Tales of the Un-Inspected.
Home Number 100,
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, 72, 82, 84, 87, 88, 89, 90, 91, 92, 93, 94, 96, 97. (Please see archive section for all reports in Tales of the Un-Inspected)

In December 2010 and 83 year old resident choked to death in this home. A coroner's inquest found she was known to be at risk of choking but care documentation and risk assessments were inaccurate.
I wanted to know firstly if this tragedy could have been foreseen and therefore prevented and secondly what lessons have been learnt by the company as a result of what happened to ensure it never happens again, this is what I discovered.

<u>Inspection Report March 2007.</u>

Care records were not always including sufficient detail on how needs were met.
There was also evidence that the home was not addressing problems as they became aware of them such as repeated problems with the heating. But overall the home is graded good.

<u>Inspection Report October 2008.</u>

Now the home is downgraded to adequate and the following is noted, The company that owns the home said the heating was fixed but was not working on the day of the inspection.
Risk assessments for health needs were not being completed (Which would include areas such as risk of choking) Communication between care staff and catering staff needs to improve. So the inspector clearly knew there were serious problems.
There are a high number of complaints about the home and two safeguarding investigations, one ongoing and one not upheld.
The inspector notes some residents were sitting in a difficult position when trying to eat, if action had been taken at this point by the

regulator it could have stopped the tragedy that was to occur two years later.

Inspection Report October 2009

Again care plans and risk assessments were found to have shortfalls in recording information.
The manager said the communication between kitchen and care staff was improved and that is accepted.
The home is now graded good.

I now will look at what action was taken by the regulator and the care home company as a result of this residents death, it is bad enough to see all the risks and do nothing to prevent a tragedy but to do nothing after someone has died in beyond comprehension.

Inspection Report March 2011.

This inspection is carried out because the regulator is now reacting to the fact that a resident has choked to death.

Care records and risk assessments are still not completed correctly. Records were seen to be filled in retrospectively on the day of the inspection, forged in other words.

There was no whistle-blowing procedure available and staff were not aware of procedures, incredible for a company so highly praised by the charity, Action on elder abuse for its commitment to encouraging staff to whistle-blow.
Many residents were subjected to being restrained in permanently reclined chairs they could not get out of and no consent was obtained to allow them to be sentenced to this form of imprisonment.
The catering staff's records are now checked and found it is now found these staff have no experience or training in providing food to people with needs such as being at risk of choking. Yet these records were checked for years and found to be in order in spite of the regulator being aware of problems with kitchen staff.
In spite of the homes assurances for years that staffing levels are set according to the needs of residents, it is now suddenly found this is not true and in particular staffing levels at meal times are not adequate.

Now it's found that past complaints were not thoroughly investigated after all and one in particular indicates the issue was about risk of choking.

The regulator says they have major concerns about the home and tells the home to improve.

<u>Inspection Report May 2011</u>

Just 8 weeks later the home is inspected again and the following is noted,

Care plans were again not fully documenting care needs.
Residents were being fed in recliner chairs which had not been put in an upright position and placed residents at risk of choking.
There was still not enough staff to meet resident's needs.
A cleaner was found to be feeding people at lunchtime but had no training to carry out this task and was not aware of the residents care plan so did not know what kind of food they needed or if they were at risk of choking.

All of the above is not considered to be a major concern and is judged minor to moderate. The report states that the company has produced an action plan and that the improvements needed are being progressed. In short the home is considered to have improved and residents are judged to be no longer at risk of choking. If you ignore the fact vulnerable people are being fed lying down by an untrained cleaner due to not enough care staff being available is beyond my comprehension but confirms my opinion of both the regulator (CQC) and this care home company.
Eileen Chubb