Tales of the Un-Inspected
Home Number 75
By Eileen Chubb © 2010

I looked at the inspection history of ……. This home is among those listed as closed as a result of CQC enforcement. However it is still open and under the same ownership.

The first inspection report I looked at for this home is dated 26th of September 2007, I have listed below the most relevant information from this report, followed by my response in bold text.

1. This report notes the home has a past history of poor care and noncompliance with requirements. Unmet requirements impact on the welfare and safety of residents and enforcement action may be considered. **To be fair the inspector lists her findings in full and sends the information to the enforcement team who do nothing, which is incredible given the state of this home.**

2. The home cares for 34 residents with dementia nursing care is not provided. The home is part of a care village operated by the same company. Current fees for the home range from 700 to 1100 pounds a week. **The fees for this home are very high for residential Dementia care and given the extortionate rates, any lack of care in this home could certainly not be blamed on too little money available.**

3. The home is staffed at minimum levels, there are two staff working 8am to 8pm on the upper floor and three staff working 8am to 8pm on the lower floor, staffing levels do not allow residents adequate support. **Five staff to 34 residents with dementia is not enough staff to offer the basics to keep people alive never mind any quality of life. The fact that staff are working 12 hour shifts is ringing every alarm bell also. Working with people who have dementia is extremely stressful, if you put staff who are working 12 hour shifts, constantly short of enough staff to care for residents, then staff will become run down and demoralized and you have a situating where abuse and neglect can easily occur. The staff are being pushed way past the limits of endurance.**

4. The homes environment is poor We found the following shortfalls, by the

entrance to the home in the car park there was a large amount of rubbish dumped, which included old furniture and electrical equipment.
There was clinical waste being stored in bathrooms.
Large areas of the home needed significant re-decoration.
Kitchen doors were ill fitting, work services stained; many carpets were worn and stained. One relative expressed concerns about security as they felt anyone could walk in. Many bedrooms were bare and had worn furniture, some had debris on the floor and dust on the skirting boards. A number of toilets were heavily stained. Chest of drawers had broken handles, a missing handle for a window and exposed screws posing a hazard. **This home is charging more for a week's stay than a four star hotel yet it has more in common with a scrap yard. I always place more importance on care rather than decoration but when neither are evident than things are as bad as it gets.**

5. One relative is paying extra for her relative to be fed by an internal domiciliary staff **agency** located in the care village; these costs are not made clear in the homes brochure. **People are paying up to 1100 hundred pounds a week and have to pay extra for their relative to be fed then what of those residents who cannot pay for this basic element of care? This company is a disgrace.**

6. There is not enough staff to care for residents, the manager and activities organizer help to feed residents. The manager often helps to carry out care tasks. Many residents were left unattended in the main lounge for long periods. Staff said they tried to get residents up before 11.30, they said they cannot get round to everyone. It was nearly lunchtime and one resident was found in their nightclothes coming out into the corridor. Staff were struggling to feed residents, serve the lunch, clear the tables and do medication; staff were trying to feed more than one person at a time. Some residents wandered of before they could be fed. Throughout the inspection residents were seen in need of assistance, one was trying to repeatedly open the doors another began to shout. Staff recruitment was not robust. The manager had no office or computer and often had to work at weekends. **This is as bad as it gets and if this is happening when an inspector is in the home then it's the bound to be even worse the rest of the time, if people are being left in their rooms without care they are being neglected and denied all basic care.**

7. Care plans contained comments such as, *x would not go to bed when told,*

xx is co-operating today, It was also noted in one care plan that a resident was at high risk of pressure sores, a later entry said skin red apply cream, another entry said skin broken apply more cream, no other action or medical assistance was sought. **Being left in bed with no care, food or fluids is the norm in this home and I am surprised people have not died for the want of care. There needs to be urgent action taken but apart from pages of requirements being listed yet again, 21 Standards are judged, 6 are Fully Met and 15 are almost met and none are considered a Major Shortfall.**

The home is not inspected again for a year.

The next report is dated 8th of September 2008; I have listed below all relevant information from this report followed by my comments in bold text.

1. Staffing levels do not allow for residents needs to be met, two staff work from 8am to 8pm on the upper floor and three staff work 8am to 8pm on the lower floor. The manager is often counted among the five care staff on duty. The Rota's showed many staff working 12 hour shifts seven days a week. Staff said a number of residents needed the assistance of two staff for their needs. One relative was paying extra for a domiciliary care agency within the care village to feed her relative at lunchtime. Staff interaction with residents was minimum, one staff member was seen trying to comfort a distressed resident but was called away leaving the person sobbing. Two residents were arguing and there was only a domestic staff member in the vicinity who tried to resolve the situation. Mealtimes showed there were clearly inadequate staff and residents who needed the assistance of two staff members meant the remaining residents were left unattended.
This information is taken from different parts of the report and is just some of the many issues of concern, but it gives me a very clear picture of a care home that should have been closed at least a year ago as the residents are not safe and whilst the inspector takes paperwork and evidence from the home to the enforcement team, no action is taken. What is incredible is the home is found to be poor at handling complaints, yet when two families raise concerns about the lack of staff with the regulator, the regulator asks the home to investigate itself.

2. Some rooms were very bare. There was a strong smell of urine. Furniture was broken, we checked the linen on beds and found it stained, one person

was in bed at 11.30 and disheveled and marked sheets and debris in the bed. People did not have access to call bells as they were tied up. There was discarded furniture by the entrance. Carpets were stained and a large amount of armchairs had food debris on them. Toilets had brown stains, drip marks and brown particles on the seats. The sluice room was foul smelling and heavily stained with brown smears, a mop head stored there had brown stains and brown particles. Other areas had mops and buckets stored which were stained and covered in brown particles. A hairbrush stored in the sluice had a quantity of gray hair in it
There is much more found wrong. The home is graded Zero star poor.

The home is still open six months later and no enforcement action has been taken only threatened yet again.
The inspection report dated 10th of March 2009, Listed below is the findings that concern me and my comments in bold text.

1. Staffing levels are **the same as before.**

2. We asked the service to provide us with an improvement plan, five requirements are now considered repeated. We issued a statutory requirement notice requiring newly admitted residents to be assessed, this is now being done. **So the enforcement taken in effect required the home to assess people's needs before admitting them to the home, regardless of the fact those needs would not be met as the home provided no care. As for an improvement plan it is way too late for that. People have been living in squalor with no care for years, frail, vulnerable, residents who are considered to be totally dependent on the care of others for all their needs, if they survived these conditions that long.**

3. Since the inspection took place there have been two safeguarding alerts investigated by the local authority, one was not upheld due to insufficient evidence and the second is being investigated. **Anyone not upholding a safeguarding alert on this home is negligent. You only have to look at the available evidence. The cries for help have managed to make it outside the home only no one is listening.**

4. There is poor handling of medication. One male resident regularly came out of his bedroom into the corridor in night clothes, staff said this person liked to stay in bed all day. **Out of sight out of mind, this is neglect if a**

person wanted to stay in bed all day they would not keep coming out of their room. The residents in this home are unable to speak for themselves due to severe dementia and leaving someone behind closed doors uncared for is not a residents choice in this home it's their fate.

5. Two people's relatives were paying for domiciliary agency staff to feed them at lunchtime. One resident was noted to become agitated when given food he not like. Some staff were involved in providing activities on the day of inspection. A staff member led a resident who had been standing over to us and said, *Look One Hundred Per Cent Dementia, But Dancing Good Yes?,* This showed no respect for dignity. **This showed staff thought inspectors would think activities were improved, which they did think so it worked.**

6. Page 28. A safeguarding referral was made in March 2009 in which a resident said a staff member had injured them, the manager spoke to the police and the community psychiatric nurse and it was agreed the investigation would go no further. **The worst abuse happens to those with dementia because they are often unable to tell and even if they cried for help no one would believe them. Given the conditions in this home I would be very surprised if some less good staff were not abusing residents, given that good staff are being forced to neglect residents daily. There are numerous other concerns I have about statements in the report, there is clearly a pattern of putting residents in bedrooms if they are more vocal in expressing their needs and this is common in homes as bad as this. I call this approach the, If you cannot hide the persons neglect then hide the person.**

The home remains Zero Star and the threat of enforcement action is made yet again, as it has been for years.

The home is so bad a, See No Evil approach is taken as it is not inspected for 6 months and then it is graded one Star Adequate. This is listed as a home closed as poor, yet it has remained open and under the same ownership and even the responsible person is the same.

The inspection report dated 29th of September 2009. The evidence that contradicts this home is improved is taken from this report and listed below with my comments in bold text.

1. Two new residents admitted to the home had not been fully assessed. **Evidence of no improvement.**

2. Relatives are paying for staff to feed their relatives. **No improvement.**

3. The home said staffing levels were increased. A staff member said they were able to do more with residents due to the number of vacancies. There were now three staff on each floor. **Later in the report.** A member of staff said to us she had been sent from another home for the day. **From another section of the report.** Staff files have been checked and one member of staff has been recruited in a non-care role and checks made. **So the home has employed no new care staff and sent over from another home a member of staff which just so happens to be on the day inspectors are in the home. No evidence of improvement.**

4. The home has made one safeguarding referral. It also emerged that a member of staff was sleeping on duty. There have been two staff members suspended and subject to disciplinary procedures after a police investigation. A further incident has come to our attention and a staff member withdrawn from the home as a protective measure. **Too much abuse to be ignored totally has spilled out into the open, one incident was reported by the home and the rest came from elsewhere, how many residents have suffered and how is kept secret but I recall the previous report where a resident tried to get help to no avail. As to improvement I see none.**
5. Meals times had improved and extra domiciliary staff were available, these agency staff were well known to residents. **These extra staff were being paid to feed residents by relatives concerned their loved one would not be fed otherwise. This is not evidence of improvement it is desperation to find some where none exists.**

In fact there is no evidence this home has improved at all unless you count the assertions made by LB the responsible person who has been on site for years whilst so much neglect has been allowed to continue unchecked.
Are the public told about this homes appalling history? No just this last sanitized inspection report. The other inspection reports had to be obtained from other sources.
This care home is not regulated it is protected by the CQC; the shame of it is the residents are not afforded protection at all.

Should the bodies pile up in this home as they did in Parkside people will ask how this can happen? This is how it happens, because of the CQC and not in spite of them.