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?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 25 and 26 November 2015 and was unannounced. The home provides accommodation for up to 51 people, including people living with dementia care needs. 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.

Summary of findings

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 people received baths or showers regularly. Staff confirmed that baths and showers were sometimes missed when they were short-staffed and this was confirmed by the care records. Night staff told us that they were not able to support everyone who wanted to get up between 6:00 am and 7:30 am as there were not enough of them.

There was a clear process in place to recruit staff and this helped make sure they were suitable, although the full employment history of staff members was not always recorded. Risk to people were assessed and managed effectively in most cases.

People received personalised care from staff who understood and met their needs well. Staff were responsive to changes in people's needs and records showed people received all essential care. Most care plans contained detailed information about how people wished to be cared for, although some lacked information about the support needed when they became anxious.

Quality assurance processes had been reviewed and comprehensive audits were being conducted by managers. However, the auditing process for care planning was still being developed and had not identified a lack of information in some care plans as they had not been reviewed.

People told us they felt safe at Blackwater Mill. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. Medicines were managed and administered safely by staff who had been trained and assessed as competent.

People praised the quality of the food. They received appropriate support to eat and drink enough and, in all but one case, action was taken if they started to lose weight.

People received effective care from staff who were suitably trained and supported in their role. Mentors had been appointed to support new or inexperienced staff. Staff followed legislation designed to protect people's rights and freedom.

People were supported to attend healthcare appointments and to see doctors or community nurses when needed. Changes had been made to the environment to help people navigate their way around the building, which included additional signage.

People were cared for with kindness and compassion and we observed positive interactions between people and staff. People were encouraged to be as independent as possible and their privacy and dignity were protected. People were involved in assessing, planning and agreeing the care and support they received.

An additional activity coordinator had been recruited and a range of appropriate activities was provided. Two activity clubs had been formed which had proved popular with people.

The provider sought and acted on feedback from people, relatives and staff to help improve the service. There was a suitable complaints procedure in place; complaints were investigated thoroughly and promptly.

People and their relatives felt the home was managed well. The managers, senior staff and the mentors were highly experienced and demonstrated a commitment to providing high quality, compassionate care to people. Staff were organised and worked well as a team.

There was an open and transparent culture. Visitors were welcomed and the provider notified CQC of all significant events. There was a development plan in place to open a further nine bedrooms and an additional dining room.

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 told the provider to take at the back of the full version of this report.

We have also made a recommendation about record management procedures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

There were not always enough staff deployed to meet people's needs.

There was a clear process in place to recruit staff, but full employment histories were not always available. Not all risks to people were managed safely.

Staff knew how to identify, prevent and report abuse. Medicines were managed safely. Staff were aware of action to take in an emergency.

Requires improvement

Is the service effective?
The service was effective.

People received appropriate support to eat and drink enough. Staff followed legislation designed to protect people's rights.

Staff were suitably trained and supported in their work. The environment had been improved. People had access to healthcare services when needed.

Good

Is the service caring?
The service was caring.

Staff were kind, caring and compassionate. People were encouraged to remain as independent as possible and treated with dignity and respect.

Staff supported people to build relationships. People's privacy was protected and they were involved in planning their care.

Good

Is the service responsive?
The service was not always responsive.

Most people received personalised care but care plans did always contain sufficient information about the support two people needed when they became anxious.

Reviews of care were conducted regularly and staff were responsive when people's needs changed. People were supported to make choices.

A range of activities was provided and two activity clubs had been formed. The provider sought and acted on feedback. There was an appropriate complaints procedure in place.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

Record management did not make it easy for staff to monitor changes in people's health. Quality assurance processes were in place, but the auditing of care plans was not effective.

There was a clear management structure in place. Staff were organised and worked well as a team. There was an open and transparent culture.

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.

The inspection took place on 25 and 26 November 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in the care of older people.

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 spoke with 10 people living at the home, four family members, three visiting friends, a GP and a visiting health professional. We also spoke with a senior representative of the provider, the registered manager, the two deputy managers, 11 care staff, three members of kitchen staff, two housekeepers and the activity coordinator. We looked at care plans and associated records for 10 people and records relating to the management of the service. These included staff duty records, three staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

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

People had mixed views about the availability of staff generally. One person said, “There seems to be enough staff; if I needed help they’d be there for me.” Another person told us “There’s always someone to help when I need it. [They] do get a bit pushed at times, but it doesn’t affect me.” A further person said staff answered their call bell “but not always as quick as you want”, because "they have others to attend to". A family member told us, “During the week things are OK; but weekend staff often seem thin on the ground. Some Sundays you don’t see anyone upstairs [on the top floor] and you hear the bleepers going for ages.”

The registered manager used a ‘dependency tool’ to calculate the amount of support each person needed, based on their mobility and care needs. However, there was no clear link between the use of the dependency tool and the number of staff scheduled to work each day. Analysis showed that 24 people were considered to need ‘high’ levels of support, such as two members of staff to help them reposition in bed or to transfer between their bed and their chairs. The registered manager told us dependency levels had decreased recently. However, this was at odds with the views of staff, who thought they had increased, and the data produced by the dependency tool which showed they were similar to those experienced a few months previously. 10 care staff were scheduled to work during the day, nine care staff during the afternoon and evening, and four care staff during the night. We looked at the staffing rosters for a five week period up to, and including, the week of our inspection. These showed the scheduled staffing levels were not achieved on 20 of the 70 day or evening shifts in this period. The registered manager told us this was due to short notice changes, such as staff reporting sick.

Care staff had mixed views about the staffing levels. Whilst some felt there were “usually” enough staff to meet people’s needs and keep them safe, others told us there were not enough staff. They said this meant people did not always receive their baths and showers. One staff member said, “It’s the baths we miss out if we’re short; you can’t do it all.” Another staff member told us “When there are 10 [care staff], we cope; but if it drops below that we don’t. A lot of baths and showers are missed when we’re short.”

Most people were scheduled to have one bath or shower each week, but records showed some had not received a bath or a shower for up to three weeks. One person told us “I’d like a bath if I got the opportunity; it’s a long time since I’ve been invited [to have one]. I’d like one regularly.” Records showed this person had last been supported to have a bath 20 days previously. A family member told us “[My relative] sometimes goes two or three weeks without having their hair washed. It’s not clear when they are bathed, but they should have a bath every week.” Records showed this person had last been supported to have a bath 19 days previously. A further family member told us “Staffing levels are better than they have been for a long time; it’s moved in the right direction. I’m not sure there’s enough time for personal care; I can’t monitor if [my relative] has baths, but she always says she would like more.” By contrast, one person told us they were supported to shower every day.

Night staff told us there were not enough staff between 6:00 am and 7:30 am to support people who wanted to get up early. One staff member said, “Four on nights is awful from six onwards because [people] want to get up. You can’t do it, so people have to wait.” Another staff member confirmed this, saying: “We used to have an ‘early bird’ [staff member] from six onwards, but not now.” As a result, they said some people who wished to get up early could not be supported to do so until the day shift arrived at 7:30 am.

The failure to ensure sufficient staff were deployed to meet people’s needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a clear process in place to recruit staff and this was monitored by administration staff to help make sure all necessary stages were completed. These included applicants completing an application form, attending an interview and supplying references. In addition, checks with the Disclosure and Barring Service (DBS) were carried out before staff were permitted to work in the home. The DBS helps employers make safer decisions when recruiting staff to work in the provision of care. Two of the three applications forms we viewed, for staff who had been recruited recently, did not include a full employment history. In one case a reference had been supplied by a care provider that the person had not listed as a previous employer on their application form. The absence of a full employment history meant the provider may not have

Requires improvement

Is the service safe?

been able to conduct all relevant checks in order to confirm the person's suitability. We brought this to the attention of the registered manager, who took action to ensure the full employment history of applicants would be obtained in future.

People's care plans included assessment of risks to their health and wellbeing. These included behaviour that put themselves and others at risk, the risk of falls, pressure injury and malnutrition, together with a plan to reduce the level of each risk. The plans were discussed with people to help make sure they did not subject them to unnecessary restrictions. For example, one person wished to have the restrictor removed from their window so they could get more air into their room. Whilst this was safe for this person, it may have put other people at risk. An agreement was reached with the person to remove the restrictor and lock the door to their room when they were not in it. This satisfied the person while at the same time protecting other people.

Risk assessments were regularly reviewed and reflected current risk levels. For example, following changes to the mental and physical health of a person, staff had talked to the person and their GP about the risks of them looking after their own medicines. They reached a decision between them that it would be safer for staff to take over the management of the person's medicines, which they did. These procedures helped protect people from avoidable harm. However, we observed one person walking along the first floor corridor and up the stairs to the top floor of the building independently. They had been assessed as at risk of falling and required staff to support them to mobilise safely; this had not been followed, which put the person at risk of harm. We brought this to the attention of the registered manager who took steps to ensure the person was supported appropriately.

People who were at risk of skin damage used special cushions and mattresses to reduce the risk. Pressure relieving mattresses were set to the appropriate level, according to the person's weight. One person's heels were at risk of pressure injury and we saw they were supported to wear foam bootees to relieve the pressure. Where people needed to be assisted to change position, to reduce the risk further, care records confirmed this was done regularly.

Environmental risks were assessed and managed appropriately. The registered manager conducted a regular 'walk round' audit of the environment and produced an action plan which they ensured was completed promptly. Records showed essential checks of fire safety equipment, gas and electrical installations were conducted. Equipment used to support people, such as hoists and wheelchairs, were regularly serviced and safe to use.

People said they felt safe at Blackwater Mill. One person told us "I feel absolutely safe." Another person said they were "as safe as you can feel". A family member said of their relative "We're happy she's safe and sound in here." The provider had appropriate policies in place to protect people from abuse. Staff had received training in safeguarding adults, knew how to identify and report abuse and how to contact external organisations for support if needed. They said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member told us they had done this and had received a prompt response. They said, "I made a statement and action was taken."

All staff had undertaken first aid and fire awareness training and were aware of the action they should take in emergency situations. Personal emergency evacuation plans were available for all people. These included details of the support each person would need if they had to be evacuated and were kept in an accessible place.

Medicines were administered and managed safely by staff who were suitably trained and had been assessed as competent. We observed part of two medicines rounds and confirmed that staff followed best practice guidance at all times. Systems were in place to help ensure medicines were ordered, stored, administered and disposed of appropriately. Information was available to advise staff how each person liked to receive their medicines and we saw this was followed. One person received their medicines covertly by staff hiding the medicines in small amounts of food to make sure the person received them. This had been discussed with the person's family, the GP and the pharmacist to make sure it was done in a safe way. In accordance with best practice, staff always encouraged the person to accept the medicines openly, and only resorted to giving them covertly when they declined to take them.

Good

Is the service effective?

Our findings

People praised the quality of the food and were satisfied with the support they received. One person said, "The food is good and fresh and the meals are warm." Another person told us "There's always plenty of [food] and it's always piping hot; and there's a choice of drinks, squashes or wine." A family member told us "Things in the kitchen have improved a lot. Food has been more varied and of better quality of late."

People's nutritional needs were assessed and reviewed regularly, and records of people's food preferences were kept in their care plans. The care records for three people identified that they had unplanned weight loss. Staff had developed appropriate action plans for two of the people, which included monitoring their weight more frequently, recording how much they had eaten and supporting them to eat more. This had stabilised their weight. However, the care plan for the third person did not specify how staff should encourage them to eat more and, although it directed staff to weigh the person weekly, this was only being done monthly. Therefore, the person remained at risk of losing further weight. We brought this to the attention of the registered manager who took immediate action to address the concern.

People received appropriate support to eat enough through prompting by staff or having help to cut up their food. When people needed one-to-one assistance to eat, staff engaged with them and supported them at the person's pace without rushing them. People were offered choices of meals and drinks, and alternatives were offered if people did not like the menu options of the day. For example, one person requested rice pudding that was not on the menu and this was supplied. Staff were aware that some people preferred to take the main meal of the day in the evening and supported people to do this when they wished. Drinks were available throughout the day and staff prompted people to drink often.

Kitchen staff delivered meals to people in their rooms in a way that ensured they remained warm. For example, soup was taken to people in a vacuum flask and served when they were ready to eat it. However, desserts were sometimes delivered at the same time as the main course, and a family member told us they had occasionally had to ask for a replacement dessert for their relative as it had gone cold.

Dining tables were set with table clothes, flowers and cutlery; vegetables were served from serving dishes and desserts were served from a trolley which made it easy for people to choose. Staff knew which people got on well and made sure they were sat together. This helped create a pleasant, sociable experience for people.

People and their families told us staff were knowledgeable, skilled and provided effective support. One person said, "They look after me well." A family member told us the care "had improved". We found staff were knowledgeable about the needs of people and how to care for them effectively. This was confirmed by a doctor who told us staff "are reliable and know what they are doing." A visiting health professional said, "The staff really know their jobs and they are friendly and kind." Staff also had a good understanding of the different types of dementia and the support people needed as a result. A family member told us "The carers are all aware of [my relative's needs], even the maintenance guy, which is good. They know how to look after her."

New staff received induction training, which followed 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. The registered manager told us experienced staff also used a form of the Care Certificate as a self-assessment tool to identify their training needs, which were then addressed.

Two members of staff had been appointed as "mentors" to new staff to support them with their development by working alongside them as role models. Staff appreciated this support and guidance. One staff member told us "They were so nice to me [when I started] and have been really helpful." Another said of the mentors, "They're good; we now know who we can go to for support."

Training records showed staff were up to date with all essential training and this was refreshed regularly. The provider had recently appointed a permanent trainer to deliver training to their homes on the Isle of Wight to help ensure consistency. The registered manager told us this allowed them to access training more quickly, for example for new staff as soon as they started working at the home. A staff member told us "I am well trained, well supported and I know I have total back up if I ever need it; you cannot say that at many care homes." Most staff had also obtained vocational qualifications relevant to their role or were

Good

Is the service effective?

working towards these. We observed that the training had been effective. For example, we saw staff supporting people using appropriate techniques and communicating with them effectively.

Staff were supported appropriately in their role and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. One staff member told us supervisions were "really useful". They added, "I raised that I needed to do some more courses and they are being arranged." Another said, "I feel valued and supported and am thanked [by management] for my work." Staff who had worked at the home for more than a year also received an annual appraisal which assessed their performance.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. These included decisions about the provision of personal care, the use of bed rails and the administration of medicines.

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 the provider was following the necessary requirements. DoLS authorisations were in place for seven people and had been made by the supervisory body with the relevant authority. In addition, applications for authorisations had been made for a further three people. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, dentists, opticians and chiropodists. Two people were supported to attend regular appointments at specialist hospital services and staff made sure they were prepared and ready for these when their transport arrived. One person had not had their flu vaccination and staff were actively following this up with the doctor's surgery on their behalf.

The registered manager had conducted an audit of the environment to assess its suitability for people living with dementia. As a result, they had improved the signage around the building to help people find the dining room and the bathrooms more easily. The corridors on each of the three floors had been painted in a different colour to help people navigate their way around the home; and photos of people, or other items of interest to them, had been put up on the outside of their bedroom doors, to make it easier for them to identify their rooms. The registered manager described how they had involved people in choosing the colour schemes and the decoration for their bedroom doors. They explained that they had been careful to try and strike a balance between people living with dementia, who needed a supportive environment, and people who retained full mental capacity, who preferred a more traditional environment.

Good

Is the service caring?

Our findings

People and their relatives described staff as "kind" and "caring". One person said of the staff, "They are very good here; I've got nothing but praise for them. They're tolerant and understanding." A family member said, "Blackwater Mill is a very caring [home] and is truly amazing in every sense. My [relative] is not in a home, she is at home." A volunteer from a national charity, who visited the home often, told us "I tell everyone this is a good home. Staff treat people well and know everything about them." Another visitor said, "All I have seen is kindness and thoughtfulness."

Staff knew people well and used their knowledge of people's backgrounds to strike up meaningful conversations and build relationships. Some people had formed attachments to particular staff members they got on with well and we saw they appeared relaxed and happy in their company. One person told us "I've built up a nice relationship with one of the carers and when she gives me a whisky we have some good banter."

People were treated with consideration and respect by staff who understood their needs and we observed numerous positive interactions between people and staff. At lunchtime staff were attentive and communicated well with people. When a new person was shown to a table they had not sat at before, staff took time to introduce them to the other people at the table and identify things they had in common with them. They made sure people were comfortable and offered one person cushions when they became unsettled. After the meal, a staff member offered to play some music; they asked people what sort of music they wanted to listen to and then adjusted the volume to meet people's wishes.

People told us they did not feel rushed by staff, who they described as "patient" and "polite". We observed a staff member take time to support a person to mobilise slowly from the dining room to use one of the bathrooms. They went at the person's pace and the journey took some time. When they arrived at the bathroom, the person decided they no longer needed to use it. Without fuss or comment, the staff member patiently supported the person to return to the dining room, again at their own pace. When another person needed to use the bathroom before going out for the day a staff member supported them to a particular bathroom saying; "I know you prefer that one." When a person's trousers started to slip down, a staff member asked if they could help the person to pull them back up. They accepted the offer of support and the staff member made sure the trousers could not come down again.

Staff spoke fondly of the people they cared for and were interested to learn about their backgrounds. One staff member said, "The residents are lovely. They're so grateful; even giving them a smile can make such a difference to them. That's why I love working here." Another told us "The residents are lovely; I get on with every one of them." Whenever staff met people, for example when passing them in a corridor, they took time to acknowledge the person by smiling or asking about them. This included non-care staff, who also knew people well and engaged them in conversation, for example about their plans for the day. This created a homely atmosphere where people were the focus of attention for everything that happened in the home. The friend of a person, who visited often, told us "What I like [about staff] is there's always a smile and a good attitude."

Staff ensured people's privacy was protected by speaking quietly and discreetly. They kept doors closed when providing personal care and described how they used towels to keep people covered as far as possible. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

People's religious beliefs were respected and catered for. People were asked about their religion or beliefs when they moved to the home and preachers or ministers from three different faith groups visited the home on a regular basis. A staff member told us "I have a strong faith, so I know how important it is that we support people to follow it if they wish to."

People were given a choice of receiving support from male or female staff and their choices were respected. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in.

When people moved to the home, they, and their families where appropriate, were involved in assessing and planning the care and support they needed. Comments in care plans showed relatives were involved in discussions about care and kept up to date with any changes required. One family member told us "We often see one of the

Good

Is the service caring?

seniors and discuss [my relative's] care and they ring me if there is anything serious." Another family member said, "I was shown [my relative's] care plan and made quite a few comments. [Staff] then amended it and I agreed with it."

Requires improvement

Is the service responsive?

Our findings

People were satisfied with the care and support they received. One person said, “The home does amazingly well. The patient gets looked after well." The visiting friend of another person told us “I do have to ‘keep on’ to the staff a bit but they are very responsive and when I raise anything they act on it straight away.”

Most care plans provided detailed information about how people wished to receive care and support. However, the care plan for one person did not specify their preference to maintain a high standard of dress and presentation, which a visiting friend told us had always been important to the person. Care plans for people with diabetes contained information about the normal range of their blood sugar levels, which were checked regularly. However, there was no information available to help staff identify the symptoms people displayed when their levels went outside this range. We discussed this with the manager, who immediately added this information to the relevant care plans.

Staff showed good insight into the needs of people who behaved in a way that put themselves or others at risk. A staff member explained that the behaviour was a form of communication and that they had to “try and work out what the person needed”. Staff were able to reassure people effectively and were aware of situations that might cause the person to become distressed. For example, they knew that one person would worry that the inspectors “were here to take them away” and suggested ways that we could reduce the person’s anxiety. For other people, advice had been sought from specialists and this was included in their care plans. The care plans were clear about how each person should be supported, how staff should approach them, when to provide additional support and when to administer medicine to help the person to relax. A family member of one of the people concerned confirmed that staff responded appropriately when their relative became agitated or upset.

However, for two people such information was not recorded in their care plans. One person had been prescribed a sedative to calm them, but no other strategies to support them when they became anxious were documented in their care plan. Records were not kept of times when the person became anxious, so staff were not able to identify the triggers or analyse interventions to see which were most effective. The care plan for another person who could become anxious stated: “[The person] spends a lot of time in their room. Staff to pop in throughout the day and give stimulation”. The care plan lacked information to guide staff about how often they should “pop in” or what form of “stimulation” should be given.

Reviews of care were conducted regularly by nominated staff members. As people’s needs changed, the senior staff members developed the care plans to ensure they remained up to date and reflected people’s current needs. People and their relatives were consulted as part of the review process and their views were recorded. However, the summary care plan, which provided a quick reminder of each person’s needs, was not always updated at the same time. This meant there was conflicting information in some people’s care records and staff may not have been following the latest guidance.

Staff were responsive to changes in people’s needs. For example one person had been given a purpose-built wheelchair that was difficult to move between floors, so staff had arranged for them to move to a ground floor room; this would make it easier for them to access communal areas of the home.

Care monitoring forms were used to record the care and support people received. The forms recorded a person’s food and fluid intake, repositioning and the provision of personal and continence care. We found these had been completed fully and were up to date, showing people’s essential needs were being met.

People were supported to make choices. Care plans included people’s preferences in respect of how they preferred to be supported and how they wished to spend their day, such as when they preferred to get up and go to bed. People’s personal preferences, likes and dislikes were recorded and known by staff. We observed care and support were provided in accordance with people’s wishes. One person told us “I’m independent and can do what I want. I can choose where I go and what I do; there’s no economy of movement.” Another person said, “I’ve seen the care plan and [support and care] happens in exactly the way I would want it to happen.”

Arrangements had been made to increase the provision of activities for people. A second activity coordinator had

Requires improvement

Is the service responsive?

been recruited and was due to start work the following week. In addition, two volunteers were being recruited to run the 'shop trolley' from which people were able to purchase personal items.

People's care records included details of their life histories, hobbies and interests. These had been used to design individual activity plans to help make sure that suitable activities were arranged. Two social groups had been formed; one, called the 'memory club', was for people living with dementia; the second, called the 'refresher club', was for people who had full mental capacity. A member of the refresher club said, "It's very good; we discuss current affairs and have a cup of tea. It's given me a big lift." We observed meetings of both clubs, and each provided appropriate mental stimulation for those attending. In addition, a wide range of other suitable activities was planned and advertised on the home's notice board, including trips to local attractions. People who preferred to spend time in their rooms were given one-to-one activity time when staff spent time discussing topics of interest with them.

The provider sought and acted on feedback from people, relatives and staff to help improve the service. For example, records of 'residents meetings' showed one person had requested more 'music and movement' during activity sessions and these had been provided. Another person had asked to be taken to the sea front to do some painting; this had been arranged and we saw the painting they had produced in their room. In addition, the provider conducted questionnaire surveys twice a year, the most recent of which was in progress. An action plan had been developed following the survey in April 2015. This included the recruitment of more staff which had been completed. However, a further action, to review and adapt the list of baths and showers to meet individual requirements, had not been completed and we found this was an area of concern for people and their relatives.

The provider had a complaints policy and procedure in place which was promoted in the 'residents handbook' which was given to each person or their representative when they moved to the home. Records of complaints made in the past year showed they were investigated thoroughly and responded to appropriately within the set timescale. Lessons were learnt from complaints. For example, in one case we saw staff practices had been changed in order to prevent the recurrence of an incident that relatives of a person had complained about.

Requires improvement

Is the service well-led?

Our findings

Records were not always kept in a way that made it easy for supervisory staff to monitor them effectively and identify changes in people's health. For example, food and fluid charts were put in a large pile at the end of each day, before being filed in an upstairs store room. This meant staff were not able to easily review how much people had eaten or drunk over a period of time. Although concerns were passed on from shift to shift, staff did not have ready access to the previous day's charts in order to assess the extent of the concern. Daily records of baths and showers were also filed in at the end of each day. Therefore it was not easy for supervisory staff to check whether people were receiving them as planned, or for the provider to confirm that people were receiving all the care and support they needed.

We recommend that the provider reviews their record management procedures.

Quality assurance processes had been reviewed and comprehensive audits were being conducted by a senior representative of the provider, the registered manager and the two deputy managers. These included audits of the arrangements for infection control, the management of medicines, accidents and the environment. In order to make the process more thorough, the audits were conducted by a different member of this team each time; this helped ensure no aspects of the audits was overlooked. This had been effective and had resulted in improvements to the safety and quality of the service overall. The same management team also reviewed care plans on a monthly basis. A small number were sampled, for particular reasons; any improvements needed were recorded and monitored to ensure action was taken. However, concerns we identified about a lack of information in some care plans had not been picked up by this process as the care plans in question had not been audited. The registered manager told us "The new forms [used to audit care plans] got off to a slow start as some care plans needed a complete re-write and we took on some new seniors who had to learn how to write them." Consequently, some care plans had not been reviewed by managers and a system was not yet in place to make sure every care plan was reviewed at some point during a set period of time.

Quality assurance processes included monthly, unannounced, spot checks by one of the managers during a night shift. A staff member told us "They have a format. They check each room to make sure people have access to drinks and call bells and talk to us about any concerns. I think they're good." The registered manager told us these visits were beneficial, both to assess the quality of care people received at night and to keep communication lines open with night staff.

Most people and their relatives told us the service was well-led. One person said, "Everything seems well organised." A visiting family member said, "I think this is a safe home, in part because the manager is always around and nothing gets past her. If she sees something she is not happy with, it is fixed straight away and I have seen her take staff to one side if they have done something she has not approved of." Another visitor told us "Life for the people living at this home is different now. They are much better because the staff know what's what; they all know who is in charge and that has made a big difference here". A visiting health professional told us "I would recommend this home to anyone and I would have no hesitation in putting my mum here if she needed care".

However, some family members were critical of the provider's head office staff and the way the building works at Blackwater Mill had been managed. One family member told us "There are always problems around finances and invoices. There was a lot of disruption during the build and the car parking was a shambles. We were supposed to have more meetings with [senior] management, but we haven't heard anything about that." Another family member said, "Relatives have lobbied hard for improvements which haven't been made. For example, there is a gorgeous garden, but it's inaccessible. We wanted a weather proof path around it, but it's never happened."

There was a clear management structure in place. This consisted of the registered manager, two deputy managers, senior care staff, two mentors and care staff. The managers, senior staff and the mentors were highly experienced and demonstrated a commitment to providing high quality, compassionate care to people. They were motivated and acted as positive role models in promoting the values and vision of the service to other staff. An 'employee of the month' scheme had been introduced to recognise staff who performed well and promoted the home's values. A staff member told us "Staff are happy and well-motivated;

Requires improvement

Is the service well-led?

it's a good team; everyone knows who they can go to for support." Another said, "We know where we stand now and we know we have a good and fair manager." A third staff member told us "The past few months have changed this home; it is now a happy place and when the staff are happy it means the residents will be happy; it stands to reason".

One of the managers worked each weekend and a manager was always available out of hours for support and guidance. In addition, each of the managers worked on shift at times to keep in touch with care staff, understand the challenges they faced and make sure people were cared for effectively. The deputy managers were able to stand in for the registered manager when they were not available, and were able to investigate accidents, incidents, complaints and allegations of abuse. The registered manager told us they were "well-supported" by senior representatives of the provider and were supported to attend regular training to make sure their care practice remained up to date.

Staff described the registered manager as "approachable" and "understanding". One staff member said "She's quick to respond and keen to resolve any problems straight away." Another told us "The management are all fantastic. The home runs smoothly now." One of the deputy managers told us "I feel as if [the home] has really turned a corner. Staff are happier and really keen; everyone is pulling together; and the residents are feeling it as well."

We found staff were organised. Their breaks were allocated by senior staff and staggered to ensure staff were always available to respond to people. Care staff understood their roles and spent most of their time in the areas to which they had been assigned. We observed senior staff monitored staff availability and checked people's records to help make sure they were receiving appropriate care and support.

Most care staff told us team working had improved in recent months. One said "We all work well and support each other now." Another told us "There's no longer a rift between day and night [staff]. The manager has got some day staff to work nights and some night staff to work days, so we understand each other's roles better now." However, some said staff shortages still made team working difficult at times.

There was an open and transparent culture within the home. Visitors were welcomed and the provider notified CQC of all significant events. The allocation of GPs to the home had recently changed and staff showed a commitment to building relationships with the new doctors who attended to see people. There was a whistle blowing policy in place, staff were encouraged to raise concerns and were confident that any concerns reported to the manager would be dealt with appropriately.

The provider had a development plan in place. This included opening nine additional bedrooms, once they had been registered with CQC, and a second dining room for people with higher support needs. The plan also included the recruitment of more staff and the reinforcing of the service's values amongst staff.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 at all times there were sufficient numbers of suitably qualified, skilled and experienced persons deployed to meet people's needs. Regulation 18(1).

The enforcement action we took:
We issued a warning notice requiring the provider to meet the regulations by 15 February 2015.