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**

Summary of findings

Overall summary

We carried this focused inspection on 12 April 2016 to check whether the provider had taken action in relation to a warning notice we issued following our previous inspection in November 2015 when we identified that insufficient staff were deployed to meet people's needs and pre-employment checks were not always conducted. This report only covers our findings in relation to these topics in the "Safe" key question.

We found staffing arrangements had improved, but there were still insufficient staff deployed to meet the needs of all people all of the time.

The home provides accommodation and personal care for up to 51 people, including people living with dementia. There were 49 people living at the home when we visited. Accommodation is spread over three floors, connected by two passenger lifts and stairwells. All rooms have en-suite toilet and washing facilities. There is a dining room on the ground floor and a selection of lounges on other floors.

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.

People and their relatives had mixed views about the availability of staff. Whilst some felt they were adequate, others felt there were not enough staff to ensure their needs were always met in a timely way. Two people said they had not received the help they needed to get to the bathroom in time. Another person said they were not supported to bathe as frequently, or at the times, that they preferred.

Care staff felt that staffing levels had improved and that they were able to meet people's needs at all times. The registered manager based staffing levels on the needs of people and an analysis of when accidents occurred. As a result, they had increased the number of care staff at certain times to enable them to better meet people's needs.

Safe recruitment processes were in place and the provider conducted essential pre-employment checks to help make sure staff were suitable to work at the home.

We identified a breach of Regulation 18 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.

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.

Staffing levels had improved, but some people continued to report delays in staff responding to calls for assistance.

The provider was unable to confirm that people's needs were always met in a timely way.

Safe recruitment processes were in place that helped ensure only suitable staff were employed.

Blackwater Mill Residential Home

Detailed findings

Background to this inspection

We carried out this focused 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 18 and 19 of the Health and Social Care Act 2008 relating to staffing and recruitment processes.

The inspection took place on 12 April 2016 and was conducted by one inspector. Before the inspection we reviewed notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law. We also reviewed the previous inspection report and a warning notice that had been issued in relation to staffing.

We spoke with 20 people living at the home, two visiting family members, and a visiting hairdresser. We also spoke with the registered manager; the deputy manager; 12 care staff; two members of kitchen staff; two housekeepers; two activity coordinators; the staff member responsible for maintenance; and the administrator. We looked at care records for eight people, staff duty records for a four week period, six staff recruitment files, records related to an analysis of falls, and records showing the dependency profile of people living at the home.

We observed care and support being delivered in communal areas. 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 previous inspection on 25 and 26 November 2015, we identified that insufficient staff were deployed to meet people's needs at all times. We issued a warning notice requiring the provider to become compliant with the regulations by 15 February 2016.

At this inspection we found improvements had been made, but people had mixed views as to whether or not there were always enough staff to support them in a timely way. Of the people or relatives who were able to express a clear view, nine felt there were enough staff available, while six felt this was not always the case.

Concerns expressed by people included the following comments: "We could do with more staff sometimes; like I could do with a jumper as I'm a bit chilly, but I wouldn't know who to ask"; "At night, when [a particular senior staff member] is on, things go smoothly; but when other people are on, they say 'You'll have to wait a minute, we've got an emergency. They [cancel] the bell and you hang around waiting and they don't always come back very quickly. I can be waiting ages"; and "They say they'll be back in two minutes and you wait half an hour. It's not very good." A family member told us, "If you press the normal button it takes some time [for staff to attend], but if you press the emergency button they are quite quick. The other day it seemed a long time; [my relative] was uncomfortable in bed it seemed a long wait until someone came."

Two people told us they had experienced delays "in the last few weeks" in staff attending to support them to go to the bathroom and said this had had a significant impact on them. One person said, "It's not normally a problem, but I have come unstuck and had an accident fairly recently. It was embarrassing." Another person told us, "If I press the buzzer, a couple of people come and attend to me, then their [pager] will ring and they get taken away to do another job. I waited three hours to go to the toilet recently. They said they were busy, but I must have pressed the buzzer around eight times. I messed the bed and my pyjamas. All the staff are excellent; there's just not enough of them. I often have to wait half to three quarters of an hour to go to the toilet; it's not good enough."

At our previous inspection, people told us they were not supported to bathe as often as they wished as staff were not available. At this inspection, most people said they were able to bathe when they wished. However, one person told us this was not always the case. They said, "I would prefer to have [baths] at night as I get restless then, but [staff] are busy." They added, "[The baths] are always in the mornings and then [staff] say 'I can't do it today as we're short-staffed'. I only have one or two baths a week." Bathing records confirmed that the person had only had two baths in the previous 13 days. The deputy manager told us there was still room for improvement with bathing arrangements, but felt this was not due to a shortage of staff.

Other people were satisfied with staffing levels and bathing arrangements. They told us there were always enough staff available to support them promptly when needed. Comments included: "If I step on my [alert] mat accidentally, they're there before you've had time to look round"; "I don't often press my bell, but when I do they're there immediately"; and "You ring your buzzer and if they're not free they tell you. If it's urgent, like you want the toilet, they fit you in; and if it's not, they tell you what time and the name of the [staff member] who'll come". A family member said, "I've no concerns about staffing levels. There's always

someone about. I get let in quickly and [staff] check to see where [my relative] is."

Staff had previously been critical of the staffing levels. However, at this inspection they told us staffing levels on each shift had improved and they felt there were now sufficient staff to meet people's needs at all times. Comments from staff included: "It's nice to have so many staff. We had 12 the other day; a lot more than there ever have been"; "It's a hell of a lot better than it was"; and "We often have 11 or 12 [care staff members] on now, which is better". The deputy manager told us, "[Staffing levels] are much better now. I get called in much less [to cover shifts]. Rotas show we are sometimes over-staffed."

The registered manager told us staffing levels were based on a dependency profile that took account of people's needs and the number of staff needed to support each person. The latest profile showed 24 people had 'high' levels of dependency and needed the support of two staff members to reposition in bed or to transfer between their bed and their chair. 21 people had medium levels of dependency which meant they needed the support of one staff member for most tasks; and the remaining people were largely self-caring.

The registered manager had also taken account of an analysis of falls at the home, which showed times when people were most likely to fall; they had then adjusted shift numbers to make more staff available at these times. They told us they had recruited additional staff, including a second activity coordinator. They had also re-instated the 'early bird' shift following feedback from people; this is a staff member who starts work at 06:00am to support people who wished to get up or bathe early. The registered manager said sickness levels had been reduced and shifts were always fully staffed. A senior staff member told us, "Staff are now fighting over the shifts as there are more staff than shifts [available], which has reduced sickness levels." Day shifts now consisted of 10 care staff, including three senior care staff; night shifts consisted of four care staff, including one senior care staff. Duty rosters confirmed these numbers had been achieved consistently during the week of our inspection and the previous three weeks. Day care staff were supported by the registered manager, the deputy manager and the head of care. In addition, ancillary staff included housekeepers, catering staff, maintenance staff and an administrator; this allowed care staff to spend all their time supporting people's care needs.

Two people in a shared room told us they had not been able to use their call bell for 48 hours. One of them said "[Staff] said they would look in every two hours, but I'm not sure they do." They added that they had not received their breakfast and had been unable to call anyone to let them know. They said, "The maintenance man was passing and spotted that we hadn't had our breakfasts. He himself collected them and brought us tea as well."

During the inspection, the call bell system developed a more widespread fault which affected most of the bedrooms in the home. The fault showed people were calling for assistance when they were not; or did not show a call when people had called. Staff subsequently put measures in place to check every room at half hourly intervals to help make sure people were able to access the necessary support. Records relating to times when people were supported to reposition in bed were completed fully on most days and showed people had received regular personal care and pressure area care when needed.

People's call bells had a 'call' button for non-urgent assistance and an 'emergency' button for urgent assistance. Staff carried pagers which alerted them when a bell was activated. They said non-urgent calls showed as 'call' on the pagers initially, then changed to 'assist' if not responded to within ten minutes, and then showed 'emergency' if not responded to after a further 10 minutes. Senior staff said they used to be able to access computer records of call bell activations to monitor staff response times and investigate complaints when people reported long waits. However, the registered manager told us this facility was no longer available. Therefore, the provider was not able to monitor or analyse response times to assess

whether sufficient staff were deployed. They were not able to validate or refute the complaints about excessive delays in response times from people we spoke with.

The failure to ensure sufficient staff were deployed at all times was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we also identified that pre-employment checks were not always conducted before staff started work at Blackwater Mill. At this inspection we found clear recruitment procedures were in place to help ensure staff were suitable to work at the home. These included a full employment history, reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home.

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 did not take formal enforcement action at this stage. 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 failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of service users at all times. Regulation 18(1).