Tales of the Un-Inspected
Home Number 66
By Eileen Chubb

I made two visits to this home and I also looked at the inspection history, these are my conclusions.

Please note this home is owned by the same company as home numbers, 33,36,41,48,49,50,54,59,60,62,63,64,65.

REGULATORS INSPECTION REPORT DATED 28TH OF APRIL 2008.

THE REPORT, HEALTHCARE, This area is adequate. Resident's needs are not met in a consistent manner despite a comprehensive care plan system being in place. We looked at three care plans and found, incidents of aggressive behavior were not always being recorded. The majority of staff has received training in pressure care which was a requirement of the last inspection. The PCT Tissue Viability nurse carried out an audit a year ago and the manager said a number of beds and mattresses were being replaced on a rolling programme, but the company has no intention at present to review the seating needs of those residents identified at risk.

My Comments, Residents are identified to be at risk of pressure sores by the PCT nurse, who recommends what equipment is required. The managers inform inspectors the company has a rolling programme to purchase new beds and mattresses but not pressure cushions. This company has prior knowledge of what is required to prevent bed sores, should residents suffer the torture of bedsores as a result then this will be deliberate abuse as the company have prior knowledge of the risk and failed to act. This is a prime example of why I have always argued that bedsores cannot be presumed to be neglect. As for a rolling programme, this is a care provider scam for avoiding loss of profit.

THE REPORT, HEALTHCARE Conti, We observed a resident at risk of pressure sores sitting all day with no pressure relieving cushion. One resident was repeatedly asking to go to the toilet and it was twenty minutes before staff responded. Another resident was seen walking about when they

had clearly been incontinent. Another resident kept asking to leave the dining room and they also had been incontinent and they fell and we observed they were wearing no undergarments. Another resident told inspectors they asked for a bottle at night and were told to pee in their pad. Some good staff interaction was observed but one resident calling for assistance was spoken to very harshly. Some staff did not speak to residents at all. We found medication awaiting collection for disposal in an unlocked room. Audits indicated medication was given as prescribed though these were not always correct with PRN medication.

My Comments, if this is happening when inspectors are watching then what is going on the rest of the time?

THE REPORT, COMPLAINTS AND PROTECTION, The home has comprehensive written policies and procedures for the protection of vulnerable adults. Since the previous inspection the home has received six complaints and three adult protection referrals, two were upheld and one was withdrawn. We spoke to staff and found their knowledge of protection to be mixed, they said they would report any abuse to the senior person on duty but beyond that were unsure what to do. According to the training matrix 83 per cent of staff has received training in abuse and adult protection. Inspectors witnessed an incident of aggressive behavior in the dining room, the care staff was in the kitchen and one resident became aggressive towards another and objects were thrown. This incident took place for over a minute and was very loud with neither carers returning to the room and eventually another staff member came to calm the situation, these incidents are not being monitored by the care plan process.

My Comments, There is a mixture of very frail elderly people with dementia and older adults with mental health illness such as schizophrenia for example. I am seeing this mixing of two very different groups more and more and it totally wrong. Firstly people with mental illness have very different needs to elderly people with dementia and it is a real risk to lump these two groups together. Someone in their eighties who is very frail and suffering from advanced dementia is totally defenseless if attacked by someone much younger who due to schizophrenia feels threatened or misunderstands the older resident's behavior and lashes out.

THE REPORT, MANAGEMENT, The majority of accident reports were not

referred to in the care plans. We the regulator has not been informed of issues that the home is required to report. This includes incidents where residents have suffered injuries. We the regulator was informed by social workers reviews of residents who were injured by attacks from other residents requiring paramedics being called to the home. These incidents were not reported to the proper authorities.

My Comments, This is noted on the very last page of the report and not under the complaints and safeguarding section but in a section where it will not have the same impact on the overall grade.

The Home is Graded 1 Star Adequate. Incredibly from the 27 standards judged, 18 are considered fully met and 9 are considered minor shortfalls but worst of all none are considered major shortfalls.

REGULATORS INSPECTION REPORT DATED 7TH OF MAY 2009.
(1 Year Later)

THE REPORT, GENERAL INFORMATION. The company has suspended placements to the home following serious concerns about poor care being brought to the attention of the local authorities by a number of health professionals and other agencies. We have sent a warning letter to the company following this inspection.

My Comments, The same old story, only after other authorities are told about the appalling care in a home the regulators decides to do an inspection and actually grade the home according to what they see. Again the CQC decide to regulate when the damage is done and even then they are more concerned with justifying why they did not act before. Now the company is given a warning letter which is a sad excuse for enforcement. As for the company suspending new placements that is because it would have happened anyway and is just a tactic to avoid damage to reputation. If only the regulator and the care company were as quick to protect the residents. As for the home suspending its self from admitting new residents, it failed to inform me of the fact when I asked about a room for my fictional relative who they were only too happy to accommodate.

THE REPORT, HEALTHCARE. Medication management is poor; there is overuse of Anti-psychotics on the dementia unit. Healthcare professionals

highlighted missing information. Continence care is still poor. The PCT tissue viability nurse carried out an audit of equipment in 2007, the company had a rolling programme of replacing mattresses but this has not been done. We found only five pressure cushions in the home and these were not fit to use.
Seventeen per cent of residents had recorded pressure sores. We found one resident who had a pressure sore not recorded in his care plan so was untreated and they had no equipment to ease the pressure.

My Comments, The regulator took the word of the home there was a rolling programme to replace vital equipment, now we see the price that has been paid for that negligence. Pressure sores are one of this company's areas of expertise; people have died crying out in pain from infected bedsores in other homes owned by this company. This is deliberate abuse that has resulted in grievous bodily harm. The company had prior knowledge of what was needed and put profit before life. I expect the dividends this company has paid out of its massive profits were paid out immediately whilst people were dying for the want of basic care equipment, dividends are not paid out on a rolling programme they are given priority.

THE REPORT, HEATHCARE Conti, Staff were only using one hoist; the company told us that all five hoists in the home were used. Residents were noted to have bruising that could have occurred during manual handling. End of life care planning is not taking place.

My Comments, End of life care planning? Would this include how someone with infected bedsores chooses to die? There is much debate about the right to die but none at all on the right to live. As to end of life care it would be better described as ending life for the want of care. What would they write in an end of life care plan? Who would chose to die from infected bedsores, bone exposed laying in urine, no care or pain relief, yet that is what many elderly people are condemned to because there is no one there to protect them. Every day I worked in care I had to fight for the right of life.

THE REPORT, Medication, Audits by a pharmacist revealed that medication had been recorded as administered when there was none in stock. Some medications were not given in the correct dose or not at all. There was over use of anti-psychotics on the dementia unit and the home was taking action

on this. Drugs were stored in a surplus medication cupboard. Symptoms were not monitored where blood tests maybe are needed for residents at risk of toxic drug side effects were not recorded. The nursing staff audited all medication daily and had not picked up the issues.

My Comments, The last inspection audited the homes audits, which is why a home's self-assessment can never be trusted and any audit carried out by a home should judge against an audit by a regulator, Unfortunately residents have been given drugs that are not licensed to treat those with dementia, drugs that have no benefits other than making staffs lives easier and have been proven to shorten the life of elderly people, which means they kill. The experts will say the risks are lowered by regular blood tests for the toxic side effects only this is the reality. The right to life is not a consideration. These drugs are a substitute for care.

THE REPORT, COMPLAINTS AND PROTECTION. The home logged 8 complaints; the home has a robust procedure for handling complaints. Complaints were logged but not what investigation took place or what resulted. We spoke to staff about abuse and safeguarding and they gave a mixed response saying they would report to the senior staff in the home.

My Comments, at the same time this was happening the company that owns this home was praised by the previous Governments Minister for older people for their commitment to encouraging staff to whistle-blow by their partnership with the charity Action on Elder Abuse, who also praised this company and its stance on abuse. However their stance on abuse is quite clear to me and there is nothing praiseworthy about it.

THE REPORT, STAFFING AND MANAGEMENT.
The numbers of staff in the home did not match those listed in the AQAA. Eight staff had left the home without explanation at the same time. New staff recruited did not have all recruitment checks carried out. Senior management from the company has implemented new systems which do not appear to be working. We the regulator is still not being informed of incidents that are required to be reported.

My Comments, It was noted previously that there were a small core of good staff in this home, the fact 8 care staff have left this home without

explanation at the same time shows a group of staff too committed to resident care to work for such a company. If I were investigating this home I would have asked to meet these staff and would have found out why they left. The reason why there is no documentation in the home as to why these staff left is highly suspect.

The home is now graded ZERO star Poor, 28 standards judged, 5 fully met, 9 almost met and 14 major shortfalls. However there were noted to be No outstanding requirements from the last inspection.

REGULATORS INSPECTION REPORT DATED 15TH OF DECEMBER 2009.
(7 Months Later)

THE REPORT, HEALTHCARE, The home needs to improve care plans so peoples mental health needs are better met. The home should make available the returns book for medication. Staff needs to have more in depth training on dementia. Medication is well administered, some care plans were difficult to review and some care plans did not include information on what had happened to the person. We found some care plans did not follow the instructions given by healthcare professionals for example where it was requested people be weighed this was not always done. We looked at tissue viability care and found in a case where a specific mattress was identified as needed this was in place. We did not find that all staff had the skills to care for residents with dementia. On the mental health unit training records did not indicate that staff had the training to care for residents with schizophrenia and bi polar disorders. The company does not check medication or comment on it in their monthly audits, but a PCT pharmacist checked the medication and said it appeared improved apart from the missing drugs returned book.

My Comments, You cannot audit medication without having full information on what came in, was administered and what was returned, which explains why the returns book is missing. The company no longer comment on medication as previously they failed to act on the gross failures they tick listed as alright. However, no comment is not a defense but a refusal to accept responsibility.
I fail to see where the alleged improvements are.

THE REPORT STAFFING AND MANAGEMENT. Staff were feeding

people without speaking to them. Complaints are not correctly handled. We have received no complaints and the home has recorded one complaint, the person had to contact the home a second time to see what was being done. People are asked their views about the home by the company but little detail is recorded. The home appears to be reporting incidents to us and we looked at those documented.

My Comments, The presumption is the home appears to be reporting incidents to the authorities that are documented, what of those that are not documented. Later in the report inspectors note staff may not always witness incidents as residents are not always observed.

THE REPORT, Conti, Staff files were not up to date with risk assessments and immigration status. Training in dementia, tissue viability was not documented. Some of the shortfalls found were righted during the inspection but some of the issues should have been reported to us by staff. At the last inspection surveys were sent out but none returned this time a small amount were returned containing little information.

My Comments, if the information above had been included in complaints and protection it would have been harder to upgrade the homes star rating. The home is returned to 1 STAR Adequate, 24 standards are judged, 10 are fully met, and 13 are almost met and 1 major shortfall.

There have been no further inspections.

WHAT I WITNESSED.

FIRST VISIT.

As soon as I entered the home I was confronted by the smell of urine and this was present throughout the home. I was taken through to the dementia unit and it was teatime, it was evident that the majority of residents could not eat or drink without assistance and the staff were struggling to provide this as there were not enough staff.
The staff were feeding several residents in the lounge area, in the dining room residents were unattended, I saw two people leave the room and wander off without eating anything. Several residents were trying to pick up food but dropped most of it on the floor. One resident was

trying to remove her clothing. In the conservatory a male resident had tipped the food from his plate onto the settee and was struggling to get up. A female resident was also struggling to get up from the sofa and was holding a bowl of what looked like custard in one hand which slopped onto her as she made several attempts to get up. It was clear that the seating in the conservatory area was way too low to be suitable for elderly people and was therefore being used as a form of restraint. I saw a staff member walking very fast down the corridor who was pulling along a resident by the wrist who could not keep up.
All the residents looked unkempt, their hair was greasy and their clothing was dirty.

The second visit was in the early afternoon and I took someone with me, we were asked to wait in the dining room. There was a resident in a very distressed state who was trapped behind the door and blocked in by a table and was continually turning and trying to find a way out and becoming more distressed with the situation as I watched. There was a member of staff present who was talking to us whilst this went on and it was only when I mentioned that the resident looked upset that the staff member moved the table out of the way and the resident left the room. It appeared this resident had been trapped since lunchtime as they had dried food on their hands and clothing, if so they would have been trapped for over three hours.
The second resident in the room was sat at a table, they had food in debris in their lap so may also have been in the room since lunchtime, this resident whilst being awake was so heavily sedated they could only move their head slightly, there gaze was locked on the wall opposite and though several people moved past them and directly in their line of vision they did not register any awareness of their surroundings. I have seen people in this state before, heavily sedated by Anti-psychotics to the degree they have been robbed of quality of life. This resident needed no care, she just sat hour after hour and whilst she was still breathing there was no life present, these drugs are used instead of care and they kill long before the heart stops beating.
The manager came and asked the staff member to show us around, we went into the main lounge, there were far fewer residents then the previous day, I mentioned this and the staff said a lot of residents had bed rest in the afternoons. There were three staff in the lounge that were sat behind a barrier writing care plan, many residents sat staring at nothing in particular, a male resident had slipped of the armchair onto a

footstool.
We were shown upstairs, we walked along corridors and though all the doors were closed we could hear movement and people calling out behind the doors. We were shown an empty room and taken back downstairs and left a short while later.