Tales Of The UN-inspected

The On-going Failures of The CQC and Home 42

By Eileen Chubb

Home 42 was first exposed by Compassion in Care in **2004**, 12 years ago **Phyllis Jewson,** aged 90 fell whilst being hoisted and suffered a Fatal brain injury.

We also exposed two further incidents that were **not** mentioned in the CQC Inspection reports at all,

Firstly in January **2009** a nurse working at this home was cautioned by The Nursing and Midwifery Council after she was discovered selling drugs she had illegally obtained from Home. The **CQC** at the time had rated the home good.

In September **2009** The home is prosecuted by The Health and Safety Executive after an untrained, unsupervised care worker working on her first shift, hoists 80 year old **Muriel Lindley** who fell from the hoist and suffered fractures to both legs and died a few days later.

How do the CQC inspect this home considering these events? They do **not** inspect at all and allow the home to inspect its self using the self assessment tick-list known as the AQAA. On **15th October 2009** the rates itself 2 Star GOOD.

Please see our full report on home 42, **BUPA run West Ridings** Care home.
Here http://www.compassionincare.com/sites/default/files/talesreports/home%2042.pdf

Also see page 15 of Breaking The Silence Part 3
http://www.compassionincare.com/sites/default/files/breakingsilence/W-B3.pdf

Since then this home has gone from bad to worse and yet is still open and still failing, people have suffered serious injuries and continue to be at high risk.

Inspection Report, January and February 2015.

The home is rated as *Requiring Improvement* in 4 areas and *Good* in 1 area.

The following issues are noted,

Page 8 "There were some concerns in how we saw one person moved and handled and how one persons dressings were applied"

Page 9 *"Staff we spoke to on Swaledale unit said they felt under pressure at times,they said they were being asked to carry out additional roles such as host and provide cover on other units with little in the way of handover. Staff also felt they were leaving people longer in their beds as they could not get round to everyone"*

Page 9 " *A resident says we are supposed to have a bath once once a week but you have to natter away at them to get one. There are some people here who hardly ever get one"*
" Another person says you have to ask continuously, its all down to the number of staff. They do care but they just don't have enough people to get around to doing things"

On activities page 9 notes *" We are short of things to do, we used to play bingo and dominoes but we don't any more. We got a new activities Co-ordinator but they are more interested in writing notes"*

<u>CQC Inspection Report September and October 2015.</u>

This inspection is taking place as a result of serious harm to residents and CQC **react** to this. Only one unit is inspected, Kingsdale. Two of the five standards are inspected.
The words of residents and staff say everything that is wrong with this home.

What some of the residents told inspectors

Page 5 "*I have fallen before and that's why I am here but there are no staff around and I am scared I will fall again so I just have to wait until they can help but there's never any staff about"*

" I have been here a month and its always the same. The staff are wonderful but they are so busy and we just have to wait until its our turn and that can be a very long time, I would fall if I tried to move by myself"

" Another person told us, I am no better in here than struggling on my own and I'm scared in here, there's nobody to rely on"

" One person called to one of the inspectors to help, please can you help me I need the commode I can see it but I cant get to it, I've been waiting ages, no one will help me"

" Its worst at bedtime when you just want to go to bed, its awful. Staff are just so busy and you have to wait until they get to you, I would even have the coal man help me when I get desperate, I would have anybody when it gets so bad, that's how it feels and its not nice to wait especially when you need the toilet"

Staff Tell Inspectors.

" I always said I wouldn't be one of those staff that said ***Two Minutes*** *to people and did not come back for ages. Now I find I am saying it because I feel so bad telling someone I cant help them when they need it"*

" Staff said they felt personally upset because they cared about the people and wanted to do their job well but low staffing levels meant they could not provide the care as people needed it"

" Staff said they knew the whistle-blowing procedure for reporting poor practice if they witnessed this, to ensure people were safe, however one member of staff said, ***I don't think people would dare to whistle blow****"*

Other issues
Agency nurses with no knowledge of peoples needs working.
Accidents and incidents not investigated.
One person had suffered serious injury's during moving and handling.
Hoisting slings were not checked and staff spoken to were unsure which hoisting slings should be used for which individuals.
There were unsafe parts of the unit, loose handrails and other serious hazards.
One person who was suffering significant pain had no pain assessment for 3 days.
Dirty dressings on wounds.
On one shift the care staff and nurses were unable to provide details of how many people were on the unit in case of fire.
Medication was not always administered safely.
Low staff moral throughout all the units

<u>CQC Inspection November 2015</u>

The home is rated Inadequate overall
The Kingsdale Unit was voluntarily closed by BUPA following the previous inspection

Issues noted

Not all equipment was suitable or safe.
Wheelchairs belonging to BUPA were dirty, had loose nuts and bolts,damaged seats and lapstraps,brake failure and missing footplates.
Staff were not competent in moving and handling

On one unit only one of two hoists was working.
One person was observed during hoisting and the sling was not positioned correctly.
Where we have been informed of people sustaining serious injuries no investigations have taken place.
Moving and handling training was still not robust.

Inspection Report September 2016

The home is rated inadaquate again and still no inforcement action is taken inspite of the home home being in special measures for 7 months. Things have got worse.

Page 7
" One person on Swaledale unit said, they did not feel safe and they were amateurish with the hoist"
" Another person on Airedale unit said they felt unsafe when being Hoisted"

" Many staff we spoke with said they would not hesitate to bring concerns to managers, ***but not all*** *said they would be comfortable to use the* ***whistle-blowing*** *procedures if they had concerns about a colleagues practice"*

" The manager said I think people are safe, their a lot safer than that were, they said there were ***no*** *problems with health and safety.* ***However*** *our findings at this inspection showed the managers evaluation was not accurate as we identified continuing concerns"*

" Staff lacked knowledge of how to use equipment"

Page 8
" *One person said they had not been out of bed for days as staff had attempted to* ***hoist them*** *in a sling that they felt* ***unsafe*** *in "*

Other issues noted.
Staff were unsure which eqipment people needed.
Care plans and risk assessments were not accurate.
Precarious *moving and handling manoevours were witnessed.*
The safeguarding system did not prompt staff to report safeguarding alerts to the safeguarding authority.
Staffing levels in some parts of the home did not meet peoples needs.

On the Calderdale unit the rota for 28 shifts showed 21 shifts understaffed. Wharfdale unit said they were often called to cover on other units leaving people on Wharfdale ***at risk****.*

Residents and relatives consistantly reported poor staffing levals.
Suitability of staff and staff training was not checked consistantly.

Two people on Swaledale unit were left sitting in the same chair all day without continance needs attended to. Both people were assessed as being at high risk of pressure sores and shoud be repostitioned every four hours,

Concerns and complaints were not always dealt with. One person had complined he had not had a bath for weeks due to having no lifting equipment, the manager said she considered this to be a query rather than a complaint.

The homes complaint records did not match those on the computor system. Some people said they did not know how to make a complaint.

Some staff said they felt well supported and some staff did not feel well supported and felt that overall leadership was ***bullying in nature****, with nothing resolved. Some staff told us they did* ***not feel confident*** *of management support* ***if*** *they followed the* ***whistle-blowing procedures****.*

There were ***numerous*** *meetings where concerns, quality issues and risk were discussed but there was* ***little evidence*** *of the outcomes of these discussions and no register to log risks.*

The manager said ***moving and handling*** *was the thing that had improved most but the slings and lifting euipment checked had no serial numbers to identify this equipment.*

The incidents in ***2015*** *which resulted in serious harm to two people had* ***not*** *resulted in any lessons learned one incident was only investigated four months later and the other* ***never*** *investigated.*

Where serious failings in the service have been previously identified around the management of risk (Kingsdale unit incidents) little action was taken to improve practice and prevent further harm. We asked BUPA to provide information to assure us of peoples safety.

Summery.

This is a home where two people died in 2004 and 2009 and where two further

people have suffered serious harm and yet the only action taken by CQC is to **just** ask BUPA for reassurence that people are safe. The people living in this home and the many good staff who have **repeatedly** tried to raise the alarm **deserve better** than BUPA and **deserve better** than the CQC.

I have given the CQC time to prove their new alledgedly improved inspection regiem but what has changed?

The CQC used to **not** disclose poor care or inconvenient information and then do **nothing about it.**

Now CQC disclose some poor care or inconvenient information and then do **nothing about it.**

Eileen Chubb