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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Blackwater Mill is a care home providing accommodation for up to 60 people in one building, some of whom are living with dementia. At the time of our inspection, there were 54 people living in the service. Blackwater Mill provides all single bedrooms and a range of communal facilities.

People's experience of using this service and what we found

Not all individual risks to people were assessed, recorded and updated when people's needs changed. This included risks resulting from people's known health and care needs.

The provider's quality assurance systems had not always been used effectively to either identify areas for improvement and/or to bring about effective improvement.

Appropriate recruitment procedures were in place however two references had not always been sought prior to staff commencing employment. There were enough staff to support people's needs. Staff had received training and support to enable them to carry out their role safely.

There were appropriate policies and systems in place to protect people from the risk of abuse and the management team and staff understood the actions they should take to keep people safe. However, not all safeguarding concerns had been reported as required to the local authority safeguarding team or to CQC.

People were supported to take their medicines safely and as prescribed. Infection prevention and control measures were in place and followed government guidance.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their family members all gave us positive feedback about the home and told us that staff were kind and caring. We observed positive interactions between staff and people.

People, their relatives and external professionals said the management team were approachable and supportive. Staff were also positive about the management team.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was Good (published 5 June 2019). At this inspection the overall rating has changed to Requires Improvement.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Blackwater Mill Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of the service and the management of individual risks for people at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Blackwater Mill Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Blackwater Mill is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A manager had been appointed who was due to commence employment shortly after this inspection. Once registered with the Care Quality Commission this will mean that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the

provider's representative would be present to support the inspection.

What we did before the inspection
Before the inspection we reviewed the information we had about the service, including previous reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We contacted the local authority to gain their views about the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who lived at Blackwater Mill about their experience of the care provided. We carried out observations of people's experiences throughout the inspection. We spoke by telephone with nine family members of people living at the home and one family member visiting during the inspection. We viewed the home's environment, looked at medicines management systems and records, records relating to the environment and risk assessments for individual people. We also looked at recruitment records for three newer staff members and assessed how the home was managing infection prevention and control.

We spoke with the provider's area manager, support manager, care coordinator, three housekeeping staff, an activities staff member and seven care staff members.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted four external health or social care professionals. We looked at policies and procedures, records of accidents or incidents, complaints and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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

Assessing risk, safety monitoring and management

● Not all individual risks to people were assessed, recorded and updated when people's needs changed.

● People were at risk of not receiving emergency resuscitation should they require this. All care files contained information relating to emergency resuscitation highlighted on the front covers. However, for two of the three care files we viewed in detail, this information incorrectly stated the person was not for active resuscitation. Information within the care file showed resuscitation should be commenced as soon as the need arose and clearly stated the person was for all active treatment including transferring to intensive care unit and cardiopulmonary resuscitation. We raised this immediately with the management team who took prompt action to review information held in relation to individual emergency treatment. The failure to have accurate resuscitation information easily available meant people may not have received the correct emergency care when they required this.

● Where people were at risk of falling, risk assessments had not been updated. For example, we noted in a person's bedroom they had bed rails in place, also that a padded 'crash mat' with a movement alert mat placed on top was beside the bed. On one side the bed rails were padded and on the other they were not. The person's care plan did not contain any risk assessments in relation to the falls prevention measures which were in place in their bedroom. The support manager and area manager both agreed the measures in place were not all required or appropriate for the person.

● Some people were at risk of skin injuries due to pressure as they were unable to move about on their own. Appropriate action had been taken to introduce alternating flow air mattresses which reduce the risk of pressure related injuries occurring. We checked a sample of these and found they were set for the incorrect weight of the person placing these people at risk of skin damage. The area manager and support manager introduced new checks to reduce the risk of this happening in the future.

● Where people had specific health care needs, these were not always documented and risks associated with these conditions fully assessed. This meant all necessary actions to manage risks relating to known health conditions may not be taken. For example, one person had a urinary catheter. Their care plan file did not include this information other than on a hospital discharge document. No risk assessment plan was in place to manage risks to the person from the urinary catheter being in place.

● Other people were living with diabetes. The diabetes risk assessments did not cover all risks related to diabetes. For example, it did not cover what actions staff should take if people's blood sugar was very high and did not include secondary health risks related to diabetes such as eyesight and foot problems.

● Where people were at risk of not eating or drinking enough additional records of their food and fluid intake were maintained. However, where these showed people's intake was low it was unclear what action

was taken. The area manager and support manager introduced new procedures to ensure staff were aware when people's fluid intake had been low.
● Where people were at risk of falling, equipment was in place to alert staff that the person may be moving about in their bedroom. However, the system to alert staff did not differentiate between the activation of movement alert equipment and a person using their call system to request routine staff support. This would mean care staff would be unable to prioritise calls from movement alert equipment.
● Staff told us people's access to outside spaces was restricted due to safety risks. From the ground floor, there was level access to a flat enclosed patio style rear garden area. However, this area was not safe for people to use unsupervised due to the proximity of a large lake, and much of the surface was gravel which would present a falls risk. Staff told us people only had access to this and other outside spaces towards the front of the home when staff or family members were available to take them outside and remain with them at all times. The failure to ensure the external environment was safe for people to use unsupervised meant they could not access outside spaces independently whenever they wished to do so.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate individual risks were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Fire safety risks had been assessed by an external fire safety specialist and detection/management systems were checked weekly or monthly as required. Moving and handling equipment, gas, water and electrical systems were checked and serviced regularly.

Systems and processes to safeguard people from the risk of abuse
● The provider had appropriate systems in place to protect people from the risk of abuse.
● When safeguarding concerns had been identified staff and the support manager had acted appropriately to ensure the person's safety. However, whilst reviewing incident records for May and June 2021 we found five safeguarding incidents had not been reviewed by the management team meaning that action to prevent reoccurrence may not have taken place. We identified this to the management team who reviewed the incident reports and took appropriate action to investigate and reduce the risk of repeat incidents. These incidents had also not been referred to the local authority safeguarding team or CQC as required. Once identified the support manager reviewed the incidents to identify actions required to reduce the risk of reoccurrence. They also completed the necessary referrals as required.
● For other safeguarding incidents appropriate action had been taken including notifying CQC, local authority safeguarding team and, where necessary the police.
● People said they felt safe using the service. A person said, "Yes I'm safe here." Another person told us, "Yes I do feel safe, the staff are nice, very kind." A relative told us, "The staff keep an eye on him, there are hourly checks."
● The support manager and staff had completed training in safeguarding adults. Staff were confident if they raised a safeguarding concern with the management team, it would be taken seriously. However, not all staff were aware that they could report safeguarding concerns directly to the local authority or CQC. One member of staff told us, "I would make sure they (person) was safe and then tell my senior or the manager."
● An external professional told us, "I have no particular concerns about this [safeguarding]."

Staffing and recruitment
● The provider had appropriate recruitment procedures however, these had not always been fully followed meaning there was a risk unsuitable staff could be employed. We found that two references were not always received prior to new staff commencing employment. Where reference requests sent to previous employers

were not returned no action had been taken to follow these up or seek other references. We brought this to the attention of the area manager who took appropriate action.
● Other pre employment checks including disclosure and barring service (DBS) checks, investigating any gaps in employment and applicants completing a health declaration had been completed. The DBS helps employers make safer recruitment decisions and prevents some unsuitable people from working with vulnerable people.
● People were supported by appropriate numbers of staff who they described as kind and caring.
● People told us they felt there were enough staff who knew how to support them. One person said, "The staff come quite quickly if I need them." Another person said, "The staff are lovely, I like them." A family member told us, "I'm quite satisfied with staffing levels. They do all they can and give her the time she needs. There are familiar faces – not every day, but I know most of them. Staff are kind and caring and all seem aware. Kind and caring to us also if we are distressed with talk us through what is happening."
● Care staff told us they felt there were enough staff. One staff member told us, "We have time to do everything we need to do." They also confirmed two staff were always available when required to support people who required a higher level of support such as with moving and repositioning. Staff were seen to have the time they required to provide people with care in a relaxed and unhurried way. We saw staff sitting with people in communal areas looking at books together and people who required individual support were not rushed at mealtimes.
● Staffing levels were determined by the number of people using the service and the level of care they required. Short term staff absences were covered by existing staff members or agency staff who were contracted to work at Blackwater Mill for a period of time. This helped ensure continuity of care for people.

Learning lessons when things go wrong
● Where an incident or accident had occurred, the provider had a process for staff to follow. Records reviewed showed that care staff completed accident and incident forms as required. There was a section on the accident and incident forms for these to be reviewed by a member of the management team. We saw that this had not always occurred meaning appropriate action may not always have been taken to investigate the incident and reduce the risk of reoccurrence.
● The provider's quality monitoring systems including logging incidents such as falls onto a computer system. This enabled patterns or trends such as time of day or location of falls to be analysed. This would help in determining if further action was required to reduce future falls.
● Family members told us they had been informed if there had been accidents or incidents and described actions taken in individual instances. For example, we were told "[Person's name] had a fall six months ago. The home has moved them to a bigger room to eliminate the risk." We were also told, "My relative fell over once and the home informed me, the GP visited and there was a hospital check-up."

Using medicines safely
● There were safe systems in place for the management of medicines.
● People confirmed that they received their medicines as prescribed and that they could request 'as needed' (PRN) medicines when necessary. Family members were also happy with the way medicines were managed. One said, "I have no concerns regarding medication and my relative's skin looks lovely now – it was dry before." Another family member told us, "I had a call to say that they had scratched their leg and it was infected. The home reported it to the GP and medication was issued."
● Arrangements were in place for obtaining, storing, administering and disposing of medicines safely. Medicines were stored securely within suitable locked facilities. Staff monitored the fridge and the room temperature where medicines were kept ensuring medicines were stored within safe temperature ranges. There were supplies in stock of all medicines people had been prescribed. Systems would also ensure that

any new medicines could be received promptly meaning there would be no delay in people receiving these.
● The home had moved to an electronic medicines management system. A staff member demonstrated this system and said this helped to ensure people always received their medicines correctly. Where changes to prescribed medicines were made appropriate systems were in place to ensure these were managed safely. There were also effective systems to ensure prescribed topical creams were managed safely and applied as required.
● Staff had been trained to administer medicines and had been assessed as competent to do so safely. Systems were in place to update training and competency assessments as required.
● A monthly audit of medicines records and stock levels was undertaken by a senior staff member using a comprehensive audit tool. Where this had identified issues, appropriate action was undertaken.

Preventing and controlling infection
● We were assured that the provider's infection prevention and control policy was up to date. However, we found that the provider's infection control auditing processes had not been updated to reflect changes introduced due to the COVID–19 pandemic.
● Appropriate arrangements were in place to control the risk of infection including that presented by COVID-19. The home's policies and procedures reflected the latest best practice guidance from the Department of Health.
● We were assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. Staff had been trained in infection control techniques and had access to personal protective equipment, including disposable masks, gloves and aprons, which we saw they used whenever needed. People told us staff always wore masks.
● We were assured that the provider was preventing visitors from catching and spreading infections. Family members confirmed they were supported to visit their relative safely. The procedure described followed best practice guidance from the Department of Health. This included undertaking a Lateral Flow Detection (LFD) test immediately prior to visiting and the wearing of appropriate PPE. For example, we were told, "There is a special room on the ground floor for visiting. I take a lateral flow [COVID–19] test. The home ensure I wear PPE. Staff wear all the PPE." Another family member said, "I take a (COVID–19) test every time I go. I wear PPE – the home gives me an apron and gloves and we are in a room on our own."
● We were assured that the provider was accessing testing for people using the service and staff. Staff told us they were tested three times a week and that people were tested each month. People had been supported to receive the vaccination for COVID–19.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. People said they felt the home was clean. One person told us, "Oh yes, just look at my room, spotless." A family member said, "Cleanliness is fantastic. Cleaners are polite but get on with their job." The home was clean and housekeeping staff completed regular cleaning in accordance with set schedules. Housekeeping staff told us they had time to complete all necessary cleaning.
● We were assured that the provider was admitting people safely to the service. The support manager said people's ability to cope with a period of post admission isolation were considered when agreeing to any new admissions. Similar procedures of isolation, enhanced PPE, and regular testing were also in place for people readmitted after spending time in hospital.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Discussions with the area manager and support manager showed they were aware of government guidelines in relation to the management of risks relating to COVID -19.
● We were assured that the provider was meeting shielding and social distancing rules for both people and staff.
● The home had been awarded 5 stars (the maximum possible) for food hygiene by the local authority environmental food hygiene team.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- In December 2020 a senior representative of the provider completed a review of the service. This resulted in a continuous improvement plan. All of the ten key identified areas for improvement had a date for completion prior to this inspection, however, only one was recorded as having been completed. Some of the areas identified in this audit and action plan reflected those we found during this inspection.
- The failure of the provider's quality assurance systems to either identify areas for improvement and/or to bring about effective improvement had placed people at risk of not receiving a safe service. Concerns we found during the inspection including the failure to take all necessary action to manage individual risks; failure to ensure all pre employment checks were completed before new staff commenced employment; not ensuring all incidents were reviewed by the management team and safeguarding referrals made where necessary meant people were at risk.
- Quality monitoring systems had also not identified that incorrect information about whether individual people should receive emergency resuscitation was readily available to care staff. The failure to have accurate resuscitation information easily available meant people may not have received the correct emergency care when they required this.
- There was a quality assurance process in place consisting of a range of audits. We viewed the infection control audit completed in June 2021. The audit proforma had not been updated to reflect changes required by COVID–19. For example, there were no references to staff wearing masks or testing for COVID–19. The audit identified areas of noncompliance but these had not all been transferred to the subsequent action plan. For example, it was noted that there was sharing of hoist slings as these were not named and hoists were not being cleaned daily. The final page of the audit required managers comments and confirmation that actions identified had been completed. There was no evidence that this had occurred and the management team could not confirm that this had occurred. We were also informed the staff member completing the infection control audit had not completed relevant training. The failure to ensure all audits are suitable for use, completed by appropriately trained staff and actions taken where noncompliance is identified meant people were at risk of not receiving a safe service.

We found no evidence that people had been harmed however, quality monitoring systems were either not in place or robust enough to ensure people received a safe service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When we identified areas which required improvement the management team were receptive to our findings and took appropriate prompt action to ensure people's safety. Other audit tools such as that used for medicines had been completed appropriately and showed that action had been taken when required.

● Registered persons are required to notify CQC of a range of events which occur within services. The provider had not ensured that CQC had been notified about all safeguarding incidents. We had not been notified about incidents where people had been placed at risk of harm such as when care staff had failed to use moving and handling equipment when moving a person, or when service users had placed other service users at risk. Although no injuries had occurred during these incidents these should have been reported.

We found no evidence that people had been harmed however, the failure to notify CQC of any abuse or allegation of abuse in relation to a person was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

● Other notifications had been received as required.

● The registered manager left in February 2020. Since then the provider had appointed two managers however, neither had proceeded to complete the registration process with CQC. At the time of this inspection the service was managed by a support manager however, their previous role of deputy manager had not been filled meaning they were working both as manager and deputy manager. An area manager told us they attended the home for one day per week to provide management support and oversight. A permanent manager had been appointed who was due to commence employment soon after this inspection.
● Due to the changes in managers since February 2020 we were unable to confirm if all necessary action had been taken in respect of a fire risk assessment and water safety (legionella) assessments which had been completed by external consultants. This had also been identified by the area manager who had arranged for new assessments to be completed. A survey of people's views of the service had been completed in the summer of 2020. We saw completed surveys however, there was no information to show if these had been collated and what actions had occurred as a result of the surveys being undertaken.
● Staff were organised and carried out their duties in a calm, professional manner. They communicated well between themselves to help ensure people's needs were met, including during handover meetings at the start of each shift.
● Staff were positive about working at Blackwater Mill. Comments from staff included: "I love it here, we all get on well", "I can always get support if I need it" and "we are a team". All said they would be happy for a family member to be cared for at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team were aware of their responsibilities under the duty of candour which requires the service to apologise, including in writing when adverse incidents have occurred. A family member told us, "They (relative) fell over once and the home informed me, the GP visited and there was a hospital check-up." Another family member said, "When the home had COVID – 19, I was kept informed, they phoned and told us how many cases they had."
● People, relatives and staff were confident that if they raised any issues or concerns with the management team, they would be listened to and these would be acted on. A family member said, "I was introduced to the last manager. I have spoken to the recent one. I would speak to (name of staff members) if I had any issues. Staff are very accommodating."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and their relatives were extremely happy with the service provided at Blackwater Mill and felt it was well managed. One person told us, "I'm very happy here". A family member said, "It seems a very calm and gentle place. Everyone seems organised – nothing is too much trouble. Obviously, staff care for the residents. I have no concerns about my relative at all."

● A person told us they had never had to raise any concerns but were aware of who the manager was and would feel comfortable doing so should the need arise. Relatives also confirmed they knew who the new manager was.

● People, relatives, staff said they would recommend the home as a place to live. For example, one family member said, "Yes, we had a good feeling about it when we viewed. We were shown round everything. [There is] always staff around. Our relative has settled in very well. Home is spotlessly clean, always."

● People, relatives and external professionals felt able to approach and speak with the management team or other staff and were confident any issues would be sorted out. Pleasant interactions were seen between people and staff throughout inspection. People appeared to be comfortable with staff who had built good relationships with people.

● Staff were proud of the service. All said they would recommend Blackwater Mill as a place to work and would be happy if a family member received care there.

Working in partnership with others

● The service worked in partnership with key organisations, including the local authority and other health and social care professionals to provide joined-up care. This was evidenced within people's care records and discussions with external health and social care professionals.

● Family members were also viewed as partners in people's care. All those we spoke with felt included in assessments and care planning and stated that they were kept fully up to date with their relative's care. One family member told us, "The care plan is up to date and appropriate."

● The support manager told us they had a positive relationship with external professionals and used them for support and advice when needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider has failed to notify CQC of all abuse or allegation of abuse in relation to a service user. Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate individual risks were effectively managed. This placed people at risk of harm. Regulation 12 (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to ensure that quality monitoring systems were either in place or robust enough to ensure people received a safe service. Regulation 17(2)(a)(b)