SHOCKING HISTORY OF FAILINGS AT CARE HOME
WHAT THE PUBLIC ARE NOT TOLD BY CQC

BY EILEEN CHUBB © 2/10/2019

BACKGROUND

Despite all CQCs ongoing attempts to discredit the charity, compassion in care, we continue to expose the shocking truth about this regulator.
Readers may recall our previous work on just one of the dishonest practices of the CQC, namely the re-registering of bad homes under alleged new owners; a practice CQC publicly announced it would be discontinuing months ago and only after the exclusive work of this charity exposed their dishonesty by publishing special evidence-based reports, please see,

CQC an On-Going Concern

CQC A Likely Story

CQC Motto Lie Lie and Lie Again

CQC the Ideal Conceal

Same Old CQC

Please note the above are just a small selection of the work we have published on this subject; we have also made every effort to get the Department of Health and Government to act, alas they have chosen to ignore our concerns completely. Please see our website news section for the countless letters raising this concern.

The dishonest practice has continued unchecked and we continue to expose the individual people affected including the below, a care home where a women was screaming in pain from an infected wound in her foot,

which was found to be maggot infested and had to be amputated, sadly the lady died. It turns out the home had a past history of poor wound care but that history was achieved under an old owner "**Morris Care**" and registered to a new owner " **Morris Care**"

We publish in the public interest

Safeguarding shambles

Please Note the above contains shocking images of care home wounds caused by neglect and indifference.

Today I spent two minutes on the CQC web-site and discovered when I checked the latest list of the homes recently rated inadequate. The first home on that list was also a re-registration home and that it had had a long and appalling history of poor care when it was owned by **Delrose McManus,** and previously called Oakdean Care home.

It is now called Bidston Lodge and is owned by **Delrose McManus,** The company owned by Delrose McManus is Hilbre Care Ltd and it has 3 homes,
Hilbre House Rated requires improvement
Hilbre Manor Rated Requires Improvement
And Bidston Lodge (Formally Oakdean) rated Inadequate.

I have looked at the inspection history of Bidston Lodge and found it has never been compliant with care standards and the years of poor inspection history have been buried in the archive by CQC as belonging to an old owner and not relevant to the current owner.

There is only one inspection taken place under this alleged new owner and the home is rated Inadequate, alas CQC have failed to provide a link to even this one and only available report.

The scant summary of the latest failings that CQC allow us to see, include,

Not well led
Not safe.
Warning notice issued
People in the home thought the new owner was an improvement* so even the people living in this home are being misled.

The last report before this home was re-registered under an alleged new owner that CQC considered a fit and proper person, included the following findings and an inadequate rating, in effect the owner of a home in special measures is re- registered as a fit and proper owner?

"At our inspection in January 2018 the overall rating for the home was, 'Inadequate'. Since then the service
has been in 'special measures'. This inspection was to see if significant improvements had been made.
At our last comprehensive inspection in August 2018 there was breaches of Regulation 9, 10, 11, 12, 13, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
In November 2018 we completed a focused inspection due to specific information of concern in relation to a lack of heating and hot water at the home. During that inspection the provider took steps to restore these essential services at the home.
At this inspection we saw that the provider had addressed many of the significant shortfalls previously identified. However, there are still some areas of concern and the provider was still in breach of Regulations 11, 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, the service continues to be rated 'Inadequate' and remains in 'special measures'."

"The provider had not taken steps to assure themselves that the service was consistently safe. For example,

the manager had not assured themselves over a period of five or six days, that an adequate fire detection system was in place on the first floor of the home. Also, the manager had appointed a new member of care staff with very little information with regard to the staff member's suitability for the role and therefore placed people's safety at risk."

The earlier archived reports list a similar litany of horrific failings by the owner Delrose McManus and include,

.2018 Inadequate

"The provider had taken some steps to ensure that people were warm in the home. However, they had not done this safely and ensured that additional risks had been mitigated. For example, Individual risk assessments had not been completed to identify and minimise the risks of using portable electric element heaters. For example, increased risks of people falling or burning themselves"

"There were other areas of concern in the environment. For example, the upper stair lift had a broken cover at the top of the track, this exposed electric wires that were unsafe and a tip hazard. A wall light in the corridor close to the manager's office had a broken glass lightshade which exposed sharp glass edges, the wall light was not very high and could be easily reached. Also, the wall light was pointing down and had two missing bulbs which meant that somebody touching the light may receive a shock from electric contacts. We were told by the registered manager that the light was not connected and therefore was not live. This was not true; the light fitting was live. There was a trip hazard from the carpet in the hallway, we asked the relief manager to secure this temporarily."

August 2018 Inadequate

"At this inspection there was breaches of Regulation 9, 10, 11, 12, 13, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
The provider had not addressed many of the significant shortfalls identified at the last inspection and in some areas people's care had deteriorated. The systems the registered manager had in place had not ensured that the service was safe and was providing effective care for people.
Some improvements had been made to the environment of the home and the safety of the administration of medication. However, parts of the environment were still not safe for people. We asked to see a copy of the risk assessment for the home's refurbishment works and we were not shown one. Systems at the home did not always reduce the risks to people's health and wellbeing.
The procedures at the home to protect people from abuse or avoidable harm were not robust. For example; the registered manager could not be assured that new staff had been safely recruited. People had not received effective support to manage their healthcare needs and; appropriate steps had not been taken to ensure that people's legal rights were protected."

January 2018

"At the last inspection we found the fire safety checks did not include checking the fire escapes. At this inspection we found no record of the fire escape being checked. In addition to this we saw that two rooms on the first floor had doors that opened onto the fire escape were not alarmed. Therefore staff would not be alerted if people wandered onto the fire escape. At the last inspection we saw that two people's bedroom doors, which were not self-closing, were being wedged open. At this inspection we identified that, although

a self-closing device had been fitted to one person's room; two other people's rooms were being propped open. Both people told us these doors were propped open at night and one person commented, "The night staff come when I need them. I don't have a buzzer so I shout them, my door is propped open with a little cupboard so they can hear me". This placed the person at significant risk of harm if there was a fire in the home."

"The management of medicines was not safe. We observed a member of staff dispensed each person's lunchtime medicines into pots and signed the relevant medication administration records (MAR) before administering the medicines to people. Potting up of medicines is not considered to be safe practice as it increases the chance of errors occurring. Signing the MAR to indicate that medicines had been administered to people before they had received them meant the MAR were not accurate, particularly if the person then refuses the medicine."

"We identified that substances hazardous to health were not always stored securely. For example we saw a selection of toiletries stored in the ground floor bathroom. The laundry area, which was not locked, contained a range of cleaning and laundry products. We saw the hot water pipes in the ground floor bathroom were not guarded. We saw there were two steps down into the laundry area, the door to which was left unlocked or secured only with a bolt. We also saw that when people used the chair lift they left the seat down and the foot plates in place. This restricted the width of the stair case which could pose a risk to anyone walking up or down the stairs. We saw no evidence that the risks these issues posed to people had been assessed or that appropriate action taken to reduce them."

Sept 2016

"However as part of the fire safety checks fire escapes were not being checked. We checked the two upstairs fire doors; one of them after opening was not able to close. The door and fixings were in poor repair. A temporary repair was done on the day to make the door safe. One of the owners told us that the faulty fire door was awaiting replacement and the metal fire escape had been booked in for repair. They showed us evidence of this. This had been highlighted to the registered manager during a fire brigade safety visit in June. The home's safety checks had not highlighted these areas of concern.

The lounge door was on a fire safe release, however this door jammed on the carpet when released. We noticed that two people's bedroom fire doors were wedged open, one with a piece of furniture. They were not self-closing. One of these people used oxygen and had an oxygen cylinder in their room. We also saw that there were not appropriate warning signs alerting people to the use and storage of oxygen at appropriate places in the building.
On the person's care file there was no risk assessment for the use of oxygen or safety guidance for staff.
There was no record of staff receiving training in the safe use of oxygen."

Aril 2014, this is the only report where the home is almost compliant failing on records only.

There are many more failings than I have time to list here but this is a typical repeat offender being repeatedly protected by CQC and this is just one of the three failing homes.