Tales of the Un-Inspected
Home Number 53
By Eileen Chubb

I looked at the inspection history of……..Home 53, these are my findings,

This is a newly built care home and ingrained problems are already an issue when the first inspection takes place.

INSPECTION REPORT DATED 11TH OF OCTOBER 2006.

THE REPORT. HEALTH CARE. Staff were seen to lift residents in a dangerous manner. Residents were placed in wheelchairs with no footrests and we had to intervene as a residents feet were dragging on the floor. There were gaps on medication MAR sheets and the handwritten alterations. Care plans did not contain all information required.

My Comments, There is already an ingrained cultures in this this home and that is a concern given the short time it has been open.

THE REPORT. ENVIRONMENT. There was no hand washing facilities in many communal bathrooms. Razors were found in a bathroom on the dementia unit. Chemicals posed a fire risk.

My Comments, Pretty much a shambles yet graded as adequate.
At the back of the report it is mentioned that the home manager recently retired, the home has been open six months.

THE REPORT. STAFFING. 63% of staff has NVQ level two which exceeds the requirements. Poor practice was observed.

My Comments, A good example of what NVQ guarantees.

25 standards are judged, 14 fully met, 4 nearly met, 7 are major shortfalls.

INSPECTION REPORT DATED 4TH 5TH AND 6TH OF MARCH 2008
(1 Year and Five Months Later)

THE REPORT. GENERAL 25 surveys were sent out to relatives, none were returned. 25 surveys were sent out to residents, none were returned. All requirements from the last inspection have been met.

THE REPORT. HEALTH CARE. Medication procedures ensure medication is administered safely. However we brought to the managers attention that medication sheets had gaps and it was not clear if medication had been given.
Care plans contain all relevant information and were updated monthly.

My Comments, that all sounds fine but there is no evidence to support it, what care plans were looked at is not mentioned and no medication audit was carried out by inspectors. Further on in this section it is noted that two residents one of whom was highly distressed and the other not wearing clothing, were ignored by staff that were present. The report goes on to state that there have been recent complaints made outside the home which are being investigated by the local authority safeguarding board which relate to lack of care. However on page 21 of the report it is stated that residents have been abused by staff and several investigations had been upheld. Yet throughout this period the regulator did not once visit the home and this crucial information is relegated to the back of the report.

THE REPORT. ENVIRONMENT. The home was showing signs of wear and tear. Wheelchairs were being stored in resident's en-suite bathrooms. Most of the carpets needed cleaning. Most call bells were out of reach and fire doors were unable to close in an emergency. Dirty clothing was found on bathroom floors.

My Comments, The home is less than two years old and even the basics are not been done to maintain the building.

THE REPORT. STAFFING. Staff have good training to meet resident's needs. Relatives express concerns there are not enough staff. One relative said they come to feed x as not enough staff to do it.

My Comments. Staff can clearly not meet resident's needs. The fact that

staff abused residents over a period of time has no impact on how this area is graded in this area, standards fully met on three out of the four judged and one minor shortfall only. However the home has been awarded the investors in people award so the fact that some staff felt there was low morale is considered minor.

The Home is graded 1 STAR ADEQUATE.

INSPECTION REPORT DATED 9TH OF MARCH 2009.
(12 Months Later)

THE REPORT. HEALTH CARE. Not all staff could say they had read the care plans. Care plans looked at were poor, bedsores were not recorded correctly. It was noted that ten people had drastically lost weight but no action was taken. Relatives told us people were often left wet. We audited medication, amounts were not correct and one MAR sheet had a post it note stuck on it changing the printed prescription. Doses had been changed by GPS which were not on MAR sheets. Call bells were placed out of reach and when a resident asked for a drink staff said she had already had one.

My Comments, Dr Shipman's idea of heaven with the medication but no surprise given the lack of scrutiny by the regulators in the past.
The report states further on that complaints about residents being repeatedly found wet and poor staff attitude have been on going. I am just surprised no one has been killed yet.

THE REPORT. ENVIRONMENT. The home is not as clean as it should be.

My Comments, That sounds a pretty bland description and you have to read much further to discover that,
1. All En-suite bathrooms are flooded with water and residents and staff have to wade through standing water. Given residents with dementia have access to these bathrooms all night every night and are unobserved; the dangers are evident to me what is likely to happen if someone slipped in that water. However given that 83 bathrooms are flooded it is not considered a risk to life and limb.

2. The inspectors say there were concerned to find a room with dried feaces and urine on the bedding.

3. There was no hot water.

4. Bedrooms were found to be dirty and in a poor state of cleanliness.

5 Call bells still being deliberately placed out of reach.

6. Fire doors were still not closing properly, that's two years now so it is fortunate there has been no fire as carnage would result.

7. The lift was not working and was addressed when inspectors pointed it out to the highly qualified competent manager.

8. Full clinical waste bags were on bathroom floors.

But the home was intending to introduce a cleaning schedule so in spite of what inspectors describe as POOR is graded as ADEQUATE.

THE REPORT. STAFFING. Staff are poorly supervised. Relatives told us of their concerns there were not enough staff. There is poor staff recruitment. We grade this section adequate.

My Comments, Again what is considered to be poor is graded as adequate. But we actually get the grade poor for the management section as in spite of the manager having every single qualification required by law, significant amounts of resident's money retained by the home had been stolen and had to be reported to the police. When staff had raised concerns about call bells they were ignored. The company's corporate audits had failed to note it and no mention of anything was written in the AQAA, well it wouldn't be that is not the sort of thing voluntarily disclosed.

The home is now graded ZERO STAR POOR
INSPECTION REPORT DATED 10TH OF MARCH 2009.
(I DAY Later)

THE REPORT. The home has met all but three of the statutory requirements. We were accompanied by a pharmacist on this inspection who made no new requirements but noted discrepancies put people at risk. There appeared sufficient staff on duty but resident's needs were not always met. Due to lack of compliance with some requirements **(Three)** statutory notices have been

issued.

The home remains Zero Star Poor.

INSPECTION REPORT DATED 19TH OF JUNE 2009
(12 Weeks Later)

THE REPORT. The home was inspected on April 21st and statuary notices were served due to the serious nature of the concerns found.

My Comments, That report is secret and I can surmise that at best people have died or suffered terrible injury due to both the regulator and care home failing to act,. The inspectors checked three care plans during this secret inspection, most likely because of information received about particular residents, and found one resident not fed and losing drastic weight, another resident being restrained in a wheelchair and a third recorded as having a bedsore in an unknown location. This inspection found the issues were still going on. If that is what is being suffered by three residents what is happening to the rest?

THE REPORT. MAR sheets were not signed; pain relief for a number of residents was not in stock on a number of occasions. Doses were not recorded and accurate records were not in place.

My Comments, yet the last inspection report 12 weeks ago said all medication requirements had been met. I wonder if both the March reports, one day a part and neither mentioning the other were ever both meant to be made public as one is a contradiction of the other and if there was ever a legal case they would reflect badly on the regulators case as they are grossly incompetent and would let any care company get away with murder.

INSPECTION REPORT DATED 7TH OF SEPTEMBER 2009

THE REPORT. Some requirements from previous inspection reports may have been deleted or carried forward as recommendations but only is it is considered people are not at risk. In future if a requirement is repeated it is likely enforcement action will be taken.

My comments, What this means is the governments halfcocked

guarantee to pursue bad care providers it worth squat as with the collusion of the regulator the scam of deleting or downgrading outstanding requirements has fiddled the need to take enforcement action.

This home was upgraded to 1 STAR ADEQUATE based on deleting all the previous requirements and in spite of all evidence to the contrary.

The Price Paid?

In February 2010, the regulator had to do what it should have done in the first place and enforcement action was taken.

For repeatedly ignoring requirements on medication and care plans, which were considered fully met at the last inspection?

At X Magistrates court the company were fined 3200 and ordered to

pay CQC costs of 731.90p

The victims were mentioned at least as CQC received a surcharge of 15 pounds for each one. Fifteen pounds for years of hell and even then the money goes to the sorry excuse of protection known as CQC.

There are over /// homes in England to date two have had enforcement action taken, not to close the homes but to fine them. Both homes are doing good business as for the care provided the only one with the answers are not telling the public.

Eileen Chubb