Blackwater Mill Limited

Blackwater Mill Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Blackwater Mill Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service was last inspected in December 2016 when we identified no breaches of regulation, but rated the service 'Requires improvement'.

This inspection took place on 7 and 8 March 2018 and was unannounced.

The home accommodates up to 60 people and at the time of our inspection 55 people were living at the home. The home was based on three floors connected by two passenger lifts. There was a choice of communal spaces where people were able to socialise and all bedrooms had en-suite facilities.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

There were quality assurance systems in place based on a range of audits. However, we found these had not always been effective in ensuring compliance with the regulations. We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

People and their relatives had mixed views about the staffing levels. Staff aimed to answer people's call bells within seven minutes, but the provider was unable to provide assurance that this was quick enough when people had activated an alarm mat and had moved to an unsafe position.

Appropriately arrangements were in place to manage medicines safely. However, we found staff did not always record the use of topical creams.

Effective systems and processes in place to protect people at risk of abuse. However, two staff members we spoke with did not understand their safeguarding responsibilities.

Most areas of the home were clean and there were systems in place to protect people from the risk of infection, although there was a build-up of potentially contaminated linen in the laundry that posed a risk of cross infection.

New staff did not always receive appropriate training to equip them for their roles until they had worked at the home for over six months. However, experienced staff were competent, received regular training and were supported appropriately.

People told us the structure of the home was supportive of their needs. However, we found excessive noise levels in the dining room, where many people spent a lot of their time. There was a risk that these could adversely affect people living with dementia.

Staff followed legislation designed to protect people's rights. However, were not aware of the people whose freedom had been restricted by law. This posed a risk that restriction might inadvertently be applied to other people.

Most people told us staff cared for them in a compassionate way, but we found this was not the case in two instances we observed. However, at all other times staff interacted positively with people.

Some staff built positive relationships with people and their families. They used appropriate techniques to communicate effectively, promoted independence and involved people in decisions about their care.

With the exception of one person whose needs staff were struggling to meet, all other people received personalised care that met their needs. Care plans contained detailed information and were reviewed regularly.

Staff demonstrated a good awareness of people's needs and responded promptly to any changes. People's nutrition and hydration needs were met and people were supported to access a range of activities.

Staff supported people to access healthcare services, including when they were admitted to or discharged from hospital. People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

Risk assessments had been completed for individual and environmental risks to people, together with action staff needed to take to reduce the risks. The provider had a contingency plan to deal with foreseeable emergencies. Staff knew what to do in the event of a fire and had been trained to administer first aid.

People enjoyed living at Blackwater Mill and felt the service was run well. The provider sought and acted on feedback from people. A complaints procedure was in place and people felt able to raise concerns.

There was a clear management structure in place. Staff were organised and completed delegated tasks in an efficient and effective way. Appropriate recruitment procedures were in place and followed.

Visitors were made welcome at any time. Staff acted in an open and transparent way when accidents occurred and the registered manager notified CQC of all significant events.

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.

People had mixed views about the staffing levels. The provider was unable to confirm that their response time to people's call bells was adequate to keep people safe.

Medicines, including topical creams were not always managed safely.

Appropriate systems and processes were in place to protect people at risk of abuse. However, two staff members did not fully understand their safeguarding responsibilities.

There were systems in place to protect people from the risk of infection. Individual and environmental risks to people were managed effectively. Staff knew what action to take in an emergency.

Appropriate recruitment procedures were in place and followed.

Is the service effective?

Requires Improvement

The service was not always effective.

New staff did not always receive adequate training to equip them for their role. However, experienced staff received regular training in all key subjects and were supported appropriately in their role.

Adaptations had been made to the home to make it supportive of the people who lived there. However, there was a risk that people living with dementia might be adversely affected by the high level of background noise.

Staff followed legislation designed to protect people's rights, although not all staff were aware of restrictions that had been applied to some people's freedom.

People's nutrition and hydration needs were met. They were supported to access healthcare services when needed. Staff made appropriate use of technology to support people.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed that some staff did not always treat people with compassion.

However, other staff interacted positively with people. They were kind and patient and build positive relationships.

Staff knew how to protect people's privacy and dignity. They supported people to follow their faith.

Staff promoted independence and involved people in making decisions about the care and support they received.

Is the service responsive?

Good

The service was responsive.

Most people's needs were fully met in a personalised way.

Staff were able to recognise changes in people as they occurred and responded promptly.

Care plans contained detailed information and were reviewed regularly.

People had access to a range of meaningful activities suited to their individual interests.

Staff supported people at the end of their lives to ensure their comfort and their dignity.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a comprehensive quality assurance process in place, but this had not identified concerns we found during the inspection and had not ensured compliance with the regulations.

People said they were happy living at the home and had confidence in the management. They were consulted about the way the service was run.

There was a clear management structure in place. Staff were organised and communicated effectively between themselves

The provider learnt from incidents and shared information between services. There was a contingency plan to deal with foreseeable emergencies.

The service had an open and transparent culture, visitors were welcomed and the registered manager notified CQC of all significant events.

Blackwater Mill Residential 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 8 March 2018 and was unannounced. It was completed by two inspectors 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.

Before the inspection we reviewed all information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us.

We spoke with 25 people who used the service and five family members or friends of people who used the service. We spoke with the provider's deputy general manager, the registered manager, the deputy manager, the head of care, seven care staff, two activities coordinators, an administrative assistant, a maintenance worker, two kitchen staff and two housekeepers. We received feedback from two health or social care professionals who had contact with the service.

We looked at care plans and associated records for seven people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of complaints, accident and incident records, maintenance records and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We last inspected the service in December 2016 when no breaches of regulation were identified.

Requires Improvement

Is the service safe?

Our findings

People expressed mixed views about the level of staffing and whether it was adequate to keep them safe and meet their needs. Comments included: "We need more staff here to help keep us safe"; "I feel safe, but we could do with more staff" and "This is a nice home, but we need more support [from staff]". Although people felt more staff were needed, they were unable to give specific examples of how this had affected them and most family members felt staffing levels were adequate. For example, one said, "There are so many staff, you have to fight your way through them [in the dining room] sometimes."

Staff also had mixed views about the adequacy of staffing. While some told us they felt there were enough staff to meet people's needs, others felt this was not always the case, especially in the mornings when they felt "rushed" and "stressed". Comments from staff included: "We need more staff, I have said it since I have started working here" and "It's a busy job. [The job] can get you down as there's a lot to do".

Staffing levels were determined by the registered manager using a tool that took account of the dependency levels of people using the service. They told us the tool did not consider the size or layout of the building, but did take account of feedback from people and staff.

The registered manager told us their target was for staff to answer all calls within seven minutes. However, they were not able to explain how this target had been set, how often it was met or whether it was quick enough to meet people's needs. Some people were at risk of falling and had pressure-activated mats to alert staff when they moved to an unsafe position. These mats were linked into the call bell system and were subject of the same seven minute response target. A seven minute response time to a person in an unsafe position is unlikely to be effective in reducing their risk of falling. Similarly, people who needed to use the bathroom urgently and could not wait seven minutes might try to self-mobilise and put themselves at risk.

The provider had access to software built into the call bell system to analyse the time taken for staff to answer people's call bells. However, we found they did not know how to use this effectively. Whilst they could establish response times in one-off instances, they did not know how to extract broader data to enable them to identify average response times, to explore trends or identify times of greater demand when more staff might be needed. When we raised this concern, the registered manager took action by contacting the software supplier to arrange a meeting to explore ways of extracting the data. This would enable them to analyse response times and conduct a meaningful review of staffing levels. However, in the meantime, we could not be assured that there were sufficient staff to meet people's needs in a timely way.

There were arrangements in place for medicines to be obtained, stored and disposed of safely.
Oral medicines were administered by senior staff who were suitably trained and had been assessed as competent, while prescribed topical creams were usually applied by care staff.

Prescribed topical creams were not always managed effectively. One person told us they did not believe their creams were applied as often as they should be. The home had introduced a new cream chart for recording the application of topical creams; however this was not always appropriate for each person. For

example, staff told us that one person should have creams applied every two hours, but the cream chart only had space to record two applications per day. Where people had more than one prescribed cream, staff did not always record which one they had applied. In addition, the topical cream charts were not always complete fully, with gaps shown for several days in a row. The provider was unable to confirm that people had received their creams as prescribed and this put people at increased risk of skin complaints.

For people prescribed 'as required' medicines (PRN), we found there was usually clear information about when and how these medicines should be given. For one person though, who was prescribed a PRN sedative, there was no guidance to help staff know when this should be given. We saw they had only received this once since it had been prescribed three weeks previously, even though their care records showed there had been times when they had become "anxious" and "aggressive". The lack of guidance meant the person might not have received the medicine when they would have benefitted from it.

We discussed the above issues with the registered manager who addressed the concerns immediately, in a way that ensured all people's medicines would be managed safely. In all other respects, medicines were managed appropriately. For example, there were effective systems in place for obtaining, storing and disposing of unwanted medicines. Where emergency medicine was required, there was a clear process to ensure this was ordered and received promptly.

The provider had effective systems and processes in place to protect people at risk of abuse and most staff understood their safeguarding responsibilities. Most staff had received safeguarding training and knew how to report incidents of abuse. However, we identified one staff member who had worked at Blackwater Mill for seven months who had not received this training. They, and another staff member who had completed their training, were not clear about their safeguarding responsibilities and did not know how to raise concerns with external agencies. We raised this with the registered manager, who took immediate action to ensure the staff members concerned attended safeguarding training. Other staff were better informed and had demonstrated their knowledge of provider's whistle blowing policy by raising specific concerns about a colleague and cooperating fully with a subsequent police investigation.

Staff completed body maps of any bruises found to people. These were brought to the attention of senior staff who investigated the cause. Records showed the provider had notified CQC and the local safeguarding authority of all relevant safeguarding incidents and had completed prompt and thorough investigations where required.

There were systems in place to protect people from the risk of infection. All staff had attended infection control training and had access to personal protective equipment (PPE), which we saw they wore when needed. They described how they processed soiled linen, using special red bags that could be put straight into the washing machine. However, we found a large pile of red bags awaiting washing on the floor of the laundry room, as the designated laundry bin was full. This was contrary to best practice guidance. This posed a risk of cross infection with other items entering or leaving the laundry room. Following the inspection, the registered manager informed us they had bought an additional laundry trolley so red bags could be stored more safely, off the floor. Other areas of the home were clean and cleaning records confirmed they were cleaned regularly, in accordance with a cleaning schedule.

Individual risks to people were managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. For example, some people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses had been provided. There was a clear process in place to help ensure they remained at the right setting according to the person's weight. In addition, records confirmed that people were supported to reposition regularly. Some people had

been given walking aids. Staff made sure these were accessible and prompted people to use them correctly. When people experienced falls, their risk assessments were reviewed and additional measures considered to keep them safe. The registered manager reviewed all falls in the home on a monthly basis to identify any patterns or trends; none had been identified, but they described the action they would take if a common theme emerged.

Environmental risks were also managed effectively. Staff protected people from scalding by checking and recording the temperature of bath water before use. They also checked the temperature of all hot water outlets on a monthly basis, including those in people's rooms. Gas and electrical appliances were serviced routinely and fire safety systems were checked weekly. Staff were clear about what to do in the event of a fire and had been trained to administer first aid. Furthermore, each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated.

Appropriate recruitment procedures were in place and followed. These included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home.

Requires Improvement

Is the service effective?

Our findings

New staff did not always receive appropriate training to equip them for their roles. Providers are required to follow the standards of the Care Certificate to make sure new staff are supported, skilled and assessed as competent to carry out their roles. The Care Certificate is an identified set of standards that identifies the knowledge, skills and behaviours expected of staff working in health and social care. The provider had recently taken the decision not to provide Care Certificate training as part of the induction process but, instead, to offer staff the opportunity to complete a level two qualification in health and social care once they had worked at the home for a minimum of six months. This meant that during this time, and in some cases beyond, staff were supporting people without having completed all the recommended training. For example, records showed that two staff members, who had worked at work at the home for seven months and 12 months respectively, had not started their level two courses; neither had 10 members of care staff who had been recruited in the previous six months.

Staff had completed a week's induction training, under the tutorship of a mentor; this briefly covered most elements of their role, but was not adequate to meet the standards of the Care Certificate and was not supported by any training materials.

Staff told us they felt they could meet the needs of all but one of the people living in the home. The person was living with advanced dementia and often behaved in a way that staff found challenging. A staff member told us, "Personally, I don't think we have had enough training around challenging behaviour. We've had some, but it could be more in depth." Our observations confirmed that staff struggled to meet this person's needs and some told us they avoided working with the person for fear of being "hurt". In addition, we identified that two staff members did not have an adequate understanding of safeguarding procedures. Therefore, the provider was unable to demonstrate that staff had the necessary knowledge and skills to support people effectively.

The failure to ensure staff were supported, skilled and assessed as competent to carry out their roles was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Experienced staff, who had worked at the home for more than a year, received regular training in all key subjects. People told us these staff supported them effectively. One person said, "Staff seem well trained." Another person told us, "The care is excellent; I am satisfied with staff support." Family members echoed these comments. One said, "I'm very happy with the care. They [staff] understand [my relative's] needs." Another said, "The home is very good, effective and caring". However, people expressed less confidence in newer staff, who they felt did not know them or understand their needs as well.

Experienced staff were supported to gain additional vocational qualifications relevant to their role. For example, five staff members were being supported to gain level three qualifications and the deputy manager was being supported to gain a level five management qualification. Experienced staff spoke positively about their training. For example, one staff member described an extended dementia course they had attended as "enlightening" and told us how they planned to implement what they had learnt in their current role.

Staff were also supported through an annual appraisal process, where they discussed their performance and development needs, together with one-to-one sessions of supervision with a manager to discuss their progress and any concerns. A staff member told us, "Supervisions and appraisal are good. We can discuss training and we're given scenarios, like safeguarding, to say what we would do in different situations."

People told us the structure of the home was supportive of their needs. Comments included: "This place feels like home" and "It's a lovely place, very bright and clean". A family member told us, "The home is suitable for [my relative's] needs and requirements." Adaptations had been made to the home to make it supportive of the people who lived there. For example, there were two passenger lifts connecting the three floors of the home and handrails along some corridors. There were also large signs to help people navigate around the home, including on some bedroom doors to help people find their rooms.

However, we found noise and activity levels in the main dining room where most people, including people living with dementia spent a lot of their time, were not conducive to creating a relaxed and calm environment. At times, there were up to 30 people or staff present, with people constantly coming and going. The door to the adjacent kitchen was often left open, creating further intrusive noise. The hard flooring in the dining room meant the food trolley made a loud clatter whenever it was taken through the room and the medicines trolley made a loud rumbling noise. On the first day of the inspection, an activity coordinator was trying to run a game of bingo for people in one part of the dining room, while a craft activity was taking place in another part of the room. In between, two large hoists were being used to transfer people from wheelchairs to armchairs, while other people were trying to relax or sleep in armchairs. At one point, a staff member shouted out, "For goodness sake, I can't hear myself think in here." Later, they shouted for someone to close the kitchen door in an effort to reduce the noise level. People living with dementia are particularly affected by high levels of background noise. It makes concentration more difficult and can lead to them becoming over-stimulated and anxious. A quiet dining room was available on the ground floor, although this was only used by people who were independently mobile and we did not see staff supporting other people to use this. We were told that people did not like to use the quiet lounges on other floors of the building as there were no toilets nearby and staff were not readily available to provide support there.

We discussed these concerns with the registered manager and the provider's deputy general manager. Following the inspection, they told us they would complete an environmental audit, using an assessment tool recommended by a national charity that supports people living with dementia. This would help identify changes that could make the home more supportive of the people living there.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found staff were following the necessary requirements. Some DoLS had been authorised and others were awaiting assessment by the local authority. However, when we spoke with staff, they were not able to readily identify which people were subject of a DoLS authorisation without going through each person's care plan where the information was stored. This posed a risk that people might be subject to restrictions that were not authorised in law. We discussed this with the registered manager, who took immediate steps to ensure staff had access to this information.

At all other times, staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Staff described how they sought verbal consent from people before providing care and support. They said they were led by the person and always acted in the person's best interests. For example, when people declined support, they described how they accepted this and offered it at a later time or asked a different staff member to offer support. Where people lacked capacity to make specific decisions, staff had completed MCA assessments and made best interests decisions on behalf of the person. These included decisions relating to the provision of personal care, the use of bedrails and the administration of medicines. Records were detailed and showed the decisions had been made after consultation with family members and other professionals, where needed.

People's nutrition and hydration needs were met and people praised the quality of the food. One person told us, "The food is nice; I get to choose what I want to eat." Another person said, "The food is good and there's plenty to eat." A family member told us, "My relative eats like a horse. They get full cooked breakfast and porridge. The meals are always warm and freshly prepared. I had lunch here once; it was gorgeous."

Each person had a nutritional assessment to identify their dietary needs. Some people needed a special diet or needed their meals and drinks prepared in a certain way to meet their individual needs and we saw these were provided consistently. For example, one person told us, "I can't swallow, so I have a soft diet." Staff were attentive to people during meals. They offered extra portions and made sure people's drinks were topped up. When people needed support to eat, this was provided in a dignified way on a one-to-one basis. When a person needed to use the bathroom during lunch, a staff member noticed and made sure their meal was kept warm in the kitchen. People were offered hot and cold drinks regularly and we rarely saw an empty cup.

Staff monitored the intake for people at risk of malnutrition or dehydration using food and fluid charts. They also monitored people's weight and took action when people started to lose unplanned weight. For example, they enriched people's meals with additional calories or sought advice from GPs. Where food supplements were prescribed, people were offered these consistently.

People were supported to access healthcare services when needed. For example, care records showed people had been referred to their GP when they had declined their medicines for three days or more. Records confirmed that people were seen regularly by doctors, specialist nurses and chiropodists.

The home was taking part in the NHS Red Bag Initiative. This is a scheme to help ensure people are supported effectively when they are admitted to or discharged from hospital and that essential information is transferred with them. This includes information about the person's medicines and their care needs. Staff told us the initiative was "going well" and had helped ensure continuity of care for people.

Staff made appropriate use of technology to support people. For example, pressure mats were used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries and an electronic call bell system allowed people to call for assistance when needed. Wi-Fi had also been installed to allow people or their visitors to connect to the internet and to allow staff to access training resources online.

Requires Improvement

Is the service caring?

Our findings

Most people told us they were treated well by patient, kind and compassionate staff. Comments from people included: "I like all the staff, they are so friendly" and "Staff treat me with dignity and respect".

However, one person told us they found staff were sometimes "a bit lacking" in compassion when they were being supported. Our observations confirmed this was sometimes the case. For example, on the first day of the inspection, we heard a staff member telling a person abruptly to "Be quiet". The person was being pushed in their wheelchair and was becoming anxious. The staff member's approach did not show empathy or demonstrate an understanding of the person's emotional needs. We later visited another person living with advanced dementia immediately after they had been supported with personal care. They had chosen to stay in bed for the day, but we saw staff had not made their bed up for them. They were laid directly on the plastic covering of their mattress without trousers or leg coverings. This would result in their legs becoming sweaty and uncomfortable. Their bedding had been left screwed up at the end of the bed, under their pillow. This showed a lack of consideration for the person and their needs. We drew this to the attention of the deputy manager who directed another member of staff to make the person's bed properly. We confirmed this had been done and later saw the person was resting comfortably in the bed. Following the inspection, the registered manager told us they had investigated both of these incidents and taken appropriate action.

With the exception of the above incidents, at all other times we observed that staff interacted positively with people. For example, staff were kind and reassuring when a person struggled to eat their lunch. They patiently reassured the person and used supportive prompts to encourage them to finish their meal. When supporting people to use equipment, they explained what they were doing at all times; for example, when pushing a person in a wheelchair, the staff member warned the person of a change of surface and said, "There may be a little bump as we go over the threshold." Other staff discretely invited people to use the bathroom, speaking quietly so as not to embarrass them. When a person became disorientated and confused in the evening, a staff member held their hand and took them to a quiet place for a chat until they had recovered.

We also heard a staff member having a conversation with a person about the name of a doll they were interacting with. The staff member spoke in terms the person could understand and it was clear from the smiles and positive reaction of the person that they had enjoyed the discussion. When the person later needed to use the bathroom, another member of staff offered to hold the doll and promised to "look after it" for the person, which they did.

Some staff built positive relationships with people and their families. Two family members told us, "Staff seem to like [my relative]." Another family member said, "[My relative] gets on well with all the staff. There's lots of good humour." Friends and family members were made welcome at any time and people could use the telephone to keep in touch with people who were important to them. At lunchtime, people sat in small groups with people they knew and got on with well. On the second day of our inspection, another person had a birthday. They were presented with a cake and all the staff sang 'Happy birthday' to them. A staff

member told us, "It's lovely to feel appreciated by the residents through the relationships you build. It's a very rewarding job, making them comfortable and showing them you care, really care, through your actions; and showing them love and understanding."

Staff used appropriate techniques to communicate effectively with people according to their individual needs. For example, one person had hearing loss and staff made sure they faced the person, bent down to their level and spoke clearly. Desserts were offered to people from a trolley and vegetables from serving dishes to help people with cognitive impairment make informed choices.

Staff knew how to protect people's privacy and dignity. For example, when giving personal care they said they closed curtains and shut the door. They described how they talked to the person throughout and used towels to keep them covered as much as possible. When using the hoist in communal areas, they used a privacy screen if there was a risk the person's clothes might ride up and compromise their modesty.

The registered manager told us they explored people's cultural and diversity needs during pre-admission assessments and later when they had settled in to the home. However, we found the form used to gain additional information about a person's background focused on questions about the person's spouse, their wedding anniversary, their children and grandchildren. This presumed they were married and had children, which might deter people from disclosing other relationships that were important to them. The registered manager acknowledged this and agreed to review the questions to help gain a better understanding of the person's background and culture.

Staff supported people to follow their faith. Most people living at the home were of one particular faith and a local minister held a service there every two weeks. The registered manager told us they knew how to contact leaders of other religious groups should the need arise and had done so in the past.

Staff supported people to maintain their independence by offering choices and encouraging them to do as much as possible for themselves. One person told us, "Staff are caring and help me to live independently." A family member told us, "[My relative] is free to roam about and there are no restrictions on when she gets up or goes to bed." We heard staff encouraging people to make choices, for example of where they wished to spend their day, what they wanted to eat and which activities they wanted to take part in. These choices were respected; for example, a person sat in the hall declined to go to the dining room for tea, so staff brought their tea to them. When the person later changed their mind and chose to go through to the dining room, the staff member patiently supported them to do this and took their tea through with them.

When people struggled to make choices, due to a cognitive impairment, staff supported them by making suggestions and giving them time to respond. A staff member told us, "We don't take liberties if people can wash themselves. We let them do what they can and also give them a choice of clothes." People's care plans contained information to help staff promote the person's independence, detailing, for example, how far the person could walk before needing support.

People and relatives told us they were involved in discussing and making decisions about the care and support they received. A family member told us, "You feel involved and they [staff] let me know if there are any changes."

Good

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. One person said, "Staff respond well to my needs." A family member told us, "Staff are good and encourage [my relative] to keep to a routine as she needs that."

We found there was a lack of guidance for staff about how to safely support a person whose behaviour was challenging. The person behaved in a way that put themselves and others at risk of harm. The registered manager acknowledged these concerns and told us they were working with health and social care professionals to obtain additional support for the person or to identify a home that was better suited to meet their needs. There is more information in the effective section of this report about how staff responsiveness was affected by a lack of training.

We found the needs of all other people that we tracked were being met fully, in a personalised way. Staff kept records of the care and support they provided to people and these confirmed that people's needs had been met consistently. For example, they included 'turn charts' for people who needed support to reposition regularly and monitoring charts of the fluid input and output of people with catheters to check they were working properly. During a handover meeting between shifts, we heard staff discussing people's needs and any additional support they might need. It was clear that staff were able to recognise changes in people as they occurred and were committed to delivering the best care possible. When allocating staff to support people, senior staff assessed which staff member was best able to meet the needs of each person and allocated them accordingly.

Before people moved to the home, one of the managers completed an assessment of the person's needs. This process was repeated before people were accepted back to the home after a hospital stay. The information gathered from the assessment was used to inform the person's care plan. Each person had a care plan which contained individual information about their specific needs and how they wished them to be met. They covered a wide variety of topics, including the person's normal daily routine, their mobility, medicines, continence, hobbies and personal preferences.

Care plans were reviewed by senior staff on a monthly basis, or sooner if the person's needs changed. Senior staff told us changes were only made after consultation with the person or their representative. In addition, people and their representatives were invited to an annual review of their care to discuss any changes they wished to make.

Senior staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew which people preferred baths in the morning and which people preferred them in the evening; they knew the support each person needed with their continence and the level of encouragement they needed to maintain their personal care. They recognised that some people's mobility varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. A family member told us this was limited to holding the hand of their relative on some days and using a wheelchair on other days, depending how tired they were.

Staff responded promptly when people's needs changed. For example, one person said they had a headache and were offered pain relief. When a person appeared to experience a seizure, immediate medical help was sought via the 999 system.

People were supported to access a range of activities. These were advertised on the home's notice board and people were encouraged to take part. They included word games, arts and crafts, movement to music, visits by pets, bingo, trips to local attractions and quizzes. A family member told us, "[My relative] loves the activities. For example, they had the pets in yesterday, which she loved. When staff saw me showing [my relative] old films on my phone, they got a [handheld computer] to use for that. I can't fault them."

The activity coordinators had talked to people about their interests, hobbies and backgrounds to help identify particular activities they would enjoy. In addition, they described how they were in the process of tailoring activities to meet the needs of different groups within the home; for example, those living with dementia, those without dementia, and those who preferred one-to-one activities.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. This was confirmed by a letter from the family member of a person who had recently died at the home. It said, "Thank you for being so kind to [my relative] especially during their last days. Amazing care." Senior staff and some care staff had received training in end of life care and were experienced in delivering this. People's end of life wishes were discussed with them and their families and recorded in their care plans. This helped ensure staff would know what was important to the person at this stage in their life and which people they wished to be consulted. The registered manager and deputy manager told us they enjoyed good working relationships with the local doctors and community nurses. They said this helped them advocate for people and ensure they had access to anticipatory medicines to manage their symptoms.

People told us they felt able to raise concerns or complaints with the management, although they all said they had not had cause to complain formally. A family member told us, "I had to ask them to make sure they put [my relative's] hearing aids in, and now they do." A complaints procedure was in place and was displayed on the home's notice board. This was only available in standard sized print, but was supported with pictures. The registered manager told us they were planning to make a large print version available, to support people with limited vision. We viewed records of recent complaints. We saw these had been investigated thoroughly and responded to promptly, in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place to assess, monitor and improve the service. However, these were not always effective and had not identified the concerns we found during the inspection. These included the lack of robust systems to assess the adequacy of staffing; the lack of robust systems to ensure medicines were managed safely; and the failure to ensure new staff were suitably trained.

Senior staff completed a comprehensive range of audits and some of these had been effective in monitoring and improving the service. For example, an infection control audit had identified that the level of skin infections was increasing, so plans were being developed for managers to observe staff practice and check they were following best practice guidance. Each audit had an action plan attached to it. The deputy general manager then worked with the registered manager to help ensure the actions were completed in a timely way.

People who could express a view told us they were happy living at Blackwater Mill and felt it was well-led. Comments included: "I like it here, it is a well-run home"; "The home is well managed and run"; "I am very happy living in this home and staff all work very well. Nothing could be better. The home is well-run and does not need any improvements" and "You can't beat living here; you never hear anyone complain".

There was a clear management structure in place consisting of the provider's deputy general manager, the home's registered manager, the deputy manager, the head of care, plus senior care staff allocated to each floor of the home. Each had clear roles and responsibilities and the management team worked well together. In addition, an 'on call' rota was in place to enable staff to access management advice out of hours. One staff member told us, "[The job is] really good, everyone is very helpful" and another said, "Management appreciate what we do; they are there for you."

Staff were organised and communicated effectively between themselves to ensure people's current needs were known and met. This was supported by daily handover meetings between shifts and regular staff meetings.

People were consulted in a range of ways about the way the service was run. These included "residents meetings" held every two months, yearly questionnaire surveys and individual discussions with people and their relatives. Any issues raised were acted on promptly. For example, some people expressed an interest in knitting, so a 'knit and natter' group was introduced. Other people liked reading, so a book club was set up.

The registered manager had recently joined the local care homes association to help share ideas and best practice with other registered managers. They had also visited a local home rated 'outstanding' and brought back some ideas to help support people at Blackwater Mill. For example, they had introduced 'rummage bags' and hats for people to explore and interact with. These are known to be popular for people living with dementia as they encourage curiosity.

The registered manager told us they received positive support from the provider, whose deputy general

manager visited every few weeks and was contactable at any time. The provider operated a number of other homes and had processes in place to share information and best practice between their services. For example, following a choking incident at another home, we saw additional guidance had been issued to staff a new process implemented.

The provider was working to develop a clear vision and set of values for staff to work to. The work was in the consultation phase and would be communicated to staff when complete. The deputy general manager told us, "It's about making sure the team work together to meet people's needs."

The provider had a contingency plan to deal with foreseeable emergencies. This was effectively put into place during a recent bout of extreme weather that caused the home to temporarily lose their water and gas supplies. After the event, a family member wrote to commend staff for "responding so well by ensuring the safety and wellbeing of all the residents". They added, "I know that for some [staff] this meant staying over at the end of their shift and for others coming in at short notice. The standard of care remained high and I was truly impressed at the way everyone rallied round. I think Blackwater staff has every right to feel proud of the way they demonstrated their professionalism. A very big 'Thank you and well done' to everybody."

People and relatives described an open and transparent culture where they had ready access to the management and were encouraged to share their views. Visitors were welcomed at any time and could stay as long as they wished. Positive links had been developed with the community, to the benefit of people. For example, a school pupil attended regularly to support people with activities and local dance groups visited on special occasions to perform to people.

The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently on the home's notice board. A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred. The registered manager showed us examples of where this had been followed and family members confirmed that they were always updated when their relative had an accident.

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 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that new staff received appropriate training to enable them to support people effectively. Regulation 18 (2)(a).