Tales of the Un-Inspected
Home Number 62
By Eileen Chubb

I looked at the inspection history of……..Home Number 62, these are my findings,

This home is owned by the same company as home numbers, 33, 36, and 41,48,49,50,54,59,60.

REGULATORS INSPECTION REPORT DATED, 4TH, 5TH AND 6TH OF FEBRUARY 2008.

THE REPORT, MEDICATION, CARE PLANS, Care plans do not match the actual support given. A resident with pressure damage did not have this recorded. Seven Medication sheets were looked at and six had mistakes. For example two had more medication in stock than they should have had and one person had too little. According to the records two people had not received their medication but a check of stocks showed they had. One person was being given out of date medication. The previous manager had reported a sedative drug that had gone missing.

My Comments, The presumption is made that all of the above are medication errors but they could just as easily be signs that medication is being misused. The drug reported as missing by the home is the tip of an iceberg when it is considered only seven peoples MAR sheets were checked and six of those are complete shambles. I note the resident with pressure damage with no record of treatment, which the inspectors presume is due to lack of recording rather than lack of treatment.

THE REPORT, COMPLAINTS AND PROTECTION, The home has clear procedures. People spoken with said they knew how to complain. Some relatives said they had made complaints but these were not recorded by the home. Three complaints were recorded with no record of what action was taken. In the last few months there has been an incident in which the manager and senior staff were unable to prevent a resident from being neglected. The company has since taken action to ensure similar incidents do not occur and this includes making sure that staff report any concerns to seniors and make a record. The manager and organization has taken

disciplinary action against staff that have not carried out their duties.

My Comments, It states on page 15 that the Manager is fully aware of all residents needs and the above contradictory information is relegated to the back of the report. It beggars belief that a manager and senior staff in any so called care home could be considered unable to prevent a resident being neglected. The resident most likely has died of neglect for it to be mentioned at all. The way this incident is worded is aimed at defending the home and the suffering of the resident is not even a consideration. The relatives who raised concerns and were ignored is also information relegated to the back of the report in favor of the inspectors opinion that watching the manager and staff is sufficient to conclude they welcome complaints to be raised. This is evidence of inspectors far too willing to believe what the home asserts.

The Home is graded 1 STAR Adequate.

REGULATORS INSPECTION REPORT DATED 24TH OF FEBURARY 2009.
(1 Year Later)

Please note all requirements from the last inspection have been deleted by using the killer clause.

THE REPORT, CARE PLANS AND MEDICATION, Staff have been fully trained in all areas including care plans and medication administration. There were some good examples of care plans that guide staff.
Most recordings did not contain any detail and just state the plan remains the same, staff were not signing or dating entries. Medication audits are carried out by the home each month. A sample of MAR sheets were examined and the following brought to the managers attention, directions from the pharmacist were not always clear for example the wording regarding doses as directed. There were gaps where staff had not signed that medication was given. The wrong codes were used.

My Comments, The requirements from the last inspection to improve care planning and medication were considered met and new requirements are made to improve these areas because if they were repeated as outstanding requirements then enforcement action would have to be taken against the home and the last thing inspectors want to

do is enforce the law. This stance will always lead to suffering for the residents.

THE REPORT, COMPLAINTS AND PROTECTION, This area is good, there are clear protection and complaints procedures in place and staff are trained to prevent people from being harmed.
The majority of complaints received were not properly logged and did not demonstrate how concerns were addressed. All staff are fully trained in whistle blowing and protection issues. There have been a number of safeguarding alerts raised with the local authority that have resulted in us and the local authority having to review the quality of the service and how the home prevents residents being harmed. The company has responded appropriately.

My Comments, This is what they call good? The complaints are ignored and when enough people have suffered the regulators takes the action of asking the home to improve areas it was told the year before to improve. The inspectors are aiding and abetting the homes negligence by allowing it to continue. They say the company has responded by arranging training which is already up to date. This is a home where staff are too afraid to blow the whistle and where relatives are ignored if they raise concerns.

The Home remains 1 STAR Adequate.

REGULATORS INSPECTION REPORT DATED 25TH OF AUGUST 2009. **(Six Months Later)**

THE REPORT, This is a random inspection to check if the home has complied with requirements from the previous inspection. Care plans generally have good information. We looked at medication records and found the wrong codes had been used. Night time medication was not always given. Dose changes to medication were not correctly recorded. Staff had signed for medication on two charts which were duplications and the second chart had then been scored through.

My Comments, This is unchanged and in spite of inspectors wanting to believe there is improvement there is no evidence of any. Still no enforcement action is taken.

THE REPORT, Activities and outings are arranged, one resident said they had been in the home two years and never been out, other residents said there were no activities.

My Comments, This home has no creditability and cannot be believed as the bits of paper on the wall promising activities are part of a charade.

THE REPORT, COMPLAINTS, The home now responds to complaints.

My Comments, There is not a shred of evidence to support this, in fact the amount of negative comments from residents is an indication of concerns being ignored.

The Home remains 1 STAR Adequate.

REGULATORS INSPECTION REPORT DATED 21ST OF OCTOBER 2009.
(8 Weeks Later)

THE REPORT, MEDICATION, The focus of this inspection was to carry out a pharmacist's inspection in order to check progress made as a result of the company's improvement plan. What we found.
33 Medication records, MAR sheets were inspected and 26 of these had one or more discrepancies, where records were not complete, recording errors had been made or medicines had not been administered as prescribed. There were a number of hand written entries on sheets and none of these had been countersigned. One resident had not received a hypnotic drug for three days as the supply had run out and a further seven days' supply was obtained but this again ran out.
My Comments, Two years of warning signs and finally a pharmacist checks a large sample of medication and finds what was always there to find, widespread misuse of drugs. These are not errors there are far too many and the patterns show drugs are being used to abuse residents. I have seen this happen first hand and know when drugs that keep residents quite, such as Hypnotics run out, it's because either the resident prescribed them is being illegally overdosed or the drugs are being used to sedate other residents. Handwritten entries on MAR sheets is another indication as printed labels are issued with medication prescribed mid-cycle. What should not be forgotten is that these drugs have been proven to have fatal consequences for elderly people and

when they are prescribed the benefits and risks should be seriously considered. When these drugs are illegally administered it should be considered in terms of attempted murder.

THE REPORT, MEDICATION Continued. There were numerous gaps on the MAR sheets and in addition discrepancies between quantities of medications received, doses administered and quantities remaining in stock. Some medications were also recorded as given but remained in the packaging and some medications were not recorded on the MAR sheets but had been removed from the packaging. Controlled drugs appeared in order but there was not always the required two signatures for administration and nor were they recorded as received. Staff have been trained in administration of medication but a record of the training could not be located. The company carries out regular audits of the home including medication audits and a recent audit showed half the medication counts were not correct but this was not addressed in the action plan.

My Comments, when a company comes up with an action plan the last thing to expect is action. The company carries out monthly audits but this would appear to be the first one to notice drugs were missing. The most telling thing of all is that neither the company, the home manager nor a single member of staff reports any one of these numerous incidents as a safeguarding issue to the authorities. If previous inspections had relied on the available evidence and had not been so eager to extol the home then the residents could have been protected, the harm that has been inflicted will never be known.
The report consists of two pages listed under two headings, the widespread medication misuse takes up most of this space under the heading, WHAT WE FOUND.
The inspector's attitude is summed up by the content listed under the heading, WHAT THE HOME DOES WELL.

THE REPORT, WHAT THE HOME DOES WELL. The administration of medicines is generally well managed and the personal wishes of residents are considered when agreeing where and when to administer medicines.

My Comments, Not much shocks me when it comes to the regulation of care homes but this statement is perverse given the failures listed. It is saying that residents have a choice of where and when they can be illegally overdosed and that makes it alright. This is why abuse in care

homes thrives because even when evidence comes to light it is justified and excused by the very people who should be protecting the vulnerable.

The remains 1 STAR Adequate.

REGULATORS INSPECTION REPORT DATED 26TH OF NOVEMBER 2009.
(4 Weeks Later)

THE REPORT, COMPLAINTS AND PROTECTION. This area is adequate; the company has a robust complaints procedure. There were nine complaints recorded mainly concerns about standards of care in the home, the majority has a response on file, one had no response and one was omitted. The staff are fully trained in safeguarding and whistle-blowing procedures. We the regulator were informed of two safeguarding issues by the home however this was not the full extent of alerts and management have been reminded of their responsibility to report issues where residents have been harmed.

My Comments, This home and the company that owns it has a culture of secrecy when it comes to abuse, their priority being one of protecting reputation before all else. This evidence was always there to see but inspectors chose to ignore it and last time this section was graded good. What has happened is that so many people have suffered and so many relatives have raised concerns over a long period of time that finally the dam has burst and the Local Authorities have been informed directly. So the home can no longer keep it secret, because even the regulator cannot come up with some sorry excuse to justify it this time.
Now everything that was always wrong is actually graded as such and a warning letter is sent to the company. But the Local Council has suspended admissions to the home so the regulator has to react.

THE REPORT, CARE PLANS, We looked at care plans on the dementia unit and found they were poor. There were numerous concerns about people's hygiene and their dignity was compromised. Odors of body odor and urine were evident throughout the dementia unit. A number of windows were open and two people sat in their bedrooms were cold to touch. People were wearing stained clothing, the men wear unshaven. One resident was wearing nightclothes two days in a row. One carer was struggling to feed residents in the dining room, many residents wandered off with no food.

Residents taking food in their rooms were not supervised which included residents at risk of choking. People were not cared for staffing levels appeared adequate.

My Comments, The list is numerous but to summarize this how the most vulnerable residents with dementia have lived.
1. They have been so badly neglected the stanch of urine and body odor is prevalent throughout the units on the upper floors.
2. People are unkempt in soiled clothing.
3. People left to wait long periods in the dining room wander of and have no food and drink.
4. Inspectors consider there are adequate staff even when witnessing one carer struggling to feed too many residents who need help.
5. People left with no care in their bedrooms, no one to help them eat or drink.
6. Residents left freezing in their bedrooms with the windows open in the middle of November.
7. Much of the food untouched and those who were able were so hungry they used their hands to get food to their mouths.
8. Not even the pretense of nutritional assessments or pressure care recorded and all the inspectors ask is the care plans contain evidence of care so things will get even worse with the few staff writing out more paperwork at the expense of the scant care there is.
9. Catering staff were not aware of anyone at risk of weight loss.
10. Despite inspectors declining to say how many MAR sheets were examined significant failures were found, such as the missing drugs and now four people's drugs had run out.
11. Sheets were hanging of beds and people were sleeping on bare mattresses and those who needed pressure care were not given the correct mattress. Bedrooms were stark.
12. The health protection agency visited the home after an outbreak of an infectious disease affected six residents.
13. The inspectors look at the staffing Rota's and could not work out how many staff were working but concluded earlier there was enough staff.
14. Staff comments indicate that staffing levels do not allow for residents to be cared for and residents suffer. Staff felt unsupported.
15. The company maintains they carried out extensive audits of the home and somehow managed to miss those starving, dying of thirst in cold stark bedrooms with no care despite the stench of neglect.

The inspectors visited this home at regular intervals the last time being just four weeks previously, they somehow overlooked all of this and now their main concern is to justify why they missed the living hell they considered to be adequate. They missed it because they chose not to look, smell, touch or take pity on those they left to suffer.

The home is finally Graded Zero Star Poor.

REGULATORS INSPECTION REPORT DATED 13TH OF JANURARY 2010.
(Six Weeks Later)

THE REPORT, Dignity needs to be protected by better odor control.

My Comments, It's not dignity that needs protecting, odor control means masking the stench of neglect can range from people left lying in urine soaked clothing until their skin breaks down and the stanch of rotting flesh from deliberately inflicted wounds that expose bone takes over. I hate the word dignity because it is used to mask abuse, to make it sound like the victims have suffered some minor embarrassment.

THE REPORT, Previous requirements on healthcare has been met but the inspectors had to prompt staff and management to carry out professional's advice on healthcare needs.

My Comments, There is no limit's the inspectors will go to say requirements have been met when there is not a shred of evidence in the two pages this report consists of. What the inspectors are doing is telling the home how to care for residents because the home is not doing it in the first place. That is all it takes to say requirements have been met.

THE REPORT. People were not supervised in their bedrooms, the majority of paperwork was not required and that which was required was of poor quality. People on the dementia units were now provided with menus giving a choice of food options.

My Comments, A choice of food but no way of getting it to their mouths. Plenty of paperwork but no actual content of use. The company is sent another warning letter.

The home remains Zero Star Poor

REGULATORS INSPECTION REPORT DATED 9TH OF FEBURARY 2010.
(3 Weeks Later)

THE REPORT, Medication was checked by a pharmacist and some MAR sheets were torn and could not be read. There were gaps and discrepancies found, improvements are required to ensure medication is given as prescribed and correctly. Codes need to be entered correctly. There were discrepancies between medication received and that in stock. A statutory notice of breeches has been served on the company.

My Comments, No change for the residents and now the statutory notice has been served, it sounds impressive but what it means is in a year or so the Multi Million pound company will go to court and get a slap on the wrist and a few thousand pounds fine, which are peanuts to them. They will then carry on as normal and if enough peoples suffering are noticed again the whole thing process starts again. What it means for the residents? Nothing just more of the same.

This Charity and reporting the suffering whilst so many are willing to believe there is a shred of protection.

Eileen Chubb

Please see archive section for all the homes in the series, Tales of the Un-Inspected.