Tales of the Un-Inspected
Home Number 69
By Eileen Chubb

This Home is owned by a large national company.

The first report I looked at for this home is dated September 26th 2008, throughout the report there are numerous failures noted but the implications of this information is not considered at all. The information listed below is taken from throughout the report and I give a brief translation in bold after each fact noted by the regulator.

There is an adult protection investigation in progress and the police are taking the lead. **Many crimes against the elderly people in care homes are downgraded to poor practice; if the police are taking the lead in an investigation then it must be concerning serious issues.**

The local authority has suspended placements to the home. **The local authority thinks the home is not good enough but the regulator does not close it.**

The home did not provide much information in its AQAA (Quality Assurance) **the home did not grade itself in the AQAA so inspectors will have to grade it according to the facts.**

People were not being assessed correctly before they moved in to the home. **The home is more interested in filling beds quickly.**

We looked at three care plans and found that one person had been treated for an infection but no record was kept of how the risk of this from spreading to other residents was being managed. **This could have spread to every resident in the home but was not investigated further even though there could be life threatening consequences.**
One person's catheter should have been changed every three days but no record of this was made. **The person is at risk of serious infection.**
One person needed their blood sugar levels checked weekly but there were periods of up to three weeks when this was not done. **There could be fatal**

consequences for this person, if there was one omission that would be bad enough but the inspector notes this is a regular occurrence. Yet it is merely noted.
A person with sore skin needed to be seen by the tissue viability nurse and no referral had been made. **This person was known to be at risk and nothing was done about it, every resident in the home that could be at risk of pressure sores needs to check but this is not done.**

Medication trolleys were left open and unattended, we audited 7 people's medications and all of these were not correct and people were not always receiving medication as prescribed and balances were not correct. **One hundred percent of the medication records checked were not correct, the inspectors did not know what came in, what was given and to who, or what was returned and accounted for?**

There are notice boards listing activities. We did not see any activities most people were asleep in chairs. This area is adequate. **Adequate for what? Those in a coma. The majority of people sleeping throughout an inspection lasting 8 hours would make me question what sedative drugs were being used or abused given what is noted elsewhere in the report.**

We could not see the complaints records. We had received complaints directly about the home which we referred back to the home to investigate. People told us their complaints were not responded to. **The regulator could find no evidence the home dealt with complaints, the regulator was approached directly by concerned relatives and referred the concerns back to the home to investigate. When every alarm bell is ringing nothing is done until things get so bad the local authority places an embargo on the home and the residents have suffered enough to warrant the police investigating matters.**

There are many other failures noted but I have only highlighted a small number, just enough to ring every alarm for me, but not for the regulator who whilst grading the home Zero star Poor, by judging 27 standards of which 12 were fully met, 9 almost met and only 6 major shortfalls, gives the home little to improve on. It will not be long before this homes grading is upped. Only 6 requirements are made which relate to,
Systems for medication, complaints records, care plans, cleaning Rota's, recruitment procedures and management cover during absences. All

relate to paperwork none relate to care. It is noted that people with large or ongoing bedsores should be referred to the tissue viability nurse in the good practice recommendations, however this shows the inspectors priorities, as this section is for the less important things such as storage facilities and so forth, open gangrenous bedsores that result in unimaginable suffering that could have been prevented are considered less important than bits of paper.

The next inspection report for this home is dated 27th of January 2009 which is just 16 Weeks later. This report contains the following information,

The local authority still has an embargo on the home. **This means the local authority feel the home is still not safe.**

Due to previous concerns about healthcare, medication, complaints and protection we focused our inspection around these areas. **This time we are going to look at what is wrong.**

The pharmacy inspector found that medication had not improved so we have sent the company a warning letter stating that if things have not improved by the next inspection we will considerer taking enforcement action. **The pharmacist found widespread issues of concerning about stocks of medication, who it was given to, what came in what went out. The same as last time, which resulted in one requirement about medication paperwork, this now results in 5 requirements about actual medication one of which relates to medication being found that did not belong to any of the current residents in the home.**

Healthcare is Adequate. We looked at four care plans. One person's bedsores are now being monitored and treated by the tissue viability nurse who has taken photographs of the various sizes of the wounds and monitored progress. **At the last inspection sixteen weeks ago it was noted one person had a sore area that needed to be referred to the external tissue viability nurse. Now one person is noted to have multiply bedsores in various stages**.

Two people were not receiving their chronic pain medication. **Chronic pain relief not given in one case for up to a week and another for one day means that those prescribed this medication were left in agony, the inspector prefers to describe this as pain. Which would also describe**

someone with a mild headache not getting an aspirin for an hour or two? Chronic pain relief is a level of pain that is extreme and every minute of suffering this level of pain would seem an eternity for the victim of such negligent care.

One visitor told us she has her lunch here every day and feeds her husband liquidized meals. This is evidence that people are encouraged to maintain relationships important to them. **This is evidence of someone who fears her husband will not be fed unless she feeds him herself.**

The home had recorded 4 complaints. We had received two complaints which we referred back to the home to investigate. The manager told us verbally what action had been taken but there was no written evidence. One safeguarding investigation has concluded and two more are being investigated, one was referred by the home and another was reported by a visiting healthcare professional, these are ongoing. **The home is being asked to investigate concerns but cannot prove what they have done. When relatives are desperate enough to go outside for help it is usually as a last resort, still people are raising concerns outside the home and still inspectors are not listening to the deafening alarms ringing.**

Staffing levels are at a minimum but the manager said they were often more staff on duty then on the day of inspection. **Any sentence that starts with the words, *the manager said,* is not my idea of evidence, especially when it's contradicted by what is under your nose.**

There were numerous other failures all pointing to worsening standards in the home, the inspectors however considered the home improved to the degree it was awarded a 1 Star rating adequate, this would in fact make even the remote threat of a warning letter and a vague threat of enforcement action being a consideration at some future time a joke.

The next inspection report for this home is dated 13th of August 2009, 7 months later. It contains the following information.

A relative told us they thought things had improved as they could now leave their husband to be cared for and they could not before. Another relative said no manager seems to stick it her and our mums suffer; we raise things with managers nothing gets done its going downhill. Another relative said they had raised concerns with the new manager on three occasions but he just

laughs. **The words speak for themselves.**

The local authority had partially lifted the embargo on new admissions to the home but put it back in place when further concerns were raised with them. **The home is good enough for the regulator but not good enough for the local authority.**

We looked at three care plans and some recorded good information such as one resident liked to use Nivea Cream. Another resident at risk of depression had this recorded correctly.
One person had a nutritional assessment for diabetes but no further records referred to this. The manager was not aware the person was diabetic and was to ring the GP as this may impact on their wellbeing. **This may kill them but the Nivea cream is being administered so that is alright then.**

One care plan recorded when a wound was redressed but what type of dressing was used is not recorded. A number of people had long dirty fingernails. Moving and handling plans were in place in one plan.

A pharmacist inspected the home in March and thought things had improved. A pharmacist carried out an inspection at this time and found that medication could not be checked as what had been checked in was not recorded and paperwork was not available. There have been problems checking what doses have been given. Doctors' visits had not been recorded and staff were not aware of what doses should be given. The medication audits carried out by the home were audited and indicated medication was administered according to good practice. **So at the time of inspection it's a mess but the homes audits state it's usually alright and that's all that's checked.**

The activities are good as the home employs a full time organizer. We spoke to the activities organizer who said she could only see people in their rooms once a week for one to one due to staffing problems she was deployed to carry out careers duties. One resident said there were not many activities as not enough staff. On the day of the inspection a game of bingo was played. **I am unable to find anything about activities that could be described as good.**

The home has received 12 complaints, regarding care delivery, **keeping people alive.** Staff attitude, **Staff that are not suitable to care for the**

vulnerable. Laundry and meals. These had been recorded. We have received three complaints which we referred back to the home to investigate. We checked the records of complaints made about the food and this was not recorded. **It would not do to check complaints about lack of care or staff as they could be considered protection issues. You have to turn pages to find that complaints are not recorded.**

It is also relegated to the back of the report that staff are trained in adult protection but that three safe guarding investigations are under way but two of them were reported by visiting healthcare professionals and only one by the home. There is an ingrained culture in this home and no amount of training will result in abusive staff reporting abusive practice.

The report states there are no outstanding requirements from the last inspection and the home remains 1 Star Adequate.

I visited the home and being unsure what kind of care my relative needed managed to access all units, the worst by far being the upper floor where I was sent first. When I got out of the lift there were no staff visible and I walked around the unit some time before I located a young male carer who looked rushed of his feet coming out of a resident's bedroom. He pointed me to the lounge area further down where I found the nurse in charge watching television. She got up and took me back up the corridor to a small lounge area where four immobile residents were seated none of whom had any pressure relief equipment and all of whom were extremely thin.
One of these residents was crying please I have been waiting age's can you take me to the toilet to which the nurse replied in a minute I will get someone to. She than started to write some of my details down. At this point the phone rang and she proceeded to discuss a resident with a relative. The issue being that the home wanted this relative to agree to the use of a Kirton Chair. Which is a bucket type chair widely seen as a form of restraint. The nurse told this relative nothing about this chair other than it was more suitable for their relatives comfort. The information given to the relative was scant and would not be considered informed consent by any stretch of the imagination. This is what the Deprivation of Liberty law offers as protection, get peoples consent by misleading them. The nurse told the relative who had agreed to sign a form next time they came in. She then turned to me and continued

taking details by which time the sobbing of the resident who wanted to use the toilet had reached a peak but the nurse was oblivious to it. This nurse only spoke to the resident after I got up and tried to comfort her, she told her she would send someone in a minute but I did not see her do so as she walked back to the dining room where I had originally located her watching TV. When I reached the ground floor I was shown around very quickly and did not see many residents at all. There were two members of staff visible and it was totally silent throughout. There were many areas of the home where the smell of urine was evident. I was concerned that so few residents were in the public areas of the home.

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