Tales of the Un-Inspected
Home Number 46
By Eileen Chubb

I looked at the inspection history of…….Home Number 46, these are my findings,

INSPECTION REPORT, Dated 15th of May 2006.

The Report There are 150 residents in the home. One resident returned a survey form.

My Comments, Those two facts are listed on separate pages, but taken together they give me an initial impression of a home where people are either unwilling or unable to give their views.

The Report This is inspection is being carried out because of two adult protection referrals from the local authority. Prior to this inspection we, the inspectors met with Xxxx Company in March 06, to discuss what improvements are to be made to the home.

My Comments, Immediately it is obvious that there are big problems in this home and have been for some time, these problems were being dealt with by asking the home to act, this obviously did not happen as two more incidents have taken place which were serious enough to trigger an inspection.

The Report Health and personal care is poor, care plans do not always reflect needs. Medication management is unsafe, there are good medication policies and procedures but they are not always followed.

My Comments, Policies and procedures are bits of paper at the end of the day. This inspection has checked medication and found the following, there was easy access to the drugs that medication was missing on a sample of MAR sheets checked, when others were checked they showed more medication unaccounted for, the home was asked to inform the police. Medication was being given from pots with no details

of what is was. Waste drugs could not be checked.

The Report There was an activities organizer on one of the units, who said she had not had any training in dealing with challenging behavior or in how to provide activities, she had worked in the home 4 yrs. This section is graded good.

My Comments, This section is graded good, in spite of this and the only evidence seen of activities are bits of paper alleging they are provided. This section also covers food, two staff members were feeding residents, one standing up, and the other sitting on the arm of a chair. When asked about choices of food offered to residents, one carer said resident's likes and dislikes were listed in the care plans but she did not get time to read care plans. Which is not unusual, care plans are firstly written to satisfy a regulator who places far too much reliance on bits of paper and far too little on common sense.

The Report The report states that the home had been asked to investigate the conduct of a staff member by the Local Authority, Disciplinary action had been taken against this staff member. Two of the unit managers have commence training on protection and dementia and will train staff.

My Comments, What this says is that the home investigated itself and took action, we the public are not told what this staff member did or what action was taken. But as the home had senior staff that needed training in adult protection and dementia as a result, it is apparent that someone with dementia was abused and it was not dealt with correctly by these staff that are identified as needing training. I would ask why were senior staff not already trained on these issues. Secondly why are these same staff considered fit to train junior staff?

21 Grades are judged 11 are fully met, 9 are minor shortfalls, and 1 is a major shortfall. Overall Adequate.

INSPECTION REPORT DATED 6th to 7th of June 2007.
(13 Months later)

The Report The last inspection was December 2006.

My Comments, that report is not available only the inspection for May 2006 is, why?

The Report Health and personal care section is considered adequate. Care plans do not always reflect needs. Residents are not always treated with respect. Wound management and falls risk assessments are not consistently documented. A sample of medication records was looked at on each unit and there were some minor errors. Staff were heard to refer to residents as Ressies and those who needed feeding as feeders. Three relative surveys were returned one was positive, the other two referred to poor care practices.

My Comments, There is an ingrained culture in the home and if you ask three relatives about care and two cite poor care practices then it needs more than just noting, it needs to be reflected in the grade.

The Report A resident said they were sleeping as not much else to do. Care staff did not get involved in activities. Many residents with recorded swallowing difficulties were fed with table spoons loaded inappropriately.

My Comments, Pile it high and feed them quick, says to me not enough staff to meet the needs of residents. It is also noted again that staff are feeding residents standing up and with little interaction.

The Report A resident was startled when her chair was tilted back and moved so it lined up with other chairs.

My Comments, The resident was not spoken to because only the chair mattered. Another example was a resident who was not eating was given a cup of tea instead but the care plan was not checked nor was investigated if the resident in question had eaten yesterday or the day before. There are numerous examples of staff treating residents in a similar way, a staff member who attempted to feed a resident who was asleep. This shows a widespread problem in this home but the inspectors just pass the information to the manager who says she is shocked as all staff have completed all training.

The Report The local council has provided details of complaints made directly to them about the home. The home was asked to suspend staff and investigate , two staff were dismissed and others were recommended to have

supervision.

My Comments, Every alarm bell is ringing, this is two years of serious complaints against this home. If 2 staff have been referred to POVA then serious abuse has occurred yet again. The relatives went to the local Authority with their concerns, this says that they had no trust in the home acting, trust is eroded to this extent when concerns are ignored by a home in the first place. It is stated the home took appropriate action, but that was stated in the last report also.

The Report A resident was slumped over in an armchair and staff said they needed more bucket chairs.

My Comments, Bucket chairs are used to restrain, staff are showing their ingrained culture yet again.

The Report Staffing is graded good, two staff had references from the deputy manager of the home, one staff member spoken to had been working at the home a month and not had an induction yet but they were working supervised.

My Comments, Care homes employ the least staff possible, staff ring in sick and staff cover from other units, it is not likely that a new member of staff is supervised constantly every minute of every shift for weeks at a time and any inspector who thinks it credible has no idea about care homes.

22 grades are judged 20 are fully met and there are 2 minor shortfalls.

INSPECTION REPORT 17th APRIL 2008
(Ten Months Later)

The Report Medication needs improving, care records were adequate but did not reflect the care given to residents, a resident was moved with a different hoist to the one specified in the care plan. Two accident records were looked at where the same resident had an accident in the bath whilst being hoisted. Some risk assessments were identical for a number of residents. Wound care was not recorded for one resident. Another resident was noted to have discolored heels but nothing else recorded in the way of actions taken. There were many records that did not allow a medication audit

due to missing paperwork. Staff did not record the dose given. Overall this is graded adequate.

My Comments, Pretty much a shambles, adequate is way too high a grade, the same thing year after year and no action is taken.

The Report One resident said they were bored and would have liked a newspaper but sometimes they give a paper when they have finished with them.

My Comments, It is implied staff are giving the newspapers when they have finished with them, I have seen a lot of homes where staff are reading newspapers but they always have one recurrent theme, the name of one of the residents is always written on the front page. This resident is asking for so a small thing and yet it is too much for this home to give.

The Report There have been 11 complaints made to the home, 3 are ongoing and has been looked at by the local council. Staff spoken to said they knew what the term protection meant, two staff said the local adult protection procedure was not shown to them. Two staff said they were confident of who to report concerns to, one said they were not. The home records state eighty staff have had training on adult protection, despite this eight safeguarding referrals have been made since the last inspection and two staff referred to the POVA register.

My Comments, There are numerous other concerns, such as staff without references, one new staff member said she would have no idea if there was a fire what to do, two new staff who the records said were on induction said they were to start induction next week. The management have failed to learn from past mistakes, but it concludes that the company xxxx. Has offered to come up with an improvement plan.
The home is graded 1 Star Adequate.

It gets worse.

The new CQC web site lists this home under the new alias of……But the Company is the same.

The CQC have now rated this home 2 STAR GOOD but this has been done without any inspection taking place at all. The name changing scam has allowed this home to not only continue unchecked but to do so with the full approval of a regulator that has endorsed the care as good without one single scrap of evidence what so ever. This is not a failure, it is negligence on a scale that is criminal.

Eileen Chubb