Alton House Care Home Closure
What CQC Fail To Mention
By Eileen Chubb ©

The CQC have issued a press release stating this home is to close following a bad inspection rating, they also mention the home has been failing since 2018. This is not true as the home has been failing for years and CQC re-registered it to the Barr Family in 2018 in spite of the long history of poor care.

The Inspection History

Inspection November 2012, The home failed on Medication.

"Alton House
22 Sunrise Avenue, Hornchurch, RM12 4YS Tel: 01708451547
Date of Inspection: 02 November 2012 Date of Publication: November 2012
We inspected the following standards as part of a routine inspection. This is what we
found:
Care and welfare of people who use services Met this standard
Management of medicines Action needed
Safety and suitability of premises Met this standard
Requirements relating to workers Met this standard
Complaints Met this standard"

Inspection Two June 2013 Failed two standards, Medication and supporting workers

"Alton House
22 Sunrise Avenue, Hornchurch, RM12 4YS Tel: 01708451547
Date of Inspection: 22 May 2013 Date of Publication: June 2013
We inspected the following standards as part of a routine inspection. This is what we
found:

Respecting and involving people who use services
Met this standard
Care and welfare of people who use services Met this standard
Meeting nutritional needs Met this standard
Management of medicines Action needed
Supporting workers Action needed"

Inspection 3, October 2013 Compliant for the first time on the 3 standards Checked.

"Date of Inspection: 02 October 2013 Date of Publication: October 2013
We inspected the following standards to check that action had been taken to meet them. This is what we found:
Respecting and involving people who use services
Met this standard
Management of medicines Met this standard
Supporting workers Met this standard"

Inspection Report 4, 27/2/2015

"Overall rating for this service Requires Improvement —
*Is the service safe? **Inadequate** —*
*Is the service effective? **Requires Improvement** —*
*Is the service caring? **Good** —*
*Is the service responsive? **Requires Improvement** —*
*Is the service well-led? **Requires Improvement** —"*

This 2015 report includes the following information

"We looked around the building, and found that not all areas were sufficiently clean. In the ground floor wet room we found faeces on the toilet and toilet frame. We also found that there was not any toilet tissue available in two of the ground floor toilets. In the kitchen we found

extremely dirty towels/tea towels hanging over a radiator near a dirty wall with dirty skirting. There were no paper towels available in the dispenser and the chef informed us that they had run out on the previous day. Three of the ten bedrooms we looked at smelt extremely strongly of urine. The rooms looked clean and beds had been made but we found that the smell was coming from the mattresses."

"safeguarding issues were not identified as such by the manager and had not been reported to the appropriate authority. We therefore recommend that the service reviews the safeguarding policy and training and take action to update their practice accordingly."

"People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12 (2) (g)."

The Next Inspection is November 2015

Is the service safe? **Requires improvement** ——
Is the service effective? **Requires improvement** ——
Is the service caring? **Good** ——
Is the service responsive? **Requires improvement** ——
Is the service well-led? **Requires improvement**

The Next Inspection is Jan 2017, two years later and still no improvement.

"Overall rating for this service Requires Improvement
Is the service safe? Requires Improvement
Is the service effective? Requires Improvement
Is the service caring? Good
Is the service responsive? Requires Improvement
Is the service well-led? Requires Improvement "

The Next Inspection in September 2018, is as bad as it gets,

Overall rating for this service Inadequate
Is the service safe? Inadequate
Is the service effective? Inadequate
Is the service caring? Inadequate
Is the service responsive? Inadequate
Is the service well-led? Inadequate

This inspection includes the following examples,

"The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.
Where necessary, another inspection will be conducted within a further six months,"

Please note the above penalties can easily be bypassed by registering the home as new when it is actually the same family.

"The service did not oversee people's medicines in a safe way. Covert medicines and PRN medicines were not
managed in a way that was safe and in line with best practice. Individual risk assessments were not detailed and not kept up to date. People's changing support needs were not reviewed, and staff were not provided with enough information about how to keep people safe from potential harm. The service had not been

adapted in a way that kept people safe from hazards and the home was not always cleaned sufficiently which meant people were at risk of cross-infection. In particular, the service did not manage the moving and handling of people in a safe way and people were being moved incorrectly which put them at risk of harm or injury. Staffing levels were not sufficient and therefore impacted on the safety of people who had high level
care and support needs. The service did not have safeguarding systems in place which meant that people were not protected from potential abuse."

"One person told us, "I have been falling all over the place," and when as asked them if staff were helping, they said, "No." One relative said, "Hoists should never be used the way they are. Staff are picking up others in bad way, it upsets me the way they use the hoists. One [person] is transported around in it." One health and social care professional told us, "They lifted a person under their arms rather than with equipment. Also, with moving and handling we are getting a lot of people with skin tears and we don't have that with other homes we visit. It wold be good if they had training on that."

"People told us they did not feel safe. When we asked people if they trusted staff to keep them safe, one person said, "No I don't think so." We spoke to relatives who had concerns about people's safety. One relative said, "The only risk is the staff, if [person] died I wonder how long it'd be before they found [person]."
This shows that the service was not always able to support people in a way that made them feel safe.
However, one relative told us, "Yes I do feel [my relative] is safe."

"People, relatives and staff felt the service did not have sufficient numbers of staff. When we asked people if
they felt there were enough staff to support them, one person said, "Not really, I am sat around waiting to
die." When we asked one person if they could have a cup of tea when they wanted, they said, "No, only
between 8.30-9.00 and after 11.00 I suppose and after that 3.00 I suppose." One relative told us, "I know they are very busy [staff]. As family members we all try and help out, staff are doing other things all of the time."

Another relative said, "I think they are shorthanded on occasion and do not have much time to have any exchanges with their clients." One staff member said, "At times we need more. Weekends is harder as they are just us. We don't have management in at the weekends." Another staff member told us, "Worse at the weekends. No management. No cleaner. Just three members of staff and a cook. If we are bathing someone that could take two people, that leaves one person to oversee the other 20 or so people. It is too much."

During our inspection we observed there were not always enough staff to support people. During lunch two people were sat together and needed help with their food. There were no staff available and so the other

person cut up their food for them. The staff rota required three care staff to be on duty during the day, and we found the required number of staff were available. However, the service had not completed any dependency assessments and advised they were not looking to recruit any additional members of staff. The service was unable to evidence they had enough staff employed to support people to stay safe and meet their needs. This demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014."

"One person told us, "It feels like a prison with four walls. It's too depressing." Another person said, "I am down. It's no life I want to live." Staff did not always know about MCA or DoLS. One staff member said, "No, I haven't got a clue what that is." Another staff member said, "Nobody here has capacity. If they don't have capacity they would have an advocate." The registered manager told us nobody had access to an advocate.

Staff did not always understand the meaning of consent. When we asked one staff member how they gained consent from people to provide care and support they said, "[Registered manager] does that. [Registered manager] has the forms I think." The deputy manager could not find any completed consent forms and said, "I don't know where they are, I don't even if know if we have them all."

We observed one person being force fed their food. The staff member did not talk to the person or ask for
their permission before putting food to their mouth. We observed one staff member go into a person's
bedroom without knocking first. The person was in their room at the time.

These are just some examples, there is too much wrong to include everything, at this point the provider, the Barr Family reregister the home to other members of the Barr Family and the past inspection reports are archived by CQC. This reregistration should never have been allowed, firstly because it needlessly put people at risk of further poor care and risk of harm, it would have saved the expense of future inspections or enforcement because if a home is as bad as this one for 6 years its going to stay bad.

First inspection under alleged new provider Sept 2019

Overall rating for this service Requires Improvement
Is the service safe? Inadequate
Is the service effective? Requires Improvement
Is the service caring? Good
Is the service responsive? Requires Improvement
Is the service well-led? Requires Improvement

Last inspection available March 2020

Overall rating for this service Inadequate
Is the service safe? Inadequate
Is the service effective? Requires Improvement
Is the service caring? Requires Improvement
Is the service responsive? Requires Improvement

Is the service well-led? Inadequate

Conclusion

People have needlessly suffered for two years, CQC continue this re registration scam regardless of the consequences, the public in checking a care homes history find themselves in a minefield of archived reports, alleged and actual old provider links and a regulator who withholds vital information: and who is incapable of recognising foreseeable risk of harm. The CQC press office to top it all issue statements that a home is closing because of CQC action when the truth is people have suffered for years because of CQC inaction.