# Beechdale Manor

## BBC Hospital Series 3 Episode 1

Last night I watched the first episode of the BBC series three, Hospital. A programme which was widely covered in the media. One of the main themes of this coverage related to Mavis an elderly lady who was occupying a hospital bed needlessly due to no care home being available. The Media highlighted the story of Mavis finding a care home and leaving the hospital as **"Heart-warming".**

I watched the programme with much concern and many questions unanswered about the **whole** story regarding Mavis.

**What My investigation discovered was more Bone chilling than Heart-warming**

Whilst there is much debate about extra funding for social care. The question that only Compassion in care have persistently asked is, where is that money going? and is it **value** for money to invest in care homes with a history of poor care.

As we stated last year on Channel 4 news, we asked the NHS to provide us via a Freedom of information request with data on, how many people were being admitted to hospital from a care setting?
This information could not be provided. Our evidence however points at repeated hospital admissions from Care homes as a result of lack of care.

I looked at all the press coverage on the story of Mavis and then decided to investigate all the facts behind the story and this is what I discovered.

There were two possible care homes that had Beechdale in their name. However the programme gave me a further clue as the ward nurse makes a reference to

the manager of the home being called Richard. Only Beechdale Manor has a manager called Richard.

I looked on the CQC website and saw the standard notice for a newly registered home stating that it was likely to be meeting all the standards and that had not yet been inspected. There was no links to any past reports or past owners so as a member of the public you would take this information given by the CQC at face value however Compassion in Care never takes anything said by the CQC at face value. We investigated further and this is what we found.

There were hundreds of pages of inspection reports buried in the CQC archive which only the very determined would ever discover.

The earliest available refer to this home been owned by bondcare Bromford Ltd. The report shows ongoing concerns about this homes past at even this stage. Examples of concerns included,

People asked about staffing levels gave mixed responses in respect of the amount of staff available to care for people and we found they may not always be sufficient staff available.

One Resident said they get me up at about 6:30 in the morning and then I have to wait for my breakfast I don't choose when I get up sometimes I could do with lying in bed a bit longer.

People were not always protected from the risk of abuse.

**MY COMMENTS**

**There are minor improvements noted in some areas but this is clearly what we term a yo-yo care home because improvements are not sustained for any acceptable level of time.**

CQC state they have continuing concerns for the care and welfare of some people using the service and had undertaken enforcement action against the registered

provider and were visiting to check to see if improvements have been made. they found that some improvements in respect of care planning care delivery and staffing levels have been made but further improvements were still required.

they visited the service again on the evening of 2nd of August following the receipt of concerning information in relation to the level of care people were receiving and during this visit found that people were not always supported as needed.

Staff are rushed off their feet there are not enough staff to see two people's needs they were told.

The next inspection in May 2012 is in response to people raising concerns about the care in the home.

One Resident spoken to said I'm worried about expressing my concerns I do feel safe but things could be better and I'm scared to talk about things that are wrong as I don't want to get any trouble or get any people in trouble.

Four out of nine relatives spoken to Expressed concerns in respect of the care their relatives received.

Another relative felt they were not listened to.

The atmosphere appeared fraught during the day with people shouting for help from staff.

Some residents were shouting and swearing at each other people were shouting at them to be quiet.

some people needed help to eat but there were no staff available to give assistance.

**MY COMMENTS**

**These reports are all archived by the CQC and the home is registered yet again to the following company care worldwide Nottingham Ltd which is registered at**

**the same address as the previous company and has some of the previous directors in charge**

Inspection report dated July 2014

The following findings are noted

Risks were found in relation to diabetes dehydration and pressure care.

One member of staff was asked about the care plans and said I've only seen one care plan since I've been here you should know what all the care plans are about but we don't.

A nurse said they had only read some of the care plans. Communication needs to improve its very poor.

Staffing levels are not sufficient.

One member of staff on the top floor told inspectors that the top floor of the building is described by staff as the, Forgotten Island, because they sometimes are the last to receive communication from management and also staffs request for assistance was not always dealt with in time.

The provider did not have an effective system in place to identify, assess and manage risks to people's health and safety and welfare in the home.

The next inspection is February 2015 and the home is rated as requiring improvement the following is noted in the body of the report.

People said they felt safe in the service but not all incidents were shared with the local authority for consideration under their safeguarding procedures.

Steps were not always taken to minimise the risk of further incidents and staff did not always record information about people's care and feedback when they should.

Staff had received training on reporting abuse in safeguarding procedures and were able to demonstrate they understood what abuse was. However they did not always report abuse as required and did not follow the processes they've been trained in.

**MY COMMENTS**

**There's been a series of incidents which has to be untangled from the CQC jargon. But it looks like resident on Resident assaults, involving two particular residents and no action was taken to prevent future incidents. It is noted that on the day of the inspection these two particular individuals were in the same room without any supervision from staff. Staff spoken to were unaware of the history between these two particular residents.**

Records of people's care were not always fit for purpose and CQC found care records were not always updated when people's needs changed.

The next inspection report is dated December 2015 and the home is rated, requiring improvement in 4 of 5 standards. The following is noted in the body of the report

Improvements were required in the management of medicines and to ensure people receive their medicines as prescribed.

Staffing levels did not always match the numbers identified as been required by the provider.

People were not always protected by the legislation designed to ensure that their rights were protected.

Not all safeguarding incidents and other notifications were being reported to the relevant authorities.

An incident which should have been reported to the local authority as a safeguarding issue had not been and this was despite the recommendation of an

external Healthcare professional that the incident should be reported.

One person said there are not enough staff carers.

Another said staff are overworked.

Another person said they don't have the capacity to treat people as individuals if you come on a Sunday it is dreadful, it is chaotic and no one knows what is going on.

People could not be assured that all staff have been properly vetted to make safer recruitment decisions. We found one person who has recently been employed at the service only had one character reference obtained when the provider had identified that references should be sought from two former employees.

People were at risk of medicine errors because recommended safe practice were not adhered to.

Some people did not have photographs on their medication sheets. There were not always protocols in place for people who were prescribed medicines to be taken as needed.

Staff were fully trained in the safe Handling of Medication and had their competency assessed regularly.

The manager did not provide visible leadership for relatives within the home. Some people and their relatives did not know who the manager was.

Some staff and relatives felt the manager did not make themselves visible and they did not feel concerns and suggestions were always acted upon or considered.

Inspection report stated August 2016 and the home is now rated at the worst rating inadequate possible. It

fails in all five standards the following is noted in the body of the report.

Potential safeguarding issues were not been reported or not reported accurately putting people at greater risk of abuse.

Identified risks to people were not always managed safely and Accidents and incidents were not well documented to show they've been appropriately responded to.

There is not sufficient staff numbers on duty.

**MY COMMENTS**

**The home is placed in special measures**
**This is a term that gives the public confidence but actually means nothing at all.**

Inspectors state the home will be kept under review and if needed could be escalated to urgent enforcement action.

**MY COMMENTS**

**There is reference to resident on Resident assault again in CQC language. The assault had not been reported which put people at risk**

Two people had developed serious pressure sores and when these had developed they should have been reported which they have not been.

A resident said the following, I got used to it now people coming into my room. One person wondered in at night one was tapping me on the face and really frightened me to death, it happens most days.

Another person said I feel safe but would like locks on the door a couple of people came in by mistake in the evenings I tell them to go and they go

Risks were not always managed so that people were not protected from avoidable harm.

Another person said I don't feel safe as I can't stand at my sink by myself and there's only one small rail by the loo, so I have to lean on the toilet roll holder.

A relative said that safety measures they put in place to keep their family member safe were not working, they said I don't have peace of mind when I leave here with these issues with managers.

Staff members supervising one of the lounges said to the inspector, would you mind keeping an eye if I just pop out quickly and talk to someone? The staff member left the room before the inspector could decline. The staff member returned three minutes later. 6 people were in the lounge with a hot drinks trolley at the time.

The plant room contained dangerous machinery and was unlocked which allowed people to access the machinery and also to leave the home unnoticed by staff putting them at risk.

Checks of the equipment and premises were not always taking place and action was not always taken promptly when issues were identified.

A person said it's bad that the lift is still not working it's been 5 weeks now so no excuse. The paramedics had to put a lady in a chair the other day to get her down.

**MY COMMENTS**

**Why were paramedics there? The hospital admission numbers from this home is something we will follow up.**

The lift had been repaired by the end of the inspection visit.

There were a large number of gaps in the medication administration records which indicates either staff had not administered people's medicines or on occasions they had not signed the sheets.

A person said there had been a massive turnaround of staff since April for some reason.

A person staff are ok but the new ones have to pick it up.

In the last staff survey some of the staff had raised concerns regarding the level of support they received and issues raised included the approachability of the manager, the lack of probationary review supervisions, appraisals and regular staff meetings.

We saw that a person's physical health care had not been properly recognised by staff.

A person said their Relative had got sores on their heels at the moment and staff didn't know they had got them. My relative is a diabetic too.

inspectors found that the person had developed two pressure ulcers they were deep ulcers before they were identified by staff.

Some staff were described as lovely, others as not genuine and very short with people at times.

A person said, I don't really make many choices apart from my clothes.

A person said they get a shower Sharon when staff they get time, the bath is broken at the minute and has been 4 weeks so it's just showers at the minute.

Information in people's care plans was not always consistent for example one person who should have been checked every 30 minutes because they could not use their call Bell, staff said they could not

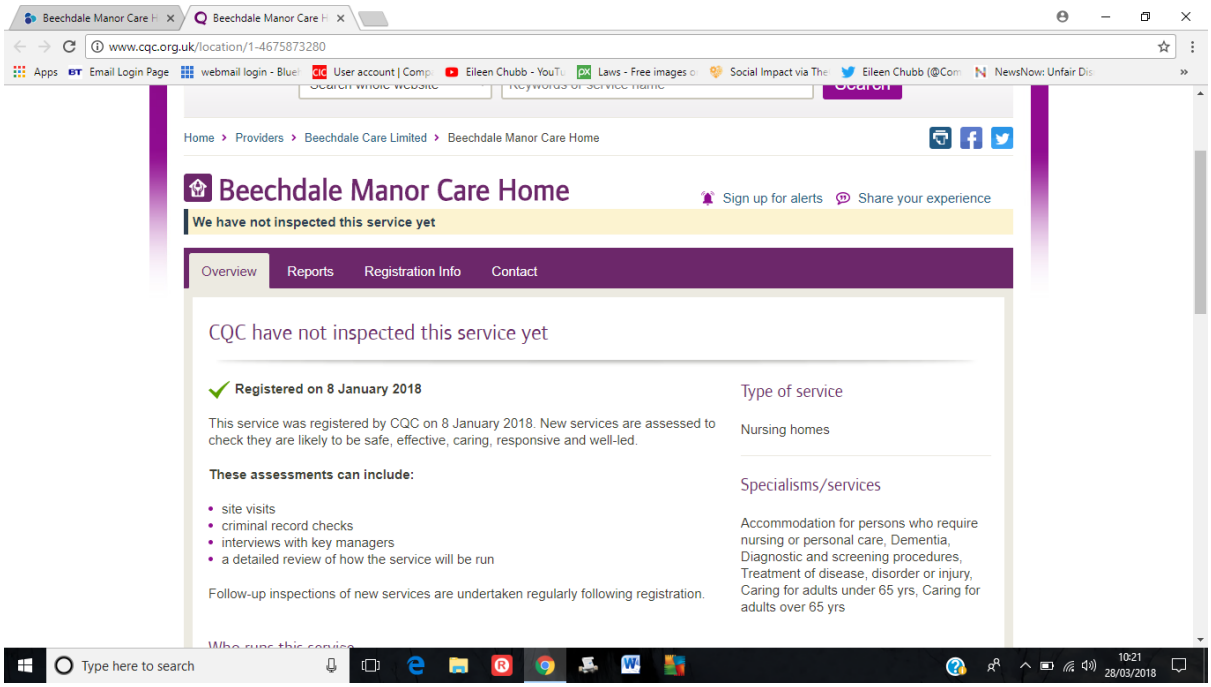
formally observe them but they looked in when they passed the room.

Another staff member said we haven't done half hourly checks for a long time.

**MY COMMENTS**

**These reports go on and on listing consistent concerns and a pattern emerges of a culture that is long established in this home.**

**This home is now listed for the third time as a brand new home with no history and it appears that the third registration is to a new owner. However no information on past reports of any kind is listed on this care homes information page.**
**we discovered that there was**
**335 pages of crucial information buried on the CQC website.**
**The total pages made available to the public? 0**



**Histories and CQC are a bone of contention that has resulted in people needlessly suffering across the country at worst, and at best where the public are denied vital information about a care home.**

**Would you employ somebody or have someone come to live in your home without knowing basic information about their past? of course you would not.**
**So why has CQC continued to use dubious tactics in re-registering homes?**
**Some homes have been registered to new owners with links to a past owners history,**
**Some homes Registered to the same owner in multiply registrations with history's sometimes archived via a link.**
**Some homes like this one with no hint of a past history inferred but a guarantee from CQC that it is likely to be good when it is anything but likely.**

**Meanwhile we continue to wait for a response from Jeremy Hunt.**

**I do hope Mavis gets the care she deserves to have. Each time we see such a story presented to us we simply question everything after all is that not what we should all be doing?**

**I know that billions of pounds of taxpayer's money has and will continue to be poured into the profits of private company's without any guarantee of care in return.**

**Mavis has paid into the system all her life, contributed to this country; she is not a bundle to parked in the next care home regardless of what that home can provide.**
**Anyone who thinks that CQC provide reliable information need to wise up to both the reality and the very real consequences for people like Mavis.**

**Knowing what I know and have exposed about CQC and Jeremy Hunt, I would not trust them to care for goldfish.**

**Eileen Chubb© 28/3.2018**

**Below some of the evidence we have sent to Jeremy Hunt**
**http://www.compassionincare.com/node/229**
**http://www.compassionincare.com/node/337**
**http://www.compassionincare.com/node/353**