Tales of The Un-Inspected
Home Number 38
By Eileen Chubb

To The Prime Minister.

I Have looked at the inspection history for…….Home Number 38, This is my report on what I found.

Inspection Report Dated 30th of May 2008.

The report states that the inspectors had attended two meetings under safeguarding procedures, as a member of staff at the home had reported allegations of abuse by another member of staff.

My Comments, These allegations were made to the authorities but it is very likely the concerns would have been made within the home first. As a result of these allegations a safeguarding team meeting was held and it was decided by this team that an investigation should be carried out by the home! This was in November 2007.
In April 2008, six months later another Safeguarding meeting is held to discuss the homes investigation. It was then concluded there had be borderline abuse and action had been taken and the staff member was no longer working at the home.
Where this abuser is now is not mentioned, they was no formal action taken to prevent her working elsewhere. There is no mention of how the staff member, who blew the whistle, was protected. Abuse allegations are made and it is six months before the authorities check if the home has taken action. If this is safeguarding than it is a joke.

Page 8 of the Report States,
Residents were not being assessed prior to admission, We Expect the home to do this rather than make a requirement.

My Comments, if you do not know what residents need at the outset you cannot care for them; therefore I consider this a failure that would warrant action, the action taken? No requirement, just an expectation.

The report states, care plans must be developed to meet assessed needs and

guide staff as to what care is needed.

My Comments, if needs were not assessed to start with, how can care plans be developed in accordance? This is a fundamental failing, what action is taken? No requirement, just an expectation.

The report states residents should have their healthcare needs acted on in a proactive way.

My Comments, to translate the jargon if a resident is really sick and needs medical assistance it should be obtained by the home. Of course this requirement relates to matters of life and death, was it enforced in the report? No it was not, an expectation this should happen was all the action taken.

The report states in the section what has improved? That requirements made the year before about risk assessments had been improved by the home and the requirement met. The report states on page 8, a requirement has been made for risk assessments to be carried out for activities people take part in.

My Comments, How can a requirement for risk assessments be met and not met on the same inspection, A risk assessment needs to be carried out on the inspectors.

The report states that the home should record concerns and allegations and keep full records.

My Comments, When you consider that allegations of abuse were made about this home and the authorities thought this home fit enough to investigate itself that is bad enough, but that this requirement has not been met at all by this home is worse, but worst of all if the fact the inspectors note the home has failed meet it and made no requirement just an expectation is mentioned.

The report states that the staff rosters must have the surnames of the staff on duty and not just Christian names as rosters are legal documents.

My Comments, I would have thought it useful to have staff names to check an abuser is no longer working at the home, what action is taken? No requirement, just an expectation.

The Report states a requirement has made that the home should develop a safeguarding policy for reporting abuse.

My Comments, it states further on in the report that it came to light the home did not have this, the last inspection said the home had this documentation, or merely there was an expectation they had it

This is page 8 of this report, a catalogue of dire failings, 12 failings in all is recorded, 4 are treated as such but the majority 8, are dealt with by the words (We Expect the home to comply.)
It gets worse.

The report states that three care plans were looked at, they all had failings, for example a resident with Diabetes had no care plan for this, and we expect the management to address this rather than make a requirement.

My Comments, The consequences of this could be fatal for the resident, Diabetes is a killer disease and I cannot imagine how an inspection could note this information and not even enforce requirements, but merely trust the home will act on this when it is a matter of life and death.

The report states, medication practices were unsafe, medication was not stored correctly, and one resident had medication on top of his wardrobe. The manager said that an independent pharmacist received medication and found it satisfactory; we did not look at this document.

My Comments, There was no medication checked.

The Report states that three staff files were checked and the following was found, No start dates for any member of staff, no first POVA checks, one staff had only one reference, another reference had no evidence to support it was from a previous employer, one staff member had worked at the home for three years without a CRB, no POVA checks and no references from employer.

My Comments, These staff had worked unsupervised in some cases for years and no previous inspection had spotted these failures before. Also as a result of these three staff files showing such failures, I would have

looked at all the files as such failures would be widespread. This situation is not uncommon and pretty much sums up what CRB and POVA amount to, a pretense of protection that useless in a care system that is unregulated and unaccountable.

The report states the manager has worked at the home 17 years and she told us that she regularly supervises staff.

My Comments, three members of the staff said they were not supervised, unfortunately they were the three with no references, no CRBs and no POVA checks, but that was not included in staff supervision.

Finally the abuse inquiry the home was asked to carry out was not entered in the homes tick list assessment (AQAA) as the manager did not think it was a safeguarding alert she was investigating.
What is worse, if it happens again and by some miracle it comes to light, the home will be asked to be its own judge and jury yet again?

The Home is graded **Zero STAR Poor. It gets much worse.**

Inspection report dated 11th November 2008.
(Six Months Later)

The report states, a requirement about staff recruitment had not been met and has been carried forward.

My Comments, No enforcement action taken on such a serious issue it is just carried over to be checked at the next inspection as if it were a matter of no importance, meanwhile even Harold Shipman would have no problem getting a job there as no one is checking.

The report states that the requirement made at the last inspection about care plans had not been met but we took the view that the home should be given more time without our making a requirement. We have made a requirement about risk assessments as they have not been carried out.

My Comments, The last report stated risk assessments were carried out and were not carried out, it seems they were not. Care plans warrant no

requirement in spite of the serious failures found in all those checked last time, including the resident with Diabetes having no care plan.

The report states that two care plans were checked and for one resident with Diabetes there were records made that included the following,
Resident had no breakfast, was vomiting, insulin given, very little lunch eaten,
Blood sugar at tea time recorded as 7.2 mills/liter, resident refused food, given sandwiches. No evidence of medical assistance requested, no evidence blood sugar checked, record made they were given glucose drink but not why, the home was not able to say what this residents blood sugar should be when comparing records. But the manager says she will contact GP, we have made no requirement but expect the home to act.

My Comments, Even when this is noted, it is not worthy of more than an expectation the home will act.

The report states that a pharmacist inspection took place, and the following was found,
Large stockpiles of medication being retained,
Controlled drugs not stored safely nor records of what controlled drugs had been administered,
Medication given to resident that had no record or label identifying what is was or who it was for.
Variable doses not recorded.
Medication being stockpiled and carried over for months made it difficult to audit.

My Comments, I consider all of those failures to be serious, a requirement was made but every day that this situation continues is a day too long.

The report states the manager assures us she would report abuse and has made a safeguarding referral, this requirement has been met.
The report goes on to state it was not clear if staff knew when to report abuse so we have made a requirement.

My Comments, The fact that the manager has not ensured her staff are aware when to report abuse is not connected.

The home is graded **1 STAR Adequate.**

Summery.

There are glaring inconsistencies throughout this homes inspections, but one thing is clear, they have failed to protect the vulnerable people whose lives they have been entrusted with.
I would say these inspectors have mistaken the concept of INSPECTING for the that of EXPECTING and that is how legal requirements are dealt with in a care system that is UNREGULATED but most of all UNACCOUNTABLE.

These inspections were carried out in the area of……and I will be dealing with this area in the next two reports.

I do not expect you to take action on this; I ask you to do what is required of you in the name of decency or hang your head in shame.

Eileen Chubb