Blackwater Mill Limited

Blackwater Mill Residential Home

Inspection report

Blackwater
Newport
Isle Of Wight
PO30 3BJ

Tel: 01983520539
Website: www.bucklandcare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Blackwater Mill is a residential care home that provides accommodation and personal care to 60 older people. Blackwater Mill provides a service for people living with dementia and or a physical disability who do not require nursing care.

People's experience of using this service:
People were happy living at Blackwater Mill. They told us their needs were met by staff who were kind and caring. People were treated with dignity and respect.
Most individual risks were managed appropriately, however we identified some concerns in how risks to people were being recorded and acted upon by staff.
Medicines were usually managed safely and people received the personal care they required. They were involved in the development of their personalised care plans that were reviewed regularly. Staff worked with local health and social care professionals to ensure health care needs were known and met.
People could make their own choices and decisions and their legal rights and freedoms were upheld. When people lacked the ability to make their own decisions, systems were in place to ensure these were made legally and in their best interests.
There were sufficient numbers of staff who had received necessary training, worked well together and received formal and informal supervision from senior staff.
The management team continually considered ways to improve the service for the benefit people living there. Where we identified areas for improvement, they acted immediately.

The service met the characteristics of Good in most areas and is rated Good overall. More information is in the full report.
Rating at last inspection:
The service was rated as Requires Improvement at the last full comprehensive inspection, the report for which was published in May 2018.

Why we inspected:
This was a planned inspection based on the previous inspection rating.

Follow up:
We will continue to monitor the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Blackwater Mill Residential Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed by two inspectors and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Blackwater Mill is a care home. People in care homes receive accommodation and nursing or personal care as single packages under one contractual arrangement. CQC regulates both the premises and the care provided, and both were looked at during the inspection. Blackwater Mill accommodates up to 60 people who require support with personal care. There were 52 people at the service at the time of the inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of our inspection.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous

inspection reports, action plans and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we gathered information from:
11 people who used the service
Seven relatives or friends of people who used the service
Five health or social care professionals who had regular contact with the service
Eight people's care records
Records of accidents, incidents and complaints
Audits and quality assurance reports
The manager, two deputy managers and two heads of care
The provider's nominated individual
Eight members of care staff
One housekeeper, an administrator, a maintenance staff member and three catering staff

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety.
There was an increased risk that people could be harmed.

Using medicines safely:
● There were systems in place to audit medicines systems. However, these had not identified that a medicine which should not be administered at the same time as another medicine were being given together for two people. Audits had also not identified that a medicine stock checked did not tally with Medicines Administration Records (MAR's) indicating one dose had not been given. Similar issues had also been identified during internal audits, meaning people were not always receiving their medicines as prescribed. A staff member had failed to sign to confirm they had administered antibiotics for a person. This should have been picked up by the next staff member administering medicines. However, there was no record that this had been noted or action taken to investigate this.
● Pain relief was offered to people during medicine administration rounds, however for those unable to verbally express they were in pain, a pain assessment tool was not being used. A senior care staff member said most people could verbalise pain, but they monitored body language and facial expressions for those who couldn't. We discussed the absence of a formal pain assessment tool with the registered manager and provider's nominated individual. The registered manager was unaware of a suitable pain assessment tool; however, the nominated individual was aware and gave an example to the registered manager who said they would introduce its use.
● There were systems in place to label prescribed topical creams with opened and use by dates. However, we found this process had not always been followed meaning topical creams could be used when they were no longer safe for application. Records of the application of prescribed topical creams showed people had received these as prescribed.
● Otherwise, arrangements were in place for obtaining, safe storage, administering and disposing of medicines in accordance with best practice guidance.
● Staff had been trained to administer medicines safely and this was reassessed annually as part of a formal competency assessment. We observed staff administering medicines in an appropriate and safe manner.
● People told us they received their medicines as prescribed. They also told us they could receive ad hoc pain relief such as for a headache, if required.

Assessing risk, safety monitoring and management:
● Not all individual risks to people were assessed, recorded and updated when people's needs changed.
● Some people were prescribed medicines (anticoagulants) which 'thin' their blood and placed them at higher risk of bleeding should an injury occur. For some people receiving these medicines risk assessments and care plans included guidance for staff in respect of this. However, for people who were prescribed Aspirin specifically to thin their blood, no risk assessments were in place. The registered manager told us they would address this immediately.
● The risk of malnutrition or dehydration was not always safely managed. People's dietary needs were

assessed and their weight was regularly monitored, however for some people, necessary action had not been taken to ensure they received their required nutritional intake. For example, one person, who was losing weight and required a soft diet, was not being offered snacks between meals or receiving fortified drinks. The deputy manager told us this person should be receiving special milkshakes, however we were not provided with evidence that this had been offered. We established that suitable snacks for people who required soft high calorie diets were not available. On the second day of the inspection, we were told about action that was being taken to make suitable snacks available for people on a soft or modified diet.

● Where there were concerns about the amount people were eating or drinking, specific records were kept. However, these were not always fully recorded meaning prompt action may not be taken if people failed to eat or drink adequate amounts.

● Where people were at risk of falling, equipment was in place to alert staff that the person may be moving about in their bedroom. However, the system to alert staff did not differentiate between the activation of movement alert equipment and a person using their call system to request staff support. Care staff said they knew in which rooms people were using movement alert equipment so would prioritise these calls. However, we noted that there was a delay in staff responding to movement alert equipment placing people at higher risk of falling. For example, we saw staff failed to respond promptly when a person activated their movement alert equipment and staff in this area responded first to a call bell activated by another person.

● Staff told us people's access to outside spaces was restricted due to safety risks. From the ground floor, there was level access to a flat enclosed patio style rear garden area. However, this area was not safe for people to use unsupervised due to the proximity of a large lake, and much of the surface was gravel which would present a falls risk. Staff told us people only had access to this area when staff or family members were available to take them outside and remain with them at all times. The failure to ensure the environment was suitable for people was restricting their freedom to access external spaces independently whenever they wished to do so. The provider's nominated person informed us that a budget had been approved to make this area safe for people.

● People and visitors felt risks were managed safely. Visitors confirmed they had no worries about their relative's safety. One relative said, "My husband is in a very safe place here, I have no concerns for him."

● Environmental risk assessments had been completed. Where these indicated a risk, action was taken to minimise this risk. Each person had a personal emergency evacuation plan (PEEP) and staff knew what action to take in the event of a fire. An external consultant had completed a full fire risk assessment of the home. Where this had identified areas for improvement, action had been taken.

● Lifting equipment was checked and maintained according to a schedule. In addition, gas and electrical appliances were checked and serviced regularly.

Systems and processes to safeguard people from the risk of abuse:

● Appropriate systems were in place to protect people from the risk of abuse.

● People said they felt safe at Blackwater Mill. One person said, "Yes, I do feel safe here and my possessions are also safe." Visitors also felt people were safe. One visitor told us, "My relative is very happy here, she is in a safe place, nothing has gone missing."

● All staff including ancillary staff, such as catering and activities, had received safeguarding training and knew how to prevent, identify and report allegations of abuse.

● Safeguarding incidents had been reported and investigated thoroughly, in liaison with the local safeguarding team. The registered manager was clear about their safeguarding responsibilities and had attended additional safeguarding training for managers.

Staffing and recruitment:

● People were supported by appropriate numbers of consistent, permanent staff.

● People told us they felt there were enough staff. One person said, "The staff are always available when I

need them, they have time for me I am never rushed."
● Care staff told us they felt there were sufficient staff available and we saw people were supported without being rushed. One staff member said, "We have time to sit down and chat with people". Another staff member said, "We now have spare time to do more baths, weights etc."
● The registered manager kept staffing levels under review, including using formal assessment tools to determine the numbers of staff required to meet people's needs.
● Short term staffing needs were filled by existing staff working extra shifts and using consistent agency staff.

● The provider had clear recruitment procedures in place. Records confirmed these were followed and had helped ensure that only suitable staff were employed.

Preventing and controlling infection:
● People and visitors said they felt the home was clean. One person told us, "The home is kept very clean as is the equipment."
● Appropriate arrangements were in place to control infection, with comprehensive audits completed monthly. Infection control risk assessments were in place, together with an annual statement of infection control.
● The home was clean and staff completed regular cleaning in accordance with set schedules.
● The laundry was well organised to help ensure clean items did not come into contact with those waiting to be washed. Potentially contaminated laundry was managed safely.
● Staff had been trained in infection control techniques and had access to personal protective equipment, including disposable gloves and aprons, which we saw they used whenever needed.
● The registered manager was aware of the action they should take if there was an infection risk at the home.
● The local environmental health team had awarded the home five stars (the maximum) for food hygiene.

Learning lessons when things go wrong:
● When accidents or incidents had occurred, appropriate action had been taken where necessary. For example, medical advice was sought, risk assessments were reviewed and any lessons learnt were discussed with staff and further training offered if required.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs:
- The provider was looking at how internet access could be provided for people, which would mean they could use technology to support their interests and keep in contact with family or friends.
- The registered manager had completed an audit of the environment to determine what measures were required to make it more suitable for people living with dementia. This showed that some actions were required and the registered manager described how they were addressing these issues. For example, work had commenced to paint hand rails in a contrasting colour to walls, increasing the likelihood that people would notice these and use them. Action had also been commenced to improve signage around the home and to help people identify their own bedrooms.
- All bedrooms were for one-person use, had ensuite facilities and were personalised to the individual. Should they wish to do so, people could have their own furniture and personal fixtures and fittings. A range of communal areas were available for people and some could be made available for private visits should this be requested.

Staff support: induction, training, skills and experience:
- At the previous inspection in March 2018, we found that the provider had not ensured that new staff received appropriate training to enable them to support people effectively. We told them they must make improvements. At this inspection, we found new staff were now receiving an appropriate induction.
- People were supported by staff who had completed a range of training to meet their needs. Training was refreshed and updated regularly. When asked if they felt staff knew how to look after them, one person said, "I do think that the staff are well trained to care for me and other residents."
- Staff told us they received plenty of training and felt supported in their roles by the registered manager and senior staff. There was a clear plan to ensure all new staff received any necessary training as part of their induction. This followed the care certificate, which is a competency based training programme to give social care staff the skills they need. Staff were supported to obtain recognised care qualifications and provided with training to further develop their knowledge and skills. Ancillary staff such as maintenance, chefs and housekeepers also confirmed they received a range of relevant training.
- In addition to set training, one of the deputy managers organised short workshops to reinforce the basic training such as dignity and respect and dementia. They planned to do further workshops including end of life care, mental capacity and safeguarding.
- Staff received regular one-to-one sessions of supervision. These provided an opportunity for the members of the management team to meet with staff, discuss their training needs, identify any concerns, and offer support. In addition, between supervisions, senior staff undertook staff observations of their practice, covering moving and handling, dignity and respect, communication and infection control. Staff spoke positively about the support they received, in particular from the deputy managers. They said the

observations were "really good" and were done in a supportive way. All staff received an annual appraisal to assess their performance.

Supporting people to eat and drink enough to maintain a balanced diet:
● People were offered a choice of food and drink and were positive about the meals they received. One person said, "The food is very good and if I want something different they will make it for me." Relatives were also positive about the food and one told us, "[My relative] loves the food here very much and eats very well, I have no complaints about that."
●Where needed, people received appropriate support to eat and were encouraged to drink often. One visitor said, "Staff are always available to help at mealtimes."

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (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 and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● People and relatives told us they were always asked before care was provided. One person said, "The staff do ask for my consent, they always knock on my door." Whilst a visitor said, "The staff are always very polite and seek his consent."
● Staff were clear they would ask people before providing care and if people declined care, they would return later to offer support. We saw daily records which confirmed this.
● Some people living at Blackwater Mill lacked the ability to give informed consent to all aspects of their care. Staff protected people's human rights by following the Mental Capacity Act, 2005 (MCA). Where people did not have capacity to make decisions, best interests decisions were made in consultation with family members and other relevant people.
● We checked whether the service was working within the principles of the MCA and found that they were. Some DoLS authorisations had been made and others were awaiting assessment by the local authority. The registered manager was aware of when additional conditions had been applied to approved DoLS and these had been complied with by the home. Systems were in place to ensure that DoLS were reapplied for in a timely way when these were due for renewal.

Supporting people to live healthier lives, access healthcare services and support:
● People told us they received healthcare support when they needed it. One person said, "If I need a doctor I would use the visiting one." External health professionals were positive about the service and confirmed they were contacted appropriately when required.
● Care records showed specific healthcare needs were being appropriately met. Where people had a specific known medical need such as diabetes, records showed routine monitoring was undertaken appropriately. Records also showed medical advice was sought appropriately when required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● Prior to admission to the home, the registered manager undertook an assessment of people's individual needs to ensure these could be met, including any specific equipment that may be required. Copies of hospital discharge documents and other information from health and social care staff were kept within care files. This helped to ensure all needs were known and met following admission.
● Care planning and risk assessments followed best practice guidance. For example, they used nationally recognised tools for assessing the risk of skin breakdown.
● Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed. Pressure relieving equipment for beds
was used safely and in accordance with the person's needs.

Staff working with other agencies to provide consistent, effective, timely care:
● When people were admitted to hospital, staff provided written information about the person to the medical team, to help ensure the person's needs were known and understood. Care plans included prepared information which provided essential information, such as any special diets or how the person should be supported with mobilising.
● A social care professional said the home worked well with them and kept them informed if there were any issues or concerns with people living at the home. A health care professional echoed these views and said the home contacted them appropriately.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence:
● Staff interacted positively with people and generally spoke about them in a respectful way. However, all staff used the term "feeds" when referring to people who needed support to eat. For example, "The meal time assistants are good as we haven't got enough time to be doing the feeds as well"; "[Person's name] has two staff to support her, apart from feeding" and "We have time to chat to people when we feed them". The use of terminology such as this may objectivise people and does not respect their individuality. We discussed this with the registered manager who agreed they needed to undertake further work with staff in this area.
● People were encouraged to do as much as they could for themselves. For example, one person self-administered their medicines and had secure storage for this. In addition, staff did a weekly stock check to help ensure it was being managed appropriately. Care staff described how they promoted independence. One told us, "If they can hold a cup I let them. If they can feed themselves, I encourage them but remain with them in case they need help. If they can undress themselves I let them, even if it takes longer. You have to let them do what they can, or it takes away their independence."
● At lunch time we saw adapted crockery such as high sided plates were available when required and staff encouraged rather than took over when people were slow to eat. A social care professional told us how the home had supported people to become more independent with a view to them returning to their own home.
● People felt staff respected their privacy. One person said, "The staff are always respectful towards me, they knock before entering to deal with me, they make sure that my dignity is respected at all times." Staff described how they supported people's privacy and dignity. This included listening to people, respecting their choices, closing doors and curtains and keeping people covered as much as possible when providing personal care. People confirmed staff always closed the curtains and ensured their dignity and privacy was maintained.

Ensuring people are well treated and supported; respecting equality and diversity:
● People told us they liked living at Blackwater Mill and were treated with consideration. One person said, "The staff are very kind and caring towards me, they know how I like things done and they take care to do it that way." Another person said, "There is a good atmosphere here and the staff get on well with the residents." A visitor told us, "The staff are very good and caring, things are done properly for my relative."
● We observed people were treated with kindness and compassion by staff. Staff spoke respectfully to people and supported them in a patient, good-humoured way. We saw a person seated in the dining room became distressed. A staff member knelt and held their hand and listened whilst the person explained why they were upset. The staff member reassured the person and stayed with them until they were more settled.

Later, we saw other staff providing reassurance for the person patiently explaining things and remaining with them until they were less anxious.

● People's protected characteristics under the Equalities Act 2010 were explored as part of their needs assessments before they moved to the home. The registered manager and staff explained how they met people's individual needs.

● People's diverse needs were detailed in their care plans and people confirmed they were met in practice. This included people's needs in relation to their culture, religion, diet and gender preferences for staff support. Staff had received equality and diversity training.

Supporting people to express their views and be involved in making decisions about: their care

● Records confirmed that people, or where appropriate family members, were involved in meetings to discuss their views and make decisions about the care provided. One visitor told us, "I am involved in his care planning and it [care plan] has been updated recently."

● Staff showed a good awareness of people's individual needs, preferences and interests. Care files included information about people's life histories and their preferences. Staff could use this information when talking with people. For example, we heard staff talking with people in the dining room. It was evident they knew what people liked to eat for breakfast and how they liked this to be prepared.

● Staff understood people's rights to make choices. One staff member said, "Even if people lack capacity [to make some decisions], they can still make other decisions, like when they want to go to bed."

● Meetings were held with people and family members. A person said, "Residents meetings are held every few months, they do seem to listen to our views." Records of these meetings were kept and showed the registered manager invited suggestions from people and family members about changes to the service provided. Key staff, such as the head chef, were also invited to attend resident meetings, meaning people could ask them specific questions or make suggestions directly to them.

● Family members were welcomed at any time. One visitor said, "There are no visitor restrictions and the staff are very welcoming towards me." The registered manager told us families could join people for meals should they wish to do so. They told us one family member joined their relative for a meal most days. Important events were celebrated and relatives had been invited to celebrate Mother's Day and Christmas with their family members.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

End of life care and support:
● Care files contained limited individual information about people's wishes as to how they would like to be cared for at the end of their lives.
● Staff told us they had known a person liked a particular type of music and this had previously been helpful in relaxing the person when agitated. They described how they had played this music for the person when they had been distressed towards the end of their life and this had had a positive calming effect for the person. However, this information had not been document in the person's care plan and other staff may not have known this. The registered manager spoke positively about their desire to provide people with high quality care at the end of their lives. They acknowledged that information about people's individual preferences and wishes for end of life care was an area for further improvement.
● Family members had written to the registered manager and staff following a person receiving end of life care. The letter said, "Thank you for the compassionate care you provided to our mother. You made her last month's comfortable and dignified. It means so much to our family."
● Some staff had received specific end of life care training. The registered manager had links with the local hospice and was aware of how to access additional training and support should this be required.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People told us their needs were met in a personalised way and this was confirmed by family members. One visitor said, "I am involved in my relative's care plan and the information is kept up to date."
● Comprehensive care plans had been developed for each person. They provided information as to how care should be provided to meet the person's needs. Short easy reference care plans had also been developed to help ensure care staff had all the information they needed to meet people's needs.
● Discussions with care staff showed they were aware of people's needs and how they liked these to be met. For example, a staff member explained why a person's lunchtime meal plate had not been removed, as this would distress them unless replaced with a plate with further food on it.
● People were empowered to make their own decisions and choices where they were able to do so. People told us they could choose when they got up and went to bed, where they took their meals and how they spent their day. Where people with capacity were making unwise choices, staff supported them to do so safely. For example, one person did not want to have their meals in a softer format as advised following an assessment by an external professional. To manage their risk of choking, staff encouraged the person to have meals in a communal area with staff supervision.
● People were happy with the activities provided. A person said, "I like the activities here and get involved." A visitor said, "My relative's dementia makes it difficult for them to participate in activities, they [staff] do encourage her though."
● Two activities organisers were employed and we saw they provided a range of group and individual activities on both days of the inspection. These were tailored to meet the different needs of people

participating. Activities staff told us the registered manager encouraged them to be creative as to how activities were provided and a budget for visiting entertainers and equipment was available. Outings were also possible either by public transport or via a community minibus.

Improving care quality in response to complaints or concerns:
● People told us they knew how to make a complaint. One person told us, "If I had a problem I would speak to the carers and if they didn't sort things out I would speak to a manager."
A relative told us when they had raised a concern previously, this had been dealt with to their satisfaction.
● The manager stated they aimed to make themselves as available as possible to people and visitors, meaning any issues could be addressed promptly before people felt the need to make a complaint. A visitor said, "If I was unhappy about something I would speak to the manager, however I have no problems."
Should people or visitors wish to make an anonymous complaint, a suggestion box was available in the entrance area.
● The provider had a complaints policy. Information about how to complain was available for people and relatives. Records viewed showed that where formal complaints had been made, they had been investigated and responded to appropriately. For example, where patterns had been identified in respect of concerns about the laundry service, action had been taken to more clearly identify individual people's clothing so it could be returned to the correct person once clean.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Continuous learning and improving care:

● At the previous inspection in March 2018, we found that the provider had not ensured new staff received appropriate training to enable them to support people effectively. We told them they must make improvements. At this inspection we found new staff were receiving an appropriate induction.

● When we identified areas for improvement during this inspection, the registered manager, deputy managers and the provider's nominated individual [legally responsible for the service on behalf of the provider company], were receptive to our findings and acted to investigate and make improvements. Information provided following the inspection confirmed that this had occurred.

● A range of audits and quality monitoring procedures were in place. The nominated individual and registered manager undertook a range of formalised audits and monitoring systems for the service. Specific teams employed by the provider, such as the health and safety team, also undertook some audits. Where audits were delegated to senior staff, the registered manager had systems in place to check the quality of these audits. Where these had identified improvements were required, subsequent audits and reports showed appropriate action had been taken. The registered manager also undertook some unannounced visits to the home during evenings and overnight.

● The provider had a clear set of policies and procedures in place, which were individualised for the service. Where there were changes in best practice guidance or legislation, updated versions of the policies were automatically received. This helped ensure the management team were up to date with any changes in how the service should be organised.

● The registered manager sought feedback from people, relatives and staff through an annual survey. We viewed the returned surveys, which were positive about the service provided at Blackwater Mill.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

●There was a clear management structure in place, consisting of the provider's nominated individual, the registered manager, deputy managers and heads of departments. The nominated individual told us they attended the home several times a month and had regular telephone and email contact with the registered manager. The nominated individual was present for the second day of the inspection.

● Since the previous inspection, there had been changes in the home's management team, which had been strengthened by the addition of a second deputy manager and heads of care. Staff roles and responsibilities were also more clearly defined and senior staff were now more able to organise and monitor the way staff were acting. Changes had also been made to the allocation of care staff around the home, to help ensure staff were working in clearly defined areas and more available for people.

● Staff were positive about the home's management team and registered manager. One staff member said,

"If I have a concern, I can go to any of the managers and they will deal with it. It's better now, more organised and less [staff] sickness." Another staff member said, "The [deputy managers] are my support. I can ask them anything and they don't make me feel stupid."

● People and visitors were aware of who the registered manager was and confirmed that they felt able to approach her should they wish to do so. One visitor said, "I can't fault the management they are very good." We saw a visitor enter the home and they spoke to the registered manager praising the way their relative was being cared for. The visitor clearly knew who the registered manager was and that they were 'in charge'.

● Staff understood their roles and communicated well between themselves to help ensure people's needs were met. One staff member said, "We all get on well and work as a team." There was a consistent staff team and staff in various roles worked well together. This was also noted by people and one said, "The staff do get on with each other and with the residents."

● The registered manager was aware of when they needed to notify CQC about incidents in the home and had done so when required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

● The registered manager consulted people and their relatives in a range of ways. These included residents' meetings and one-to-one discussions. A person said, "The staff do let us know what is going on with events and other things." One person said, "The home is well managed, resident's meetings are held every few months, they do seem to listen to our views." Records of meetings showed a range of topics were discussed with time available for people to raise any specific questions of their own.

● Where people or relatives identified areas for improvement action was taken.

● Staff meetings were also held and the registered manager had an 'open door' approach, meaning staff could raise any issues or questions at any time. Following concerns being raised to the local safeguarding team, staff had been reminded about the homes whistleblowing procedures and the registered manager had encouraged staff to inform them if they had concerns about the service.

● Staff spoke positively about the registered manager and told us they felt valued and listened to by them.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

● The registered manager demonstrated an open and transparent approach and encouraged staff to do the same. They understood their responsibilities in this respect. Where people had come to harm, relevant people were informed in writing, in line with the duty of candour requirements.

● The previous performance rating and full report was displayed in the home's entrance hallway making it available to all visitors and people. This information was also included on the home's website with a link to the full report.

● Friends and family members could visit at any time. They told us they were made to feel welcome and were offered refreshments. One visitor said, "There are no visitor restrictions and the staff are very welcoming towards me."

Working in partnership with others:

● Staff had links to other resources in the community to support people's needs and preferences. This included links with local church communities and the registered manager described how they hoped to develop further links with nearby schools. The home had extensive grounds including a large lake. This had been made available for a local community picnic.

● Health and social care professionals were positive about their working relationship with the registered manager and said they would recommend the home.

● The registered manager was clear about who and how they could access support from should they require

this. They told us they had attended training for social care managers and this had helped them have a greater understanding of what support was available and how to access this. The registered manager said that since the training they had felt more "open" to seeking support.