/2010
6	9	13	There must be evidence that people have received their medication as prescribed by their GP or other health care professional. This is to ensure that people's health care needs are fully met.	13/08/2010
7	9	13	Robust records must be kept of medication received into the home, medication administered and medication returned to the pharmacy. This is to ensure that there is a clear audit trail of all medication that comes into the home and leaves the home.	13/08/2010
8	18	13	The local authority	13/08/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, 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
			safeguarding adults team must be notified of any allegations or incidents of abuse involving people living at the home. This is needed to protect people from the risk of harm.	
9	38	37	The Care Quality Commission must be notified of any incidents that may affect the well-being or safety of people living at the home. This is needed so that any such incidents can be monitored by the Commission.	13/08/2010

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	Monitoring charts should be used for such things as food and fluid intake and 'turns' so that staff always have current information available to them and to evidence that appropriate care is being provided.
2	9	MAR charts for previous months must be removed from the medication file to reduce confusion, but they must then be retained and be available for checking at all times.
3	9	Regular checks of medicines kept in the home, medication record keeping and staff practice should be made and recorded.
4	9	When prescribed medication is not administered, appropriate codes should be used on MAR charts to record the reason why.
5	9	Identification photographs and personal information should

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
		be permanently fixed to all MAR chart dividers.
6	30	There should be evidence of all training courses that have been attended by staff, either by production of a certificate or by retention of the attendance sheet.

Reader Information

Document Purpose:	Inspection Report
Author:	Care Quality Commission
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

Helpline:

Telephone: 03000 616161

Email: enquiries@cqc.org.uk

Web: www.cqc.org.uk

We want people to be able to access this information. If you would like a summary in a different format or language please contact our helpline or go to our website.

© Care Quality Commission 2010

This publication may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the publication title and © Care Quality Commission 2010.