Tales of the Un-Inspected
Home Number 48
By Eileen Chubb

I looked at the inspection history of ……..Home number 48. These are my findings,

INSPECTION REPORT DATED 27TH OF NOVEMBER 2007

THE REPORT. We have received five complaints about the home; we asked the home to respond to two of these complaints, which related to the lack of heating in the home. There have been two safeguarding issues and they were not reported by the home. We are concerned that staff did not report these incidents. Since the inspection we received another complaint that there was not enough staff to care for residents.

My Comments, Five relatives have gone to the authorities with their concerns; this says to me there are serious problems in this home as people are going outside with concerns. As for the heating not working, it is worth noting that this company has a prior history of hyperthermia fatalities.

THE REPORT. We spoke to residents and a staff member overheard what the residents told us and passed this information to other staff in the home. This is confidential information and people have the right to raise concerns with us.

My Comments, This is not a home where concerns can be raised.

THE REPORT. Medication is not recorded as given as prescribed; this was a requirement from the previous inspection also. There were good medication policies and procedures but the MAR sheets had problems. There was no clear indication if a number of medications had been given, variable doses were not recorded, and one resident may have received an overdose of paracetomol. Medication is not being given as prescribed.

My Comments, Pretty much a shambles and an abusers sweetshop. Care plans are given little mention but are considered to be adequate

and improved since the last inspection.

THE REPORT. Activities are poor, care staff is expected to carry out activities but a number of people have said there are staff shortages so there is little stimulation. Residents said they could not get up or go to bed when they wished. Food was often served cold, menus said a variety of food was offered but residents said there was not enough choice.

My Comments, A clear picture is emerging of what life must be like for the residents in this home, the basics are not even being provided, the home has all the right paperwork but you cannot survive on paperwork. These residents are at high risk of food poisoning if cold food is being served daily it is only a matter of time before it happens. When you consider that food poisoning can often be fatal if the victim is elderly and in poor health I would have expected action to be taken.

THE REPORT. There were soiled pads on the floor, carpets were frayed and dirty, bathrooms were being used to store equipment, one bathroom had wall and ceiling tiles missing and the bath was dirty with a dead wasp in it. The heating of rooms was not attended to promptly by the company who are costing the equipment to control the heating. Rooms seemed warm so we have made no requirement on this.

My Comments, This inspection took place in November and in spite of two complaints about lack of heating and no action being taken to rectify this, no requirement is made as the inspectors say the rooms were heated. Firstly how many rooms were checked is not mentioned. The inspectors judged the temperatures by what they thought was acceptable for their comfort and without considering that elderly people in a nursing home will have poor mobility and will be more susceptible to cold. As for the dead wasp in the bath in November it says this room has not been used for months.

THE REPORT. We received a complaint about staff shortages in the home, we asked the company to investigate and they concluded that on one occasion there were staff short on a shift due to staff sickness.
My Comments, This is what happens when you ask a company to investigate its self, denial there is a problem results in that problem not being addressed. If you read further in the report however you will see what other evidence is available,

1. One of three staff surveys said there is usually enough staff, the other two staff said there is never enough staff on duty, one staff survey said, We are always rushing around, unable to give proper care to the residents.
2. Residents said, I shout and shout but no one ever comes. Another resident said they had rung their bell but no one came for an hour and they needed the toilet.
3 Staff morale was low, one member of staff said a lot of good staff were leaving, other staff said they felt unsupported and communication with management was poor, another staff member said things could be improved by different management and a different company running the home.
This is not a situation that can be allowed to continue surly.

24 standards are judged, 13 are fully met, 9 are almost met, and 2 are major shortfalls.
It gets much worse.

INSPECTION REPORT DATED 21ST OF APRIL 2008
(5 Months Later)

THE REPORT. The AQAA says,

My Comments, That is the main evidence, relied on. Where things are noted that the home could do better, every single shortfall is followed by the words, we expect the home to manage this rather than make a requirement.
The Home is graded 2 STAR GOOD.

The Consequences for the Residents?

INSPECTION REPORT DATED 3RD OF MARCH 2009.
(12 Months Later)
THE REPORT.
On The 3rd of September 2008 a protection of vulnerable adults, now know as safeguarding alert was raised and we attended a meeting in October. It was concluded that the home had failed to provide proper and adequate care of a resident who was at high risk of Malnutrition. There had been poor record keeping and quality assurance.

My Comments, the AQAA was not enough for the resident who has at worst died of hunger or at best nearly died of hunger. Either way you cannot eat an AQAA. I note this information was received in September and a meeting held in October, not quick enough as all residents in this home are in danger. My Verdict? Corporate manslaughter or gross negligence by both the home and the inspectors because it was foreseeable and therefore preventable.

THE REPORT.
On the 5th of September a safeguarding alert was made after concerns about the care of a resident from the home who was taken to hospital inn a deep Diabetic coma and suffering from grade four pressure sores which had no dressings on them, and were clinically dehydrated. It was found that staff had failed to monitor sugar levels or take action when deterioration was evident.

My Comments, at worst this resident could have died from neglected diabetes, infected bed sores or thirst, at best this resident could have died from neglected diabetes, infected bed sores or thirst. Either way they will have suffered torture we cannot begin to comprehend and it was inflicted in a place where they were supposed to be cared for. My Verdict? Corporate Manslaughter or gross negligence by the home and the Inspectors.

THE REPORT.
We received information from one of the safeguarding practitioners that considerable progress had been made in minimizing the risk of one resident being abused by another resident.

My Comments, This is another statement that makes my heart sink when I see it. It must have considered serious abuse for any action to be taken and it is not stated what so in order to make a judgment I will tell you about the last time I saw that exact same statement made. I received information that vulnerable female residents were being repeatedly sexually abused by a male resident. It was all reported correctly but the safeguarding practitioners considered that the risks would be greatly reduced by staff monitoring this male resident constantly. However as this home like every other was running on the lowest staff numbers possible, it took just one staff member going sick for further sexual attacks to occur. Unfortunately this is the real world and not the world,

Safeguarding Practitioners live in.

THE REPORT.
In December 2008 we received information that a resident at the home was not being cared for and had not been washed and had sores in their groin

My Comments, when there have been dead wasps noted in baths previously it comes as no surprise to me, unfortunately the inspectors did not pick up on this. The complaint included the terrible smell of the resident, I know that smell well it is the stench of neglect.

THE REPORT. We received information on December 30th 2008 after an allegation of abuse had been made by a member of care staff. It was found that this member of staff had been working unsupervised and had not received a Criminal Records Check until two days after the alleged incident had occurred. It was found there had been a delay by other staff in the home to report the abuse they knew had taken place.

My Comments, It has been obvious to me from the first reports that this is not a home or a company where concerns can be raised.

THE REPORT. On the 6th of January 2009 we received information that a resident had wandered out of the home and been found by the police 45 minutes after the person was found to be missing.

My Comments, The report fails to say how long the resident was missing for before the home noticed that information should have been included.

THE REPORT. We received information on the 27th of January 2009 that a resident was able to leave the home unobserved and was found on the open fire stairs and had a fractured arm cuts and bruises.

My Comments, How long they were missing is not included.

THE REPORT. On the 17th of February 2009 we were informed by the safeguarding team that a resident with Diabetes had been treated by the home for low blood sugar but when they did not respond only monitoring took place. An ambulance was not called for thirty minutes. It was stated it was not company policy to test diabetes sugar levels routinely if the resident

was stable.

My Comments, Nothing has been learned from the previous incident because this company is dire.

THE REPORT. We received an AQAA from the home and due to the concerns we have decided to bring forward the next key inspection to 20th of April 2010.

My Comments, No hurry after all its only life and death for the residents that still survive.

THE REPORT. A requirement has been that the home must not forge care plans and medication records need to show people receive medication prescribed to them.

My Comments, The AQAA that resulted in this home being given two stars is not mentioned but it was equally falsified. Given this homes previous I would have thought there would be some impact on their credibility.

The Home is now graded ZERO STAR POOR.
It Gets Worse.

INSPECTION REPORT DATED 11TH OF JUNE 2009.
(12 Weeks Later)

THE REPORT. We did not assess what the home does well on this occasion.

My Comments, Given the circumstances you would be clutching at straws to find something this home does well unless you use the AQAA.

THE REPORT. Medication is not right but instead of making a requirement we expect the home to act on this.

My Comments, This is a home that has ignored requirements what makes the inspector think their expectations will be met, they are again gambling with people's lives.

THE REPORT. Care plans do not contain accurate information and we make

no requirement and expect the home to act.

My Comments, The inspectors are laying the ground for the next inspection when it will be asked if there are any outstanding requirements and if no requirements were made they will be able to upgrade the home and the public will be misled into believing the care has improved.

THE REPORT. The AQAA said staffing had improved. We have received a written complaint about staffing in the home, we spoke to staff and found two groups saying different, one group was happy the other said they were distressed at the poor care they able to provide to residents. We believe staffing has improved.

My Comments, Staff have written to the regulator saying they were not able to provide care and the regulator chooses to believe what the AQAA says. I commend the staff who blew the whistle outside the home for their bravery and I recognize such staff really care about the residents by taking such an action. It's a shame the regulator is there for the company.

The home is not graded until the next key inspection.

INSPECTION REPORT DATED 21ST OF JANURARY 2010.
(7 Months Later)

THE REPORT. Medicines are given to people with regard to their dignity.

My Comments, but not with regard to their health. The AQAA says medication has been audited by the home and that's as far as the evidence goes. However if you read further you will find that a requirement has been made as the expectations were not met.

THE REPORT. Due to the positive improvements we made regarding residents with pressure sores has been met.

My Comments, No requirements at all were made at the last inspection, so concerns must have been raised and investigated in secret.

THE REPORT. The requirement made about risk of choking has been met.

My Comments, Again this must be an incident since the last inspection as no such requirement was made.

THE REPORT. Care plans were not up to date or accurate we have made this a requirement. Staff are putting intuitive information in the records.

My Comments, They are forging care plans still.

THE REPORT. We looked at two care plans and found a resident with diabetes had no blood sugar test for the past 20 days, the manager stated it was not company policy to check blood sugars of residents with stable diabetes.

My Comments, Diabetes is a killer disease and should never be treated as otherwise. People have stable diabetes as a direct result of monitoring not from a lack of it. The second care plan said the resident was at risk of choking and needed pureed food. The manager or any staff were aware of this.

The whole way through this report I can see evidence that is noted by the inspectors and then ignored in favor of the AQAA.
The local authorities have refused to place people in this home since 2008 and what is the regulator concerned about? That the profits of the home are being impacted on.

Five Reports and I note there is one thing missing from each one, the words. ENFORCEMENT ACTION WILL BE TAKEN.

The home is upgraded to ONE STAR ADAQUATE not only has this been done without a single piece of evidence to support it, it has been done in spite of all the available evidence to the contrary.

Eileen Chubb