Designated Disaster

By Eileen Chubb©

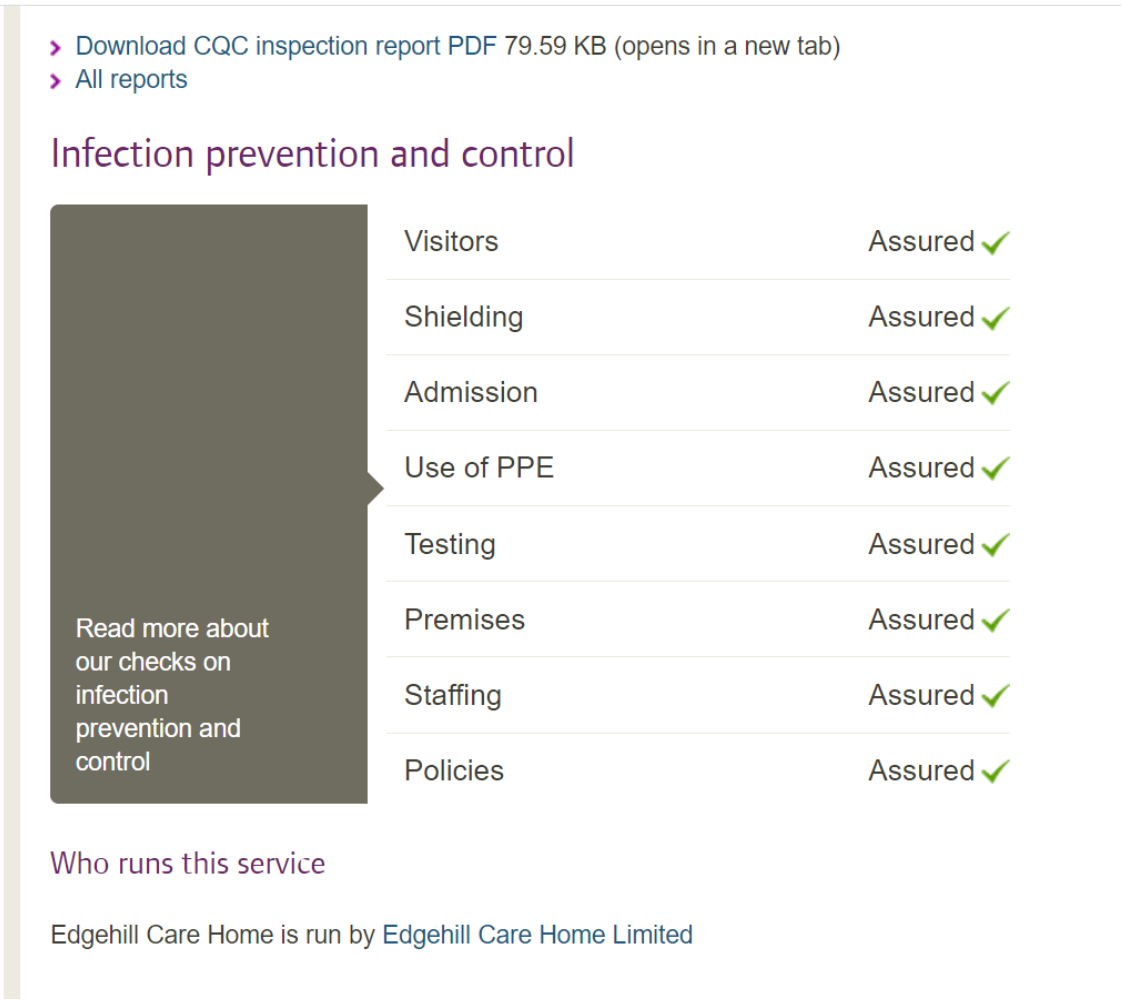
**Please note before reading this report, that as a result of the malicious allegations and political attack on this charity, the Charity Commission has said we should not be criticising regulators such as the CQC. All Trustees are in agreement that this report and the work of this charity should continue to save thousands of lives by exposing the shocking failures of the Government and regulators. If we are the kind of charity that you the public want, then please support our fight against censorship.*

Today I spent 4 hours reading the latest guidance from both the Health Department and CQC on how **some** care homes are to be designated services for admitting NHS discharged patients who are confirmed to have tested positive for COVID-19.

The Health Department has stated that homes rated Excellent or Good are preferred **but** has left it to the discretion of CQC as to registering homes which are not compliant with the regulations.

How Homes are designated

The CQC will inspect a home and carry out a special Covid assessment judging the following areas:



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Infection prevention and control

Read more about our checks on infection prevention and control

Visitors	Assured ✓
Shielding	Assured ✓
Admission	Assured ✓
Use of PPE	Assured ✓
Testing	Assured ✓
Premises	Assured ✓
Staffing	Assured ✓
Policies	Assured ✓

Who runs this service

Edgehill Care Home is run by Edgehill Care Home Limited

However, what I have discovered today is that CQC are **not** just designating excellent or good homes but are choosing the worst of homes as designated homes for discharging hospital patients into - patients who have tested positive for COVID-19.

I cannot find any evidence that families have been informed. Unless people are prepared to spend hours trawling the Health Department and CQC websites, they would have no idea their loved ones were being put at such risk.

Today I did a spot check of **143** care homes that are failing to meet basic standards, which have been listed as Requiring Improvement overall and found the following:

Homes rated Requires Improvement but not yet Covid rated. **81**

Homes rated Requires Improvement and inspected for Covid designation but **failed** standards **9**

Homes rated Requires Improvement and inspected for Covid designation and judged **almost Compliant 22**

Homes rated Requires Improvement and inspected for Covid designation and rated **fully Compliant 31.**

Many of these care homes have serious shortfalls and some have a long history of failures.

For example Osbourne Court rated Covid Compliant in all areas but a long history of serious care failings, some of the **most** recent failings were serious enough to warrant enforcement action yet this **same** home is rated Compliant as a COVID-19 designated home.

CQC standard inspection report extracts June 2020

"People and relatives were not always happy with the care and support they received. People at times did not receive the appropriate personal care. The admission process to the home needed to be addressed so that people had a positive start to their stay. Some staff were friendly, and some were attentive to people's needs. However, at times staff were not responding to people when they asked for help or showed signs, they needed support. People, their relatives and staff told us there were not enough staff to meet people's needs. Staff were trained and felt supported.

People felt safe but staffing issues made them feel more at risk. Staff were aware of how to promote people's safety. Regular checks were not in place to ensure staff worked in accordance with training and in accordance with regulations. Unexplained injuries were not always reported or fully investigated.
Equipment was damaged making it difficult to clean it effectively".

We have identified breaches in relation to person centred care, promoting people's safety, treating people with dignity and respect, consent and governance systems.

For requirement actions of enforcement which we are able to publish at the time of the report being published:

Where we are taking or proposing to take enforcement action but cannot yet publish the actions due to representation and appeals process. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded"

"Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
At the last inspection this key question was rated as Requires Improvement. At this inspection, this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed"

"controlling infection
• Some equipment seen was damaged and dirty. For example, a shower chair was stained, and the covering was torn. This meant that it could not be cleaned effectively. We saw hoists were not clean and some bumpers on bedrails were also torn.

Due to unexplained injuries not being consistently reported and investigated appropriately, infection control shortfalls and gaps with medicines, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People gave mixed views about if there were always enough staff to meet their needs. One person said, "They come quite quickly most of the time if I ring my bell, they have never not come if I have used my bell." Another person said, "I

need two people to help me and sometimes they manage with one, that's why I don't want to get out of bed so much."
- *Relatives agreed there were not always enough staff. One relative said, "The staff here are fabulous, but they are spread so thinly that it affects peoples' care." Another relative said,*

- *"On paper there are enough staff, but weekends are very bad and there is no senior management on the units then. I know there aren't enough staff because I am here every day and I see them looking for help and overhear them saying to people 'we are short of staff' and I often see relatives looking for staff for help with the toilets and there is no one to help."*
- *Staff said there were not enough staff to support people. One staff member said, "People are not able to get up out of bed often enough." Another staff member said, "The result of the reduced staffing levels is that we are constantly rushed providing support for people to have personal care and eat. If we are rushed and stressed constantly we will not have as much patience and tolerance as we need."*
- *On arrival the registered manager told us that the provider had instructed them to reduce staff by one on each unit during the afternoon.*

- *We discussed this with the provider's quality team members, about the decision to reduce staffing on a unit which mainly supports people living with dementia. People living with dementia can become more unsettled during the afternoon and evening. The provider's representative agreed that this would need more of a review.*
- *On the day of inspection, we saw that staff were around but often gathered in groups chatting rather than attending to people. We saw that several family members came at lunchtime. One relative said, "I try to get here at lunchtime to make sure [person] eats and to ease the burden on the staff trying to help people to eat."*

“The building had been designed in a way that allowed people to move around freely. There were communal areas for people to use. However,the home was tired and tatty and in need of painting. Some ceilings, including bedrooms, had significant water staining from a leak. One relative said, "They have constant maintenance issues. They have had two incidents of flooding because the boilers were not properly maintained. The staff say the maintenance man is incompetent."

- *The orientation board in the dining room of the unit supporting people living with dementia was not updated. The day and date was set to two days previous and the time was set to 1pm. This was not helpful in reorienting people during breakfast.*

Bedrooms were personalised in some cases. There were not enough shower rooms available.”

“People told us that they were not always happy with the care they received. One person said, "Today they changed my pad at 7.30am because it was wet through, soaking, my nightdress, the sheet everything. She changed my nightie and the sheet but didn't wash me, didn't have time just wiped my back with a wipe." Another person told us, "They never ask me if I want a shower, sometimes I will ask but they never come and ask me."

- *A relative told us, "They (staff) keep saying they will cut her finger nails, but they don't, they don't have time to do things like that, but they say they will. I brought in the nail clippers." The person's finger nails were long and dirty. We found this to be the case for others too.*
- *We saw that one person who was new to the home had not received personal care as there were no toiletries to use and this had not been identified by care staff or the management team.*

- *Care plans covered all areas of people's needs but were basic. For example, where one person may refuse care and be at risk of self-neglect, the care plan stated, 'Record in daily notes, encouraged to wash, offered showers'. There was no reference to the person's preferences or choices to give staff clear guidance on how to prevent the risks of self-neglect.*
- *Plans did not prompt staff to act when supporting people living with dementia.*

• *One person's behaviours had escalated so staff asked for the mental health team for input. The person was prescribed paracetamol as needed for pain. The mental health team suggested that the person's behaviours indicated they may be experiencing pain so advised paracetamol to be given three or four times a day routinely and then re-assess. The mental health team re-visited nine days later and found the person was back to their old self and their behaviours had diminished."*

Cedar House

CQC inspection report extracts November 2020

"Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. During the inspection, we made the decision to widen the scope of the inspection to become a focused inspection which included the key questions of safe and well-led"

"The overall rating for this service is 'requires improvement'. However, as the service is rated inadequate in the caring key question from the last inspection, we continue to place the service in 'special measures'. We do this when services have been rated as inadequate in any key question over two consecutive comprehensive inspections. The inadequate rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and we will re-inspect within six months to check for significant improvements."

“The provider had not always ensured that the care and treatment provided to people was appropriate, met their assessed needs, or reflected their preferences. This was a repeated breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014”

Cedar Court
Inspection June 2020

“Risk assessments and support plans were in place to help staff to deliver safe care to people. However, staff did not always follow these and we witnessed unsafe practices which put people at risk of avoidable harm. People received their medicines as prescribed. However, staff did not follow the provider's medicines policy in relation to medicines to be given 'as required', and medicines which were given covertly.

People were not always protected from the risk of infection and cross contamination. On the day of our inspection, there was a malodour which persisted throughout the day. Staff did not always follow the provider's health and safety and fire policy and procedures and there were significant safety risks identified during our inspection.

People were not treated in a kind and dignified manner all the time. The staff worked in a task-focussed manner and did not always meet people's needs or consult them in relation to what they wanted to do. Staff were not always aware of their needs. People's communication needs were not always met.

The provider's quality monitoring systems were inadequate as, although they had identified many of the shortfalls we found during our inspection several months ago, we found the service failed to demonstrate they were providing care and support that was safe, caring, effective or responsive. This put people at risk of harm.”

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures.

This will mean we will begin the process of preventing the provider from operating this service"

“Assessing risk, safety monitoring and management;
• Risks to people's safety and wellbeing were assessed and recorded, and there were guidelines for staff. However, on the day of our inspection, we witnessed staff did not always follow these and support people safely, putting them at risk of avoidable harm.
• We saw staff supporting a person to transfer from their armchair to a wheelchair. They did not put the wheelchair's brakes on and did not support the person to position themselves safely before being transferred. This meant the person felt unsafe and was showing signs of distress. Although staff were reassuring them, they only noticed the brakes were not on when the person was half sitting on the chair.
• One person was attempting to stand up from their wheelchair. The foot plates of the wheelchair were down, and the person nearly tripped over these as they stood up. One of the person's slipper got caught on the foot plates and came off. The staff member looked at the slipper and kicked it under the table. The person walked around with one slipper on for at least the next 20 minutes.
• One person was at risk of rolling out of bed and sustaining injuries. The risk assessment included measures in place to reduce the risk and these were in place. For example, a sensor mat was on the floor so staff would be alerted should the person get up unaided. However, we noticed that the person's feet were out of the bed and touching the mat, and this had not triggered the alarm. We raised this with staff who confirmed this did not seem to be working. We discussed this with the registered manager who checked and found the mat was not plugged in properly. This meant the person could have fallen out of bed and staff would not have been alerted.
• During the morning, the fire alarm went off and a fault was found on the fire panel, which prevented

the system from being reset. This meant the codes to the doors were no longer working and there was a risk people may go out unsupervised. Whilst the registered manager took prompt action to ensure staff were positioned near the doors leading to outside, they had not secured the internal doors leading to the stairs. There were no signs to deter people from accessing the area, and we found a vacuum cleaner lead running the full length of the stairs. This posed a trip hazard to people and others using the stairs.

- *We found a tub of thickener on top of a cupboard which had not been locked away after lunch. Thickeners are used to make all liquids, including beverages and soups, a thicker consistency that is less likely to cause people to choke. However, if misused can be dangerous and therefore should be secured where it could not be accessed"*

- *"People were not always protected from the risk of infection and cross contamination. At our last inspection, we made a recommendation in relation to infection control because people who required the use of hoists to mobilise did not have their own allocated slings and there was a risk of cross contamination. We also found there was a strong malodour in areas of the home. At this inspection, we saw people had been provided with their own slings, the provider had a cleaning programme in place which included the cleaning of equipment and undertook regular infection control audits. Actions from the audits were reflected in the provider's improvement plan. However, there was still a strong malodour in areas of the home which we found throughout the day.*
- *In some of the lounges, there was a smell of faeces. Staff did not seem to notice this. We did not see people being consulted or supported with personal care during our observations and when people were being assisted from the lounge to the dining room.*

- *Some of the furniture was unclean and marked. In one of the bedrooms, the person's armchair was greasy. A bathroom on the first floor did not store any personal protective equipment (PPE) for staff to use. The drawer labelled for PPE contained someone's medicated cream. The commode shower chair contained a liquid, and this was not emptied all day.*
- *Before, and throughout lunch service, staff kept coming in and out of the room. To start with they needed to keep opening the door because it kept shutting (due to the problem with the fire alarm system). There was no hand sanitiser in the room, so whenever they came in and out they were not following best hand hygiene practice.*
- *None of the people using the service were given the opportunity to wash their hands and there were no wipes offered. There were no obvious tissues in the room and at one point a person wiped their face and nose on the table cloth. None of the staff did anything about this. One person dropped their serviette on the floor. The staff picked this up and gave it back to them. They were not offered a new one. One person dropped their cutlery on the floor. No one picked this up for the duration of the meal.*

The provider had failed to protect people from the risk of infection and cross contamination. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014."

"at the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported

- *People were not always treated with kindness and compassion by staff when they supported them, as their approach was task focussed. The majority of staff did not show affection for people who used the service or indicate they liked them or could see from their perspective.*
- *One staff member told us they liked working at the service and thought people were interesting. However, they added, "Care is not as bad as you think it will be. You have to change people and I thought I would really hate that but it is ok." They showed no concept of how it might feel for the person being changed.*
- *We observed care and support on both floors during the morning. In one of the lounges, the television was on. People were showing no interest in the program, but the staff were watching this. Shortly after this the fire alarm went off and all the doors closed. One person woke up and said, ''Not again this happened yesterday.'' Staff went to the assembly point. Nobody offered reassurance or explained why the fire alarm went off.*
- *A member of staff came in with the tea trolley, sighing loudly. They put some biscuits on a plate using their hand, and poured a drink for a person saying, ''Here you go [Person], a cup of tea.'' The person then said, ''I wish I could find my cardigan'', but the staff member did not respond.*
- *As people were bought to the dining room for lunch, most staff were polite and asked them if they would like to sit down. However, we heard one staff member tell a person to, ''Come and sit your bum over here.'' Later they called across the room to other staff, and repeated twice, ''[Person] has conked out in [their] chair.'' The same staff member called out to a person to ask how their 'itch' was.*
- *One person was attempting to walk around but was constantly told to sit down. One staff member said, ''Where do you want to go? Do you want to sit down.'' The staff member then took*

them by the arm and lowered them into any armchair. The staff member then sat down next to the person and watched the television.

- *The person got up on numerous occasions and was either told to sit down again, or the staff member blocked their way. We heard the staff member say, ''Come on'' and pointing to the chair, ''Sit down, here and down.'' They then lowered the person by the arm and placed them in the chair, saying, "Here is a drink."*
- *We saw a member of staff move a person's wheelchair from behind without warning or explanation to the person."*

Summery

I could list similar failings from dozens of recent CQC inspections of all these homes, homes with a long history of poor care or failing to maintain compliance consistently. Incredibly I looked at **8** of the worst rated homes of all, those rated inadequate and found even **2** of those were judged as meeting all the criteria to become a designated home.

Elderly patients with Covid 19 are being discharged into these failing care homes, homes that struggle to provide safe care, but as this charity alone exposed recently, elderly people are being discharged without any choice of home being offered. The duty of care to ensure vulnerable people are going from hospital to a safe environment has been completely disregarded.

The homes we have highlighted to today struggle to provide basic care to their existing residents. Thousands of elderly people will die as a result of these policies and just when we think the complacency, stupidity and dishonesty can get no worse, we discover this. We will continue to report on these issues because the lives of the most people are being put at risk. We know that placing people with Covid into good care homes is high risk,but

placing people into **bad care homes,** that is another level altogether.

Eileen Chubb

25/11/20