Tales of the Un-Inspected
Home Number 72
By Eileen Chubb

This Home is owned by the same company as homes 33,36,41,48,49,50,54,59,60,62,63,64,65,66,67,68,70,71.

I looked at the inspection report dated 17th of April 2007 and noted that the home had been taken over by the above company a few months previously. There were no outstanding requirements from previous inspections. I have listed the most information relevant information from this inspection report below, followed by my comments in bold text. Due to subsequent events in this home I have looked at specific areas of care in particular.

Staff have received refresher training in safeguarding and manual handling which has improved the care provided.
This is an indication that there have been identified problems in these two areas.

All risk assessments were completed comprehensively. It was clear however that a number of people continue to lose weight despite referral to healthcare professionals and the use of food supplements. The quality of the food has improved but it's not clear if the food provided to people with mental frailty is effectively meeting their needs.
To get to the point, firstly risk assessments being filled in correctly is no guarantee of care being delivered in this home.
Secondly the inspector is looking at the quality of food being delivered whilst I would question if food was delivered at all given comments taken from throughout the later sections of the report.

A relative visits every day to feed their parent and monitor their food intake.
The inspectors do not choose to see this as an indication that relatives cannot trust the home to feed people; it is seen as something to commend the home for in encouraging food intake.

We observed people were served food on trays in their bedrooms; however

these were out of reach.
Some people were served their food before staff could assist them to eat and the food was later refused as it was cold. A number of residents were observed eating their food with their hands. Residents were observed to have eaten little but this was not accurately recorded in their food intake charts.
This says a lot about the delivery of food and explains why people continue to lose weight in spite of being recognized to be at risk. Prior knowledge of the risk means the situation is not one of neglect but one of abuse.

Staff spoken to had a clear understanding of what constituted abuse and whistle-blowing procedures.
Entering false information in care plans is not thought to be a problem.

The company carries out regular audits and maintenance and servicing of all equipment is carried out to ensure the home is a safe and a risk free environment.

22 standards are judged of which 12 are fully met and 10 are almost met.

The next inspection report for this home is dated May 2008, one year and one month later.

Three care plans were checked and contained all relevant risk assessments such as falls, nutrition, manual handling.
3 care plans checked from a total of 137, is not enough, also the paperwork and the reality are two very different things in this home.

One member of staff was observed to be attending to a resident when called away to attend to something she gave no explanation to the resident, we spoke to the manager about this and the staff member was suspended.
This tells me there are not enough staff in the home but the inspector hones in on what he considers disrespectable behavior, rather than looking at why the staff member was being asked to do two things at once.

The manager said that the nutritional value and presentation of food had improved. Some staff appropriately assisted residents to eat, in some cases

there was little or no interaction between staff and residents, on one occasion we saw a member of staff feeding a resident called away to do something else and who gave no explanation to the resident.
This is yet another indication there are not enough staff to feed all the residents who need help, the inspector sees this as a lack of respect or dignity but I see it as something much worse, if there are not enough staff to feed residents when inspectors are watching, then it is bound to be much worse the rest of the time.

We saw evidence that regular audits were carried out to check gas and electrical and fire equipment. We noticed an unpleasant odor and the manager said it was due to the dressings of one resident.
It rings alarm bells when a residents dressings smell bad enough to be noteworthy as someone who has smelt the rotting flesh of infected bedsores I would have investigated any such smell. As for auditing the homes audits this amounts to an over reliance on Quality Assurance.
The home is graded 1 Star Adequate.

Nine Months later an 83 year old resident is taken to hospital from this home suffering from alleged hypothermia and she died a few hours later.
The regulator then inspects the home in February 2009, to check the actual heating as opposed to the Quality Assurance.

This inspection is the result of a recent death at the home and subsequent visits by Social Services under safe guarding vulnerable adult's procedures had raised serious concerns about the temperatures of the home and the safety of those living there. We checked the home was monitoring the temperatures and records showed they were. The temperatures on the second floor was lower than the other two floors by around five degrees, we spoke to residents who said they felt chilly. A procedure has been put in place.
It is Social services again that tells the regulator what is going on the care homes they inspect, too late for those who have suffered.
There are no outstanding requirements listed and no new requirements made; the home remains 1 Star Adequate.

Just 12 weeks later it is inspected again and is graded 2 Star Good, the report dated May 2009, and the evidence for this?
The AQAA quality assurance, the following information is also noted,

The home must ensure that important documents that monitor pressure care and fluid intake are complete.
Not my idea of good.

We looked at the records of five residents and found recordings were not made in stances, such as fluid intake of residents at risk of dehydration not made, up to date body maps recording injuries or wounds, turning charts of residents at risk of pressure sores not completed.
Not my idea of good.

The home has four dignity champions.
The residents will have a dignified death whilst dying from thirst and avoidable bed sores.

Residents were observed having lunch and were assisted by staff.
The residents behind closed doors, the most vulnerable, were not checked.
I cannot list much more as anything that begins with, The AQAA or the home said, is not evidence. The home is not inspected again. 11 months later a second resident dies after being admitted to hospital and found to have a broken leg, she died a few days later. The home deny she suffered any injury but a post Mortem and Coroner's inquest found she had suffered trauma to her leg which resulted in bleeding and blood clot, aggravated her existing heart condition and she died from acute heart failure. The injuries occurred a few days before the home sent her to hospital. A broken leg, no painkillers and no one noticed for days in care home? In a Two Star good care home according to the regulator. As yet no one has died of bed sores or hunger that we know of, but all the warning signs are there.