Bupa Care Homes (CFHCare) Limited

Ringway Mews Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1, 2 and 3 June 2016 and was unannounced.

Ringway Mews Nursing Home was last inspected in July 2014 when we identified five breaches of the regulations we reviewed; these related to the safe management of medicines, care assessments not being fully completed or regularly reviewed, the keeping of contemporaneous records, the storing of confidential information and having effective quality audit systems in place for the service.

Following the inspection in July 2014 the provider wrote to us to tell us the action they intended to take to ensure they met all the relevant regulations. Part of this inspection was undertaken to check whether the required improvements had been made. We found improvements had been made.

Ringway Mews Nursing Home is owned by BUPA Care Homes. The service consists of four 30 bedded units; Lancaster, Shackleton, Anson and Halifax. Each unit specialises in either nursing or residential care. Each unit has a lounge, dining area, a conservatory, a smoke room and a kitchenette. All bedrooms are single with no en-suite facilities. Accessible toilets and bathrooms are located near to bedrooms and living rooms.

The service had 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. They were supported by a clinical lead for the service.

People told us they felt safe in the service and had no concerns about the care and support they received. They told us staff were always kind and caring. Staff had received training in safeguarding adults and knew the correct action to take if they witnessed or suspected abuse. Staff were confident that the unit managers, clinical lead and registered manager would act on any concerns raised.

We noted improvements had been made in the management of medicines. Guidance for the use of 'as required' medicines and thickeners were in place. One unit did not use the same monitoring tool to ensure the medicine administration records were fully completed. This was implemented after the inspection. Topical cream charts were not in place for staff to record when they had applied any topical creams. Body maps were not used on one unit. We have made a recommendation about the use of topical cream charts and body maps.

A process was in place to recruit suitable staff. Care staff received the induction, training and supervision they required to be able to deliver effective care. We saw that the staff were very busy during key times of the day such as when people were getting up and at meal times. Most people told us there were sufficient staff on duty to support people in a timely manner. The night staff on one unit thought more staff were required, especially when supporting people to go to bed at night.

All areas of the home were clean. There was a malodour on one unit at the entrance to the lounge area. The registered manager told us a carpet cleaner would be purchased to regularly clean the carpet in this area. Procedures were in place to prevent and control the spread of infection; however they had not prevented the malodour on one unit. Systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and gas supply. Regular checks of the fire systems and equipment were completed.

People and their relatives told us they received the care they needed. Care records we reviewed showed that risks to people's health and well-being had been identified and plans were in place to help reduce or eliminate the risk. We found three people had additional support needs that were not covered in the standard care plans. These had not been recorded in an additional care plan. Care records on three units had been regularly reviewed to help ensure they accurately reflected people's needs. However on one unit the monthly reviews had not always been completed.

Systems were in place to help ensure people's health and nutritional needs were met. Records were in place for the care provided, for example when people were re-positioned and for people's food and fluid intake. Records we reviewed showed that staff were proactive in contacting relevant health professionals to ensure people received the care and treatment they required.

We found people's records were securely stored in locked cabinets in the office in each unit. Other confidential information was stored securely.

People we spoke with told us that the staff at Ringway Mews were kind and caring. During the inspection we observed kind and respectful interactions between staff and people who used the service. Staff showed they had a good understanding of the needs of people who used the service.
An end of life champion had been identified for each unit who had received training in end of life care. They advised the staff team when supporting people at the end of their lives. We saw some people had made advanced decisions about what they wanted at the end of their life.

We found the service was working within the principles of the Mental Capacity Act (2005). People's capacity was assessed and best interest decisions recorded where appropriate.

A programme of activities was in place to help promote the well-being of people who used the service. This included monthly trips out, for example to Knowsley safari park and Blackpool.

Staff told us they enjoyed working in the service and received good support from the registered manager and clinical lead. Regular staff meetings took place and staff said they were able to make suggestions and raise any concerns they had at the meetings.

There were effective systems in place to investigate and respond to any complaints received by the service. All the people we spoke with told us they would feel confident to raise any concerns they might have with the unit managers or registered manager.

We noted there were a number of quality audits in the service completed by the Bupa area manager and clinical lead; these included medicines, care records and the environment. Action plans were completed following the audits. The audits had identified some of the issues found during this inspection; however the required actions to correct them had not been completed. The audits had not identified other issues we found; for example the need for additional care plans for some people.

Monthly statistics were compiled for monitoring purposes on a range of areas; for example nutrition, safeguarding referrals and hospital admissions. This meant any trends or patterns of behaviour could be identified and action taken when necessary to keep people safe.

During this inspection we found breaches of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because additional care plans were not in place for some people's identified needs and the audits completed by the service had not identified the issues found during this inspection or issues that had been identified had not been actioned. You can see what action we told the provider to take 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.

The management of medicines had improved; however one unit has not recorded all medicines administered. Protocols were in place for 'as required' medicines. We have made a recommendation about the recording of topical creams.

Risk assessments were in place. However on one unit they had not all been regularly reviewed.

There was a safe system in place to recruit suitable staff. Staff had received training in safeguarding adults and knew the correct action to take should they witness or suspect abuse.

Sufficient staff were on duty to meet people's needs. At key times the staff were very busy.

Is the service effective?

Good

The service was effective.

Care staff received the induction, supervision and training they required to be able to deliver effective care.

Systems were in place to assess people's capacity to consent to their care and treatment. Best interest decision forms were used where people lacked capacity.

People received the support they needed to help ensure their health and nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

We witnessed two occasions on Halifax unit where the support was not caring.

People who used the service told us staff were kind and caring in their approach. Staff we spoke with were able to show that they knew people who used the service well.

Contemporaneous records were kept for re-positioning and fluid intake. Records were securely stored.

An end of life champion had been identified for each unit to support people and staff at the end of people's lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The standard care plans contained enough information to guide staff on the care and support people required. However, care plans had not been completed for some people's additional needs.

A programme of activities was in place, including regular day trips.

The provider had effective systems in place to record and investigate any complaints they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A registered manager was in place as required by the service's registration with the CQC.

The quality assurance processes had not identified all the issues we found during this inspection. Where issues had been found in the audits action had not always been taken to address them.

Staff told us they enjoyed working in the service and found the manager to be both approachable and supportive.

The provider had systems in place for gathering the views of people who used the service and their relatives.

Ringway Mews Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 1, 2 and 3 June 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience on the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. The second day of the inspection was carried out by two adult social care inspectors One adult social care inspector returned on the third day of the inspection.

Before our visit we asked the provider to complete a Provider Inspection Return (PIR) form and this was returned to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed the information we held about the service including notifications the provider had sent to us. We contacted the local Healthwatch organisation and the local authority's commissioning team, the NHS nursing home service, Manchester Clinical Commissioning Group (CCG) and Manchester City Council's safeguarding and infection control teams to obtain their views about the service. Some feedback we received raised concerns about staff being unable to meet the wide range of needs of the people supported on one unit (Halifax Unit) when the unit manager was not working. The other organisations we contacted did not express any current concerns about the service provided at Ringway Mews Nursing Home.

During the inspection we carried out observations in each of the four units in the service, including over the lunchtime period. We spoke with 28 people who used the service, eight visiting relatives, and two visiting

health professionals. We also spoke with the manager, the clinical lead, two unit managers, five registered nurses, 16 members of care staff, an activity coordinator, a Bupa Clinical Development Manager who visits Ringway Mews each week, the deputy chef, two housekeepers and two laundry assistants.

We looked at the care records for 15 people who used the service and the medication records for 27 people. We also looked at a range of records relating to how the service was managed; these included five staff personnel files, staff training records, quality assurance systems and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with said they felt safe living in the home. Comments people made to us included, "Oh yes I feel safe, it's like being at home", "Yes, the staff are very good" and "I'm glad I moved to Bupa; it's the best decision I have made." The visitors we spoke with had no concerns about the safety of their relative or the care they received. One said, "I can't fault it; I feel re-assured when I leave."

At our last inspection we found appropriate arrangements were not in place to manage medicines safely. The medicine administration records (MARs) had not all been signed when medicines had been administered, protocols for when 'as required' medicines were to be administered were not in place and guidance and recording for 'thickeners' used where people are have difficulty swallowing and are at risk of choking were not accurate. At this inspection we found improvements had been made.

We reviewed 27 medicine plans across all four units. We found protocols for 'as required' medicines were now in place for the majority of people we looked at. However, we saw one person who had recently moved in to the Shackleton unit and one person in Anson unit whose medicine had been changed from a regular dose to an 'as required' dose did not have protocols in place. These protocols provided guidance for staff on the reasons why a person might need an 'as required' medicine and the symptoms a person might display to indicate they needed the medicine if they were unable to ask staff directly. This meant the service had implemented protocols for 'as required' medicines but two had not been completed.

We looked at how thickeners were managed by the service. We saw guidelines were in place to inform staff of the consistency of fluid required for each person. The care staff or hostess (a staff member who assists at meal times) who gave the person the thickened drink completed a chart to state they had used the thickener. The care plans also included details of the amount of thickener to be added to fluids to ensure the correct prescribed consistency. This meant people were receiving thickened fluids as prescribed.

We reviewed the MAR sheets for 27 people across all four units. We found they had been fully completed on three of the units. On Shackleton unit we found three MAR had not been signed on every occasion to confirm people had received their medicines as prescribed. We saw on three units a checklist was completed after each medicines round by the nurse or senior carer who checked that the MAR sheets were fully completed. On Shackleton unit we saw a weekly audit was completed. This had identified missing signatures on previous MAR sheets. One senior carer told us where missing signatures were identified the unit manager or senior on duty that day was made aware of it. They said the unit was getting better with fewer missing signatures now the weekly check was being made. We asked the registered manager why a different audit tool was used on Shackleton unit. They informed us all units have been told to check the MAR sheets after each medicines round. She requested a nurse from another unit visit Shackleton to show them the checklist in use in the other three units. After the inspection the registered manager emailed us a copy of the checklist now in use on Shackleton unit.

We saw additional medicine care plans were in place when a person was prescribed a short course of medicines. However, on Shackleton unit we saw the prescribing instructions for one short course medicine

had not been fully written on to the MAR sheet. This medicine needed to be taken 30 – 60 minutes before food. Staff administering this medicine would not be aware of this from reading the MAR sheet. It is important that the full prescribing instructions are written on the MAR sheet so staff are aware of these instructions when administering the medication.

We saw creams were stored in the medicines room on each unit. We were told the care staff applied the topical creams. They then informed the nurse or senior carer they had completed this. The nurse or senior carer indicated this on the relevant MAR sheet. On three units this was with a code to state the cream had been applied but not by the person signing the MAR sheet. On Shackleton the senior carer signed the MAR sheet to state they had applied the cream when they had not done so. We were told topical cream charts were not used so care staff were not able to record when they had applied the cream. Accurate recording of the application of creams is important to ensure it is applied as prescribed and there is accountability as to who has applied the cream. We asked the registered manager about topical cream charts. She told us they should be used, with care staff signing the topical cream chart each time they have applied the cream.

Body maps were in place in three units to indicate where the cream needed to be applied. These were not in place on Halifax unit. The deputy unit manager said they had been told to remove the body maps. We asked the registered manager about the use of body maps. She told us they should be in place and had informed the deputy manager they needed to be re-instated on Halifax unit.

We recommend that the provider looks for a best practice solution to ensure that cream charts and body maps are consistently used across all units.

Overall we found improvements had made in relation to medicine management although we recommend the provider refers to NICE guidance to ensure the correct systems are in place for all people who use the service.

We saw two people were administered their medicines covertly. This meant the medicine was added to food or drink without their knowledge. We saw assessments were in place to agree this was in people's best interests. We checked the stock of medicines held for three people to see if this corresponded with the records; we found this was the case.

We saw medicines that were controlled drugs were stored and recorded correctly, and a weekly stock check was carried out. Controlled drugs are drugs which by their nature require special storage and recording.

The nursing staff and senior carers who administered medicines told us they received medicines training and were observed administering medicines three times before they completed the medicines round on their own. We saw annual competency observations were also completed

At our last inspection we found people's risk assessments had not been regularly reviewed or updated when people's needs changed. At this inspection the records showed that risks to people's health and wellbeing had been identified, such as risks associated with reduced mobility, poor nutrition and the development of pressure sores.

The risk assessments we viewed on three units had been reviewed on a monthly basis. However, on Anson unit we looked at six people's risk assessments. Three had been reviewed monthly, two had not been reviewed when they should have been in the last month and one had not been reviewed for the two months between February 2016 and May 2016. This person was identified as at a high risk of developing pressure ulcers. The nurse in charge told us the risk assessments were reviewed each month when the person using

the service was the 'resident of the day'. The 'resident of the day' is a person on each unit who is identified as the person whose care plans and risk assessments will be reviewed on that day. If this is not possible for any reason it would be noted in the diary for the nurse to complete the review the next day. We did not see entries in the diary stating the risk assessments had not been reviewed for the plans we looked at. This meant that the nurse who was responsible for reviewing the care plans and risk assessments for the 'resident of the day' had not communicated that they had not been able to complete the task. Therefore no one else completed the task.

The clinical lead completed a daily walk round each unit. She checked the tasks for the 'resident of the day' from the previous day had been completed. This had not identified that the risk assessments we saw had not been updated. The unit manager told us on the next day of our inspection the risk assessments we had found had been reviewed and a nurse had been given the role to check all paperwork on the unit was up to date.

We saw accident and incident forms were completed appropriately and all falls were recorded in each person's care file. Risk assessments and management plans were reviewed following an incident or accident. The forms were collated and reviewed by the clinical lead and registered manager and analysed to identify any trends.

Staff were able to explain how they safeguarded people living at Ringway Mews and who they would report any concerns they had to. We saw staff had received training in safeguarding vulnerable adults; this was confirmed by the staff we spoke with. One staff member said, "I would report it to the unit manager who would inform [registered manager]." Staff were aware of the Bupa 'Speak Up' confidential telephone line and said they were confident action would be taken by the registered manager if they raised any concerns. We saw safeguarding information was on display in the offices of each unit. During the inspection we witnessed an incident on Halifax unit. When we spoke with the registered manager she was aware of the incident and had reported it to the local safeguarding team. This meant that the systems for reporting safeguarding incidents was in place and should help ensure that the people who used the service were protected from abuse.

Most people who used the service and relatives we spoke with thought there were normally enough staff members on duty to meet their needs. Comments we received included, "There's enough staff; very rare occasions when they are very busy and I have to wait", "Staff always come when I buzz" and "There's always staff around." However some people told us they had to wait for staff to support them sometimes as staff were busy. Staff we spoke with thought that whilst there were some very busy periods, especially when people were getting up, going to bed or at meal times, there were usually enough staff on duty.

The feedback we received from one health professional raised concerns about the staff's ability to support the wide spectrum of needs of people living on Halifax unit, especially when the unit manager was not present. Some people required nursing care, others were living with dementia and others had behaviour could be perceived as challenging. We found Halifax to be a very busy unit with some people having high needs. The deputy unit manager thought there were sufficient staff to meet people's needs, as three people had additional one to one staff in place and there were currently three people in hospital. In addition the relatives of three people living in Halifax unit visited every mealtime and supported their loved ones with their meals. We saw relatives were able to have a meal with their loved ones. The day staff we spoke with thought there were usually enough staff on the unit. People and relatives we spoke with on Halifax unit felt the staff were able to meet their needs in a timely manner. However the night staff on Halifax unit did not think there were sufficient staff on duty to meet people's needs.

From our observations throughout the inspection we saw staff were busy at key times such as meal times and people had to wait for a while for assistance at these times. Staff were also task orientated at these times. We saw staff respond in a timely manner to call bells throughout the day. We were also told that people went to bed at varying times so the evening and night staff were able to provide support as required. We asked the registered manager about staffing levels at Ringway Mews. We were told a dependency scale is used from the pre-admission assessment to establish the staff required for each person. If additional support is required this is agreed with the funding authority. We saw three people on Halifax unit who had additional one to one staff support to meet their needs.

We were told and rotas we saw confirmed, that agency staff were not used very often at the service. Staff covered shifts when their colleagues were on leave or sick.

We looked at the procedures in place to help ensure staff were safely recruited. We looked at five staff personnel files. The files included an application form, proof of identity documents including a photograph and a criminal records check from the Disclosure and Barring Service (DBS). The DBS identifies people barred from working with vulnerable people and informs the service provider of any criminal convictions noted against the applicant. We saw the registration PIN numbers for the qualified nursing staff had been checked with the nursing and midwifery council. We noted the employment history for one person had not been completed on the application form and was not recorded elsewhere in the file. The registered manager sent us the information after the inspection stating it had been separated from the rest of the information and was in a tray waiting to be filed.
This meant that a safe system was in place to recruit staff suitable to work with vulnerable people.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. We looked around each unit of the service and saw the bedrooms, dining rooms, lounges, bathrooms and toilets were clean. People and relatives told us they thought the home was kept clean. There were no malodours in three of the units. However there was a malodour at the entrance to the lounge on Shackleton unit due to regular occurrences of incontinence on the carpet at that point. The unit manager and registered manager agreed. They told us a small carpet cleaner would be purchased for the unit and staff trained to use it. The remainder of the unit was odour free.

Records showed, and staff confirmed, that infection prevention and control training was undertaken by all staff. The housekeepers we spoke with confirmed they had also completed this training and knew of the action they should take to help prevent the risk of cross infection.

We asked if people who required support using a hoist had personal slings when they required personal care. We were told disposable slings were available. The registered manager said personal slings had been ordered for all people who required them for personal care tasks.

Our observations during the inspection showed that staff used personal protective equipment (PPE) such as gloves and aprons appropriately when carrying out tasks. We saw that the local authority had completed an infection control audit in November 2015 and the service had been rated as 'green' (high compliance) overall.

We checked the systems that were in place to protect people in the event of an emergency. We found that personal emergency evacuation plans (PEEPs) were in place for all people who used the service and a copy was kept by the main door to each unit to be accessible to staff. These plans were brief and detailed if a person was independently mobile, required support from one person or would require two people to evacuate them as they were not mobile. Two emergency evacuation blankets were available in each unit.

This meant information was available for the emergency services in the event of the building needing to be evacuated.

Records we reviewed showed that the equipment within the home was serviced and maintained in accordance with the manufacturers' instructions. This included the fire alarm, call bell and emergency lighting systems. Records we looked at showed regular checks were carried out on gas and electrical items and the water system. This helped to ensure that people were kept safe.

We saw a business continuity plan was in place for dealing with any emergencies that could arise. This informed the registered manager and staff what to do if there was an incident or emergency that could disrupt the service, for example a gas leak or an interruption of the electricity supply.

Good

Is the service effective?

Our findings

All the people we spoke with during the inspection spoke highly of the skills and knowledge of the staff team. One person said, "The staff know what they are doing." One relative told us, "The staff have the training and know [name] well to be able to support her."

We were told new staff received a one week induction programme before starting work on one of the units. This included four days of class room based training courses and one day shadowing staff on one of the units. They would then shadow an experienced member of staff for one day before being part of the rota.

Staff told us they had received the training they required to carry out their roles effectively. One said, "You can ask for specific training if you want to; I've done dementia training." We were shown the training matrix used to record all training completed by staff. We found staff had received mandatory training, which included, safeguarding vulnerable adults, manual handling, fire safety and infection control. Staff we spoke with confirmed they had annual refresher courses. Staff also received training in dementia care and managing challenging behaviour where required.

Staff told us they had the opportunity to undertake a vocational qualification in health and social care. The registered manager confirmed that 93 of the staff team had achieved the vocational award. We were told the service had a Bupa trainer allocated to them for one week every month. The trainer completed courses and observational assessments of practice. They attended the service in the evening to support the night staff as well as during the day.

Staff told us they received regular supervisions and an annual appraisal with the unit managers. The unit managers had regular supervisions with the registered manager. We saw the registered manager had a matrix to monitor when supervisions had been completed. One unit had been behind in completing their supervisions due to sickness of the unit manager. The registered manager had asked the deputy unit manager to complete the supervisions for staff team on the unit. The deputy manager was in the process of completing these supervisions.

All staff and unit managers said that they felt supported by the registered manager and clinical lead. All staff we spoke with knew the registered manager and the clinical lead, who completed a morning checklist for each unit every day and felt able to raise any issues or concerns they had with them.

This meant the staff were provided with the skills, knowledge and support to provide effective care.

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 made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. 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 found that it was.

We saw in the care files that a 'resident choices and preferences: mental capacity assessment' was completed for each person who used the service. This recorded an assessment of a person's capacity to make decisions in a range of areas, for example choices and decisions over care, safety, moving around and personal care tasks. A person's ability to make decisions in each area was assessed as having capacity, having variable capacity or lacking capacity.

Where a person lacked capacity a 'best interest decision' form was used to record the decision to be made, who was involved in the best interest decision, the person's known wishes and the alternative options considered. The Clinical Development Manager told us part of their role was supporting the service with capacity assessments and best interest decisions. We saw additional best interest forms were being completed for people in every area they had been identified as lacking capacity. They were also undertaking additional training in the MCA, DoLS and best interest decisions, initially with the unit managers and senior care staff, before including all staff.

We saw that some people had an independent mental capacity advocate (IMCA) appointed to advocate on their behalf if they did not have any family members who could represent them.

Staff clearly explained to us how they supported people to make everyday choices about their care and support. One staff member said, "We ask people what they want and show them things such as clothes so they can choose what they want to wear." We observed staff asking people what they wanted throughout our inspection. Staff explained that if a person refused support they would come back later to offer support again or ask a colleague to support them instead.

We saw that twenty six people had authorised DoLS in place and a further 45 applications had been made to the local authority and were waiting to be assessed. The registered manager had notified CQC as required when DoLS applications had been authorised.

We observed the morning handover meeting between the night shift and the incoming day shift on three units during the inspection. The handover was used to inform staff of people's wellbeing and any changes that had been noted. Staff told us if they had been off work for a period, for example annual leave, they would receive an extended handover from the unit manager on their return to work. This meant the staff were kept up to date with any changes in people's needs and support.

People told us, "The food is very good; I get a choice and can ask for a snack if I wake up at night and feel hungry." Menus were planned on a four week rota. People were offered a choice and an alternative menu was available such as jacket potatoes or salad if people did not like the main choices available that day. We observed the meal time experience on all four units. We noted staff encouraged people to eat as much as possible and provided individual assistance and reassurance to people who needed support to eat. The meals were of generous proportions and were well received.

We spoke with the deputy chef about people's diets. They explained they received information from each unit if people required fortified meals or a mashable or pureed meal. A summary of this information was kept on a white board in the kitchen so the correct number of special diet meals were sent to each unit. The deputy chef also explained how cultural diets, such as halal meat, were catered for when required. The most

recent inspection from the environmental health department had awarded the service a 5 (Very Good) rating.

We saw there were systems in place to help ensure people's nutritional needs were met. Staff monitored people's weight on a monthly basis. We were told a Malnutrition Universal Screening Tool (MUST) champion had recently been introduced on each unit. This meant one staff member on each unit was responsible for ensuring people were weighed monthly and their risk of mal-nutrition calculated. Those found to be at risk would then be referred to the dietician or speech and language team (SALT). The champions were being supported by the Clinical Development Manager. We spoke with a member of the SALT team. They said the home made appropriate referrals to the team and followed the instructions provided. This meant people's nutritional needs were being met by the service.

Each person was registered with a local GP. Three units had access to the NHS nursing home team and the remaining unit is on a pilot scheme for a residential unit. People were referred to the team and they visited the units each week to review their health needs, with the aim of reducing hospital admissions. Staff could also ask for the team to visit a person if they became unwell. The nursing home team were positive about the pilot scheme on Shackleton unit and the commitment to people's care shown by the staff team.

We saw that referrals were also made to occupational therapists and district nurses when required. We saw that people at risk of developing pressure sores had the appropriate pressure relief mattresses in place and records were kept of when people were supported to re-position. The District Nurse we spoke with said, "There is excellent wound care at the home; staff refer people straight away and follow all of the guidelines they are given." This meant that people's health needs were being met by the service.

To support people living with dementia to independently find their own bedrooms we saw each room had a small memory box next to their door for small items or photographs of the person. The toilet doors were painted a bright colour in contrast to the walls. This meant people were able to maintain their independence more easily by knowing where they were going.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with said the staff were kind and caring. One person said, "Staff are very, very kind here," and another said, "Staff listen to me when I have something to say; they are very good" and "Staff know me and treat me very well." Relatives told us, "[Name] is in good hands; I couldn't ask for any better" and "There are excellent staff who got the extra mile for [Name]."

At our last inspection we found contemporaneous records were not kept in relation to people's care. We also found confidential information was displayed on the office notice boards and some additional records and observational charts were seen in the dining areas of three units. At this inspection we found positional changes and fluid charts were in place for people that required them. We saw that confidential information was stored in lockable cabinets in the office. Additional records and observational charts were not left in the dining areas. This helped to ensure that the confidentiality of people who used the service was maintained. We observed positive caring interactions between staff members and people living at Ringway Mews. Staff were seen responding to people's needs in a caring way. When communicating with people, staff would get down to the person's level and address them by their name (or preferred name) and spoke clearly. They waited for a reply before they took any action. However we also saw one care worker on Halifax unit supporting a person who used the service on a one to one basis. They linked arms or held the person's hand but did not speak to them or respond to their constant questions. From the person's care plan we saw staff should converse with the person and validate their conversation to aid their periods of lucidity. We were told the care worker did not usually work on Halifax unit and did not know the person. We observed two other care workers answering the person's questions and conversing with them. We were informed after the inspection that the care worker would not be undertaking one to one support with this person in future. We also observed on Halifax unit an incident, which was reported to the registered manager by the deputy unit manager and a staff member.

Three units had a calm atmosphere throughout our inspection. Due to the needs of people supported on one unit there was some shouting and noise. Staff were seen to re-assure people and quickly diffuse situations where people became agitated in a calm and professional manner.

Staff knew the needs of the people they were supporting and understood the meaning of person centred care. One said, "It's how people like to be spoken to, their preferred name and ensuring their appearance is good." Staff also described how they maintained people's privacy and dignity when providing personal care. One staff told us, "I talk to people so they know what I am going to do when I'm supporting them."

Care records we reviewed included information regarding people's interests and their family and social history. This should help staff form meaningful and caring relationships with the people they supported. Care plans also included information about the things people were able to do for themselves. One staff said, "I encourage people to try to do things for themselves; if they can't do it I support them."

We looked at the arrangements in place to help ensure people received the care they wanted at the end of their life. We saw each unit had been accredited with the Six Steps end of life care programme. The Six Steps

is a nationally recognised programme for supporting people and their families about making advanced decisions about the care they want at the end of their lives and their wishes after death. We were told each unit had a Six Steps champion. Staff told us they were given guidance and advice by the champion about a person's end of live care. Care plans were in place for people who wished to discuss their end of life care. One relative told us, "I've already been involved in making an advanced decision for [relative name] that they will stay here at the home and not go to hospital when the time comes." One staff told us, "We try to make the relatives comfortable and lay a person's body out in bed so relatives can come to see them if they want to."

We saw a new 'Your future' booklet Bupa were due to introduce. This was a comprehensive advanced planning document to encourage discussions with people and their family, where appropriate, about their end of life care.

Staff said that they received support from their colleagues and managers following a person's death. This was provided on a one to one or group basis.

We saw visitors coming and going throughout the inspection. One person said, "My family come to see me whenever they want to." We observed family members visiting people over meal times and supporting their loved ones with their meal. We saw the relatives were able to eat a meal with their loved ones if they wished to do so.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that staff responded well to their needs. A relative said, "Staff know [Name] well, his mood and the way he communicates with nods and with his eyes."

At the last inspection we found the care records were not accurate and did not reflect the care and treatment that was required or provided. At this inspection we found improvements had been made. We saw food and fluid charts were fully completed and up to date.

We looked at the care plans for 15 people across all four units. We saw a pre-admission assessment was completed before a person moved to Ringway Mews. Information from the person themselves, their family where appropriate, hospital staff and the social worker was included in the assessment. Staff told us they were able to read the assessment prior to a person moving to the service. A verbal handover was also given by the unit manager or nurse who had completed the assessment.

A set of care plans and risk assessments were completed when the person moved to the home. Clear timescales for the completion of certain documents was in place. The care plan was reviewed by the clinical lead 72 hours after admission.

The care plans contained information about people's social care needs and preferences. The plans stated what the person was able to do for themselves and what support they needed form staff. Where the service had identified specific care needs not covered in the standard care plans an additional plan of care was used to record these. This helped ensure the staff had the information they needed to meet people's needs.

However, we noted that one person on Halifax unit had been identified as needing three or four staff to support them with their personal care needs due to their agitation. There was no additional plan of care to guide staff how they were to provide the support to minimise the person's anxiety and possible challenging behaviour. Staff were able to describe to us how they supported this person with their personal care.

We also saw two people on Shackleton unit had an agreed protective plan in place following a safeguarding incident in July 2015. There was no mention of this protection plan in the care plans for these two people. Staff were aware of the protection plan and were recording the information required by the protection plan on a daily basis.

We found this to be a breach of Regulation 9 (3)(b) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We raised these issues with the registered manager. Following the inspection we were sent new additional plans of care for all three people.

We saw that most plans were reviewed monthly and updated as required. However on Anson unit we looked at six people's care files. Three had been reviewed monthly, two had not been reviewed when they should

have been last month and one had not been reviewed for the two months between February 2016 and May 2016. We were told on the second day of our inspection that a nurse had been given the role to check all paperwork on the unit was up to date.

We saw daily notes were written for each person detailing the support they had received that day and general information about their health. However on Shackleton unit we saw that the daily notes were written after lunch during the day and so did not contain any information about the afternoon, tea time or evening before the night staff started their shift. This meant that information relating to the needs and support people required may not have been fully recorded.

Relatives we spoke with said that they and their family had been involved in agreeing and reviewing the care plans with their relatives. One relative said, "Me and my daughter come to the review meetings." They also said the staff kept them informed and up to date with how their relative was and any changes that occurred.

We asked about the activities available for people living ay Ringway Mews. We were told a team of four activity officers were employed by the service to arrange and facilitate activities on all four units. On the first day of our inspection a trip to Knowsley safari park had been arranged. We saw information about other day trips that had also been organised. We were told one trip a month was arranged. People we spoke with said they enjoyed the trips out. The senior activities' officer explained that there was one activity per day for each unit. People also went to other units to take part in activities if they wanted to. During the inspection we saw a singing session, bingo and a quiz taking place; however during a quiz on Halifax unit we saw only one person tried to answer questions and there was little participation from other people when we were there. People also went out locally for lunch or to the park when the weather was nice.

We looked at the system for managing complaints in the service. We noted a complaints procedure was in place which provided information about the process for responding to and investigating complaints. We saw the complaints policy displayed in each unit and formal complaints were recorded centrally. Notes of any investigations were kept as well as the response given to the complainant. If a complaint could not be resolved by the unit manager or registered manager a Bupa area manager investigated the complaint. People we spoke with and their relatives said they would talk to the unit manager or registered manager if they had a complaint or concern. One said, "If I needed to I would talk to the staff; they are all approachable."

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with CQC. The registered manager was supported by a clinical lead and the unit managers.

At the last inspection we found the systems in place to monitor the quality of the service were not robust enough as they had not identified the shortfalls found in during the inspection.

We looked at how the registered manager and clinical lead were monitoring the quality of the service. We saw audits were completed in areas such as medicines and care plans. We saw records of monthly night time visits to the service undertaken by the registered manager or clinical lead. The clinical lead undertook a daily walk around of each unit which provided an overview of areas such as hospital admissions, end of life care, people's health and the resident of the day. Daily meetings were held with the unit managers to discuss any issues or concerns, staffing levels and any clinical issues that had arisen. We saw monthly audits were completed by the area manager and the Bupa clinical development manager.

Any actions required were highlighted in the audits. The issues we found with medicines management on Shackleton unit, the care plans not all being reviewed each month on Anson unit and the daily notes being written in the afternoon had been highlighted in previous audits by the area manager and Bupa clinical development manager. However the identified issues had not been rectified. The audits had not identified the different tool being used on Shackleton unit to monitor the MAR sheets had been fully completed, or that care staff were not using topical cream charts to record when they had applied any cream. They had also not identified the need for additional plans of care required for some people.

This meant that whilst routine audits were taking place and actions identified they were not always being implemented on each unit. Care plan audits had not identified that they did not always contain guidance for staff on people's specific support needs. We found this to be a breach of Regulation 17 (1) (2)(a)(b) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We noted that immediate action was taken with regard to the short falls identified during our inspection.

A home quality matrix was compiled monthly and sent to the central Bupa quality monitoring team. This included details of pressure sores, nutrition, medicines errors, GP reviews, DoLS and safeguarding incidents

We saw minutes from team meetings held on each unit, including input from the staff themselves. Meetings were also held with the laundry team, activities team. Heads of departments meetings took place monthly. Staff were also kept informed through the use of a staff notice board.

Annual surveys were completed for people who used the service, their relatives and staff. The results were collated and actions identified. From the residents meetings and survey feedback additional day trips had been planned and a bar area had been built on Lancaster unit as part of the recent refurbishment of the home.

We were shown a set of new policies being introduced by Bupa. These were in the form of booklets and grouped policies together into groups such as Resident care, Medicines and Quality Assurance.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC. We checked the records at the service and that all incidents had been recorded, investigated and reported correctly.

We asked the registered manager what they considered to be the key achievements in the service since our last inspection. They said it was working with the staff team and building their moral and gaining their trust. They identified the key challenges as continuing to coach the staff team so they can improve their documenting and recording on the Bupa paperwork.

Staff we spoke with during the inspection said they enjoyed working at the service and were positive about the registered manager and clinical lead. The staff were confident they could approach their unit manager, registered manager or clinical lead if they had any concerns and they felt they would be listened to.

People who used the service and relatives we spoke with all said that they would talk to the unit managers if they had any concerns. They told us the unit managers were approachable and were confident that any issues would be dealt with promptly.

Overall we found improvements had been made at Ringway Mews, however there were some inconsistencies between the units. For example in recording on the MAR sheets on Shackleton, the reviews of care plans on Anson unit, the odour on Shackleton unit and the staff levels on Halifax to meet people's wide ranging needs. The service needs to ensure all units are following the same systems and standards.

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 9 HSCA RA Regulations 2014 Person-centred care Additional care plans had not always been completed to guide staff in how to meet people's needs. Regulation 9 (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits had not identified the need for additional care plans or missed reviews of risk assessments. Actions identified in audits had not always been completed. Regulation 17 (1)(2)(a)(b)