Tales of the Un-Inspected

Home 74

By Eileen Chubb

This care home is on the list of homes said to have been closed by the regulator CQC.

This homes past inspection history and record of providing poor care has been wiped from the official record so is no longer available from the CQC website but I managed to obtain these reports via another means.

I looked at these reports and found the following areas to be the most concern, and I decided what I would look for when I visited the home.

1. The homes most recent inspection report is dated March 2010 and states the home has changed ownership.

What I found

This is totally untrue the home is owned by two sisters and has been for over twenty years they have just registered the name of a new company as owning the home but they are the directors. The CQC inspection report goes to great lengths to state this is a new company even though the two sisters are noted to be present in the home.

2. A condition of this homes registration is that they should not admit any new residents; this is very unusual so I put it to the test.

What I found

I visited the home looking for a place for my fictional relative and was offered a place.

3. The now secret inspection reports noted these owners were admitting residents to the home without assessing their needs.

What I found

Whilst visiting the home another potential customer was also looking for a place for their relative and was also offered a place. This home is firstly in breech of its condition of registration and secondly up to its old bad habits.

4. There were numerous concerns in the past about how this home cared for people's nutritional needs, the basics of life. Residents were noted to be seriously underweight and their food intake not monitored.

What I found

Immediately on entering the home I saw a resident was seated in the dining room slumped sideways in a chair with a biscuit and un-drunk cup of what appeared to be tea in front of her. This lady was seriously underweight to the degree her bones were clearly visible as she had so little flesh covering her entire body. Though I spent over an hour in the home at no time was this lady encouraged or prompted to eat what had been placed in front of her. She was wearing a bib to protect her clothes which indicated she had been sat at this table since breakfast. She had no pressure cushion and would be at risk of developing a pressure sore due to her weight. She was woken and taken into the lounge after an hour and left to sleep in a chair. At lunchtime all the residents were taken by staff to the dining room except this resident who staff said could eat later. So a seriously malnourished resident was left without food or drink for another meal.

5. This home has a past history of providing poor food.

What I found

I was shown three weeks of menus, I noted liver and onions with seasonable vegetables was due to be served this day. I told the manager my fictional relative was a very poor eater and was told they had cared for people with poor appetites in the past and it would not be a problem. I said my relative preferred traditional food and was not keen on any foreign or processed food and was told they did not provide anything like that. However I noted from the menu that the food listed was very cheap, with a heavy reliance on jam Sandwiches, beans, and fish fingers, Pizzas, sausage rolls and pork pies. I noted that bacon and egg was not offered at breakfast but was listed as a main meal. The owner said lunch was served at twelve thirty and that many people were seated in the dining room but the tables were not set and there was no sign of lunch. I looked through the glass into the kitchen and saw empty pots and pans but a dirty looking deep fat fryer was cooking something on the stove, which would not have been the promised liver and bacon casserole. I felt the staff were reluctant to let me see the food being served.

6. The home cared for both elderly people and adults over 50 with mental health issues. These two groups have very different needs and it is my experience that mixing these groups can involve a risk. For example a younger person faced by a frail elderly person with dementia may find the older persons behaviour distressing and lash out causing serious injury. I noted concerns had been raised by a staff member who felt these two groups should be separated. I would look at this on my visit.

What I found

Whilst these two groups were seated in separate lounges there was nothing to stop residents moving from one to the other, the bedrooms upstairs also made no distinction between older and younger people. I commented that one resident looked young to be in the home and the owner said the home also cared for younger adults, at no time was I informed that the younger adults could have conditions such as schizophrenia or other mental health illness.

7. The recent inspection report noted the home had a manager.

What I found

It was clear this manager was a member of the care staff; the sisters were the managers in this home and always had been. It was also a concern that most of the staff team were the family members of the owners.

8. Residents at risk of falls did not have risk assessments.

What I found

Even if all the paperwork was in order, residents who were clearly unsteady and who were attempting to move across a narrow hallway in clear sight of the owners, who briefly glanced at them but made no attempt to monitor their progress or assist them in any way. The hallway being narrow and over crowed with other residents, a visitor with a pram, two black rubbish bags, the owners myself and two other visitors, one of whom had a large dog and her elderly relative.

9. General. What I found four residents were in the lounge known as the ladies room, one lady seemed quite independent and was talking to a carer who was looking after a visitors small baby. Two residents slept throughout what was quite a noisy period and the fourth lady watched was awake but unresponsive to her surroundings and appeared to be sedated.

Many residents looked unkempt and had dirty looking hair in particular one resident whose hair was so matted and dirty it hung in large clumps.

I saw no evidence that residents could access any drinks and saw known offered. I was shown three empty rooms and around five occupied rooms and noted the occupant's permission was not asked. One of these rooms belonged to a male resident and there was a smell of tobacco. There was dirty underwear left on the windowsill, bedside cabinet and several other places.

Before leaving I noted that lunch was still not served, the owners were very keen to talk about the problems they have had with the local authorities social services, which included the information that social services wanted to closed the home and even turned up with ambulances to move people out and that they banded together with a home down the road which they were also trying to close and fought to stay open. This was followed by the information they were treated fairly by CQC who helped them stay open in spite of Social Services.

This home is claimed by CQC to have been closed by enforcement but in fact it was protected and allowed to stay open, its past history wiped and the public denied crucial information they would need to make an informed choice. Would anyone put their relative in a home where there were concerns about poor care going back years, where it was so bad Social services raided the home and tried to remove people? The answer is no. Please see this week's BBC Radio 4, file on four, which has covered this charities work in exposing abuse where it matters, on the front line.

Eileen Chubb