HC one Special

By Eileen Chubb ©February 2019

Introduction

This week I downloaded the latest CQC reports on four homes owned by HC One, all four are rated inadequate. I am aware of at least another 20 homes which are currently rated good by the CQC but which are anything but good.

Recently The former Chief Executive of the regulator CQC, Sir David Behan became a director of HCOne. We have repeatedly highlighted our concerns about Sir David Behans conduct to the Department of Health and their response to date was to recommend Behan for a knighthood.

The suffering continues for vulnerable people because of a complete lack of accountability but those who fail to act are rewarded and honoured for their misconduct. It is clear the only people guaranteed employment are those such as David Behan and Andrea Sutcliffe.

The below four homes are all rated inadequate. There are common themes that run through each home, the main theme is the lack of nursing staff and in spite of this, these homes are claiming continuing healthcare funding from the NHS. This money should be paid back by the company when such nursing care has not been provided.

There are many dedicated care staff in all these homes but what will happen when those staff become so demoralised they leave?
All of these homes are said to be in special measures: alas David Behan has stated publicly he does not know what the term "Special Measures" even means, a great choice for a care company director.

The care or lack of it, being provided in all of these four homes is life threatening,
people left without food and drink due to lack of staff.
At risk of choking,

Pressure sores
Prescribed medication not given
Wounds not dressed or recorded,
Unexplained bruising and injuries,
Waiting for hours calling for help,
Living in squalor,
And many more major failings

The first home is Elmwood

"At our last inspection in March 2018 we found Elmwood Nursing Home to be on breach of five regulations of the Health and Social Care Act. These breaches were in relation to safe care and treatment; dignity and respect; staffing; consent and poor management. As a result of these findings we rated the service 'Inadequate' and placed Elmwood Nursing Home into 'Special Measures'. At this inspection we found the service to be in continued breach of all five regulations and identified breaches of two further regulations. The additional breaches were in relation to protecting people from abuse and notifying CQC of incidents were people had been harmed."

"People continued to be at risk of unsafe care and treatment because care records continued to contain inaccurate information about people. The incorrect details in care records included the wrong textures for food and consistencies of drinks for people who were at risk of unsafely swallowing. Care records showed that people were at risk of pressure sores worsening because dressings were not changed as frequently as prescribed. People were not adequately safeguarded from abuse and improper treatment because the provider failed to notify the CQC and Local Authority when people had been harmed. This prevented the appropriate level of investigation from being carried out. The provider continued to deliver nursing care to people without directly employing nurses to manage care to people on each floor.

"People were not protected from the risk of abuse and improper treatment. The provider failed in its duty of care to appropriately report serious incidents in which people had experienced harm. We reviewed care records and found that one person had been admitted into hospital with a grade three pressure ulcer. A pressure ulcer is diagnosed as grade three where there is full thickness skin loss leaving a deep crater but the tissue surrounding the wound is undamaged. In a letter to the service a concerned healthcare professional instructed the care home to raise a safeguarding alert with the local authority and to inform the CQC. The service did neither. In another example, a person had bruising four centimetres in length along their forehead with discolouration beneath one eye. Staff did not know how this injury had occurred and the service did not make a safeguarding referral to the local authority or inform the CQC. In a further example, we saw a person with plaster cast on their arm on the first day of our inspection. We reviewed their care records and found the

person had experienced a fracture wrist. The provider sent a notification to the CQC on the day of our inspection, which was seven days after the fracture occurred, but only after we had enquired about the person's injury. The service had not informed the local authority safeguarding team. Our concerns regarding the provider's failure to make safeguarding referrals were heightened by a local authority enquiry substantiating a finding of neglect against the provider in April 2018."

The Next home is Ferndale court

"On this inspection we found the provider had not ensured that sufficient numbers of suitably qualified, competent skilled and experienced persons were being deployed effectively. The registered provider had also failed to ensure that their systems were being implemented or followed effectively to assess, monitor and improve the quality of the service. Furthermore, the registered person had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a complete record of complaints.

"This inspection was brought forward in part due to the Commission receiving information of concern amounting to allegations of neglect. The specific allegations of neglect were being investigated by the local authority and an allegation of serious assault was referred onto the police. The information shared with the Commission indicated potential concerns about the management of alleged safeguarding concerns occurring at the location which were risks examined on this inspection.

"The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures ….We asked people if they felt safe and reviewed the systems in the home to check if they were keeping people safe. One person told us, "There isn't enough staff, they are too busy." A second person said, "I have to wait for the toilet. It was 7.15pm. I was left on the toilet for 2.5hours. I was buzzing and buzzing. It was 8.40pm when they came to get me. The staff who went off at 8pm, didn't tell the staff who were coming on", and a third person we spoke with said, "I know staff come in at night to check on me."

"The registered manager and provider had not followed their own safeguarding system. We raised concern regarding one person who had visible marks on their skin which had not been recorded in their records or

'body mapped'. The person could not recall when the bruises had appeared or why. Despite this, the provider had not requested a general practitioner to assess the marks and they had not ensured there was a clear contemporaneous record to explain when the marks first appeared. We expect the provider to follow the safeguarding policy and record/body map all marks and report all unexplained bruising to the Safeguarding Authority. This had not been actioned by the registered manager/provider. We found a second person who told us they had been pulled by a staff member resulting in a dressing being applied on their arm/bruise. Upon checking the person's records, we found no record of the marks/bruise in the person's care records to explain when they appeared. The provider acted immediately upon us raising concerns with them. They confirmed they checked all existing body maps and completed a body map for everyone within the home during the inspection."

"We asked people if they were provided with choices. One person told us,- "There is a choice, you are asked when it (meaning food) comes. Another person said, "I like my cup of tea in my china cup. They keep giving it to me in a plastic baby cup. I hate it, I won't drink it." A third person we asked told us, "No I don't choose really, no one listens."

"We also received concerning information from relatives and the local authority during our inspection raising concern people were not having enough to eat and drink. These concerns were being investigated by the Local Authority. The choice being offered for lunch was soup or sandwiches. We observed people's food and drinks were not always within reach. Records we viewed confirmed people were not being offered snacks after their tea time meal at around 5pm. The registered manager confirmed food was not offered after the tea time meal and supper was not being offered. For people who needed support to eat and drink they were not supported enough to provide them with the maximum opportunity for them to have their nutritional needs met. We observed food and drinks for two people, who needed support ***to eat*** *and drink had been left on their table. One person's food was served at 12.46pm which consisted of sandwiches, a cup of tea and a supplement drink. At 1.16pm their sandwiches were taken away, the cup of tea still there which was now cold. Another person's soup and sandwiches were served at 12.46pm but 30 minutes later they were still*

there; the soup was cold. We were therefore, concerned people were not being provided with the optimum opportunity of having enough nutrition or fluids to always maintain their health.

“People who were able to speak with us were asked for their views about how they were being cared for. One person said, "Staff are ok, it depends on who is on." A second person said, "I like staff, some are nicer than others" and a third person told us, "I have a pad on in the night. Staff check through the night to see if it is dry. I don't need a pad. I'm not incontinent, I don't need one. My daughter has told them but they still put it on". A fourth person told us, "Sometimes I'm in pain in the night. I ask for pain relief. Some staff shout at me, it is a while ago now, it has got better". A fifth person told us "The (description of job role) who works here is very nice, they look after me more than the care staff", A sixth person told us "all staff speak to me in kind way". Another person who we approached said - "They won't want you to talk to me, they will not like it".

“We found some people appeared unkempt in their appearance such as with dirty long finger nails, clothing with breakfast food on them in the afternoon and another person who had not been supported to have a wash or had their hair brushed. Some people's bed linen was stained and was not always fitted appropriately. One person who had a pressure mattress had only a valence sheet over the mattress which had not been fitted. Another person had important certificates on their wall, one of which they said was missing as a staff member had knocked it off their wall in their bedroom some weeks previously. The glass within the frame had broken. This had not been replaced to ensure the certificate was secured back in place on the wall. We were therefore, concerned people's dignity and respect for people's belongings was not always being upheld. People's human rights were not always being upheld or adhered to as their basic care needs were not always being met.”

“We asked people if they had needed to make a complaint. One person told us, "There is no point

complaining, no one listens, nothing gets done." A relative told us, "The care is poor. I have made numerous complaints it's no use. Nothing changes". We looked into the complaints system and found not all complaints received had been dealt with appropriately. The complaints system had not been followed with a contemporaneous record of all communications with the complainant, record of meetings and outcomes.
We found some complaints which the registered manager was aware of were safeguarding concerns which had not been reported to the local authority. On this inspection we found evidence staff were not always following safe practices in relation to Safeguarding and moving and handling which were placing people at risk of abuse or harm. We found no record of one person's bruise and mark on their arm which they told us had been due to a staff member handling them roughly. We also found no body map or record of another person's marks on their arms to confirm when they had appeared, size of the marks and position of them to monitor their skin changes. If not for this inspection and our request for a medical assessment of the marks, the provider had not taken action to either seek medical advice as to what may be the cause of the marks or recorded them.

We asked the registered manager what the biggest challenge was within the home and they responded it was related to agency staffing. On this inspection we found multiple issues and concerns which the registered manager and provider were aware of however, the registered manager and provider had not communicated they had found some of the same concerns as found on the inspection until we met with the provider following the inspection. Therefore, the transparency and lack of openness had contributed to the culture within the home. We found the culture was introspective, not always reporting concerns and issues appropriately.

The Next report is priory gardens

“People and relatives told us there were insufficient staff to provide safe and effective care. Many relatives

advised us they came in to assist staff otherwise their relation would not be cared for properly. Staff were extremely busy, and became task-focused in their roles due to the continuous demands on their time. This was to the detriment of team work on occasion. Staffing rotas did not reflect the amount of staff needed in relation to people's true dependency levels."

"We found significant concerns with staffing levels as people had to wait for attention or we found relatives were substituting care provision as they observed how busy staff were. One person told us, "They leave me in bed for my breakfast. So that I can reach it, they put it on my belly. My porridge is cold because they are waiting for another carer to come and lift me up, I need two." Another person told us, "I haven't been asked today if I want to get up. I have not had my hair combed today." One relative said about their relation, "I came this morning at 10.15am and they weren't up, not dressed, no food or drink."

"We observed staff were constantly busy. We saw a large number of people stayed in their rooms and this meant people in the lounge were often unattended. We observed many periods where staff were not visible.
One care assistant said, "Staffing levels are a struggle as I can't be in two places at once. If a person needs support, others are left to wait." During lunchtime on Grace one person asked to use the toilet and was told by a care assistant, "We can't while we're doing lunches. It's protected mealtimes. Cross contamination."
When questioned by the inspector they continued, "We can't because [name] needs two and a hoist. There's only two of us and we're serving meals." When asked if there was any other help such as a manager, they told us, "No, there is no one to call on."

"In Grace people were not supported to eat. We observed one person positioned too far away from the table and no adjustments were made by staff, another person put their napkin in their soup and then pushed their bowl away. Of five people in the room, only four had soup and one person had nothing. No staff were present in the dining room for five minutes as they were serving meals elsewhere in the unit. One person was eventually supported by kitchen staff on an individual basis as specified in their care plan. People were given a visual choice.

We also observed another person with a bowl of soup by their leg in their bed which they were unable to reach as they were laid back. They asked the inspector to assist them to a better position. When questioning a care assistant as to why this person was in bed, they replied, "They are aggressive and will change their mind if we try and help them." When the position of the soup was highlighted and the care assistant asked if the person was supported, they replied, "They don't want to be supported." Another staff member stated "We like to give them independence." However, our observations did not indicate their independence was being promoted. We later observed this person eating independently while out of bed.

“People felt there was not much to do in the home. One person said, "We have a sing-a-long maybe every few months, that's OK. I watch the TV as there's not much else to do." Another person told us, "The nurses put the TV on when they come; they don't ask me what I want to watch. I don't go out at all. I stay in bed all the time."

We saw one person had dressings on their left arm and right ankle. We looked at their care records. In the daily records for May 2018 we saw the person also had wounds to their legs and a dressing had been applied. We saw a skin integrity care plan dated 27 April 2018. This showed the person had a skin tear to their wrist which had steri-strips applied. There was no mention of the leg wounds. We asked the nurse if there were any wound care plans or treatment plans for these wounds. The nurse checked and said there were not any and that they would do them later that day. We asked when the wounds had last been dressed and the nurse said they didn't know and they would do them later that day. They said they did not know there were steri-strips on the arm wound.

We saw the person's feet and lower legs were red and swollen. The daily records showed the GP had visited the day before the inspection and prescribed antibiotics and recommended the person's feet were kept elevated but we observed the person was sat with their legs down. We asked the nurse who said they had

tried to elevate the person's legs on a stool but staff said the person kept trying to sit on the stool. We asked if they had considered other options such as a recliner chair but the nurse said they didn't think they had a spare one.

Two other relatives spoke of concerns they had raised regarding staff, both in relation to conduct and practice. One relative was not happy as the staff member was still working and they felt the issue had not been addressed although the relief manager advised us this investigation was ongoing and the staff member had been removed from working with this person, and the other had discussed concerns with their relative's specific equipment not being used properly. This had led them to complain on multiple occasions with eventual success. Complaints records showed appropriate responses had been made to those which were recorded as such. We found not everything was recorded as a complaint which possibly should have been. The service had received compliments for staff responses, in particular for end of life care.

The next home is pytchley

"There was no clinical supervision of nursing staff. Staff failed to recognise when people were unwell and required medical assessment. Nursing staff failed to take appropriate clinical observations or always refer people for medical assistance in a timely way. From our findings at this inspection, we raised six safeguarding alerts relating to 11 people. These alerts are subject to an on-going safeguarding investigation.
At the inspection we brought all of our concerns to the attention of the registered manager and the provider who took some immediate action to ensure people's safety.
People were at risk of not being referred to medical care in a timely way. Staff had recorded in daily notes that seven people showed signs of ill health. The signs included changes in people's behaviour, diarrhoea, vomiting, frequent falls, 'funny turns', reduced urine output, sleepiness, reduced communication, not eating or drinking and weight loss. Care staff reported these signs to the nursing staff. Nursing staff failed to take

people's full set of clinical observations to assess whether they required medical treatment. Clinical observations are the measurements of people's temperature, respirations, pulse, blood pressure and oxygen levels; all of these observations are required to accurately assess people's clinical status. People's records showed people continued to be unwell, and nursing staff eventually sought medical advice when people were seriously ill. This was a concern as a delay in seeking medical help can result in people not receiving treatment for infections; which carries a risk of developing sepsis. Sepsis is a serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. There had been three people admitted to hospital with sepsis in the last month."

"People were at risk of not receiving prompt medical care for injuries from falls. There was no reliable system in place to record people's clinical or behavioural observations for a planned period of time after a fall. People continued to be at risk after a fall as injuries may not be immediately apparent and continued observations over a time period would help staff to identify if a person has incurred an injury after a fall. For example, one person had frequent falls. Although staff took some observations they did not take a complete set of clinical observations, or take these observations regularly or for a set time. Where staff had recorded the persons observations, their blood pressure and pulse indicated they could be bleeding or in shock. We were concerned as staff stopped taking their blood pressure and took two hours to call the GP. Staff later recorded the person had a low oxygen level but staff did not call for medical assessment. This person continues to have frequent falls with limited clinical and behavioural observations; they continue to be at risk of undetected injury.

"People did not always have suitable wound management. For example, two people had not had their wounds redressed at the prescribed frequency, increasing their risk of infection. Another person had been identified as having a wound three days before our inspection, but did not have a wound care plan and no action had been taken to assess or dress the wound."

"People were at risk of not receiving safe care as there were not enough permanent staff who understood

people's needs. There were three permanently employed nurses, however, one of these had handed in their notice and was off sick. There were agency staff employed who relied on the risk assessments and care plans which were not always complete or accurate. Staff told us the rotas were not a true reflection of staff on duty. They told us staff would often call in sick, but the rotas did not change to reflect this. On the day of inspection there were two nurses, one of whom was an agency nurse. People were not receiving their care in a timely way, such as having their meals later than planned. For example, we observed one person received their breakfast close to lunch time, which meant they were unable to eat their lunch and missed a meal; this person had lost 11% of their body weight in six weeks. People were at risk of falls as there were not enough staff deployed to supervise people who were at high risk of falls to communal areas. People did not receive their planned care as there were not enough regular staff that knew people's needs to ensure people did get their care even when the care plans were not updated."

"There was not enough clinical management to oversee the safe care of people receiving nursing care with long term conditions such as diabetes and heart conditions. Staff did not have systems to monitor people's blood pressure, pulse, breathing or blood sugars for indicators they were out of normal or acceptable range. People were at risk of not receiving care that met their needs, as staff did not have systems in place to know or recognise when people were unwell. People were at risk or acquiring infections as there were no systems in place to regularly assess and monitor people's wounds or urinary catheters."

"