Tales of the Un-Inspected
Home Number 47
By Eileen Chubb

I Looked at The Inspection History of……Home 47 and these are my findings,

INSPECTION REPORT DATED 7TH AND 29TH OF MAY 2008.

THE REPORT. There has been a real improvement in how staff communicates with residents.

My Comments, It is also noted that a relative informed inspectors that they witnessed some staff lose their temper with residents on occasions.

THE REPORT. Health and Personal Care, There had been complaints made about the care of a resident previously, we checked this resident's care plan and found that they had a nutritional risk assessment which identified that they were at high risk, but no further action had been taken to contact a dietician. Wound care was checked and instructions from the Tissue Viability Nurse had been recorded but not acted on. The care plan for this resident had not been updated since last year. The manager said staff knew what to do to care for this resident, when we asked the staff they said they did not know any of the information.

My Comments, This persons relatives had raised concerns about their care previously and yet all these serious issues are still found to have not improved. This says to me that there is a serious problem in this home and all care plans should have been checked.

THE REPORT. When we returned for our second day of inspection there had been significant improvement in the information recorded in care plans.

My Comments, The inspectors have failed to grasp that writing up care plans to reflect that care is given is not a substitutive for care. This resident could not have received this care as staff were totally unaware this care was required. The damage has already been suffered. The resident was not checked at all.

THE REPORT. Medication Management was poor, when we checked some of the medication we found medication had been signed for but not given on 19 occasions, MAR sheets were not up to date or accurate, medication did not tally with the records. When we returned on the second visit an action plan had been put in place and a full audit had been carried out.

My Comments, When medication is checked mid cycle it is for a four week period, If residents had not received medication on 19 occasions out of 28 days then there is a big problem. No medical assistance was requested for those residents.

Also MAR sheets not being up to date or accurate is a way of playing down the fact that anything could have been administered to these residents and there is not a single safeguard in place other than the bits of paper in the office called, Robust Medication Procedures, but only a fool would place any credence in those. However the home puts in place an action Scam and audit's the medication so that's alright by the inspectors.

Medication is described as poor but is not graded as poor, it is graded Adequate. The section healthcare has four standards, 1 is fully met and 3 are Minor shortfalls. There are no major shortfalls. I find that incredible given that you can die of starvation, infected wounds or a lethal dose of un-prescribed drugs or for the want of medication prescribed but not administered.

THE REPORT. The improvement in the attitude and approach of some staff was striking, this should continue across all of the staff.

My Comments, Any staff that have made such a striking improvement should not be working in care at all.

THE REPORT. The home has good complaints procedures. The service has responded to complaints but not the action plan following complaints last year.

My Comments, This translates as this company will listen to your complaints and pretend to act on them but do nothing.

25 standards are judged, 16 are graded fully met, and 9 are graded minor shortfalls. The home overall is graded 1 Star Adequate.

INSPECTION REPORT DATED 1ST OF APRIL 2009
(12 Months Later)

THE REPORT. Staff is recording good person centered information in care plans such as how a resident likes to be shaved, wound care was not up to date, and the computer system had not flagged up when wound dressings needed to be changed. Instructions from the Tissue Viability Nurse had not been followed. People are at risk of not receiving pain relief, one dressing had not been changed for ten days, it is of concern that we made requirements about these issues in, 2005, 2006, 2008, we may have to take enforcement action.

My Comments, I note that that they only may take enforcement action, this renders it a possibility only. Years of residents suffering and action Scam after Action Scam but nothing changes.
What Person centered care plans mean in reality is that you can have your preferred choice of hairstyle whilst you die of infected wounds screaming in pain but overall that's considered alright because your hairstyle choice being met makes up for the agonizing death.
Also the regulator should be aware of the fact that a computer is in the office and the staff are on the floor, and the computer that can change dressings or provide any kind of actual care has not been invented yet.

THE REPORT. Medication is audited and has improved. Some medications had run out. Some residents are on sedating medications, these are reviewed by a consultant psychiatrist, and the doses that are being administered should be recorded. Some medications were handwritten on the printed MAR sheets. Some medications had been changed by hand on the Handwritten MAR sheets.

My Comments, Firstly Anti-psychotic drugs are not licensed for the treatment of dementia. The home is registered to provide nursing care for residents with dementia.
Secondly regarding the consultant psychiatrist who is alleged to have reviewed these prescriptions, the inspectors did not check how many times has he seen the residents either in the home or at hospital or if he relied on information provided by the home.
Thirdly, the justification for giving these drugs was not checked and given the lethal risks involved it is something that should have been.
Finally I have seen first-hand a power abuser give these drugs in lethal

doses.
How is it done? Firstly it is easy to say a resident is aggressive and get such drugs prescribed. Once enough residents are on these drugs it is easy to accumulate a stockpile by giving some residents little and others higher doses. The residents who need more care because they move or speak are the target of this kind of abuse. Someone would notice if this was happening you would think but that's easy to get round by hand written alterations on the sheets or not stating what was given when the dose is variable. Let's face it the inspectors note all these things for years but fail to make any connection to the possible consequences.

THE REPORT. There is a clear policy on deleting complaints. Concerns have been raised with the regulator that the home is not reporting safeguarding issues to the authorities for weeks.

My Comments, To be fair I think the word deleting in relation to complaints is a typing error, however it's a more suitable description of this homes culture, in fact it's the first time inspectors have made a correct assessment.

THE REPORT. The AQAA did not reflect what we found.

My Comments, I do not know what is worse, the fraudulently completed AQAA or the expectation of the inspectors that such a document would reflect the truth.

The Home is now graded Zero Star Poor

INSPECTION REPORT DATED 24TH OF JULY 2009.
(4 Months Later)

THE HOME IS NOW GRADED 2 STAR GOOD

THE REPORT. Care plans sampled now record good wound care and better information. We observed a relative complaining to the manager that the care plan was not correct, the manager attended to it. Medication policies are good and medication is reviewed.

My Comments, The main evidence is taken from the AQAA even when they observe incidents that contradict this they note it but ignore what it indicates. No audit of medication is carried out. Wound care recording has improved so immediately it is presumed would care have improved.

THE REPORT. Activities have improved with upcoming events listed such a party for a resident due to be held.

My Comments, Not a birthday party but a leaving party for a resident getting out and going to another home.

THE REPORT. One relative told us the home was not what they expected when they moved in.

My Comments, This requirement has been graded as good by the inspectors for years.

The Rest of the report is based on the AQAA, action scams and that some residents were watching a film that had been put on during the inspection.

The Home is now judged to be good at dealing with complaints, the same policies are in place that always have been, the home has not received any complaints but the AQAA says they would deal with them if they did.

There is no evidence what so ever to support this home being awarded two stars, the whole report is marked by desperation to upgrade this home at any cost. There is no evidence to support this home has no manager so the company bring in the regional manager to put a better gloss on the AQAA. This home is now not required to be inspected for years and even then the AQAA may be accepted instead.

CQC charge this charity five pounds for every inspection report over the first ten. That is more expensive than the Harry Potter books. JK Rowling writes a better plot than CQC who have lost the plot if they ever had it in the first place. I never fail to be angered when I read these reports because I am ever aware of the consequences for those that have been failed.