Appalling conditions exposed
At Overton House Care Home

By Eileen Chubb ©

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. The home was infested with Rats
. Soiled clothing left on floor for days
. Insects were crawling up the inspector's legs

Vulnerable people were left living in squalor at a care home CQC registered in 2017 and described on the CQC website as "likely to be good". It was over a year later in September 2018 that CQC inspected the home for the first time and found people had been living in a home that was filthy, dangerous and put people at high risk of harm.

There is only one CQC inspection report for this home dated September 2018 which stated that,

"We last inspected Overton House in 2016 when the service was owned and operated by a different provider and at that time, we rated the service 'Good.' However, in 2017 the business was sold to a new provider and in August 2017 Overton House was re-registered with CQC, as is the legal requirement."

My Comments
Between 2017 and September 2018 the CQC will have displayed an information page stating that they considered this home likely to be compliant in all areas. See our special report CQC a Likely Story for full details on how the public are being misled about care home standards.

However, the following extracts from the CQC inspection report September 2018 contain the following information, information that tells us what is likely to have been happening in this home throughout the period that CQC presumed it compliant.

*“On the first day of our inspection we conducted a tour of the premises at Overton House. The tour included
the basement, communal areas and resident's private bedrooms. During the tour we found significant areas
of concern relating to the prevention and control of infection and found systemic poor practice which
placed residents at a serious risk of harm.”*

*“We found the outside space to the rear and side of Overton House to be exceptionally unsafe. The concreate
floor was uneven and posed a serious falls risk, hazardous materials associated with building maintenance
had been discarded, there were loose bricks and rubble present which posed a risk of injury and steep
concrete steps leading down to the basement area posed a serious falls risk.”*

*“Throughout the premises we found window restrictors were non-compliant with Health and Safety
Executive (HSE) guidance or were missing entirely. We also found that whilst a care call alarm system was
situ there were no pull cords available that would assist a resident to raise an alarm when they found
themselves in difficulty or in the event of an emergency.*

*“The majority of care staff were well intentioned, but it was evident, through talking to staff and from our own
observations, that management and staff had been become completely disengaged from the service and
there was an apathy across all aspects of the home. This had a detrimental impact on the quality of care
being provided at Overton House. At provider level, there was a distinct lack of care and compassion shown
towards the people who used the service. As evidenced by the conditions in which people were living.*

“In the laundry basement area, we found conditions to be insanitary and visibly dirty. Soiled items of clothing and bedding had been thrown on the laundry floor, two washing machines full of laundry and several baskets of laundry had not been attended to and there was a strong odour of urine. Soiled and contaminated laundry was stored in plastic shopping bags and had not been placed in dedicated water soluble 'red bags' and therefore posed a serious risk of cross contamination. There was no laundry assistant on duty during the first day of inspection and staff said this was a regular occurrence with soiled and contaminated laundry items often left unwashed for several days. This meant there was frequently a shortage of essential items such as bedsheets, quilts and blankets. We corroborated this by viewing the linen store and we found there to be insufficient bedsheets to meet the needs of residents because one resident had diarrhoea at the time of our inspection.”

“We found Overton House to have a serious and widespread problem relating to the control of rodents. Bate traps were located throughout the home, including in resident's bedrooms. We viewed an external out- house to the rear of the premises and found perishable food items were being stored unsafely. For example, potatoes were stored on the floor in a container without a lid, carrots were stored on a shelf in a container with an ill-fitting lid, and butternut squash was stored in an open cardboard box, underneath a tool kit.
Furthermore, located next to the food storage area, we found highly volatile paint tins, paint thinners, paint brushes and other decorating/maintenance materials. The environmental conditions within the out-house were filthy and wholly inappropriate for the storage of perishable food items.”

“We found poor and unsafe practices related to infection control. For example, mops, buckets and cleaning cloths were not colour coded and the same items of equipment were used throughout the service, irrespective of the area being cleaned. Paper towel dispensers and liquid soap dispensers in communal toilets and bathrooms were empty which meant there was poor and unhygienic practices for hand hygiene. Throughout the service there was a lack of a personal protective equipment available at the point of care. This posed a risk of cross contamination as staff could not easily access disposable gloves or aprons when providing personal care.”

"In one bedroom that was occupied we found a serious malodour of urine and the carpet was damp in places due to urine contamination. In a second room we found another serious malodour of urine; this bedroom was a shared room, occupied by two residents, one of whom was reported to be doubly incontinent of both urine and faeces on a regular basis."

"Throughout the home all carpets were visibly dirty, worn and in a state of disrepair. During the second day of inspection, in the carpeted dining area, an insect was seen to be crawling on the trouser leg of a CQC inspector and a second insect was seen to be crawling along the carpet."

"An Environmental Health Officer also attend Overton House and they provided a report to CQC which confirmed Overton House had a serious problem in the following key areas: Inhabitation of rats, the origin of which had been located above an exposed open drain above the basement area; poor environmental management of the building and premises, including a failure to carry out routine maintenance, which meant holes in wooden floors and skirting boards had not been adequately attended to, this left the home vulnerable to rodents; A failure of the provider to effectively manage the contractual relationship with the pest control company, including a failure to fully acknowledge the extent of the rodent problem and the actions that were required to rectify the problems. The Environmental Health Officer also confirmed the insects observed in the dining room were carpet beetles.

"With regards to the risks associated with unsafe premises, we looked at a health and safety inspection report completed by an external company in April 2018. This report highlighted five areas that that were deemed 'high risk'. The definition of high risk as stated in the report was: 'contravention of statutory requirements that could lead to fatal or serious personal injury, ill health, issuing of an improvement notice and / or which

may lead to legal proceedings by the enforcing authority indicating areas of non-compliance. These matters require a planned programmed of action to eliminate or control the risks identified.' The five areas of concern as stated in the report were: gas safety; risk assessments related to employee safety; asbestos;

My comments.
The questions I ask is why did the CQC wait until September 2018 to carry out an inspection?
Why the serious risks highlighted above were not treated as a safeguarding issue and reported by the home in April 2018?

"The provider of Overton House had installed a closed-circuit television surveillance system (CCTV). Whilst this was not in use in residents' private bedrooms, the CCTV system was installed and operational in all communal areas and in the manager's office. However, the provider was unable to provide any documentary evidence to demonstrate they had taken into account guidance issued by CQC on the use of surveillance in a care setting. We also asked the registered manager whether residents, or their lawful representatives had been consulted before the CCTV had been installed and we were told they had not.

We also established the CCTV was monitored remotely offsite from Overton House at another business premises belonging to the provider. This meant the registered manager at Overton House had no ability to view or playback any CCTV recordings in the event an urgent situation. For example, if a resident had fallen in a communal area but the fall was unwitnessed. Furthermore, during our inspection of Overton House, it became apparent to members of the inspection team that they were under surveillance by the provider, from their offsite location. We were informed by the registered manager that on several occasions the provider had telephoned the registered manager at Overton House to enquire what we were doing. For

example, the provider telephoned the registered manager to object to an inspector taking evidential
photographs in and around Overton House.
The evidence outlined above demonstrates a failure to ensure the installation and operation of a CCTV
system at Overton House was in the best interest of residents and a failure to take account of guidance
published by CQC on the use of surveillance in a care setting.

"People's social needs were not being met which exposed them to an unacceptable risk of social isolation.
Throughout the inspection we did not observe any meaningful activities taking place and we found no
evidence that the home had historically attempted to engage people in activities that were non-care related.
Whilst a very small number of people were able to access the wider community and leave Overton House on
a daily basis, the vast majority of people either remained in one of two lounges all day or simply slept in their
bedroom."

My comments
Again, there is no evidence to support the CQC assertion that this home was likely to be compliant in the time between registering and this first inspection report.

Yet another home with CCTV a measure some campaigners mistakenly believe will promote good care

See our report Reality CCTV Check for our researched, fully evidenced and detailed work in this area.

"Since the new provider took over Overton House in August 2017, the home had not been well-led. Every
aspect of the service had been allowed to deteriorate which meant fundamental standards of quality and
safety could not be met. The multiple breaches identified in this report demonstrates widespread systemic

failures by the registered persons in providing safe and effective care. Whilst the provider made a business decision to close Overton House in the days following CQC's inspection, we have taken enforcement action to remove the providers registration in respect of the carrying on of a regulated activity at Overton House."

My Comments
If CQC are acknowledging the reality in this home since the new provider took over then why did the information, they provided to the public say something completely different? I.e. that the home was likely to be good in all areas.

"We asked for a variety of records and documentation to be made available to the inspection team. All too frequently this information was not provided in a timely manner and when presented, was incomplete. This delayed the inspection process and demonstrated poor management and governance. Furthermore, whilst reviewing documentation related to staff rotas, we found a number of discrepancies which lead us to believe records had been falsified. We asked the registered manager about this and they admitted this had taken place."

The public have the right to accurate and truthful information on care homes, but we have exposed for years that the regulator CQC are not only failing to provide the truth about care homes but are misleading the public by stating a home has been checked to ensure it is compliant with regulations prior to being registered with the CQC. This practice allows the worst homes to open for business without proper checks being made and the result is vulnerable people are harmed. We have informed the Health Department of this issue as well as many more dangerous and dishonest practices, but the Government have chosen to ignore our evidenced work and failed to act.
We will continue to expose the suffering that results from these failures.

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