Dear mum fell and broke her hip in her flat in September 2016. After being discharged from hospital she went to a local nursing home in Beckenham, initially for respite stay. Unfortunately, despite many enquiries into long term care in her flat. It was decided amongst the family that she would be safer with long term care at the nursing home.

We had looked at many local nursing homes whilst mum was recovering in hospital. The one she stayed at had an overall 'good' report. The report for 'Service well-led' stated 'requires improvement'.

Compared to the other homes we visited, this appeared to be better.

Soon after mum arrived at the N.H in September 2016, in the evening, I was with her in her bedroom waiting for 2 carers to come and wash, put her pyjamas on and put her to bed.
We were waiting for an hour. I kept asking for someone to come to the nurse downstairs. Mum was very tired. Only 1 carer came in, she looked very sullen, it was nearly the end of her shift before the changeover.
We chatted, making light conversation. Mum was in her wheelchair; I helped the carer wash & dress mum. Suddenly she lifted mum up by her arms from the wheelchair, I was shocked and said l would help, also saying that mum had broken both her shoulders in the past.
I helped put mum in her bed with the carer.
As the carer was tucking mum in bed she said to me, "I don't like working with old people"

I was completely shocked, I then said, "Why are you working here then". She didn't answer and left the room.
I chatted to mum for a while, (she didn't hear what the carer said).
I went home feeling angry and also worried about mum.

I reported this incident to the then Matron. She said she would have 'a chat with the carer'

A new Matron/Registered Home Manager started in June 2017.

On 30/6/17 my sister and I had an informal meeting with the new Matron in the garden of the N.H.
We discussed with her mum's loving character and independence before her fall. How she responds well to gentle care.
We discussed mum's care due to her visual impairment and assistance during mealtimes and if the carers could switch her CD music on in the eve.

We discussed some early concerns of the care before the Matron's position at the N.H.
This was; no water in the jug by her bedside table; sometimes she had no pyjama bottoms on when put to bed; the emergency button and cord were sometimes found on the floor and not left on her bed.
We reiterated our concern to her over the incident with the carer in September 2016.
She said she would hold a meeting with her, and this was "not acceptable" and discussed the possibility of a 'retraining care course' for the carer. She would be monitored too.

We felt more at ease after this meeting.

The Matron's written report back from this meeting covered some of the above points, although under the headed section: Carer Moving Mum in bed without any assistance, the first paragraph was An untrue statement.

In her flat, mum had a carer, J, who for part of the week would come and help her dress in the mornings and eves. Also prepare her breakfast. They got on so well and had many laughs together.
On the day mum fell and went to hospital, J came later to see mum and I drove her home.
(My sister was away on holiday).
J visited mum in the nursing home (unpaid then). Mostly in the evenings for a chat and would make mum a cup of tea.
Also L came to visit mum ay the N.H. (We paid her). A lovely caring person.
They were of great emotional support to mum and myself. They were wonderful company to mum and became great friends.
K worked for L, (equally supportive and caring). She visited mum on a few occasions.

On 8th August 2017, K visited mum in the evening. She called me saying that mum had complained of a 'sore leg'.
She lifted up the duvet cover, the single sheet underneath covering mum, was full of blood. K lifted the sheet and found to her distress that mum's leg had a deep cut and was covered in bruises.
She had been put to bed and left in that state.
K pressed the 'call button' and waited a long time for a carer to arrive.

In October 2017, 'Review Forms' from the N.H. were left in the Reception Area for family and friends of residing residents to fill in and give their reviews.
K and J filled in the forms.
K reported the incident of mum's leg. (I will send a copy of her report in an email attachment and also a photo from that eve visit of mum's cut and bruised leg).

On 9th August 2017, I had a meeting with the Matron reporting the incident of mum's cut and bruised leg.

On 25th October 2017, the Director of the N.H. called a meeting for my sister and myself.
(The matron was away on holiday).
The 'Review Form' had been highlighted by CQC and Social Services. They had concerns over K report and also J report.

The Director was very unhappy about the reports and did not believe their contents.
He stated that mum's carer friends could no longer visit her.
He said a future meeting to be held with the Matron to discuss and review this arrangement.
(See copy of attached letter on 3rd November 2017 from director on an email attachment).

At this meeting I informed the Director that with 30+ residents, at night there are only 2 care workers and 1 nurse. He felt this was sufficient.

On 17th November 2017, I had a meeting with the Matron. I said to her I would like "A heart to heart chat" about having the continuity of visits from mum's carer friends. I explained that mum greatly benefits from their visits. A great deal of laughter and chat, together with a cup of tea or water to help with her hydration too.

The Matron informed me she would discuss this matter with the Director and Director of Care and let me know.

Three months had gone by, and I had no verbal or written correspondence back from them.

On 19th November 2017, I visited mum in the evening. Her first words were, "Oh, it's so lovely to see you."
(I had previously seen her at supper time and straight afterwards 2 care workers had taken mum to bed). One was the same care worker who had stated "I don't like working with old people" in September 2016. The other carer was a regular male locum, whom mum liked, and they joked together.

I came back in the early evening that same day to visit mum. The nurse on duty came to check mum's catheter.
Mum wore pyjama top & bottoms. The nurse could not find her catheter bag, which would normally be around her ankle with a Velcro taping.

(The day before, mum had a new catheter tubing and bag). I was with her at the time.
With some difficulty, the nurse found the catheter tubing wrapped TWICE around her upper thigh and the bag under her upper thigh.
We were both shocked. I helped the nurse gently unravel the catheter tubing and bag.
On the same leg. There was a dressing on mum's shin, which had been previously placed a few days before.

This dressing had been dragged partially back to expose the wound.
All this was very distressing to see, and of course would have been distressing and painful for mum at the time.
The nurse filed in a report that evening.

I sent a letter to Lucy reporting this incident of poor care handling, also stating that I did not want any further care handling to my mum from the female care worker who helped put her to bed that evening.
(See copy of my letter reporting this incident on 19th November 2017 to the Matron and also copy of her reply, dated 14th January 2108, in an email attachment).

Please note that on the first page and last paragraph of the Matron's letter, is an untrue statement, which I have asterisked.
The catheter bag and tubing was changed the previous day, the 18th of November 2017, by 2 different carers. I was present at the time.

I was not present at the time the 2 care workers on the 19th of November 2017 put mum to bed.
Ass mentioned the catheter bag was changed the night before and the tubing is always the same length.
There is no stand that the catheter tubing and bag are attached to.

On the second page of the Matron's letter, under section 3.
All is an untrue statement, apart from the carer 'not being allocated to care for your mother'.

On 22nd February 2018, a meeting was held at the N.H. which my sister and myself attended.
The matron, 2 Directors and a Social Worker were also present.

The discussion being 'The Ongoing Issue of Evening Visits'

(Please see copy of my statement letter of report from the meeting of 22nd February 2018 and the letter report from the Director from the same meeting. (Both in an email attachment).
On 14th May 2018, both my sister and I received an email from the Matron for a meeting with Social services.
2 dates were proposed – 22nd or 23rd May 2018. These were work days and too short a notice for me.
I emailed back on the 14th of May 2018, saying, 'unfortunately I am unavailable for the proposed 2 dates. (I have a copy of both the Matron's email and my reply email).

On 14th June 2018, both my sister and I received a 'NOTICE TO QUIT' from the Director of Care.

I also received on 14th June 2018, a letter from the Matron, saying 'we have been left with no option, as this decision was not taken lightly…….

The first paragraph statement is untrue. I had responded to the matron's email for proposed meeting dates in May saying I was unavailable (hence my copied email) I was awaiting a further response for further dates to be offered.

Needless to say, we were both in shock. My sister was away at the time, and I phoned her.

We decided to respond a few days later. On 21st June 2018 I sent a letter to the Director of Care, disputing 'The Notice to Quit'.

Also on 21st June 2018, I sent a letter to the Matron in response, I highlighted that I had emailed her on 14th May 2018. Together with attached copies of my reply to her email on 14th May 2018.

(Copies of the Notice to Quit, the letter from the matron, the copy of my reply to the Director of care and copy of my letters to the Matron are in an email attachment).

A Mental Capacity Assessment and Best Interests Plan was produced on 10th July 2018 from Social Services and a copy was sent to my sister and I.

Again, many more untrue statements were within the report.

First paragraph stated 'LBB social Service received phone call from LP xxxxx nursing home care manager on 29/11/2017 reporting that client daughter Toni is causing a problem in the home. Lucy reported that Toni, client daughter has agency staff going into the home late at night and waking up the client from her sleep'.

Mum's carer friends did not visit very late at night. If she happened to be fast asleep, they would not wake her.

The report states that mum fell asleep often whilst the social worker was asking her questions and she had to continually wake her up to finish asking the questions to her.

The report stated – Mrs D is at risk of: -

Psychological abuse – through the issue of being kept awake until late in the night and having no choice in this which results in a disturbed sleep and interrupted care routine.

Neglect – Mrs D psychological and physical needs are being neglected by her daughter as she is not complying with her mother's care/support routine which in result has a significant impact on her functioning ability, emotional state, maintaining her nutritional needs and compliance with her care.

Another statement in the report was - 'Toni's visits at night has been causing Pam (my sister) worry and distress.

Another statement – 'Mrs D to move to a new nursing home, where Toni will continue to visit until the early hours of the morning to stimulate and support Mrs D.
Toni continues to arrange for additional paid carers to attend the nursing home to support Mrs D.

(I have a copy of the full report).

Despite my dispute of the 'Notice to Quit', I did look around at other local nursing homes.

A matron from a nearby home visited mum. She was kind. She stated that my mum was too frail and weak to be moved.

From 29th June 2018 to 19th July 2018, evening visits for my sister and I were only allowed up to 8pm.

On 19th July 2018, my sister and I and family, friends and carer friends were allowed to visit mum in the evening after 8pm.

4 days later on the 23rd of July 2018, our mother passed away.

I have written in a book dates and notes of when I visited mum and her carer friends too.

I would regularly help brush mum's teeth in the evening, they were generally unbrushed.
She was always pleased to see me, and we would always hug each other.
We had wonderful chats and would laugh and sing together. I would make a cup of tea for mum, or she would drink water. She was always thirsty.

This would be the same when her carer friends came to visit.

Here is a summary of some dates and notes: -

22/11/2016 - evening - no water jug and glass on bed side table. Mum in bed with her day clothes on.
27/11/2016 - evening - mum had no pyjama bottoms on in bed. I pressed the call button for carer who helped me put pyjama bottoms on.

29/11/2016 - evening - no water jug or glass near the bed. Emergency call button on the floor.

(Some further dates have been mislaid).

03/07/2017 - evening - mum in bed with no pyjama trousers on. Her catheter bag was under her middle back. The bag had become detached, and she was lying in a large pool of saturated urine. The top sheet and blanket were also soaked with urine.
She also had no duvet cover for 3 days.

I pressed the call button, a carer came, and I helped her to change sheets and wash mum. She put pyjama trousers on mum. A new duvet cover was brought in.

27/07/2017 - evening - large area of black bruising on mum's lower right leg. I reported it to the nurse on duty.

28/07/2017 – evening – mum in bed with no pyjama trousers on. Her catheter bag was wrapped around her waist. I pressed the call button and eventually a carer came to help place catheter bag in correct position and put her pyjama trousers on.
The carer noted down this incident.

08/08/2017 – evening – mum on antibiotics for infected cuts on her legs.

13/08/2017 - evening - mum had no pyjama trousers on. I pressed call button for carer, after an hour of waiting, I managed to put on mum's pyjama bottoms.

24/08/2017 - afternoon - saw mum in lounge at suppertime. She had soup all spilled down her front. She was reclined right back in her reclining chair. There was no bib/serviette on her.

24/10/2017 - evening - mum had a dressing on top of her right hand. There were 2 cuts on top of her left hand, these were undressed. I reported this to the nurse on duty that evening.

From 29th to 31st October 2017, mum had no duvet on her bed, despite regular requests from both my sister and I.

26/11/2017- evening - mum had dressings on both of her arms and legs.

05/12/2017 - N.H. phoned during the day to say mum had caught the top of her hand on a button. They had put a dressing in the hand. She was also on antibiotics for a urine infection.

06/12/2017 - mum's eye glasses gone missing. (This was a regular occurrence.) Sometimes in the evenings, I'd find them on the floor in the lounge by her reclining chair, or on top of the mantelpiece in the lounge.

16/01/2018 - evening - mum in bed, a glass of water was tipped over on the bed. Mum was calling out. Her pyjama trousers were soaked and her bottom sheet.
I pressed the call button. 45 mins later 1 carer came and together we changed the bottom sheet and mum's pyjama trousers.

12/02/2018 - evening - mum in bed. Her room smelt strongly of urine. Loren was visiting mum too. Loren pressed the call button. A carer came and changed the catheter bag.
We noted black bruises on mum's legs.

04/03/2018 - evening - mum in bed, only 1 sheet on top of her. Found plate from suppertime with sandwich under the sheet. Mum had been in bed all day. No one had helped with her suppertime.

04/03/2018 Continued - mum's pyjama trousers had ridden up to the top of her legs. Catheter tubing exposed. Mum was leaning to edge of bed. No duvet.
I helped to straighten her up and gave her the sandwich in small pieces and a cup of water.

12/03/2018 - afternoon - My sister told me that she found mum unresponsive and dehydrated in her bed. Mum's catheter was full of blood.
I came to see mum.
The N.H. wanted to send mum to hospital. My sister and I said mum required fluids to become hydrated and responsive.
Together we gave mum water through a straw and very small amounts of ice cream little by little.

Mum in a short period of time became responsive and chatty.

This situation happened a few times at the N.H.

02/04/2018 – afternoon - my sister went to see mum. She was in bed all day. She found mum's dinner all over her bed. She reported this to the nurse. We were constantly asking for carers to assist mum at mealtimes, at this stage. This was always asked for in meetings with the Matron.

03/04/2018 - evening - I find mum in bed with no pyjama trousers, no pads or underwear on. Her bedsheets were pulled back. She was exposed. Her catheter bag was high up by her left hip.
I pressed call button, 10 minutes later a carer came and together we put a pad on mum and put underwear and her pyjama trousers on.
The carer filled out a written report of this incident.

12/04/2018 - evening - mum lying at sharp angle in bed. Her right arm caught between edge of mattress and profile wooden edges of bed.
She has a cut to her right elbow and there is blood on the sheets.
I pressed the call button, and a nurse puts a dressing on mum's elbow.
Mum's pyjama top was all undone, I fasten it up.

30/04/2018 – afternoon - my sister called me to say mum was in bed and very dehydrated. Her urine was very dark in the catheter bag. My sister gave mum small amounts of ice cream, little by little. She began to improve.
In the evening I gave mum small sips of water, little by little. She was improving more and more.
Antibiotics were prescribed. Mum had recently just finished a course of antibiotics for urine infection.

03/05/2018 – evening – Mum in bed with a flannel completely covering her face and left there.

21/06/2018 – mum has chest and urine infection – more antibiotics. Helped her with a drink of water in the evening.

22/06/2018 – The start of up to 8pm visiting time allowed!

11/07/2018 – mum not eating much today. Asked for a bowl of ice-cream. Fed mum slowly and she ate all the ice-cream. Her hairdresser friend came and set her hair in bed.

13/07/2018 - 7pm Dr A K visited mum in her bedroom. We discussed the 'Notice to Quit'.
He was unaware of this. He stated "It was a Deprivation of Liberty" – Mental Capacity Act 2005.

16/07/2018 – suppertime – mum in her wheelchair, leaning sharply over left side of chair. I gently straightened her up and propped some cushions behind her. Helped to feed her some soft food and ice-cream.

17/07/2018 – 23/07/2018 – mum in bed. She spoke to me for the last time on 17th. "Best friends always".
Received email from the Matron - Family and friends were allowed to come in then at any time in the evening.

23/07/2018 – mum passed away peacefully.

God Bless you Mum. XXXXXXX