Blackwater Mill Limited

Blackwater Mill Residential Home

Inspection report

Blackwater
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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This inspection took place on 15 December 2016 and was unannounced. The home provides accommodation and personal care for up to 51 people, including people living with dementia. There were 46 people living at the home when we visited. Accommodation was spread over three floors, connected by two passenger lifts and stairwells. All rooms had en-suite toilet and washing facilities. There was a lounge and a dining room on the ground floor, further lounges on the middle and top floors, and bathrooms on each of the floors. A patio was accessible to people via level access from the first floor.

There was a registered manager in place. 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 2008 and associated regulations about how the service is run.

At our last comprehensive inspection, we identified there were not enough staff deployed to meet people's needs. We issued a warning notice and told the provider to make improvements. We followed this up at a focused inspection in April 2016. At that time, we found some improvements had been made, but there were still not enough staff deployed to meet people's needs at all times. We issued a requirement notice and the provider sent us an action plan telling us how they would meet the regulation.

At this inspection, we found there were enough staff deployed to meet people's needs and call bells were answered promptly. However, the service experienced a high level of staff turnover during the past year and needs to demonstrate that it can sustain an appropriate level of staffing to enable them to meet people's needs consistently.

There were appropriate arrangements in place for the safe handling, storage and disposal of oral medicines. However, topical creams were not always managed safely. Some were out of date or not available and records indicated they had not always been applied.

Most people were positive about the standard of care delivered. However, some were critical of the communication skills of staff whose first language was not English. We were not assured that all staff were able to understand people's needs and communicate with them effectively.

People were complimentary about the meals and most people's nutrition and hydration needs were met. Staff monitored the amount people ate and drank and took action if their intake was not sufficient. However, people's preferred foods were not always provided when they declined the food that was offered.

Staff followed legislation to protect people's rights and freedom, although applications to restrict the liberty of two people had not been submitted in a timely way. This meant they were subject to restrictions that had not been authorised.

People were cared for with kindness and compassion. We observed positive interaction between people and staff. Staff supported people to build friendships and maintain relationships that were important to them. They respected people's privacy and involved them in planning the care and support they received.

People told us they felt safe at Blackwater Mill and recruitment practices helped ensure only suitable staff were employed. Staff knew how to identify and report safeguarding concerns.

Individual and environmental risks to people were managed appropriately. There were plans in place to deal with foreseeable emergencies. Staff knew what action to take in the event of a fire and fire safety systems were tested regularly.

Staff received appropriate training and support for their roles. New staff followed a comprehensive induction programme and all staff were supported to obtain relevant qualifications.

People were supported to access healthcare services and staff followed medical advice. Care plans were comprehensive and reviewed regularly. Staff demonstrated a good awareness of people's individual support needs and responded promptly when people's needs changed.

Staff encouraged people to make choices about every aspect of their lives. People had access to a wide range of activities, including one-to-one activities with dedicated activity coordinators.

People were positive about the management of the home. There was a clear management structure in place. Staff were organised and understood their roles. Senior staff were experienced and demonstrated a commitment to providing high quality, compassionate care to people.

There was an effective quality assurance process in place to assess and monitor the service. The provider sought and acted on feedback from people to improve the service and there was an appropriate complaints procedure in place.

There was an open and transparent culture. Visitors were welcomed at any time. Managers were visible and 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 told us there were enough staff to meet their needs; however, the service had a high level of staff turnover and the staffing levels needed to be sustained over time to ensure people's needs were met consistently.

Oral medicines were managed appropriately, but the administration of topical creams was not managed safely. Some creams were not available to people and gaps in the administration records indicated people may not have been receiving them consistently.

Recruitment practices helped ensure only suitable staff were employed. People felt safe and staff had received training in safeguarding adults.

Risks to people were managed appropriately and there were arrangements in place to deal with foreseeable emergencies.

Is the service effective?

Requires Improvement

The service was not always effective.

People were positive about the standard of care they received. However, some were critical of the communication skills of some staff whose first language was not English. We were not assured that all staff were able to understand people's needs and could communicate with them effectively.

Most people's nutrition and hydration needs were met, although people's preferred foods were not always provided when they declined the food that was offered.

Staff followed legislation to protect people's rights and freedom. However, applications to restrict the liberty of two people were not made in a timely way, which meant they were subject to restrictions which had not been authorised.

People received care from staff who were suitably trained and supported in their work.

People were supported to access healthcare services and staff followed medical advice.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They responded positively when people became anxious or upset.

Staff supported people to build and maintain relationships. They protected people's privacy and dignity at all times.

People were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were supported and encouraged to make choices about every aspect of their lives. Staff responded promptly when people's needs changed.

People had access to a range of activities run by two activity coordinators.

The provider sought and acted on feedback from people to help improve the service.

Is the service well-led?

Good

The service was well-led.

People enjoyed living at the home and felt it was run well.

There was a clear management structure in place. Staff understood their roles and were organised.

Senior staff were experienced and demonstrated a commitment to providing high quality, compassionate care to people.

Effective records management and quality assurance systems were in place.

There was an open and transparent culture. Visitors were welcomed, the managers were visible and CQC were notified 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 15 December 2016 and was unannounced. It was conducted by four inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 11 people living at the home and three friends or family members. We also spoke with the provider's general manager, the registered manager, the care support manager, five care staff, two members of the kitchen staff, an activities coordinator and the administrator. We looked at the full care plans and associated records for six people, plus parts of care plans for a further six people. We also looked at staff duty records, recruitment files, records of complaints, accidents and incidents, policies and procedures 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.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection, in November 2015, we identified there were not enough staff deployed to meet people's needs. We issued a warning notice and told the provider to make improvements. We followed this up at a focused inspection in April 2016. At that time, we found some improvements had been made, but there were still not enough staff deployed to meet people's needs at all times. We issued a requirement notice and the provider sent us an action plan telling us how they would meet the regulation.

At this inspection, most people told us staff had time to meet their needs and that call bells were answered promptly. One person said, "I feel there are enough staff." Another person told us, "If I use the call bell in my room staff come as quickly as you can expect." A family member told us, "Staffing seems to be okay. There were times when it did feel a bit short staffed, but they seem to be on top of it now."

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 said they took account of this and feedback from people and staff when using the tool. Staff absence was usually covered by existing staff working additional hours with occasional use of agency staff if a person needed one-to-one support.

However, some people and their family members felt staff were overworked at times. Comments included: "They work really hard"; "They are overworked at times, but they cope"; and "[Staff] could do with help, as they always work hard and seem to work long hours." These comments were echoed by some staff members, one of whom told us, "There's too much to do and not enough time. We have to prioritise [people's care] depending on the circumstances." They said this meant, for example, that some people had to wait until they were supported to visit the bathroom after lunch. Another said, "It's a stressful place to work and you always feel you haven't done enough and it makes you feel bad."

The provider had recognised staff were becoming tired and attributed this to the shift system they were working. In response, they had recently introduced a new shift system. This made the daytime shifts shorter, which the registered manager said would make them easier to cover if staff reported sick at short notice. However, the new shift system had only been operating for a week, so had not been evaluated fully.

We looked at the staffing rosters for a four week period up to, and including, the week of our inspection. These showed the scheduled staffing levels were achieved on every day. The general manager analysed the time taken for staff to answer people's call bells using software built into the call bell system. They told us their target was to answer all calls within seven minutes. They did not have any data available for this time period; however, a dip sample of five days showed that between 86% and 93% of all calls were responded to within five minutes. The registered manager felt this indicated they were close to meeting the target. We observed that call bells were answered without undue delay during the course of the inspection.

The service experienced a high level of staff turnover. A total of 67 staff were employed at the home and 44 staff members had left the service during the previous year. The majority of the staff who left were care

workers. The care support manager had analysed the reasons for staff leaving which they found the most common reasons given were 'personal reasons', 'competition from other providers' or 'dismissal' (normally due to poor attendance). In an effort to reduce staff turnover, they told us they were focussing their recruitment efforts on local staff who were new to care. They said this would allow them to "train and mould" the staff to meet the needs of people living at the home.

Given the high turnover of staff and the history of not deploying enough staff, the provider needs to demonstrate they can sustain adequate staffing levels over a period of time in order to assure themselves that people's needs will be met consistently.

The process used to recruit staff was safe and helped ensure staff were suitable for their role. The provider carried out relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people effectively. Staff confirmed this process was followed before they started working at the home.

There were appropriate arrangements in place for the safe handling, storage and disposal of oral medicines. Staff administering medicines had received appropriate training and had their competency assessed. Staff were observed administering medicines competently; they explained what the medicines were for, did not hurry people and remained with them to ensure the medicine had been taken.

Medication administration records (MAR) showed people received their oral medicines as prescribed and this was confirmed by people and family members. Guidance had been developed to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. Where people were not able to state they were in pain, a pain assessment tool was used. We saw that PRN medication had been given to people and the reasons why this had been administered had been accurately recorded. One person had recently been prescribed a strong PRN pain medicine. Guidance had not been put in place for its use, but we saw it had been given and the care support manager took action to develop the necessary guidance immediately.

However, prescribed topical creams were not always managed safely. The creams were kept in people's rooms, together with clear guidance to staff about when and where these should be applied. One person had run out of their cream and the topical cream chart showed it had not been applied for the previous two weeks. Another person did not have access to all of the creams that had been prescribed to them. In addition, one cream that was in use had passed its safe 'use by' date and two others did not have a date of opening recorded. Staff told us all the topical creams should have a date of opening recorded as they had a limited shelf life once opened and they relied on these dates to know when to stop using them. The topical cream charts for other people's creams were not complete, with gaps shown for several days in a row. One person told us staff applied their creams daily, although they did not always record this, but staff were not able to confirm that other people had always received their creams. The failure to ensure creams were applied consistently, as required, meant there was a risk people could develop skin complaints. We discussed this with the registered manager. They showed us a recent medicines audit that had also identified the management of topical creams as an area for improvement and included plans in place to address the issue.

People told us they felt safe at Blackwater Mill. One person said, "I feel safe living here, surrounded by trees and a nice outlook." A family member told us, "I feel [my relative] is safe. You can share concerns with staff and they take it on board. If [my relative] is unwell, they will call me and let me know."

Staff had the knowledge to identify and report safeguarding concerns, and acted on these to keep people

safe. They told us they would have no hesitation raising concerns and had confidence that managers would take appropriate action. One staff member said, "If I had concerns about people, I'd be straight in the office and they would deal with it." Staff were also aware of external organisations they could contact for support, including the local safeguarding authority. Where safeguarding concerns were identified, senior staff conducted thorough investigations and took action to protect people from harm.

Where individual risks to people were identified action was taken to reduce the risk. These included, for example, the risks to people of falls, choking, poor nutrition and skin damage. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. We saw these were being used correctly. People were also assisted to change position regularly to reduce the risk of pressure injury. Moving and handling assessments set out the way staff should support each person to move. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance.

Risks posed by the environment had been assessed and were being managed appropriately. Equipment, such as hoists and lifts, was serviced and checked regularly. Upstairs windows had restrictors in place to prevent falls and fire exit doors were alarmed so staff would be aware if anyone had left the building without staff support. The temperature of hot water at water outlets was controlled through special valves and maintenance staff monitored these regularly. This helped protect people from the risk of scalding. The registered manager reviewed accidents and incidents on a monthly basis to identify any patterns or trends and described the action they would take if any were identified.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire. Fire safety systems and fire drills were conducted regularly. Personal evacuation plans had been developed for people and included details of the support they would need if they had to be evacuated. In addition, staff had been trained to administer first aid.

Requires Improvement

Is the service effective?

Our findings

Most people and their relatives were positive about the standard of care delivered. One person told us, "It's wonderful here; they look after me so well." Another said, "I feel looked after 100% night and day, I can't grumble." A family member told us, "[My relative] is well looked after. I've no complaints about his care at all."

However, some people told us they sometimes had difficulty communicating with staff whose first language was not English. One person said, "Language is a problem here as they have some [non-UK] staff who are not very good at English. But they do make an effort, some of them." A family member told us, "There are four or five [non-UK] staff who are super, willing and pleasant; but the problem is their language [skills]." This was confirmed by our own observations. When speaking with one care staff member, they responded to every question by putting their thumb up and saying "Okay". We were not assured that they understood people's needs and could communicate with them effectively.

We discussed staff communication skills with the registered manager. They acknowledged that some staff, who had recently arrived in the UK, were still developing their language skills but felt their other skills and caring qualities were of benefit to people. To minimise the impact that their limited communication skills had on people, the registered manager said they were usually assigned to work alongside experienced staff who were able to communicate effectively with people.

People were complementary about the meals provided and from discussions and observations people clearly enjoyed their meals. One person told us "All the food is excellent." Another person described the food as "very good and very impressive". A family member told us, "[My relative] is happy with the food; perfectly happy with it. He gets a choice of two or three options and is asked what he would like. There's lots of choices for dessert as a dessert trolley comes round and it looks lovely."

Most people's nutrition and hydration needs were met. Care plans included information about people's food preferences, although this information was not always known by care staff and was not always used to provide preferred food to people. For example, one person's care plan stated they loved bananas. The person was reluctant to eat and records showed they would refuse some meals. However, there was no record of them being offered bananas during the week preceding the inspection. A staff member who was caring for them on the day of the inspection did not know about this preference. When people declined food, they were sometimes offered alternatives, but records did not show that this was always the case. For example, another person was reluctant to eat and records showed they usually declined mousse puddings. The deputy and registered managers told us that the person disliked being supported to eat by staff and preferred finger foods. We saw that on some occasions they were offered, and ate, sandwiches; however, these or other finger foods had not been offered on a regular basis.

Staff told us they could provide people with food and drinks at any time they were requested or required. We saw that one person had been offered cereal one evening when they had declined their tea-time meal and another person was provided with sandwiches during the evening. Cakes, crisps and chocolate were

available at all times. Drinks were available throughout the day and staff prompted people to drink, when needed.

Staff monitored the intake for people at risk of malnutrition or dehydration using food and fluid charts. They also recorded people's weight and the body mass index (BMI) for each person, which the registered manager monitored closely. Staff took action when people started to lose unplanned weight or if their BMI fell below the expected level. 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 who ate independently were offered varied and nutritious meals which were freshly prepared. A daily lunch menu was displayed and offered of a choice of two main meals. Lunchtimes were a social event and meal times were relaxed. The dining room, which had recently been refurbished, was welcoming and tables were attractively laid out with fresh flowers. Staff were on hand to provide assistance and support when required. A dessert trolley was brought to people's table's allowing them to make informed choices about what they wished to eat

Staff understood the Mental Capacity Act (2005) and their responsibilities within this. 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 explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would act in the person's best interests. Care plans contained information about the specific decisions people required staff to support them to make. For example, best interests decisions had been made in relation to a person's wish to leave the building, the provision of personal care, the use of bedrails and the administration of medicines. These were detailed and showed that the decisions had been made after consultation with family members and other professionals, where needed. Care plans also contained information as to who had the legal right to make other decisions on behalf of the person. When in place, we were told copies of the legal documents confirming this were held. Where people had capacity to make decisions about their care, they had signed appropriate consent forms within their care plans.

When we spoke with staff, they were clear about the need to check people were in agreement with the care and support they were offering and explained how they acted in people's best interests. For example, a staff member told us of one person who had a sweet tooth but lacked the capacity to make decisions about their diet. They described how they supported the person to eat "an appropriate amount of chocolate" to help ensure they received a balanced diet.

People can only be deprived of their liberty 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 found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. However, we found two DoLS applications were not submitted promptly. The need for applications had been identified a year ago, but the applications had only just been made. This meant they had been subject to restrictions that had not been authorised. The registered manager attributed this to an oversight by a manager who had now left the service. They were taking action, through the care plan review process, to ensure applications were made promptly in the future.

The registered manager was aware of specific conditions which had been added to one DoLS authorisations and confirmed these were complied with. DoLS are approved for a set period of time and the registered

manager should reapply for a new assessment shortly before the existing DoLS runs out. The registered manager had contacted the DoLS lead at the local authority to discuss DoLS which had expired. Emails viewed showed they were in the process of reapplying for these.

People's needs were met by staff who had received appropriate training. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. For example, 10 staff members had attended training in delivering end of life care to people living with dementia. A staff member told us, "We get all the training we need; it's all sorted out." Most staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques; and they explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance.

New staff completed a comprehensive induction programme before they were permitted to work alone. Arrangements were also in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, staff were encouraged to obtain vocational qualifications in health and social care and 16 staff members had gained these.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision which were organised consistently. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal, with the registered manager, to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from the managers and staff mentors on a day to day basis. One staff told us, "The mentors are really good; very thorough." Another said, "I feel supported in supervision, which I have every six weeks. I've just had an annual appraisal which went really well."

People's general health was monitored and they were referred to doctors and other healthcare professionals, when required. People were seen regularly by doctors, opticians and chiropodists as required. Blackwater Mill had equipment suited to the needs of people living there. We saw that the registered manager had reassessed a person who had been in hospital and requested specialist equipment including a bed and mattress from the district nurses before they had accepted the person back from hospital. We saw this included individual equipment where necessary, such as hoist slings and slide sheets. Another person had returned to the home from hospital. Medical staff had directed that the person should not lie flat but should be supported at an angle of 45 degrees at all times. We saw the person was being cared for in accordance with the directions of the hospital and a staff member confirmed this was always followed.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. They described staff as "lovely" and "friendly". One person told us, "Staff have all been very kind to me." A family member told us, "[My relative] is very happy here. Staff are lovely and caring." A letter we saw from the relative of a person who had received care recently said, "Thank you for the outstanding care. I could not have had more support and the respect you showed was wonderful." Another said, "You looked after [my relative] like a member of your family."

We observed positive interactions between people and staff throughout the inspection. One person was being fully supported to eat in a caring and unhurried way. The staff member was sat with the person and spoke to them kindly about things that were important to the person. For example, they asked after a family member who had been unwell. The staff member checked the person was comfortable and asked if they had enough to eat. When people were helped to mobilise, staff allowed them to move at their own pace whilst giving encouragement and reassurance.

When a person became agitated after lunch, staff tried a number of strategies to reassure and calm the person. They offered them the option of changing to a more comfortable chair, which they declined. Different staff members tried different approached to support the person, including giving the person time alone. When the options had been exhausted, staff moved the person to join them at a table where they were writing their notes. They offered the person a drink and a snack, and interacted calmly and informally with the person while completing their work. Another person, who was encouraged and supported to attend a music activity, was reassured that if they didn't like it the staff member would take them back to where had been sat.

Staff supported people to build friendships and maintain relationships. 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. A relative told us "[Staff] make us feel part of a big family." At lunchtime, people sat in small groups with like-minded people who they knew and got on with well. This created a positive ambiance which people clearly enjoyed.

People's privacy was protected at all times. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible and explaining what they were about to do. A staff member told us, "We often lock the doors as well to stop other residents wandering in." When a person's skirt started to rise up, as they sat down, staff intervened and offered them a blanket to cover their legs. When staff asked people if they wished to use the bathroom, they did so quietly and tactfully, so as not to cause any embarrassment to the person. In addition, confidential care records were kept securely and only accessed by staff authorised to view them.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they received. Comments in care plans showed that this process was on-going. For example, we saw letters to family members inviting them to attend meetings to review their

relative's care plan. One person told us, "I am involved in my care plan and staff carry out regularly reviews with my [relative] as well, as he now has power of attorney."
Family members told us they were kept up to date with any changes to the health of their relatives.

Good

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. Before people moved to the home, one of the managers completed an assessment of the person's needs and identified other support they may need to enable staff to care for them effectively. This process was repeated before people were accepted back to the home after a hospital stay. For example, one person was assessed as needing a special bed with a pressure reducing mattress and this was put in place before the person returned. Care plans were comprehensive and informative. They covered a wide variety of topics, including: the person's normal daily routine, mobility, medicines, continence, hobbies and personal preferences.

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 needed to be encouraged to drink; the support each person needed with their continence; and when people liked to get up and go to bed. 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. Staff recorded the personal care they provided to people, including if people had declined care such as a shower or bath. These records showed people were supported to meet their personal and other care needs.

Some people had diabetes and staff monitored their blood sugar levels in accordance with instructions given by their doctors. Information in people's care plans provided clear guidance to staff about actions to take if blood sugar levels were particularly high or low. Clear guidance was also available to enable staff to support people when they became anxious or agitated. One person's care plan said, '[The person] can become aggressive during personal care. Staff need to give [the person] space, leave and return later. If this does not work consider changing the staff member'. Staff confirmed they adopted this approach, when necessary, and said it was usually effective.

Staff responded promptly when people's needs changed. For example, records showed that medical attention had been sought when people were not well or had appeared unusually confused or withdrawn. People were also offered pain relief when staff identified they were in pain. People's care plans were reviewed monthly or sooner if needed to make sure they reflected people's current needs. Changes were made when people's health declined or improved. For example, a family member told us, "[My relative] had a falls mat when he first came into the home, as he was very frail, but it's not needed now."

At the beginning of each shift, a 'handover' meeting was held. We observed one of these meetings and heard people's needs being discussed in a professional, caring way. It was evident that the senior staff knew people well. One person had appeared to be increasingly low in mood during the morning and ideas were shared about how this could be managed.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, and how and where they spent their day. We observed that care and support were provided in accordance with people's wishes. For example, we heard people being offered a choice of drinks and activities. One person's care plan explained that they liked to have breakfast and watch television

before being supported to get up and washed; staff confirmed they supported the person to do this.

People had access to a wide range of activities organised by two activity coordinators. 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, bingo, trips to local attractions and quizzes. One person particularly enjoyed painting; they had an easel in their room and their paintings were hanging in their room and on the walls of the corridor outside. Another person said, "I try to attend activities and I'm asked what I would like to." A family member told us, "I'm pleased with the home. [My relative] likes to be social and gets involved in activities as much as he can."

We observed a word search game in progress during the morning that was well-attended. In the afternoon, a children's choir sang carols; people were given hymn sheets and joined in enthusiastically. People who chose not to engage in group activities were offered the option of one-to-one activities in their room. One person told us, "I don't go to activities but staff come and see me in my room."

The provider sought feedback from people through the use of survey questionnaires twice a year. These showed most people and their relatives were satisfied with the care provided at Blackwater Mill. Comments from people were used to make improvements to the service. For example, a family member had asked to be notified when their relative had medical appointments and a system had been put in place to facilitate this. Another person requested a change to the supper menu and a meeting was arranged for them to meet and discuss this with the chef. This had subsequently led to the provision of more regular snacks for people during the day.

'Residents meetings' were held every two months and were also used as an opportunity to seek the views of people and family members. For example, people had been consulted about the redecoration of the dining room and their ideas had been incorporated. One person told us, "I try to attend residents meetings and I feel listened to." Another person had requested a fish tank for the home and the registered manager told us they were raising funds for one to be installed in a new 'sensory room' they were developing.

People knew how to complain about the service and there was a suitable complaints procedure in place which was advertised on the home's notice board. This was also advertised in a picture format to make it more accessible to people. A family member told us, "I've no complaints, but I'm aware of the formal procedure should I need to complain. If I have any concerns I would talk to the management."

The registered manager told us a common source of complaints from people had been the laundry. In response, they had built a new laundry room with a separate room for ironing. They said this had provided a more organised environment and would reduce the likelihood of clothes going missing. We saw complaints were investigated and responded to promptly, in accordance with the provider's policy. For example, a written response to one complaint was provided within a week, together with an offer of compensation for lost clothing.

Good

Is the service well-led?

Our findings

At our last comprehensive inspection, in November 2015, we made a recommendation that the provider reviewed their record management systems as it was not easy for staff to monitor whether people had received all the care and support they needed. At this inspection, we found improvements had been made. Records of care were organised and enabled staff to identify if people's needs had changed or had not been met.

People told us they enjoyed living at Blackwater Mill and felt it was run well. One person said they had "nothing but praise" for the registered manager. Another person told us, "It's a wonderful, wonderful home; they take care of us every day." A family member told us, "The [registered] manager is approachable and accessible as the office is at the entrance to the home." A thank you card we viewed from a relative included the comment, "We have found the standards in every department to be excellent. We have made many friends during [our relative's] stay."

There was a clear management structure in place consisting of the provider's general manager, the home's registered manager, the care support manager, plus senior care staff responsible for organising and running the day to day shifts. Staff were organised in their work. They were allocated to support people in each area of the home and were clear about their areas of responsibility. Their rest breaks were scheduled, together with details of which staff member would cover while they were taking their break. Senior staff monitored staff availability and checked people's records to help make sure they were receiving appropriate care and support.

The managers, senior staff and the mentors were experienced and demonstrated a commitment to providing high quality, compassionate care to people. They were motivated and acted as positive role models to other staff. One senior care staff member told us, "There's a good team of seniors and we help each other out." An 'employee of the month' scheme was in place to recognise staff who performed well and promoted the home's values. Most staff told us the managers were "approachable". One staff member said, "I feel valued. [The managers] really looked after me when I was off sick." Another told us, "The managers are supportive." Staff were clear about the expectations of the service and managers closely monitored their adherence to these. Where these were not met, the provider's performance management procedures were used appropriately.

There was a regular meeting programme with staff from each area of the home, including a general staff meeting. These provided an opportunity for staff to raise issues and give their views about the way the service was run and the quality of care being delivered. For example, the new shift system had been discussed with staff and their ideas had been incorporated. A staff member told us, "At the end of the meeting the manager will ask each individual member of staff if they would like to add anything to the meeting."

An effective quality assurance system was in place. This involved regular auditing of key aspects of the service by the registered manager, the care support manager or the provider's auditor. They included audits

of care planning, care delivery, medicines management and infection control. Where changes were needed, specific actions were developed and implemented. For example, a recent audit of care plans identified that additional information was needed to support a person's skin integrity. The senior staff member responsible for this person's care plan was tasked with doing this and the registered manager checked that it had been done. The health and safety audit had identified that some staff needed to refresh their fire safety training and we saw this was booked.

The provider's general manager visited the home weekly to provide support to the management team. They took an overview of the quality assurance processes, reviewed specific aspects of the service, such as call bell response times, and dip sampled a selection of records. The registered manager told us they had a good working relationship with the general manager and valued their support.

There was an open and transparent culture within the home. Visitors were welcomed and were able to come and go as they pleased. There were good working relationships with external professionals and the provider notified CQC of all significant events. There was also a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The registered manager operated an open door policy. They, and the care support manager, were visible around the home, interacting with people and staff throughout the day. An 'on-call manager' system was also in place so staff could access advice and guidance out of hours.

A duty of candour policy had been developed to help ensure staff acted in an open and honest way when people came to harm. A person had fallen and sustained a broken hip. Their relative had been contacted immediately and was given the relevant information verbally; however, this was not followed up in writing. We discussed this with the general manager and the registered manager. They were clear that this should have been done, and took immediate action to help ensure this would always be done in future.