

**Tales of The Un-Inspected**  
**Home Number 41**  
**By Eileen Chubb**  
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**To The Prime Minister.**

**I recently looked at the inspection history for.....Home Number 41, these are my findings,**

Inspection Report Dated April 29<sup>th</sup> and May 6<sup>th</sup> 2008.

The Report lists what comments were made by relatives and staff about the home.

**My Comments, All these comments are highlighted in italics; presumably the prominence normally given to positive comments could not be given when the most positive thing said about the home is that, it's alright.**

The Report States that six care plans were looked at, one residents care plan had not been updated since late 2007, risk assessments were generally satisfactory and had been kept under review, we saw one wound care plan was not in place and assessments not dated or fully completed.

**My Comments, No other care plans were checked; the residents affected were not checked.**

**In total 26 standards were assessed, 17 were graded as 3, standard met, 9 were grade 2, minor shortfalls. None were graded a major shortfall. The home overall was graded 1 STAR adequate.**

**February 26<sup>th</sup> 2009 (9 months later)**

**A Resident from the above care home, 85 Year old William Perrin dies after being admitted to hospital. Hospital staff contacted Social Services. An inquest was later held and the details emerged that, Mr. Perrin began to lose weight drastically and on admittance to the home was 71kg, which dropped to 40kg in the weeks before his death. He developed pressure sores on his buttocks, heels and lower back**

**which were measured as grade four, meaning tissue was exposed. He a suffered a wound to his finger which the home had not properly reported and it developed into Gangrene. A consultant from the hospital who gave evidence described Mr. Perrin as Emaciated and crying out in pain from his sores when he was admitted to hospital.**

**The coroner said it was one of the worst nursing home cases she had seen. It was concluded that Mr. Perrin had died from a heart attack but that the sores contributed to his death as his heart gave up. Death by natural causes contributed to by neglect was the verdict.**

**A reporter from the local paper, Craig Burnett, wrote an excellent report on the case and published pictures of the wounds. This reporting is first class and shows the true horror of what happened to this defenseless elderly man. Please see <http://www.thisislocallondon.co.uk>**

Inspection report dated 22<sup>nd</sup> of April 2009.

The report says, a number of safeguarding issues have been looked at by the Local Authority, which highlighted a number of areas that needed improvement and good progress has been made.

**My Comments, The local Authority brought in an independent inspector to see what had gone wrong. They paid someone to do the job of the regulator, because the regulator had failed.**

The Report states that eight care plans were checked, seven had good information and one was found to have not been improved and had not been updated since the year before.

**My Comments, The year before six care plans were looked at and five were considered to have good information, one was found not to have been updated since the resident moved in the year before. I fail to see the improvement, if one person in every eight residents in the home are missed that is too many. Even if only one resident is missed they could be subject to the same level of care as Will Perrin, only I use the word CARE lightly.**

The report states The Local Tissue viability Nurse now visits's the home and when we spoke to her she said staff were working well to heal some significant wounds.

**My Comments, The Tissue viability nurse told the inquest that her concerns about Mr. Perrins loss of weight were not acted on by the home. If there are residents with significant wounds in the home then they too could have suffered the same fate as Mr. Perrin whose ordeal came to light because he got out of the home. What he suffered would never have been noted by the regulator otherwise.**

The report states, staff training on reporting abuse has been arranged for all staff.

**My Comments, The previous inspection report said, staff have training to teach them how to recognize and report abuse**

The report states that a resident said, the biggest thing is the lack of freedom.

**My Comments, What crime did they commit to be locked up?**

The report states that a member of staff told them the company could do better by paying more attention to how staff are implementing their training.

**My Comments, The staff member did not feel they could raise it with the company or there would be no need to raise it with the inspectors. Was this information investigated? No.**

The Report states, The Home is improving.

**My Comments, The home is graded 1 STAR Adequate the same as the year before, but the devil lies in the detail of individual grades and they compare as follows,**

**CHOICE OF HOME No Change.**

**HEALTH AND PERSONAL CARE. No Change**

**DAILY LIFE, ACTIVITIES, Last time one grade of 3, three minor shortfalls. Improved in spite of resident who was locked in.**

**COMPLAINTS AND PROTECTION. No Change**

**ENVIRONMENT. No Change.**

**STAFFING. No Change.**

**MANAGEMENT. No Change.**

The report states no outstanding requirements from last inspection.

**My Comments, This is a blatant lie as the requirement made on care plans is repeated again as was not met from last inspection, the only possible motivation for deliberately implying the home complied with the law when it blatantly did not, is to mislead the public into believing this home complies with requirements, when evidence it has ignored such requirements in the past would be inconvenient.**

**If this home is improved, was it over-rated last time or under-rated this time? Either way they have miserably failed a defenseless elderly man and even then what is their first concern, protecting the home.**

**I look forward to hearing what you are going to do about it and hope no one connected to this company has power to influence Government policy or we will end up with inspection reports being blacked out in the same way expenses were.**

**Eileen Chubb**