Bupa Care Homes (ANS) Limited

The Hornchurch Care Home

Inspection report

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17 August 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Hornchurch Care Home on 26 July 2016 and 17 August 2016. This was an unannounced inspection.

Hornchurch Care Home is registered to provide accommodation, nursing and personal care for up to 55 older people, some of whom maybe living with dementia. At the time of the inspection, 45 people were living at the home. The home has three units, each for people with particular needs, such as people that required nursing and dementia care. There were approximately 15 to 20 people living on each unit.

We previously inspected Hornchurch Care Home in March 2014, when they met the Regulations we inspected.

The home had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. The registered manager was on leave on our first day of inspecting the home but we were able to speak with them when we visited the home again on 17 August.

Care staff understood their responsibilities to protect the people in their care. They were knowledgeable about how to protect people from abuse and from other risks to their health and welfare. Medicines were managed and handled safely for people. Arrangements were in place to keep people safe in the event of an emergency. The home followed their recruitment procedures to ensure staff were safe to provide care to people.

We were not assured that there was an adequate number of suitable and qualified care staff on duty to respond quickly to the needs of people living on some of the units, particular on days when the home was short of staff. Care staff told us that they did not have the support they needed to keep people safe. Some people complained that they had to wait for long periods before receiving personal care.

The environment within the home was safe and clear of any health and safety hazards. Infection control procedures were in place and equipment was used to safely move and transfer people. Staff undertook training and received supervision to support them to carry out their roles effectively. The registered manager and the staff team followed the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff training records showed they had attended training in MCA and DoLS. People were supported to maintain good health and had access to health care services when it was needed.

People received a nutritionally balanced diet to maintain their health and wellbeing. People's fluid intake and output was monitored but not always measured or recorded accurately. People's needs were assessed.

Their care and support was planned and delivered in line with their individual care needs. The care plans set out how each person should be supported to ensure their needs were met. Care plans were person centred but they were not always updated or reviewed when people's needs changed.

We observed that staff had positive and caring interactions with people living in the home. Staff respected people's privacy and supported them to express their views. Some people did not feel their dignity was respected because they were not provided with personal care when they required it. People participated in activities, with the support of staff but some people felt lonely and isolated and did not have many things to do to occupy themselves. People did not feel they had the ability to make complaints and asked relatives to do so on their behalf. The home responded to complaints appropriately.

The home had a clear management structure in place. The registered manager was appointed six months prior to our inspection and we saw that they had taken steps to improve the safety and standard of the home. We noted that most of the home had recently been redecorated. People and staff told us they found the registered manager approachable and supportive. The registered manager demonstrated an understanding of their role and responsibilities. There were systems to routinely monitor the safety and quality of the home provided.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
There were not always sufficient numbers of staff to meet people's needs, such as when staff called in sick. People felt that the service was short of staff.

The service had whistleblowing and safeguarding procedures in place. Staff understood how to identify and report abuse.

The home had a system to monitor and audit medicines. Medicines were administered safely and records were accurate.

Is the service effective?

Good

The service was effective. Staff were supported in their roles and received regular supervision and training.

Consent to care and treatment was sought in line with the requirements of the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards (DoLS) was understood by the registered manager and staff.

People were supported to eat and drink healthy and nutritious meals that met their dietary needs. Fluid charts did not always contain relevant information.

Is the service caring?

Good

The home was caring. People were mostly happy at the home and staff treated them with dignity and respect.

Relatives were satisfied with the level of care provided by the staff.

Care and support was centred on people's individual needs and wishes. Staff knew about people's interests and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all people were supported to participate in activities of their choice.

People's individual choices and preferences were discussed with them. People's health, care and support needs were assessed. Care records were not always up to date or consistent with other records.

People did not feel encouraged to express their views. However, complaints were investigated appropriately.

Is the service well-led?

Good

The service was mostly well led. The home had a registered manager who made improvements to the safety and standard of the care home.

More effective quality assurance and monitoring systems were in place, which included regular audits and seeking the views of people, relatives and other stakeholders. However some improvements were required to ensure that all risks were identified.

Staff and people found the registered manager to be approachable and provided good leadership. They were supported by senior managers.

The Hornchurch Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection took place on 26 July and 14 August 2016 and was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home and to provide a rating under the Care Act 2014.

Before our inspection, we reviewed the information we held about the home. This included the last inspection report for March 2014. We spoke to the local contracts and commissioning team that had placements at the home. We also reviewed notifications, safeguarding alerts and monitoring information from the local authority.

We also reviewed the provider information return (PIR). The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. The PIR also provides data about the organisation and service.

The inspection team consisted of one adult social care inspector, a brain injury and dementia nursing specialist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we observed how the staff interacted with people and how they were supported. We viewed people's bedrooms with their permission. We spoke with 17 people who were using the service and four relatives. We spoke with four care staff, a registered nurse, the registered manager, the deputy care manager, a regional support manager, a clinical lead and a training officer.

We looked at six care files, staff duty rosters, six staff files, a range of audits, minutes for various meetings, medicine records, accidents and incidents records, training information, safeguarding information, health and safety folder and policies and procedures for the home.

Requires Improvement

Is the service safe?

Our findings

Most people and their relatives told us that they felt save living in the home. One person told us, "Yes I am very safe." Another person said, "I am very happy here, I feel safe." However, some people told us that they did not feel safe. One person said, "No, I don't feel safe. By the time staff come, anything could have happened to me." Another person told us, "I have been left waiting for assistance for hours for a pad change." We spoke with a relative and they said, "I think there is enough staff here for my relative and they have settled well."

During our inspection, we saw that care staff were present on each unit. The staff duty rotas showed that up to four care assistants and a nurse were on duty on each unit during the morning and then in the afternoon. The home had staff working through night times with one care staff and one nurse on each unit. The registered provider had implemented a staffing needs assessment for each person and the registered manager said that the current staffing levels were reflective of the registered provider's recommendations. They said, "There is reduced dependency needs in the home now and we have a few empty rooms, which we have kept because we stopped admissions for a few weeks to get the home stabilised." The registered manager also told us that the home had recruited additional care staff to cover any shortfalls and that they were able to meet people's needs. However, we did not see this in practice on our first day.

There was not a sufficient number of staff available to respond to people quickly on the day of the inspection. The registered manager told us that two care staff that were due to be on duty had called in sick, which meant the staffing levels were lower than normal and cover staff was not available. On several occasions during our inspection, we heard a person calling out in distress, sometimes when their door was closed. We saw that care staff came in to their room and sat with them, only after a prolonged period of calling out. We brought this to the attention of the deputy care manager who told us, "They often call out. They get distressed when their relative is late. I will get someone to see them." We saw that these behaviours were documented in the person's care plan. However, we were concerned that the person was not attended to sooner by staff working on the unit and they could not be heard from behind a closed door. Staff were attending to other people. We spoke with one person who told us, "I find that staff are not always available when I need them especially at night and in the middle of the day. They don't have time to talk to me."

We saw during the lunchtime meal service that care staff were not always available to respond to people who were in their rooms because they were assisting people with their food in the dining room. We noticed that a person was repeatedly regurgitating their food on to the floor but care staff were not available to assist them. We spoke to the registered manager about this person and they told us, "They are known to do this and we try to maintain their dignity. But they become frustrated if we fuss over them and continually try to clean up the food and fluid spillage." We saw that this was noted in the person's care plan.

We found that on some occasions, only one member of care staff was available on the unit when other staff took their breaks. We spoke to care staff and one staff, who had completed all their required training, said, "I think we have enough staff to give care to people. But during lunch time we are over-stretched and at other times when we have to take our breaks, there are not many staff on the unit." Another member of staff said,

"I am the only one on the unit at the moment, the staff are on their breaks." We were concerned that even though the home was not fully occupied, there were not enough staff or suitable cover arrangements in place, such as when staff
were absent through sickness. Another person we spoke with, told us, "I would like more efficiency with the care systems in my everyday day to day care. The staff are too busy, they cannot attend to me because they are short of staff. Some of them are so good and very caring but some of them are rushing all the time."

Records we reviewed showed there were staff on duty to meet people's needs safely but not enough to meet their needs in a timely manner. Staff responded promptly to people who pressed their call bell buttons in their rooms but less promptly to people who did not press them and called out instead. Care staff and nurses were supervised on each unit by a unit manager. However, they did not always have the time to observe care staff, which meant that they were left unsupported at times. The unit managers were usually in pre-admission assessments, writing and evaluating care-plans, managing medicines or in meetings with other health professionals. This meant that there was little time to provide care staff with support, which put them under pressure to ensure people were attended to.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had safe staff recruitment processes in place. We looked at staff recruitment files and saw that references and Disclosure and Barring Service certification (DBS) was obtained, to ensure that staff were safe and suitable to work with people. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. However, we noted that one member of staff was recorded as going absent without leave for a long period during 2016 but we did not see what action was taken by the home. After the inspection, we received information from the local authority that the home had employed another member of staff who had their registration suspended by the national regulator of nursing and midwifery. We spoke with the registered manager and they told us that they were informed of the suspension and that the staff member no longer worked in the care home. The registered manager assured us that the home had followed their recruitment procedures, although some information about the applicant was not originally disclosed to them. The registered provider will ensure that their recruitment processes are robust so that people are not at risk of receiving unsafe care.

The provider ensured people lived in a safe environment and a regular programme of safety checks were carried out. The corridors of the building were fitted with rails to assist people who were less mobile and corridors were generally kept clear. The home was clean, tidy and clear of any obstructions which would breach health and safety regulations. The home had effective infection control measures, such as hand washing notices and care staff used personal protective equipment (PPE) like gloves and aprons. We also saw that fridge and freezer temperature checks were carried out to ensure that food was kept fresh. There were storage facilities for COSHH (Control of Substances Hazardous to Health) materials. Fire regulations were displayed in the hallway. There were Personal Emergency Evacuation Plans for each person and staff were knowledgeable about them. On the day of the inspection, there was a fire drill and staff responded according to the home's fire drill procedures.

We found that the garden near the front of the building, whilst being in use, was not always safe because there were potential hazards, such as broken paving stones and a steep section in the grass area that led to harder ground. We noted that a fence had been installed across this area for people's safety and that the registered manager had identified some of these issues. The registered manager said, "I aim to redevelop the garden for our residents so that they can come out here a bit more safely. I have done a risk assessment

and I want to put up some rails for people to help them walk around it. I have only just recently got the fence put up." During our inspection, we saw twelve people using the garden and they were accompanied by staff and relatives to keep them safe.

The home had appropriate guides and practices in place to ensure people were safeguarded from the risk of abuse. The home had safeguarding policies and procedures, which included contact details for the relevant local authority and the Care Quality Commission. We saw that safeguarding training had been delivered to staff. The registered manager and staff knew how to report safeguarding concerns appropriately, so that the local authority and the CQC were able to monitor safeguarding alerts that were raised. We saw that the home had internally implemented recommendations and actions following a safeguarding alert that was investigated, to ensure that an incident was not repeated. Staff were able to explain what constituted abuse and the action they would take to escalate concerns. Staff felt they were able to raise any concerns and were confident that they would be provided with support from the registered manager. One member of staff said, "I shall try to stop the abuse if I can or ask for assistance. Then I shall inform my manager and make an entry in the notes. The manager will report it to the Safeguarding Agency and the police."

The home had a whistleblowing procedure and staff were aware of their rights and responsibilities with regard to whistleblowing. They were able to describe the process they would follow and understood how to report concerns about the practice of the home. One staff member said, "If I had concerns I would report it to the police or the CQC."

Care and support were planned and delivered in a way that ensured people were safe. Records showed risks to people had been assessed when they first came to the service. Up to date guidelines were in place for staff to follow. These covered areas such as keeping people safe. Some people were identified as at risk of pressure sores, which can occur when people have to remain in their beds for long periods of time. We saw that detailed and clear information was provided to staff to minimise this risk. This included provision of air mattresses and instructions concerning the monitoring of these, regular recording of a person's weight, their need for fluids and a balanced diet, checks required on skin integrity and the application of barrier cream. Staff had clear instructions about how to minimise the risk of pressure sores and carried out the routine checks required. Care plans detailed how often people required turning or repositioning in their beds. Records confirmed that staff repositioned people at regular intervals, as set out in individual care plans.

We saw other risks assessments, for example, about the risk of falls. People were encouraged to use aids such as walking sticks and frames. We found that the beds of people at risk of falling out of bed were fitted with bed rails and bumpers to prevent and minimize the risk of falling or getting their clothes caught. Records showed that people at risk were monitored daily. The instructions for staff about minimising risks were clearly outlined in their assessments. A staff member said, "We also use body maps to indicate the site of the pressure sore. We also take pictures regularly to monitor progress of the wound. We also involve the district nurse and tissue viability nurse (TVN) for advice."

We observed that staff used appropriate techniques and equipment to transfer people safely, including hoists. We noted that at times, there was not always enough space to move and transfer a person in the lounge area because they were in a corner near a doorway. Some people told us that mobility equipment, such as wheelchairs, were uncomfortable or too large. They also said that their rooms were too small for a hoist to be used. The registered manager said, "All of the rooms in the home are an adequate size for moving and handling with a hoist. Wheelchairs are purchased by the resident or a relative and fitted to their individual needs. Most of the staff have completed their moving and handling training." Training records we viewed, demonstrated this.

People were supported with their medicines and these were stored safely. On the day of our visit, we observed medicines being administered by a registered nurse during lunch time. We were informed by the deputy care manager that, "Medicine rounds are done after meal times to avoid disruption during meals." We saw people received their required medicines at the required times and staff followed the home's medicine policy and procedures. Systems were in place to ensure that medicines were ordered, stored, administered, disposed and audited appropriately. One person said, "The staff always give me my medicine on time." Nursing staff who administered medicine wore a tabard, which was a special item of clothing to indicate that they were providing people with medicine and were not to be disturbed.

Care staff ensured that medicines were administered and logged on a medicine administration record (MAR) sheet. A MAR is a document showing the person's prescribed medicines and recording when they have been administered. Care staff checked people's medicines on the MAR and medicine label, to ensure they were taking the correct medicines. Care staff also explained to people what the medicine was for and asked how they wanted the medicine to be taken. We found that MAR sheets were appropriately used and contained no missing information. Medicines were stored securely in trolleys or in a refrigerator and kept at the recommended temperature. The temperature of the refrigerator was checked daily and staff described the action they would take if the temperature of the fridge was not at the recommended setting. One staff member said, "I would transfer the medicines to the nearby unit and contact the pharmacist and GP."

Unused medicines were disposed of appropriately by staff and collected by a specialist pharmaceutical contractor. The home had suitable arrangements for the administration, storage and disposal of controlled drugs (CD), which are medicines which may be at risk of misuse. CDs were administered and signed for by qualified staff who audited them to ensure that they were accounted for. We saw that sharps containers were stored safely. Sharps containers are for used medical needles and syringes. There was information available to staff for sharps injuries and the first aid box was checked regularly. We saw that there was a sufficient number of staff qualified to deliver first aid in the home.

Good

Is the service effective?

Our findings

People said that the care staff were helpful and supported them in their daily lives. One person said, "I would thoroughly recommend the home to others. The staff are very friendly and have had good training." We spoke with a relative of a person living in the home and they told us, "We have been made to feel very extremely welcome. My family and I have been very happy with the way my [family member] is being treated."

We checked whether the home complied with the Mental Capacity Act (2005). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that staff demonstrated a good understanding of the principles of the MCA. One staff member said, "When a person lack capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive. A person who has capacity is free to come and go as they wish." Another told us, "The way I use the MCA in my daily work is my daily practice. I give our residents the opportunity to choose simple things like, what time they would like to get up, what type of clothes they would like to wear, whether they want me to cut their food for them."

The provider had suitable arrangements in place for obtaining consent, assessing mental capacity and recording decisions made in people's best interests. We found that where people were subject to capacity assessments and DoLS applications, there was appropriate documentation from the local authority.

Care staff sought people's consent and agreement before providing support to them. This consent was recorded in people's care files. One person said, "The staff ask me before they come in." A relative said, "The staff are good at communicating and always ask for consent and our involvement." For example, one relative described how they helped staff with the care plan for their relative and "staff sought my permission and consent to remove [my family member's] bed rail when it was required."

Care staff received opportunities to develop their skills and to provide effective care and support. We noted that all staff completed training in a number of key areas to ensure they were competent to do their job. Staff told us the training they received was relevant to their role and equipped them to care for people and meet their needs. For example, staff had received training in safeguarding adults, awareness of mental illness, dementia and learning disabilities, moving and handling, MCA/DoLS, infection prevention, medicine management, health and safety and fire safety awareness. Care staff were supported by senior staff, registered nurses and other health professionals such as dieticians, occupational therapists, tissue viability nurses (TVN) and physiotherapists to help them carry out their roles and ensure that they followed the correct guidelines. Care staff had received training in managing risks to ensure that people were safe and

protected from harm. They were knowledgeable about the use of rails and bumpers on beds and demonstrated effective knowledge and skill in how to manage the care of people in order to prevent pressure sores.

Care staff who were recently recruited, completed an initial five day induction and shadowed more experienced workers in their second week, to learn about people's individual care needs and preferences. The deputy care manager said, "The staff undergo a thorough induction and training programme. They are supernumerary during that period." This meant that new staff were supervised when carrying out any personal care and not counted as regular staff. Records confirmed that the registered manager authorised new staff to deliver personal care, once they completed a competency assessment and mandatory training.

We viewed the training schedule and saw that induction training was completed by all staff and internal refresher training for staff was provided. The training included Care Certificate standards, which were a set of standards and assessments for health and social care workers and required them to complete modules, in their own time. We saw that most of the care staff had Care Certificate work in progress. Some care staff were also encouraged to enrol on to diplomas in health and social care. This showed staff received opportunities to improve their knowledge and refresh or develop their skills. We spoke with a member of staff who worked in the home as a care assistant and they told us, "My induction was very helpful. After a week of shadowing I felt confident to do the job. The managers are very supportive and send us reminders and updates about different things."

Care workers said they had regular supervisions where they had the opportunity to discuss the support they needed, guidance about their work and any training needs in order for them to develop and gain further skills. Supervision sessions are one to one meetings with line managers where staff are able to review their practice and performance. Records confirmed that supervision meetings took place every two to three months, in addition to team meetings, which care staff said they found helpful and supportive. Staff received appraisals annually to monitor overall performance, practice and to identify any areas for development to support staff to fulfil their roles and responsibilities. Schedules for supervisions, mid-year appraisals and end of year appraisals were in place.

Staff also received training in fluids and nutrition management so that people were kept hydrated and provided with suitable meals that they enjoyed. We looked at five fluid balance charts which measured the fluid intake and output of each person, such as water and perspiration. Staff measured this by carrying out assessments and measuring people's body weight and urine output. The charts help staff to determine whether a person is adequately hydrated. A care staff member said, "We also make sure that the resident has adequate fluid and nourishment." We were concerned that some charts and care plans did not specify the amount of fluid or liquid taken, how it was to be taken and how care staff would encourage the person to take types of liquid refreshment.

During our inspection, we observed a lunchtime service on two of the units. The food was kept warm in a heated trolley. People who preferred to have their food in their rooms were served by staff and provided with assistance. A person told us they were happy with the meals provided. They said, "I get plenty of food, I enjoy it." We noted people were provided with a balanced or nutritious diet which was of their choosing, even if they were not on regular menus. People's food preferences had been recorded in their care plans. We saw that a copy of the menu was displayed in corridors and dining rooms. We noted that dining rooms contained tables that were set appropriately with cutlery, napkins and condiments.

Staff monitored people's health and care needs, and consulted with professionals to support them to maintain good health. People's dietary intake was monitored and recorded. People were weighed on a

regular basis, which was evidenced in their files. Care plans showed that people received access to healthcare services and received on going health care support. People were visited by a G.P on a weekly basis and received regular checks on their physical wellbeing. One person told us, "When I want to see the doctor, I inform the staff and they make appointments for me." We saw that a person with diabetes had appointments with a district nurse, diabetic nurse, chiropodist, optician, dietician and a G.P. and received personal care before their breakfast. One staff member said, "The home keeps in regular contact with palliative care nurses, the hospice and dementia care specialists."

Good

Is the service caring?

Our findings

Most people we spoke with told us they thought that the staff were caring, they were treated with dignity and their privacy was respected. One person told us, "I am very happy with BUPA they treat me right, all the people are very caring." Another person said, "I would like to say how friendly and helpful the staff are." A relative remarked that their family member was "well cared for" and that it was "easy to speak to staff. We go to the nursing station which is fully accessible in the corridor." People were happy that their friends and relatives could visit them and take them on outings, if they were able. We saw people had the ability to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. Relatives visiting the home also told us that the staff were very good at communicating with them and that their consent and involvement in their family member's care was always sought and encouraged.

We saw that people were appropriately washed, dressed and ready for the day by middle of the morning. However, some people were not happy with their level of care because they felt their dignity and privacy was not respected. We asked why this was and one person said, "When the staff don't come on time to take me to the toilet, it makes me feel completely humiliated." Another person said, "Yesterday, I still hadn't been washed or dressed by 12 noon. I was not happy." We saw that the management team undertook a walk round of the home each day to ensure people were cared for appropriately but we were not assured that incidents like these were always identified.

Otherwise, staff had a good understanding of how to promote people's privacy and dignity and help them be as independent as possible. A staff member told us, "I try to preserve people's independence and respect by addressing them by their preferred name and respecting their decision. I encouraged them to do as much for themselves as possible. Sometimes when they refused to do something, I ask them why but I came back later when they are much calmer."

Staff knocked on people's door before entering their rooms and addressed them by their preferred names before providing personal care. A staff member said, "We put a screen in front of the bed so that if anybody passes by the room they can't see what the person is doing. One person likes the bed room door open, so we respect their decision."

We observed care staff attending to people's needs in a way that was caring, kind, respectful and patient. For example, staff would hold people's hands if they became anxious and listened attentively to the person. Care staff were skilled in calming and relaxing people and making them feel better. Care staff treated people as individuals, respected their human rights and allowed them to make decisions. We found that people and their relatives were comfortable around staff and some people knew who the senior managers were.

Care staff knew people well and had received training in equality and diversity. This meant that staff treated people equally, no matter their gender, race or disability. They were respectful and had a good understanding of all people's care needs, personal preferences, their religious beliefs and cultural backgrounds. One staff member described how they provided care to a person and said, "I remember that

they [the person] can be anxious and they shout but is not aggressive. If you stay in the room for a while they soon calm down and smile."

Requires Improvement

Is the service responsive?

Our findings

Most people we spoke with and their relatives told us the home responded to their needs. One person told us, "There is plenty to do." Another person said, "It starts with the desire to help people then from the care staff to the nurses and doctors, right through to the managers. I know this is a good place." Relatives said that the home took their views into account and responded to any complaints or concerns.

People's needs were assessed and care and support was planned and delivered in line with their individual care plan. Some people received Palliative or End of Life care, which was care for people with a terminal illness. People had their own detailed and descriptive plan of care. The care plans were written in an individual way, which included health care needs, any nutritional requirements, likes, dislikes, the activities people liked to do and what was important to them. The information covered aspects of people's needs and clear guidance was provided for staff about how to meet their needs.

Care records showed that people's needs were assessed before they moved in. Care plans were scheduled to be reviewed every month and people had been involved. The care plans identified actions for care staff to support people. Care staff knew people's likes and dislikes and personal histories. They were able to handover any significant information to each other when taking over the next shift and also recorded them in daily handover notes. There was a clear process for the assessment, planning, implementation and evaluation of care. There was an initiative called Resident of the Day, which was delivered by a system of key working. This meant that care staff were allocated responsibility of a person's individual preferences, care and assessment on a particular day. The key worker evaluated the care plans and was responsible for the implementation of care. However, some people and relatives said they had not seen a copy of their care plan. One person said, "They told me that I have a care-plan, but I cannot tell you what's in it because I have not seen it. I would very much like to see it." We noted that daily logs for each person did not always correspond to the requirements in their care plans and some of the entries made by the care staff were not checked and countersigned by a registered nurse, to ensure they were of a satisfactory standard. Care plan reviews did not always take place when scheduled and fluid charts did not always provide enough information. This meant that the care provided was not always consistent with people's needs and people were not always responded to so that risks to their wellbeing were mitigated against.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were supported to engage in a programme of activities inside the home and in the garden. There was an activities timetable for the week on display in the home. On the day of the inspection, we saw that there were two coordinators who arranged activities such as games, music and singing. A hairdresser was available for people and one person said, "I have my hair done regularly." Another person told us, "I am just about to get my hair done by the hairdresser." We saw a large number of people being supported to have afternoon tea in the garden and we noted that most people were happy and engaged in conversations with each other and with care staff.

We spoke with some people who did not attend the garden party and they told us they felt "lonely and isolated." One person said, "There is nothing for me to do. I am bored. There are no activities but a person helped me with my knitting today." The deputy care manager told us that a person from Age Concern attended the home on some days to "visit all residents on all floors."

The home took into account the wishes and opinions of people. We saw a notice board which contained in large print, a list of activities or food that people requested, such as "a cockney knees up" and "pancakes" and a second list showing how the home responded to each request. The home was responsive to the needs of people, particularly those with dementia. For example, we noted that people's rooms were personalised, the corridors were colourfully decorated and there were clear signs for direction. This helped people with dementia find their way around the home. There were many rooms that did not have the person's name or a label on their front door and labels that were in use were likely to peel off. We were assured by senior managers that that pictures or labels would be reviewed and fixed on people's doors more securely so that their rooms were more personalised and people could be identified.

An easy to read service user guide was given to all people when they moved in to the home. The guide contained information about how to make a complaint. Some people did not know how to complain and one person said, "I am not sure what to do, nobody told me." People asked relatives to complain on their behalf because they were unsure of the process. A relative told us, "Yes I know how to complain and would speak to the registered manager." Another relative said, "It's a good service but I think there is always room for improvement." Staff knew how to respond to complaints and understood the complaints procedure.

We looked at the complaints policy and we saw there was a clear procedure for care staff to follow should a concern be raised, including who they should contact. We noted that any issues and complaints were brought to the attention of the management team. We looked at records and saw that investigations were carried out and action was taken promptly in response to concerns. Complainants were written to formally by the registered manager to acknowledge their complaint. We noted that after a complaint was upheld, action was taken and measures were put in place to prevent re occurrence. People and relatives were informed of the outcomes and were satisfied with the response. Actions and notes of meetings that had taken place were dated and detailed clearly. This showed that the home took complaints seriously and used them to make changes and improvements.

Good

Is the service well-led?

Our findings

The home had a registered manager in place who was appointed in January 2016. There was also a deputy care manager who supported the registered manager and provided cover for when they were away. Relatives, staff and people who used the home told us that the management team were responsible for a good care home. One person told us, "The manager is nice but they don't always have time to speak to me." Staff said that the registered manager was hard working and had made efforts to improve the home. One care staff member said, "The new manager is putting things in place to improve things for everybody." A nurse told us, "I have been here for many years and I love the job. I love the residents. The new manager is good and trying to make things better."

We saw that quality assurance and monitoring systems were in place, which included seeking the views of people and their relatives and this was recorded. For example, the home issued a survey to people annually. Topics included on the survey covered overall satisfaction with their care, the home, choices and complaints. We saw the results of the survey from last year were mostly positive. The home was in the process of sending out questionnaires for this year. Records showed that the management team carried out daily, weekly and monthly audits, which were recently implemented by the registered provider, to assess whether the home was running as it should be. The registered manager also took part in a walk around of the home each day, to check that people were well and systems were in order. Meetings took place every morning between managers, senior carers and nurses where any issues were discussed and actions were identified and carried out.

People benefitted from an open culture within the home. Care staff were able to raise any issues and found the registered manager to be helpful and supportive. Staff enjoyed working at the home and felt confident in meeting the challenges of their day to day work. However, one of the staff told us, "It's very good here, we have improved a lot. All we need is more permanent staff." The registered manager told us that they were recruiting more senior care staff. They said, "A lot of staff left in recent months and we have a new management team and head of departments, which has been difficult. There has been a lot of change but I am determined to make this home a success." On the first day of our inspection, we spoke with a regional support manager who provided assistance to the deputy care manager. They told us, "I provide relief cover and I support the managers. Hornchurch Care Home has got a good registered manager now, and we will make improvements." The registered manager felt supported by senior managers and said, "Yes all the regional managers and directors are really nice and helpful. They are very supportive. They visit all the time to check how things are going. We just needed consistency and hopefully we have it now."

The registered manager had initiated a redecoration programme in the home and had made some operational changes, such as the recruitment of unit managers on each unit. The registered manager said, "The home was quite dilapidated when I started. We had to do a lot of work to get it up to standard so I started with redecorating the floors. They were all one colour and it was not homely." We saw that work was continuing to be carried out during our inspection.

We saw that various meetings took place between staff on each unit and the managers. Agenda items that

were discussed included topics such as feedback from relatives, record keeping, supporting new staff, supporting people who lived in the home, nurse call systems, medicine management and any maintenance work. One staff member said, "We have staff meetings quite regularly. We talk about the home, our residents' health and any issues." People and relatives were also invited to meetings which were an effective way for the registered manager to respond to feedback. For example, some relatives felt that nurses were not demonstrating 'enough responsibility' on their respective units. We saw that the registered manager took action by ensuring that all nurses were "managed by competency and observation of practice and instructed to manage their staff and not pass it on to managers." This demonstrated that the management team took on board negative feedback to make positive changes that empowered staff.

The registered manager understood their role and responsibilities. We found that people's records were kept securely which showed that the home recognised the importance of people's personal details being kept securely to preserve confidentiality. The registered manager notified the CQC of incidents or changes to the home that they were legally obliged to inform us about.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain an accurate record of each person, including updates and reviews of care and treatment provided. Daily notes were not always checked and signed off by senior staff. Fluid chart records did not contain enough detail about the amounts of fluid and how they were to be taken. Risks to people were not always mitigated against by responding to their everyday needs. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have sufficient numbers of qualified and experienced staff to meet the needs of people in the home and provide support to care staff. Regulation 18(1)