Closure of a Care Home on the Isle of Anglesey

Section 3 Review Report

July 2014

This report is issued under section 3(1) of the Commissioner for Older People (Wales) Act 2006.

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Contents

Introduction 3

How I conducted my Review 4

The years prior to closure 6

The period of time leading to closure 11

The relocation of residents 19

What lessons have already been learnt? 22

Findings and Recommendations 24

Appendix A: “Escalating Concerns with, and closure of, care homes providing services for adults” 30

Appendix B: The Care Homes (Wales) Regulations 2002 31
Introduction

This is a review, which I have carried out under s.3 of the Commissioner for Older People (Wales) Act 2006, of the circumstances that led to the closure of a Care Home on the Isle of Anglesey (the Care Home), as well as the process of closure itself. This review was conducted as a result of significant contact from the relatives of older people resident in the home and others in the locality with an interest in how the home was run and the manner in which it was closed.

Specifically, this is a review of the extent to which the Isle of Anglesey County Council (the Council) and the Care and Social Services Inspectorate Wales (CSSIW), discharged their functions in order to safeguard and promote the interests of residents, particularly during the time of its sudden closure. Gwynedd Council also commissioned places in the Care Home but its role was significantly less than that of the Isle of Anglesey County Council in the Care Home closure process itself.

The Care Home closed in March 2012 but there are wider lessons to be learned from the circumstances leading to its closure and also the closure process itself. It is not the purpose of the report to look at every individual detail of the home’s demise and closure but to draw from the evidence available some broad themes and learning. The story is told in a chronological manner because this is the most effective way of seeing it unfold.

It is clear from the evidence that warning signs were not heeded as early as they could have been and, after reading this report, I am certain that no-one would want to see the situation repeated in any other care home in Wales. For the benefit of older people we need to learn from past events and make changes for the future.

Sarah Rochira
Older People’s Commissioner for Wales
How I conducted my Review

My early involvement with the Care Home arose when the new owners of the property contacted my office in search of assistance.

They had purchased the property after the company that had owned the Care Home went into liquidation. The new owners had no links to the former owner and did not intend on using the property as a care home.

On entering the home, the new owners discovered the abandoned personal property of former residents which included clothing, wedding photos, hymn books and much loved Bibles containing personal items such as Orders of Service from family weddings. They also came across sensitive documentation about residents and staff.

The new owners sought guidance from the Council as to what they should do with the sensitive documentation and the personal property.

The Council held that documentation relating to individuals who had been residents of the Care Home at the time of closure had been transferred with the relevant resident to their new home. The documentation that remained at the Care Home was therefore of a historical nature and was the sole responsibility of the Care Homes liquidator.

The Council took no action in relation to the personal property as it was their opinion that the property was not definitely identifiable as being the belongings of the homes residents at the time of closure.

My initial concern was to ensure that the sensitive documentation that had been left at the care home was safely collected and secured by the responsible parties – this was a process that took many months as it involved liaising with the Information Commissioner’s Office, the liquidator, the companies whom the liquidator had contracted to secure the data and the liquidators legal advisors.

Once the data had been safely secured, I contacted Gwynedd and Anglesey Councils and asked that they write out to former residents who were still living or to appropriate representatives where the former
residents did not have mental capacity, to ask them to share with me their experience of life at the home and their experience of its closure.

A number of individuals contacted my office to share their experiences and these experiences have helped inform the content of this report.

I also wrote to both the Chief Inspector of CSSIW and the Chief Executive of the Council asking them to paint a picture of the home in the years prior to its closure by providing me with the details of any concerns that were raised and how they were addressed. I also requested that they explain to me the specific events that led to the sudden closure of the home, within a weekend, and the documentation that supported the process of closure.

Representatives from my office also inspected the care home on the invitation of the new owners and saw for themselves the personal possessions that had been left behind.

Throughout this report the ‘Owner’ of the Care Home is referred to. It is important to understand that the Owner also assumed the responsibility of being the Responsible Individual for the Care Home. In broad terms, it is the role of the Responsible Individual to supervise the management and operation of the Care Home. An individual can only be registered to this post if CSSIW are satisfied that they are fit for the role.

Neither the Owner nor the home’s liquidator was subject to this review and they were not approached to provide evidence for the purposes of the review.

The information gathered from families, residents’ representatives, CSSIW and the Council forms the basis of this report.
The years prior to the closure

The Care Home had operated as a Care Home since 1984 and was purchased in November 2005 as a going concern by a newly formed company that had been founded with the intention of acquiring a care home that specialised in dementia care.¹

The Care Home was situated in a small village in rural Wales and was registered to provide accommodation and care for no more than 22 persons over the age of 65 who had a diagnosis of dementia. The residents of the Care Home were some of the most vulnerable in the community and had significant care needs.

**June 2006**

In June 2006, CSSIW published their first inspection report on the Care Home since the new Owner took over. The existing manager, who had over 21 years of care home management experience, remained in post and the inspection report was generally positive.

It was noted that the new Owner, who was based in London, was visiting the Care Home at least once every month but that he had been reminded that to comply with the relevant regulations² he must also write, and send to the manager, a report on the conduct of the Care Home following each visit.

The paid carers commented that they were expected to undertake cleaning responsibilities on top of their caring role and the Owner stated that the employment of a cleaner was under consideration.

Although most residents lacked capacity to provide their own feedback, families spoke highly about the standard of care their loved ones received.

**June 2007**

By June 2007, the CSSIW inspection report noted that the manager had resigned her post because of ill health and a temporary manager had

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¹ Care Home on the Isle of Anglesey Information for Creditors, 25 April 2012, Directors Statement of Company History
² The Care Homes (Wales) Regulations 2002, Regulation 27
been appointed. The inspection report identified a high turnover of staff since the previous inspection. All new staff would have been trained by the new manager.

In this June inspection report, it was documented that no progress had been made in employing a cleaner but the Owner confirmed that it remained his intention to do so. The report stated that an upgrade of facilities was required and that this had been budgeted for by the Owner.

The Owner was also documented as making the required monthly visits and submitting the accompanying written reports. Residents’ families continued to report satisfaction with the standard of care at the home.

**June 2008**

In June 2008, the inspection report again documents concerns about the décor and facilities of the premises. The high turnover of staff and the recruitment of inexperienced staff were both discussed with the manager and the Owner. The report documents that the manager would invite families to six monthly review meetings but the response to these invitations was very weak. Families, however, felt that communication from staff and the manager could have been better. As previously, the Owner was also documented as making the required monthly visits and submitting the accompanying written reports. A cleaner had been employed.

The inspection report highlights that the home had received one complaint and had been subject to adult protection processes on two occasions as a result of concerns raised about the supervision of residents. As a consequence, the home was required to ensure that the grounds were made safe and secure.

**June 2009**

In June 2009, the inspection report documents that seven complaints were received about the Care Home since its previous inspection and the majority of complaints related to the standard of both external and internal décor and maintenance. Concerns were also expressed about staffing levels and the security of the building. The report outlines that the Owner of the Care Home responded appropriately and addressed the complaints.
CSSIW upheld a complaint made in November 2009 that a staff member had been appointed without the required Criminal Records Bureau and employment checks. As a consequence, the Care Home was issued with a compliance notice and was advised that enforcement action would be considered if this happened again in the future.

July 2010

An inspection report for July 2010 documented the high level of relatives’ satisfaction with the care provided at the Care Home. It was recorded that a programme to upgrade the premises externally and internally was underway. Again, there had been a high staff turnover since the previous inspection. The Owner was recorded as visiting the Care Home once a month and is said to have kept in daily contact by phone and email. It is noted that the manager resigned her post in October 2009 and a senior staff member had applied to CSSIW to become the registered manager. This would indicate that the Care Home was without a registered manager at least between October 2009 and July 2010.

Alongside the July 2010 inspection report, CSSIW undertook a thematic inspection of infection control at the home. This was prompted when the Care Home experienced an outbreak of an unidentified infectious disease in January 2010. The Care Home co-operated with the Public Health Department in addressing the outbreak. Residents were isolated and visitors to the Care Home had to wear protective clothing. Relatives commented that they felt staff dealt well with the situation. CSSIW required the Care Home to organise up-to-date training on infection control and report back on the arrangements that had been put in place.

In January 2011, an incident at the Care Home was reported whereby a carer was accused of assaulting and verbally abusing a resident. The incident was investigated by the Council’s adult protection team and considered by the Police. No evidence was found to substantiate the allegation and the carer, therefore, continued in their employment at the Care Home.

On 29 January 2011, the Council raised concerns with CSSIW about the cleanliness and deterioration in the fabric of the building. This was fed back to CSSIW with the intention that it informs an imminent inspection
of the Care Home, although this inspection appears not to have taken place before 13 April 2011.

In April 2011, concerns were raised with CSSIW that the manager was not responsive and that hoists and crash mats were not provided at the Care Home. The individual was advised to resolve the issue with the manager. The allegation was considered as part of the next CSSIW inspection but was not substantiated.

**May 2011**

The May 2011 inspection report was the last report that was issued, and in the public domain, before the Care Home was closed. Again, families reported a high level of satisfaction with the care their relatives received. Although money had been spent on improving the facilities and the premises, it was noted that further works were required both internally and externally. There was still high staff turnover since the last inspection but it was stated that the situation had improved. The Owner was reported to visit the Care Home once a month, however the last written report based on his visits was dated July 2010.

In June 2011, there was a further reported incident involving the carer that had been involved in the January 2011 incident. Again, the allegation was one of physical assault and verbal abuse. The carer was instantly dismissed for gross misconduct and the incident was investigated by both the Council’s adult protection team and considered by the Police.

In August 2011, a resident sustained a bruise to the side of the face after being hit by another resident. The residents involved did not have mental capacity and although the incident was considered by the adult protection team it was concluded that the most appropriate response was to review the care needs of each resident to see if they had been appropriately placed at the home.

Both Councils were undertaking regular reviews of individual residents in the Care Home throughout the course of the year. No serious concerns were raised about the Care Home during these reviews.
**January 2012 onwards**

From January 2012 onwards, conditions at the Care Home appear to have deteriorated and, on 16 March 2012, both the Council and Gwynedd Council began actively transferring residents to alternative placements. The last residents were moved from the Care on 19 March 2012 and the Care Home was voluntarily closed by the Owner on 20 March 2012.
The period of time leading to the closure

Several incidents occurred in the months running up to the closure in March 2012 that indicated that all was not well at the Care Home.

In early January 2012, the Secretary of the company that owned the Care Home resigned from his post. The reason for this resignation is unknown.

Later that month, concerns were raised anonymously with CSSIW about residents being inappropriately dressed, a lack of heating and inadequate hygiene provision. The person raising these concerns agreed that they would speak to the manager and to get back to CSSIW if they were not satisfied with the response.

In early February 2012, the Owner failed to return essential monitoring documentation to the Council, despite having been given a deadline extension. When the extended deadline was not met, the Council decided to visit the Care Home but received a request from the Owner that the visit be delayed by a month because it was possible that the manager of the Care Home was about to resign.

Resignation of the manager

The manager resigned her post on 7 February but did not give a reason to CSSIW for her resignation until 2 March. During an interview, the manager shared with CSSIW her concerns about her workload and explained that she had been unable to influence expenditure on cleaning, food and the activities schedules as this was under the control of the Owner. She did not, however, have any concerns about the care provided to residents and did not feel it necessary to raise any such issues with CSSIW or the Council.

When CSSIW made contact with the Owner to confirm that the manager had resigned, the Owner said he would be writing to them to outline management arrangements at the Care Home. He did so on 17 February.

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3 Care Home on the Isle of Anglesey Information for Creditors, 25 April 2012, Statutory Information
and CSSIW wrote to him on 24 February confirming that the notification had been received.

Whatever the reason for the manager’s resignation, the consequence for the residents and staff of the Care Home was that they were without a manager. The Owner stated⁴ that following the resignation, the running of the home would be carried out by two senior carers nominated to cover the day to day management duties. This arrangement was put in place as a temporary measure until a new manager was appointed. There is no evidence to say that these two senior carers had the necessary qualifications, experience and skills to manage a care home and they were not registered with the Care Council for Wales.

At this point, there were 16 residents in the Care Home, the majority of whom had been placed there by the Council and Gwynedd Council. It is not clear exactly how many were funding their own care at the home, i.e. not placed there by either Council.

**Out of Hours alert**

At 16:33 on Saturday 3 March, the Council’s ‘Out of Hours Team’ was contacted by a carer who was distressed and asked that social services attend the Care Home as a matter of urgency as she considered conditions at the Care Home to be inhumane. She said there were only two staff members delivering care to 16 residents and described how a resident had sat in their own urine for a couple of hours because staff did not have time to change her. The carer referred to the fact that the manager had left four weeks previously.

It later transpired that there had been an outbreak of diarrhoea and vomiting at the Care Home that had lasted ten days but that neither the Public Health Department nor the residents’ GP had been informed of the outbreak. This meant that the outbreak was not properly managed. This was despite the fact that the Care Home had had an infectious disease outbreak in January 2010 and that further training in how to respond to such incidents had been given to staff.

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⁴ Care Home on the Isle of Anglesey Information for Creditors, 25 April 2012, Director’s Statement of Company History
At around 18:00, social workers from the Council’s Out of Hours Team went to the Care Home and found two carers on site – they alone were responsible for meeting the care needs of all 16 residents, which included the cooking of the evening meal. The social workers experienced a strong smell of urine, faeces and vomit as they entered the Care Home. The social workers spoke to the two carers, who were clearly upset. One of the carers was cooking the evening meal for the residents and explained to the social workers that she could no longer cope given the low staffing levels. She was adamant that she and the other carer had spoken to the Owner about this and highlighted that, because of the lack of staff, they were not able to administer medication as routinely and carefully as they should. Additionally, a cleaner was only employed for five days a week and so, as it was a weekend, the carers also had to do the cleaning.

When one of the social workers contacted the Owner, the Owner denied any knowledge of a problem. He was told by the social worker that there needed to be at least three, preferably four, workers on each shift and that CSSIW would be informed of social services’ concerns. The social workers felt that he demonstrated a lack of responsibility.

The social workers considered whether adult protection measures had to be taken and decided that they should. Whilst they were there, one resident was admitted to hospital with heart problems and two others were still in bed with diarrhoea and vomiting.

The social workers also looked around the home and noticed that the décor was neglected, the home was dirty (faeces stained on the floor in the corridor) and the whole place was chaotic with the carers close to tears.

On the social workers return to the Care Home later that evening there was an additional staff member on duty, however, that staff member explained that she had not previously worked there as a carer and this was her first shift. The carers were advised that there would be a further visit the following day so that the situation would be monitored and that there were to be at least three workers on per shift.
The discovery of wider concerns

On Sunday 4 March another two social workers visited the Care Home at lunchtime and found residents waiting for their lunch in the lounge area. On entering the building there was a very strong smell of faeces and the floor was sticky underfoot. A couple of the residents were still experiencing the effects of the diarrhoea and vomiting outbreak. There were four carers present and another four scheduled for the following shift. In addition, there was a cook. The staff had attempted to clean the Care Home as well as they could.

The social workers asked to look around the Care Home and recorded that, in their opinion, all the rooms were poorly furnished and shabby with old furniture. There were cracks in some of the rooms that looked like they might be structural faults. One of the rooms was occupied by a resident who was in bed and the floor was covered with a considerable amount of faeces. A carer told the social workers that the faeces had been on the carpet for several days. The carer explained that the resident had had faeces over his body for days and his feet were black with hardened dirt because he would not allow the carers to clean him. The carer said that if they ever tried to clean him he would become violent and the GP had prescribed medication but it had had no effect. She agreed to move the resident to another room immediately, stating that he was inappropriately placed at the Care Home. It is important to note that this resident was a self-funder with no social worker.

The carer who had raised the Out of Hours alert confirmed that there was no manager and that she was concerned about the running of the Care Home. She said that the Owner visited infrequently. She said that all staff had the required Criminal Records Bureau (CRB) checks but that some of those CRB checks were now out of date or carried over from previous employment (which was not sufficient) and that no new forms had been completed. She related concerns about low staff morale and sickness rates, maladministration of medication, the chaos of the staff office and the general cleanliness of the Care Home.

The Out of Hours referral report completed by the social worker on 4 March 2012 makes clear that the she felt that the Care Home was appalling and not fit to care for older people and that some of the
problems had been longstanding. She was clear that the fabric and décor of the Care Home had clearly been allowed to deteriorate over a long period of time and staffing levels had been low for some while. In her opinion the Care Home was not fit for purpose and, more worryingly, the situation had only come to light by chance. She commented that the residents could have been left like that had social services not been made aware.

**Addressing the problems**

The diarrhoea and vomiting outbreak was dealt with and the Care Home was cleaned. The gentleman in the room with the soiled carpet was moved to a clean room and the carpet was removed and destroyed. Social services arranged for emergency staff to be on standby should the Owner be unable to maintain staffing levels.

The Council attempted to alert CSSIW over the course of the weekend but it is recorded that the numbers on the website were no longer in use or rang out.

On Monday 5 March, a meeting was held between the Council and CSSIW (the Health Board was not present and appears to have played very little role in the closure). The meeting was held under the ‘escalating concerns’ procedure (see Appendix A)

At the meeting, the events of the past 48 hours were discussed. The Head of Adult Services had contacted the Owner of the Care Home who did not seem to be too bothered or concerned about the situation. The Head of Adult Services felt the Owner was struggling to run the home; there were signs of a lack of financial investment and he had no background in social care.

It was agreed that on-going support should be provided to the Care Home and a contingency plan was put in place for Council care staff to work there on a short term basis if required. The Owner of the Care Home was due to visit the Care Home from his London base in two days’ time, on Wednesday 7 March, but was urged to visit as soon as possible. The Council decided to take responsibility for the resident who was a self-funder and who had to move room. An embargo was placed
on the Care Home which meant that nobody else could be placed there and referrals were made to the adult protection team.

A second meeting was held that day, following a visit to the Care Home by social services, the adult protection coordinator and the local CSSIW inspector, to check on the situation. During that visit further discussions were had with senior carers. The Care Home did not appear equipped to be a dementia care establishment as there was no evidence within the homes environment that the home was ‘dementia friendly’ in any way. Also, it was noted that amongst themselves, certain staff referred to residents by their room number and not their name. There was evidence that medication recording was not consistent or complete and care plans were not well managed. A record of visits by the Owner indicated that visits had been made in July 2011 and then in January 2012 suggesting a significant gap between visits.

This visit served to confirm that the decision taken that morning to instigate the ‘escalating concerns’ procedure was correct and it was acknowledged that the Care Home could face closure. Action was taken to safeguard the residents, e.g. checking their medication, reviewing their care needs, ensuring the home was warm, ensuring there was enough food and constant monitoring of the situation. It was also agreed that residents’ families would be informed of recent events and that any feedback from families would be noted (although note comments from families in the next section ‘The Relocation of Residents’).

At the next meeting, which was held on 7 March, the Owner was present and was questioned on how the situation had arisen. His responses to questions around staffing levels were unclear and this caused those present some concern. Contact had been made with residents’ families who had indicated that the care provided had been excellent. The meeting concluded that the residents were not considered to face an immediate risk to life or limb and that they would be safe if staffing levels were maintained and resolved to allow the Owner a limited amount of time to make the required improvements.
CSSIW inspection

The following day, CSSIW carried out an inspection of the Care Home. They noted that, amongst other things, there had been no review of residents’ care needs since December 2011; three senior carers had handed in their notice, that incidents involving residents at the Care Home had not been recorded since the departure of the manager and that the system of storing and administering medicine was lacking.

This was fed back to the meeting on 9 March 2012, as was the Council accountant’s assessment that the Care Home was to be classed as a “high risk business”.

The final week

On Tuesday 13 March 2012, between 18:30 and 19:00, a carer from the Care Home contacted the Out of Hours Team to advise that a staff member who was meant to work the night shift had called in sick and there was no replacement available. The Council arranged for a carer to attend the Care Home to cover the night shift. Following this shift, the Council carer reported that residents were not given incontinence pads before they went to bed and, as a consequence, their beds were soaking wet with urine.

At a meeting on Wednesday 14 March 2012, it was noted that over the weekend the Owner had appointed a new manager, however it was made clear that the appointee did not have sufficient experience of the type of care that the residents required to take on the role. It was also acknowledged that residents’ families were not aware of the full extent of the concerns at the Care Home.

During the meeting, the appointment of Independent Mental Capacity Advocates (IMCA’s) was discussed. The role of an IMCA is to safeguard the interest of those with nobody else to speak for them when they lack the mental capacity to do so for themselves when certain decisions are being made. It was noted that there was no need to instruct IMCA’s as all residents had family.

By this point in time, five of the sixteen residents had been assessed as requiring nursing care - a need that the Care Home could not meet. It transpired that there was no member of staff at the Care Home who had
the training or skills to undertake the necessary assessments. Residents were therefore not receiving the care they required.

On Thursday 15 March 2012, the Council issued the Care Home with a formal notice of contract default and made it clear to the Owner that residents would be moved to other care settings.

By Friday 16 March 2012, the Owner had informed both the Council and CSSIW that he had decided to close the Care Home. Residents were relocated to alternative suitable accommodation between this date and the 19 March 2012. The Care Home was voluntarily closed by the Owner on 20 March 2012.

The Owner stated\(^5\) that, from his perspective, the difficulties at the Care Home began when occupancy levels dropped in the latter part of 2011, but that it had been possible to secure a small profit by making adjustments in expenditure and staffing levels to suit the number of residents at the time.

Regardless of the Owner’s decision to close the Care Home, CSSIW informed him that their inspections had identified significant regulatory breaches and he was therefore advised of their intention to issue a notice to cancel registration. Formal notice of a proposal to cancel registration was issued on 3 April and a notice of decision to cancel registration was issued on 2 May.

\(^5\) Care Home on the Isle of Anglesey Information for Creditors, 25 April 2012, Directors Statement of Company
The Relocation of Residents

The relocation of the sixteen individuals who were resident at the Care Home to alternative suitable accommodation was carried out between Friday 16 March and Monday 19 March. The Council moved them because of concerns about the safety of the residents and the inability of the Care Home to meet the needs of at least five residents.

The families of residents who contacted my office have been consistent in their reporting of the events of those days. Many referred to being caught completely unawares by the news that the Care Home would be closing, especially given that they had attended needs assessments the day before the closure was announced and were reassured that there was nothing seriously amiss:

“I was called to a meeting at the Care Home with two social workers and a carer where my mother’s needs were discussed. At the end of the meeting I asked what was happening in the home as they were without a manager. They told me that everything was fine and that the owner was going to comply with what was asked of him - that was 3 o’clock on Thursday (15 March)”.

When one relative asked a social worker why residents were being moved she was advised that “they were worried that the [care home] staff would not turn up the following morning”.

The same relative also asked why social services could not have stepped in for a few days to meet the staffing requirement so that the closure did not have to happen so quickly. It is clear from correspondence with the relatives that communication about the reasons for moving the residents could have been far clearer.

Regardless of whether or not the Council could have managed the closure differently, what they failed to do was to convey to relatives that they were making decisions that they felt best protected the interests of residents.

A common theme was linked to the packing of residents’ belongings into black bin bags, with many relatives emphasising this as particularly undignified. It was also commented that the packing was haphazard:
“clothes were out in black plastic bags as the carers had hardly any time to pack their possessions”

Numerous individuals reported that residents had lost personal possessions in the move:

“I was not able to locate her birth certificate which she had kept in her handbag, which was also gone for good!”

Others talked about the losses of much loved wedding rings and photographs, clothes and books.

Some respondents likened the scenes at the Care Home on the day of closure to an animal market:

“residents were herded like animals into various cars, taxis, ambulances and taken away, some with families who could only look on.”

and

“they [residents] were like animals being shunted here, there and everywhere”.

A number of families described the impact on them:

“The fear in their faces still haunts me, it was appalling, they had no idea what was happening to them, it was as if it was a case of it’s got to be done let’s get on with it”.

and

“It affected me and my family very badly the way that social services decided to close the home. It was done with no dignity at all”

The above comment also demonstrates that this relative felt that the decision to close the Care Home was taken by social services. In fact, although the Council was removing residents because of safeguarding concerns, the decision to close the Care Home was determined by the Owner.

Several of the people who contacted my office indicated that although they were aware that their relatives were to be moved, they were unable to be physically present when the move took place because it happened
so suddenly. This meant that some residents would have been without assistance or anyone to represent their wishes.

A number of families reported that their families arrived in their new care homes in clothing that was not theirs – presumably the property of other residents. The representative of one resident explained that they had not realised the Care Home was to close and did not, therefore, cancel the final two direct debit payments for the resident’s care fees. The resident suffered financially as a consequence of the home closure:

“The total funds owed are £2,866 – the repayment is not likely to come about”.

By 19 March 2012 no residents resided at the Care Home.
What lessons have already been learnt?

Following the closure of the Care Home, the Isle of Anglesey County Council, Gwynedd Council, Betsi Cadwaladr University Health Board, CSSIW and the North Wales Police agreed to commission an Independent Management Review of the events that led to the closure of the Care Home and how the agencies that were responsible for safeguarding the Care Home’s residents had responded to those events.

The Independent Reviewer did this by reviewing the documentation relating to the Care Home and conducted structured interviews with relevant professionals before issuing a report and recommendations for action. The Independent Management Review does not appear to have spoken to residents, Care Home staff, families or representatives.

The Independent Management Review report made fifteen recommendations:

- Isle of Anglesey Council should undertake annual contract compliance and Quality Assurance visits to all registered establishments and include a financial viability assessment in this process.
- Isle of Anglesey Council should review the membership criteria, guidance and monitoring arrangement for members of the Approved Provider Scheme.
- CSSIW inspection visits and Isle of Anglesey Council Quality Assurance visits should be co-ordinated thereby ensuring that an inspection / monitoring visit occurs every six months.
- All commissioning authorities should satisfy themselves in respect of quality assurance and contract compliance issues. Gwynedd Council should undertake annual contract compliance and quality assurance visits to all registered establishments and include a financial viability assessment in this process.
- A risk / vulnerability assessment scoring matrix should be developed to identify establishments at high risk. This matrix should incorporate client group vulnerability (dementia), staff turnover, financial stability
and delays in submitting monitoring documentation or request for delayed visits.

- Isle of Anglesey Council (and any other placing authority) and CSSIW should continue to seek the written views of all visiting staff and families as part of the inspection and monitoring processes.
- CSSIW should conduct an interview with the registered manager within seven days of receiving a notification of resignation and notify the Local Authority of the outcome.
- Isle of Anglesey Council and Gwynedd Council should ensure that individual annual reviews are undertaken annually for all residents at the placement.
- Individual annual reviews should include a section for “other concern” to be noted.
- The Local Authority should review the individual annual review documentation and process and ensure that the written views of all visiting staff and families are requested and recorded.
- All individual annual reviews are signed off by the team manager.
- A ‘learning event’ should be organised for agency staff in order to develop increased awareness and a ‘heads up’ approach to visits.
- CSSIW should ensure an out of hours response is available in situations of significant concern.
- Isle of Anglesey Council should review the Escalating Concerns policy in respect of the JIMP, POSG, communication strategy and the commissioning of advocacy services.
- Betsi Cadwaladr University Health Board should ensure attendance at the JIMP and nominate a senior manager as a primary contact / co-ordinating point.

These recommendations were considered and then transferred into an Improvement Plan.
Findings and Recommendations

The recommendations of the Independent Management Review report and the subsequent Improvement Plan are helpful and should bring about some change. However, some of these actions need to be explained in language that can be understood, and later referred to, by older people and their families. There are also aspects of the planning and carrying out of an emergency move that require further consideration by the Council and CSSIW. Therefore, my recommendations ask CSSIW and Anglesey Council to provide me with a written response in plain language that outlines the action they will take in future in response to the matters listed below.

Two of the recommendations are about early indicators of potential problems and how this information is gathered and reflected upon. Three pertain to the actual closure of the Care Home and how it could be done better in the future.

1. Consistently high turnover of staff

This report shows that the annual inspection reports of CSSIW consistently recorded high staff turnover at the Care Home. This is often a typical feature of care homes because care staff may work in a care home for a short period of time for a variety of reasons: people retire, they move away from the area, they find a ‘better job’ or they find they are unsuited to the role.

In some care homes, there remains a constant cohort of staff who ‘hold the fort’ as others come and go and this can sustain continuity in care and standards. In other care homes the constant ‘churn’ of staff presents a greater problem – it may point to a problem with a manager, or care staff’s struggles with working in a badly resourced environment, or it may point to a depleted recruitment pool. These are all issues that should be discussed with the care home owner in depth at as early a stage as possible so they can be addressed.

This review of the Care Home demonstrates that a shortage of staff, and a shortage of appropriately skilled staff, can leave a care home and its
residents at risk of harm. Where inspection reports – or indeed any other kind of report, verbal or otherwise – indicate that there is consistently high staff turnover, this should be treated as an early warning sign that the care home requires closer monitoring.

**Recommendation**

In order to minimise the risk of substandard care or harm to older people, CSSIW and the Isle of Anglesey Council should outline clearly to me, so this can be shared with older people and their families, how they monitor consistently high staff turnover and the reasons for it. They should also explain what factors would give them cause for concern and how they address those concerns. I will publish this information as an addendum to this report.

**2. Other early indicators**

Apart from high staff turnover and lack of appropriately skilled staff, there were other clear indicators that the Owner of the Care Home on the Isle of Anglesey might have been facing financial difficulties. As early as 2008, inspection reports spoke of concerns about the internal and external décor and maintenance of the Care Home.

The 2010 inspection report detailed the outbreak of an infectious disease at the Care Home and the need for staff to receive updated training in this area – it may have been that there had not been enough paid staff to cover the time taken out to receive such training. In 2012 concerns were raised anonymously with CSSIW about residents being inappropriately dressed, a lack of heating and inadequate hygiene provision.

Whilst these matters in and of themselves do not necessarily mean that there was a lack of financial investment, they could have been an indicator that all was not well. The evidence also shows that the Owner did not submit written reports between July 2010 and January 2012 - indicating a significant period of time during which he was not meeting his statutory responsibilities\(^6\) to visit the Care Home at least once every

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\(^6\) The Care Homes (Wales) Regulations 2002, Regulation 27
month and prepare a written report on the conduct of the Care Home. He failed to return monitoring documentation to the Council in February 2012, which might have indicated a dwindling interest in the Care Home as a business venture.

It does not seem that these potential early indicators of financial problems were looked at more closely at the time. With hindsight, based on the Care Home manager’s interview with CSSIW after she left, we know that she was frustrated that she was unable to influence expenditure on cleaning, food and the activities schedules as this was under the control of the Owner.

**Recommendation**

CSSIW and the Isle of Anglesey Council should outline to me how they pool and consider all evidence available to them to build as a complete a picture as possible of a care home. They should also explain what factors would give them cause for concern and how they address those concerns. I will publish this information as an addendum to this report.

**3. Communication**

In June 2008, the CSSIW inspection report notes that families felt communication from staff and the Care Home’s manager could have been better. It is not clear from the evidence submitted to me, or feedback from families/representatives, what the extent of communication on a regular basis was between families and the Care Home. However, without exception, the families/representatives of former residents that contacted my office described how the closure of the Care Home had caught them completely unawares. Even the day before residents were moved, families/representatives had been given reassurance that the situation was under control. Therefore, when they were told that the Care Home would be closing, they had no real opportunity to consider suitable alternative homes for their loved ones.

The Owner’s decision to close the Care Home and the consequences of this decision could have been better communicated to residents, families and representatives. It was not clear why the Care Home had been closed and some people thought that the Council had made the decision to close it.
Recommendation

CSSIW and the Isle of Anglesey Council should outline to me their policy for communicating with families and residents’ representatives when a care home is closing in difficult or emergency circumstances. I will publish this information as an addendum to this report.

4. Self-funders (those who pay for their care from their own money)

The majority of the residents in the Care Home had their places funded by a Local Authority / Local Health Board. For those who did not, lack of communication had financial consequences; for one person this amounted to £2,866 due to a direct debit not being cancelled on time.

It needs to be remembered that self-funders contract directly with a care home. In the situation outlined in this report, it seems that there was no notice given to the representatives of self-funders that the contract was ending; neither had their representatives / families been kept informed of developments and the potential of the Care Home closing.

Thankfully, the Council took responsibility for the self-funding resident who was found in dire circumstances in his bedroom, but the Council was not obliged to do so.

Recommendation

CSSIW and the Isle of Anglesey Council should outline to me how they would expect independent care home providers to communicate with residents who are self-funders, their families or representatives when a care home is closing in difficult or emergency circumstances, so that the self-funder’s financial position is protected. I will publish this information as an addendum to this report.

5. Independent Mental Capacity Advocacy

The Mental Capacity Act 2005 provides for a type of statutory advocacy through Independent Mental Capacity Advocates (IMCAs). In certain narrow circumstances, IMCAs represent those who lack capacity. Staff in the NHS or a Local Authority, for example, doctors, care managers
and social workers, all have a duty to instruct an IMCA where the eligibility criteria are met.\(^7\)

A person must be referred to the IMCA service where a decision is being made about a change of accommodation and there is no-one who can be consulted, e.g. family or a representative, about the decision. The decision to move the residents of the Care Home had to be made quickly; the evidence shows that the Council did have time to consider appointing IMCAs but made the decision not to do so since residents had families.

Evidence suggests that the majority of residents at the Care Home did have family or another representative. However, a number of the residents’ representatives or family told me that due to the suddenness of the decision to close, they were unable to attend the care home at the time of closure – in the main because they lived some considerable distance from the Care Home.

The Mental Capacity Act Manual\(^8\) states that an IMCA may be appointed even where a person does have family or friends. The overarching aim is to ensure that a person who lacks capacity is fully supported and represented when important decisions are made about their life. Since not all family or representatives could be present for the move, some residents would have been without someone who could help them voice their questions and concerns, answer their questions or act in their best interests.

**Recommendation**

The Isle of Anglesey Council should outline to me the circumstances in which they would appoint an Independent Mental Capacity Advocate:

a) when a care home is closing;
b) when a care home is closing as a matter of urgency;

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\(^7\) For more information see ‘Making Decisions’, Office of the Public Guardian 2007

c) when the older person has family or a representative, but that family member or representative cannot be involved or present at the time of the home closure.

I will publish this information as an addendum to this report.

6. Being treated with dignity

This report clearly shows that during the move several relatives thought their loved ones were ‘herded like animals’ and were fearful with ‘no idea what was happening to them’. They felt that the focus was on getting the move done and that very little consideration was given to those people who were being moved. One relative stated that “it was done with no dignity at all”.

Whilst it is acknowledged that this was a move that was carried out within a short space of time, it seems that there was very little consideration of the best way in which to carry out the move for each individual resident, particularly bearing in mind that all residents had a form of dementia.

When representatives from my office visited the Care Home, the new owners pointed to a number of personal possessions that had been left there such as ornaments, hymn books, bibles, spectacles and hearing aids. The new owners, in December 2012, had asked the Council to try and reunite residents with their possessions and had also raised concerns that personal files had been left in the Care Home.

The Council took no action in relation to the personal property as it was their opinion that the property was not definitely identified as belonging to the individuals who were resident at the home at the time of closure.

In addition, the Council held that documentation relating to individuals who had been residents of the Care Home at the time of closure had been transferred with the relevant resident to their new home. The documentation that remained at the Care Home was therefore historical and was the sole responsibility of the Care Home’s liquidator.

Section 48 of the National Assistance Act 1948 states that where a person is being moved because a Local Authority is providing
accommodation for them, and that person has ‘moveable property’ for which no other suitable arrangements have been made, then the Council has a duty to ‘take reasonable steps to prevent or mitigate loss thereof or damage thereto’.

Although some effort was made to move residents’ belongings, there does not appear to have been a clear plan to ensure that personal possessions, some of which would have been treasured possessions to residents and to their families, were not lost in the process. Once alerted to the existence of personal possession at the Care Home by the new owners of the property, the Council did not feel that they could identify the rightful owners.

**Recommendation**

The Isle of Anglesey Council should outline to me how it would, in similar circumstances in the future:

a) ensure that residents are treated with greater dignity;  
b) ensure that personal possessions are not lost or forgotten about.

I will publish this information as an addendum to this report.

Written responses to these recommendations should be sent to me no later than 18 September 2014.

Sarah Rochira
Older People’s Commissioner for Wales
18 July 2014
Appendix A

‘Escalating concerns with, and closure of, care homes providing services for adults’

This guidance, issued by the Welsh Government in May 2009, can be found here:


It is statutory guidance intended to address the management of escalating concerns with, and closures of, care homes that are registered with the Care and Social Services Inspectorate Wales (CSSIW) to provide services to adults, including those providing nursing care. It is issued under section 7 of the Local Authority Social Services Act 1970 and sections 12 and 19 of the National Health Service (Wales) Act 2006. It sets out local authorities’, local health boards’ and NHS Trusts’ responsibilities in this area and sets out ways in which these responsibilities can be discharged. It is also issued for information to other interested organisations and bodies and to all registered care homes providing services to adults.
Appendix B

The Care Homes (Wales) Regulations 2002

These regulations apply to care homes in Wales and came into force on 1st April 2002. They can be found here:


The regulations make provision for the operation of care homes in Wales with specific reference to the registered persons, conduct of the home, premises and management of the home.