WHAT WAS KNOWN ABOUT THIS HOME?

Home 125.

This home was previously a council home and people were very happy with the care for many years. Then it was taken over by a new company.

A relative contacted me in late 2011, his mother had been a resident at this home a number of years and had been well looked after and happy until recently when everything had changed.
He often found his mother (Mrs. P) unkempt, distressed, and could find no staff. He saw other distressed residents left unattended by staff for long periods.
Mrs. P became unwell with a urine infection she was not treated properly. She had a bad fall and broke her hip, she died during the operation.
The family raised detailed concerns that care was not being provided because staffing levels had been cut resulting in people being left unattended and falling. That medical care was not given in relation to UTIs, that good staff were demoralized by the situation and the home was dirty. It was clear that if such a situation continued unchecked it would place other vulnerable people at risk.
I wrote numerous letters to Dame Jo Williams CQC, and to the Chief Executive of the company on behalf of the family. None of the families concerns or mine were ever addressed.

At this point the homes last inspection had taken place four years previously in October 2007,
A self-assessment took place a year later.
In 2009 CQC decided not to inspect again but to ask the home for a self-assessment.

The first actual inspection takes place in, AUGUST 2011 and this report notes on pages,

Page 3.
The inspection is taking place in reaction to the CQC being told there are concerns.

In all 7 areas of concern were looked at and all but one judged compliant. This inspection would seem to have taken place in response to the concerns about Mrs. P.

Page 12.
Incidents are not all reported but the home is judged fully compliant.

Page 15.
CQC judge there are enough staff to meet needs.

<u>WHAT HAS HAPPENED SINCE?</u>

The lost opportunity to act on the identical concerns raised 2 years earlier when serious issues were not investigated or addressed, though these issues were reported in detail at the very highest level of the CQC meant the home was not held to account and as a direct consequence of this failure to act other people have suffered harm.

CQC INSPECTION NOVEMBER 2012.
I year 3 months later.

Page 4.
Most relatives tell inspectors there are not enough staff.

Page 6.
Meal times have been changed as there has been a high number of falls, CQC look at this information in terms of choice and ask if people have been consulted about it. I would have looked at staffing and times of falls. I would have checked how many people had fallen.

Page 7.
The only activity is a TV playing the same film over and over.
There is a strong smell on the ground floor. This is said to be an overpowering smell of urine. The CQC conclude this smell does not promote dignity. I fail to see what dignity has to do with it as a smell such as this is an indication of persistent neglect.

Page 9.
Some staff said they knew what to do about abuse.
Some staff said they knew where the whistle-blowing policy was kept.
The contacts details for CQC were not available and the adult protection guidance and contact details had not been updated since 2005.
This area is judged compliant.
I would question that judgment in light of the evidence.

Page 10.
The home is said to be dirty.
Three toilets are checked on the ground floor two of which had faeces in the bowels all day. There was urine on the floor of another toilet.
Dirty equipment is found.
A soiled incontinence pad was on the ground outside a fire exit.
The chairs in a lounge are dirty and stained.
Something had been spilled in one corridor and walked through the home.
This area is judged non-compliant

Page 13.
It was difficult to monitor where people were. But the consequences of this are not considered as this could result in unobserved or preventable falls.
Staff Tell the CQC that there are not enough staff to monitor people.
Inspectors now see people left for long periods unattended.

In total 8 standards are checked and action is needed in 4. However whilst I could see clear indications that people were at risk of suffering falls in the same circumstances that had proven fatal in the case of Mrs. P, the CQC did not look at falls at all, even though they were told people were at risk.

CQC INSPECTION JUNE 2013.
Seven months later.
6 standards checked and now the home is only compliant in one.

Page 4.
CQC are reacting to concerns raised after foreseeable harm has taken place.

Now the CQC say people are not protected from excessive and unlawful restraint.
The home is still not clean
They finally concede there are not enough staff to care for people.

Page 6.
The only area compliant relates to choice so people must have made a choice to be abused.
The CQC think the carpets being replaced will stop the neglect.
The relatives and residents meetings have been used as scam to make a home look better than it is.

Page 8 and 9.
People have suffered malnutrition and these pages list all the evidence on this area.

Page 10 and 11
31 episodes of verbal or physical violence are referred to and the fact that not all these incidents were reported is also mentioned.
A staff member tells the CQC they saw another member of staff wrap their arms around a resident and they both fell to the floor.

Page 12.
The home is still dirty.
A large amount of feces are found in a bath plug hole and dried around the rim of the toilet.
The ground floor still smells of urine.

Page 14.
Medication is a total shambles
It is noted that controlled drugs cannot be audited. 8 vials of morphine are unaccounted for.
There are no records of what controlled drugs came into the home so they cannot be audited.

Page 16.
Says there are not enough staff to care for resident's needs. One staff member was seen to be alone when an incident occurred.

Page 17,
Three staff raise concerns with the CQC.
Clear evidence the home is always short of staff.

CQC INSPECTION DECEMBER 2013.
Now the home is in meltdown. The Health and Safety Executive contact the CQC about a high number of falls. If the CQC had investigated the concerns about Mrs. P when they were informed, other people could have been protected. However a large number of people have suffered serious injuries after falling in similar circumstances.

These are listed on page 27 as,

Fractured leg 30/6/13
Fractured leg 22/7/13
Fractured ribs 08/8/13
Fractured leg 08/9/13
Fractured leg 19/9/13
Fractured hip 25/10/13
Fractured arm 25/10/13
Fractured wrist 22/10/12
Fractured wrist 04/06/12
Fractured hip 16/04/12

CQC say they were only informed of one of the above incidents. But only now decide to investigate the documents that were always available to them had they decided to monitor events in light of the case of Mrs. P. It emerges further injuries also took place in the same time period,
Injury 26/7/13
Injury 02/9/13
Injury 29/8/13
Injury 05/11/13
Injury 04/08/13

CQC say the home must inform them in future of such incidents.
The Health and Safety Executive inform the CQC of another incident since their inspection so they still have failed to prevent further harm.
Broken wrist 28/10/13
The home did not inform the CQC.
The CQC discover from a member of staff that a staff member has been suspended because of an allegation of abuse. CQC were not notified of this either.
A further abuse incident is listed on 5/11/13 but is also not reported to the CQC.
Throughout this report there is evidence that people have suffered the consequences of the low staffing levels, which were first raised two years earlier.

Page 4-5
Fire rescue raise serious concerns that information on people's needs in the event of evacuation were not recorded.
Relatives have serious concerns.
CQC now speak to 16 members of staff.

There were many good caring staff working at this home but I was made aware that a number of these good staff had left disheartened over the past two years. A small number of good staff remain.

Page 28
Confirms this and refers to the fact a large number of agency staff have been used.

Page 5.
Staff lacked the attributes and in some cases, the compassion and empathy to care for people.
There are major concerns, safeguarding and the police are involved.

Page 8-9
Before inspectors even entered the building a distressed resident was observed by the entrance.
A member of staff was heard being hostile.
There were two entries written by staff that inspectors judge to be disrespectful but which I consider to be attempts by staff to record their concerns about the neglect they are witnessing, these are clearly cries for help but are not heard by the CQC, The first entry states,

"Went into xx room to give care and found him in fetal position, with his feet under the bed. He looked like he had been made comfortable with a pillow under his head and a sheet over him whilst his duvet was covered in feces on the bed. The sheet and his clothes were soaked in urine,,
The second entry said,
" Xx was covered in feces this morning which was dried on,,

The CQC say the above are characteristic of how staff systematically failed to show respect.

Page 10, 11, 12
Relates to 30 incidents of people found on the floor or fallen (further to those who had broken bones listed above)
People who were known to be at risk of falling were not referred to the GP.
Medical intervention was not obtained for people who had suffered head injuries.
The home smelt of urine
A number of people had suffered significant weight loss and/or Dehydration
A person with a pressure sore had no care plan and was not cared for.

Pages 13-14
Drinks were out of reach.
A member of staff approached the inspectors and told them they found a resident that morning with their lips and mouth stuck together as they were so thirsty.
Another person is found severely dehydrated, who had no food or drink in the previous 14 hours.
Another person is sent to hospital suffering from severe dehydration during the inspection.

Pages 17-18-19
Some people were being locked in their rooms at night.
Further injuries were noted in peoples care plans
A resident was found to have sustained bruising to lip, arms, elbows and wrists, the records said this resident had punched a staff member.

Another person was found with swollen right hand. These incidents were not reported.

Pages 19-20
Mattresses were found heavily stained in urine and feces. The foam on some was soaked through.
Cleaning charts were filled in before the cleaner arrived.

A care worker tells the inspectors the smell in this place is so bad she has a cough.
The home needed urgent rewiring as there were many faulty sockets but this had not been done.

These are not all the concerns listed but just some examples. The CQC say the home should be closed and no doubt if that happens the CQC will issue a press release stating they took swift targeted action once aware of concerns. However the reality is they ignored detailed extensive concerns when they were fully informed of concerns that something was very wrong two years earlier. They failed to pick up on issues during previous inspections and only do so now because they are told things are wrong.