

Tales of the Un-Inspected
Home Number 84
By Eileen Chubb
(This Report Is the Copyright of Eileen Chubb 2011)

This Home is owned by the same company as homes, 33, 36, 41, 48, 49, 50, 54, 59, 60, 62, 63, 64, 65, 66, 67, 68, 70, 71, 72, 82.

The home was taken over by this company in 2007 and the first inspection report in 2008 contained the information that staffing levels were reduced. The first thing this company does when it takes over a home is to cut staffing levels to the bone. Throughout the report information is noted but not connected by inspectors to any cause, but I know that as soon as you cut staff, you cut care.

There are many failures noted by the regulator but I have decided to concentrate on the areas I have summarized below.

The residents, relatives and staff all tell the regulator there are not enough staff.

Calls bells are not answered.

There are no longer any activities provided.

People feel if they complain their concerns are ignored.

The home failed to report safeguarding issues to the Local Authority yet they are considered fit enough to investigate.

The home is graded 1 Star Adequate.

The next inspection is 9 months later in February 2009.

The first thing I found of concern is the Killer Clause has been used. (I call this the Killer Clause because if a home fails to meet requirements and the regulator know they are likely to continue failing, the regulator deletes the requirements in order to avoid taking any action. In short the regulator protects the home and the vulnerable residents have to suffer the consequences)

The regulator again notes the concerns of residents, staff and relatives who say there is not enough staff.

The residents on the dementia units (who are the most vulnerable and always suffer the most) are noted to be not dressed properly, did not have access to drinks or assistance to eat.

People's calls for help are unanswered.

There are no activities and the activities organizer has gone to the hospital with a resident.

Staff are leaving which is hardly surprising.

Complaints are not acted on.

Yet the regulator states there are no outstanding requirements and despite clear evidence of falling standards of care, the home remains 1 Star Adequate.

The next inspection is 9 months later in November 2009.

The Killer Clause is used again.

On Page 8 it notes that there has been a significant drop in standards and describes the care being received by residents as poor, but grades it as adequate.

There are still no activities.

Safeguarding concerns not reported, complaints not acted on.

Not enough staff.

Records missing.

Widespread neglect of residents.

The staff are considered by residents and relatives to be excellent but rushed of their feet.

The Home remains 1 Star Adequate.

The next inspection takes place just 8 Weeks later in January 2010.

Only 4 pages of scant evidence conclude all requirements have been met.

The home remains 1 Star Adequate.

The next inspection is 4 months later in May 2010.

It notes there is such a long delay in food arriving resident's wander of, which means they had no food.

One member of staff was seen feeding on resident, in a home of 75 residents, only one was being fed, I would have asked how many needed to be fed to get a true picture of the scale of neglected residents.

There is a smell of urine.

Staffing levels are considered alright but were not checked.

The average inspection report consists of 30 pages, this report contains just over 2 pages, if inspectors refuse to see the problems then they will

not have to act on them. The problems remain.

I visited the home and was shown around the dementia unit. There was one senior carer who was also doubling up as deputy manager and two carers on this unit.

I noted the following,

The residents I saw were highly dependent on the staff for all their needs.

The vast majority of residents were in their rooms behind closed doors. I saw the two young carers with a hoist standing hesitantly near a female resident and when they thought I had passed by I looked back and saw they were changing this resident's continence pad in the main lounge. This happens when staff care enough to keep people dry and comfortable but there is not enough staff to allow time to take people to their room to attend to such personal care.

Some people who were obviously immobile had no pressure relief cushions under them and looked uncomfortable.

Another resident was sat slumped over a table.

I was told there were 3 empty rooms so the home was nearly full, but there were few staff in evidence throughout the home.

The senior carer said he had worked at the home since it opened and had seen owners, he talked about the first owner and how much training and support was given by them, but he said nothing about the company that currently owns this home. This carer had a great empathy with residents who had dementia and several residents approached during this time and he responded to them immediately and with real compassion.

Whilst the care residents received was severely restricted to the most basic physical care, it was obvious even this level of care was delivered not because there were sufficient staff but because the few staff that were working that shift on that particular day was willing to work beyond their employers requirements.

I know many care staff who would leave residents sitting in urine soaked clothing if there was no time to change them, these staff were doing their best given the number of dependent residents.

This company has made millions in profits by cutting staffing levels until the care of residents is down to luck, if there is any care at all.

Eileen Chubb

