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

Overall summary

Ringway Mews currently comprises of four units, Lancaster, Halifax, Anson and Shakleton, each accommodated up to 30 people. The service provides accommodation for people who require nursing or personal care and for those people who live with dementia. Each unit has their own designated staff team. There is a general manager in overall charge of Ringway Mews and each unit has a designated unit leader. The units are single storey buildings and set in their own grounds. Accommodation on each unit comprises of a large dining room /lounge and all bedrooms are single occupancy. There is ample car parking space and public bus services run nearby.

The service was last inspected in May 2014. All areas we assessed at that time were judged to be meeting the regulations at that time.

This was an unannounced inspection carried out on the 21 and 22 July 2015. At the time of our inspection there were 118 people living at the service.

The manager is registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.'

We found breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

People's care records did not contain sufficient information to guide staff on the care and support they required. We found no evidence to show that people and/or their relatives were involved and consulted about the development of their care plans. Confidential information in respect of people's care was not securely maintained.

We found the provider did not always adequately assess risks. This was in relation to people's health and well-being.

We found the system for managing medicines was not as safe as it should have been. The provider did not ensure the proper and safe management of medicines.

Systems were in place to assess and monitor the quality of the service provided but they were not robust enough to identify the issues of concern we found during the inspection.

Systems were in place to safeguard people from abuse. However during the inspection we were made aware of issues, which had not been brought to the registered manager's attention. **We have made a recommendation that all staff are reminded of their responsibilities when allegations are made to them so people are kept safe.**

The provider had requested authorisation in all instances where people were potentially being deprived of their liberty. **However we have made a recommendation that principles of the Mental Capacity Act 2005 are consistently applied so that valid consent is sought, acting in accordance with people's wishes.**

A programme of refurbishment was being completed throughout the service to enhance the standard of accommodation and facilities provided for people.

A safe system of staff recruitment was in place. This helps to protect people from being cared for by unsuitable staff.

We saw how the staff worked in cooperation with other health and social care professionals to help ensure that people received appropriate care and treatment.

Checks were made to the premises, servicing of equipment and fire safety. Staff told us there was enough equipment available to promote people's safety, comfort and independence.

Sufficient numbers of staff were employed, who received on-going training and support to meet the medication, physical and emotional needs of people living at Ringway Mews.

During our visit we saw examples of staff treating people with respect and dignity. People living at the home and their visitors were complimentary about the staff and the care and support they provided.

People were offered adequate food and drinks throughout the day ensuring their nutritional needs were met.

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?

Requires improvement 

The service was not always safe. Suitable arrangements were not in place with regards to the management and administration of people's prescribed medicines.

We found the provider did not always adequately assess, monitor and manage the risks to people ensuring their health and well-being was maintained.

Staff had access to procedures to guide them and had received training on what action to take if they suspected abuse. We found senior staff had not always reported incidents to the registered manager so that relevant action could be taken to protect people.

People were supported by sufficient numbers of staff that had been robustly recruited to work with vulnerable people.

Suitable arrangements were in place to ensure the premises and equipment used by people was safe.

Is the service effective?

Requires improvement 

The service was not always effective. We found the provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). However the principles of the Mental Capacity Act 2005 (MCA) had not always been considered when making decisions, where people potentially lacked the capacity to do so for themselves. This did not ensure people's rights were always protected.

Staff told us and records showed they had received all the necessary training and support. This helped them to develop the knowledge and skills needed to carry out their role.

People were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met.

Staff worked in cooperation with other health and social care professionals to ensure that people received appropriate care and treatment.

Is the service caring?

Requires improvement 

The service was not always caring. People's records and information about their needs were not stored securely. An accurate, complete and contemporaneous record of people's end of life care and treatment was not in place to show this was provided in a dignified way.

Staff were seen to be polite and respectful towards people when offering assistance. Staff spoken with knew people's individual preferences and personalities.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive. People and their relatives were not always involved and consulted with. People's assessments and care records did not include clear information to guide staff about how they wished to be cared for.

People were able to spend their time as they wished and people's visitors were made welcome. We saw activities were offered as part of people's daily routine. However not all the people were able or wanted to join the activities provided.

People had access to information about how to raise concerns. We were told and records showed that issues and concerns brought to the registered manager's attention had been addressed.

Is the service well-led?

Requires improvement

The service was not always well-led. The service had a manager who was registered with the Care Quality Commission (CQC). Staff told us that the manager was approachable and proactive in getting things done.

We saw systems were in place to monitor and review the service. However some checks were not effective in ensuring people were protected from the risks of unsafe or inappropriate care and support.

The registered manager had notified the CQC, as required by legislation, of any accidents or incidents, which occurred at the home. This information helps us to monitor the service ensuring appropriate and timely action has been taken to keep people safe.

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 21 and 22 July 2015 and was unannounced. The inspection team comprised of two adult social care inspectors, a specialist advisor 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.

During the inspection we visited the four units, spending time speaking with people who used the service, their visitors and staff. Throughout the two days we spoke with eight people who used the service, six visitors, four nurses, six care staff, the activity worker, a cook, the registered manager and the regional support manager. We also spoke with a member of the Nursing Home Service who was visiting the service at the time of our inspection. The Nursing Home Service, provided by the University of South Manchester, consisted of medical staff and nurse practitioners.

We looked at the environment and the standard of accommodation offered to people and during the mealtime period 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. We also looked at 14 people's care records, four staff recruitment files and training records as well as information about the management and conduct of the service.

Before the inspection, we had received a number of issues and concerns about the quality of care and support offered to people. We contacted the local authority commissioning team to seek their views about the service. We also considered information we held about the service, such as notifications. Following our inspection we contacted the Clinical Commissioning Group (CCG) to seek their views about the service and received feedback from the service lead for the Nursing Home Service.

The provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

During the inspection we asked people if they felt safe living at the home. One person told us, “Very much so". Another person said, “Yes, I’m very happy”. We also asked visitors if the home provided a safe environment for their relative. Four of the six visitors we spoke with were happy with care provided and felt their relative was safe. One visitor said, “I can’t speak for others but I am very happy. I’m made very welcome and they [staff] are very kind”. Two people felt there was room for improvement.

We asked staff how they kept people safe. One staff member said, “We do constant observations. There is always staff in the lounge, aware of people at risk of falls and those with behaviours that may challenge and the corridors are checked half hourly.” Another staff member said, “We make sure that the unit and the garden area are kept hazard free.” Other staff gave examples where people required two staff to assist them or where intervention techniques were needed where people displayed behaviour that challenged. From our observations and what we were told, staff were able to demonstrate their understanding of people’s needs and knew how to support them in meeting their individual needs safely.

We checked the systems for the receipt, storage, administration and disposal of medicines on two of the nursing units; Anson and Lancaster. The systems in place on both units for the storage, ordering, receiving and disposal of medicines overall were safe. We found however that the arrangements for the recording and administration of medicines were not as safe as they should have been.

On Lancaster Unit we found that medicines, including controlled drugs, were stored securely and only the qualified nurses had access to them. We checked the medicine administration records (MARs) of seven people who used the service. On three of the MARs we found that staff had failed to sign when a medicine had been given. To help protect the health and well-being of people who use the service the administration of doses of medicines must be recorded on the MAR. This is to ensure that staff are aware of the last time the dose was administered and to ensure they do not duplicate the doses.

The record of one person who was having a pain relief patch applied had, on two occasions, the wrong information documented. Although the documentation on the MAR was accurate, the patch site application record stated that the person was receiving a lower dose than they were actually given. Inaccurate record keeping placed people who used the service at risk of harm.

We saw that staff were recording the temperature of the medicine fridge at least daily. We saw however that staff regularly recorded that the maximum fridge temperature was higher than it should have been. No action had been taken to address this. Medicines may spoil and not work properly if they are kept at the wrong temperature.

On Anson Unit we found that medicines, including controlled drugs, were stored securely. We were told that only the qualified nurses and the unit manager had access to, and administered, the medicines. The unit manager is not a registered nurse and should not be giving out medicines, including controlled drugs, to people who are assessed as requiring nursing care, unless certain conditions, laid down by the Nursing and Midwifery Council (NMC), are complied with. **We recommend that the provider considers current NMC guidance in relation to the delegation of nursing care to others.**

We checked the MARs of four people who used the service. It was identified on one of the MAR’s that some medicines were to be given 'when required'. There was no information available to guide staff when they had to administer the medicines that had been prescribed in this way.

We were made aware from a discussion with a person who used the service that they were prescribed a pain relieving gel. There was no evidence on the MAR to show that it had been recently prescribed and therefore it had not been administered. We questioned the reason for this and were initially told by the nurse that it may have been discontinued. A check of the previous MAR showed that it had not been discontinued. This meant there was no evidence to show that the person had been receiving their medication as prescribed. On both Lancaster and Anson units we saw that several people were prescribed 'thickeners'. Thickeners' are added to drinks, and sometimes food, for people who have difficulty swallowing, and they may help prevent choking. Inspection of the MARs showed that the nurses were signing that they were giving the thickeners when they were not; the thickeners were being given out either by the care or ancillary staff. We saw that people were not given the correct consistency of fluids and staff spoken with were not always able to tell us the correct consistency required for each person. The care

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plans and other records were not accurate in relation to how much thickener needed to be added to the fluids to ensure the correct prescribed consistency. Failing to provide people with the correct prescribed consistency of fluid placed them at risk of choking.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. We found there was a breach of Regulation 12 (2) (g) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014

We saw the home had some emergency resuscitation equipment in place. We were shown the defibrillator that was kept on Anson Unit and whilst one of the nurses told us they had received training in the use of the equipment, they were not able to tell us if any other staff on the unit had received the training.

One of the care records we looked at showed the person was at very high risk of developing pressure ulcers. A discussion with the staff and a relative showed that this person's health had recently deteriorated and they had become extremely immobile. We saw however that the risk assessment in relation to pressure ulcers had not been reviewed for two months. We were told by the nurse on the unit that risk assessments were reviewed routinely on a monthly basis but more often when a person's care needs were changing.

The care records of two other people who used the service showed that despite being at very high risk of developing pressure ulcers their risk assessments had not been reviewed for two months.

The care records of one person showed that despite being at risk of falls, the risk assessment had not been reviewed for two months. Their care record showed they had sustained a fall since the last assessment review. The care record of another person showed that despite being at risk of falls, the risk assessment had also not been reviewed for two months. Their care record showed they had sustained 15 falls since the last assessment review. There was no evidence to show what action was to be taken to further reduce the risk of falls.

Risk assessments need to be reviewed regularly so that any change in a person's risk factor can be identified and the appropriate action taken where necessary.

Failing to regularly review risk assessments placed the health and welfare of people at risk of harm.

People's health and welfare were not protected because risks to their health and safety were not always identified. Risks that were identified were not regularly assessed. In addition the provider did not do all that was reasonably practical to mitigate the risks. We found there was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014.

During this inspection we found the home was clean and free from malodour. There were designated housekeeping staff for each of the units and a team of laundry staff. We saw infection prevention and control policies and procedures were in place. Staff were seen wearing protective clothing, such as; disposable gloves and aprons when carrying out personal care duties. Hand-wash sinks with liquid soap and paper towels were in place in the bedrooms, bathrooms and toilets. We also saw red and yellow bags, used for the management of soiled or clinical waste were also available. Staff spoken with told us they had received training in the control of substances hazardous to health (COSHH) and infection control. A review of training records confirmed what we had been told.

We looked at the laundry. This was spacious and well organised. We were told there were currently three laundry assistants. A further person was being appointed. Laundry staff felt this would help in managing the workload.

Whilst looking around the environment we found there were issues with the water supply on Shakleton and Halifax units. For example; on Shakleton unit there was no water supply to the hand basin in the staff toilet and three of the toilets on Halifax unit had either no hot water or only one tap was working. On the Lancaster unit we saw the shower chair was unclean and soiled, four toilet seats were chipped and one of the sluice rooms had been left unlocked. A cleaning trolley had been stored in the sluice, which contained cleaning products. Our findings were shared with the registered manager. We were told bathroom facilities were being improved as part of the refurbishment taking place. Following the inspection the registered manager advised us that new toilet seats had also been ordered.

Requires improvement

Is the service safe?

Prior to this inspection we had received information of concern from visitors to Ringway Mews about the care and support people received and that sufficient staffing was not provided at core times of the day to meet people's needs, particularly on Lancaster unit.

One the first day of our inspection we arrived at 7.00am. We had been told by a concerned visitor that people were left for periods of time without staff supervision as care staff were assisting other people to wash and dress. We spent time throughout the day observing how staff were deployed. We found on the Lancaster unit there were periods of time when people were unsupported. For example; on two occasions we saw one person, who was at risk of falls, attempt to stand and move without assistance. We discussed our findings with the senior nurse and registered manager. We were told by the registered manager that nursing staff had been instructed to spend their time in communal areas whilst completing paperwork so people could be assisted should this be needed. This was confirmed by one of the senior nurses we spoke with and seen when we visited both Anson and Halifax units. On the second day of our inspection we saw that staff were present throughout the day on the Lancaster unit. The registered manager reassured us that this would be reinforced again with the staff team.

We were told that staffing levels were kept under review due to the changing needs of people. The registered manager gave us an example where staffing levels had been altered on one of the units as it had been identified that additional support was needed at specific times of the day. Due to this an additional night time shift had been agreed to the staffing quota for this unit. We also saw that three people required one to one support due to their individual needs. We found that additional staffing arrangements were in place to provide this level of support.

We examined staff rotas, spoke with people, visitors and staff about the staffing levels. Rotas confirmed what we had been told about staffing arrangements on the units. People commented; "The staff are very helpful", "I just ring my buzzer if I need anything" and "I like the staff, they always help me". Two visitors said staff were "generally around" and "They [staff] are kept very busy".

Staff spoken with said that levels were maintained and that this had recently improved following the appointment of new staff. Staff commented; "We are fully staffed here, in an ideal world we could do with another carer as the unit is always very busy but we have enough time with people." Other comments included; "Yes there's enough staff, although can be hectic if sickness isn't covered, they try their best to cover and most staff will pick up extra shifts" and "We are fully staffed." We were told that the use of agency staff was kept to a minimum. One staff member said, "Sickness is covered mostly with our own staff if it is a carer, but we have to go to agency if it's a nurse." One unit manager said, "Yes we have enough staff; we have a hostess for the whole day" and "Staffing for the night shift is under discussion as we would like another carer".

We looked at four staff personnel files to check how the service recruited staff. We found that a safe system of recruitment was in place. The recruitment system was robust enough to help protect people from being cared for by unsuitable staff. The files showed the following; application forms that documented a full employment history, a medical questionnaire, a job description and at least two professional references. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Records showed that the registration of the nurses was checked regularly with the Nursing and Midwifery Council (NMC) to ensure they remained authorised to work as a registered nurse.

We saw that suitable arrangements were in place to help safeguard people from abuse. An examination of training records showed that staff had received training in the protection of adults. Policies and procedures to guide staff in safeguarding people from harm were also in place. We asked staff to tell us how they safeguarded people from harm. Staff spoken with confirmed they had completed training in safeguarding and behaviours that challenge and were able to demonstrate a good knowledge and understanding of their responsibilities. One staff member said, "I feel able to report unsafe practice."

During the inspection we were made aware of two incidents that occurred whereby people who used the service alleged they were spoken to in an abusive way by a member of staff. We were told that the incidents were reported to the nurses on the unit, one by the person's relative and the second by a carer. We spoke to the registered manager who informed us they were unaware of

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the incident and that no incident report had been completed. **We recommend that, to help ensure the health and well-being of people is protected, the provider looks for a best practice solution to ensure that all staff are reminded of their responsibility to report to management when an allegation of abuse has been made to them.** The registered manager advised us following the inspection that these matters had been referred to the local authority in line with the safeguarding procedures.

Staff spoken with were able to demonstrate their understanding of the homes whistle blowing procedure, 'Speak Up'. They knew they could raise concerns in confidence with the registered manager and contact people outside the service if they felt their concerns would not be listened to. One staff member gave us an example where they had used the procedure.

We looked at the documents that showed the equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This helps to ensure the safety and well-being of everybody living, working and visiting the home. We saw that adequate equipment and adaptations were available to promote people's safety, independence and comfort. We observed staff on two of the units assisting people to mobilise using a hoist. Staff were seen to offer explanations and reassurance to people.

We looked at what systems were in place in the event of an emergency occurring within the home, for example a fire. The records we looked at showed that a fire risk assessment had been undertaken in 2014 and some requirements and recommendations for action had been made. Immediately following the inspection the registered manager provided us with further information to show that the identified action had been addressed. We saw records on each of the unit's to show that regular fire safety checks were completed and personal emergency evacuation plans (PEEPS) were in place to assist the emergency services in the event of an emergency arising to help keep people safe.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The registered manager was aware of their responsibilities in making application to the supervisory body (local authority) where people assessed as lacking the mental capacity were potentially being deprived of their liberty. We were told 60 applications had been submitted however only three people currently had a DoLS authorisation in place. The registered manager had developed a matrix so that the authorisation and renewal of DoLS could be monitored.

We saw policies and procedures were available to guide staff in areas of protection, including the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). An examination of training records showed that all but one staff member had completed the training provided. Staff spoken with on the Halifax unit, which supports people living with dementia and complex needs, were able to demonstrate their knowledge of the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) and were aware applications been made for people on the unit. This training should help staff understand that assessments should be undertaken, where necessary, to determine if people have capacity to make informed decisions about their care and support. It should also help staff understand that if a person is deprived of their liberty, they will need special protection to make sure that they are looked after properly and are kept safe.

We found some care files contained a mental capacity assessment, completed by staff, which identified if people had the ability to manage activities of daily living themselves, such as getting dressed, taking a shower or walking around. This form helped identify which people were able to advocate for themselves and those who needed help in making decisions.

We looked at records where decisions had been made in a person's 'best interest'. People had not always been consulted with or consented, where possible, to specific decisions about how they were to be cared for. For example, one person had bed rails in place. There was no evidence of the person consenting to this, or evidence that a mental capacity assessment had been completed and best interest decision having been made where the person lacked capacity to make it themselves. We discussed this with the registered manager who said that due to changes in the care planning documentation some of the records had changed. However we were advised this would be implemented.

Another person records showed the person used a Kirton type chair. This type of chair restricts people's movement. There was no information to show why this chair was being used or how the decision had been made in the person's best interest. Records should clearly show how people are involved in planning their care and support. Where people are not able to make these decisions for themselves, records should show how decisions have been made in their best interests so that people's rights are protected. However on a third file we saw detailed information to show that a best interest meeting had been held with relevant parties about the person's future plans.

We recommend that, to help ensure people's rights are protected, the provider consistently applies the principles of the Mental Capacity Act 2005 are considered so that valid consent is sought, acting in accordance with people's wishes.

We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Ringway Mews. We spoke with four nurses, six care staff and examined training records. Training records showed that staff were offered on-going training opportunities. Courses included areas such as; moving and handling, fire safety, safeguarding people from abuse, care for a person with dementia, Mental Capacity Act 2005 and deprivation of liberty safeguards, pressure care and nutrition and hydration. The registered manager also provided evidence to show that nursing staff received updates in clinical practice in areas such as; catheter and stoma care, bloods and cannulas, use of syringe drivers, Six Steps – end of life care, pressure care prevention and wound care.

Staff spoken with confirmed they had received on-going training. One staff member from the Halifax unit, which supports people living with dementia and complex needs said they had completed training in 'behaviours that challenge', and "Knowing the resident is important". Other staff told us; "They constantly have training on", "I do all of the training provided" and "We have courses on all the time".

Requires improvement

Is the service effective?

Records looked at also showed systems were in place to ensure staff received regular supervision and appraisal. We were told by the senior nurse on the Lancaster unit that these were not up to date due to the unit manager vacancy. They said they had requested supervision training so that they could facilitate individual meetings with staff. The registered manager was aware of this and had recently completed supervision meetings with the night staff on the unit. Other staff we spoke with said they had an opportunity to discuss their work with their unit manager and felt supported in their work. Staff told us, "There's good team work, we work together under pressure and look after people well" and "The teamwork is good on the units".

We were told that clinical supervisions were completed with the clinical services manager to ensure nursing staff were up to date with their clinical practice. The registered manager showed us a matrix, which helped her to monitor that regular meetings were held with all members of the team. We also saw that verbal and written handover meetings were undertaken on each shift to help ensure that any change in a person's condition and subsequent alterations to their care plan was properly communicated and understood.

We looked at how people were supported in meeting their nutritional needs. One the first day of our inspection we arrived at 7.00am. We were told that breakfast was served from the main kitchen from 8.00am however provisions were also available in the kitchenettes on each of the units. We saw that people who were dressed and sat in the lounge had been provided with hot and cold drinks and toast, until breakfast was served.

We asked people for their views about the food served at the home. People told us they had plenty to drink and had a choice about when they wanted to eat. On each of the units we visited we found that people were provided with plenty of hot and cold drinks and snacks throughout the day.

We looked at the kitchen and food storage areas and saw good stocks of food were available. Staff told us that food was always available out of hours. A discussion with the cook showed they were knowledgeable about any special diets that people needed and were aware of how to fortify foods to improve a person's nutrition.

We observed lunch being served. Each unit has a hostess (catering assistant) who provides support where needed. The meals looked nutritious and the portions were ample. People who needed assistance with eating their meal were supported in a discreet and sensitive manner. We did note, particularly on the Lancaster unit that most people did not eat their meal in the dining area, preferring to remain in their bedroom or remained seated in their lounge chair.

During the inspection visit we were made aware that the service was supported with health care by the Nursing Home Team. The Nursing Home team, provided by the University of South Manchester, consisted of medical staff and nurse practitioners. We were told that, during weekday working hours, the team responded to requests for consultations and reviewed people's care and prescribed medication. Staff told us that the Nursing Home Team also referred people to other health care providers such as dieticians and speech and language therapists. They also made urgent and non-urgent referrals to hospitals.

During the inspection we spoke with a nurse practitioner who was visiting people being cared for on Anson Unit. The nurse spoke positively of the care provided by the staff on the unit. We were told the staff were always helpful, quick to alert the team when people were ill and complied with any instructions or advice given.

The care records we looked at also showed that people had access to other health care professionals, such as opticians, dentists, a chiropodist and the interventions team who support people living with dementia.

Accommodation comprised of four identical single storey buildings. Units were kept secure with entry via an electronic keypad door. All bedrooms were single occupancy, with several bath and shower rooms and separate toilets throughout. Corridors were sufficiently wide for people who used wheelchairs and aids and adaptations, such as handrails, were provided throughout to promote people's mobility and independence.

We were told that extensive refurbishment work was planned throughout the home. During our inspection we saw that work had commenced on the Shakleton unit. This was well managed with no environmental risk to people.

Requires improvement

Is the service caring?

Our findings

People described staff as “nice and kind”. One person told us, “I like my carers”. Another person said, “Some staff are ok”, whilst someone who had recently moved into the home described staff as “excellent." This person’s relative also said staff were "brilliant". During the inspection we saw a number of visitors either sitting with people in their own rooms or in the lounge areas. One visitor told us, “I can visit any time and I can see my [relative] privately”. Another visitor said, “I come all the time, I’m always made welcome and the staff are very friendly”.

We observed how staff interacted and supported people on each of the units. Staff were seen to be patient, offering reassurance to people who were unsettled or anxious or needed assistance with their care.

We were made aware that one person who used the service was very ill and at the end of their life. We visited this person in their bedroom to see how they were being cared for. They were sleeping and looked comfortable and pain free. A special type of bed that helps staff position people more easily was in use, and a specialised pressure relieving mattress was in place. This was to help prevent pressure sores and promote comfort.

Their relative told us, “They are looking after [relative] really well and also looking after us. I have no complaints about that at all, everyone is being very kind” and “Nothing has been too much trouble”.

Nursing staff told us that the person was taking sips of fluids only and because of this was receiving ‘mouth care’; the equipment in place for mouth care however was not clean. We asked if the care being delivered, such as fluid intake, mouth care and positional changes was being recorded. We were told that it was not as it was not the policy of the company to record the care delivery on care charts. Staff told us that information about the overall care was recorded in a daily report. To ensure the health, welfare and safety of a person is protected, it is essential that an accurate complete record of the care and treatment provided to a person who uses the service is kept. Failing to keep such a record could result in the care not being delivered when it is needed.

We found this was a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An accurate, complete and contemporaneous record of the care and treatment provided was not in place.

We discussed this with the registered manager who stated this was not company policy and that the staff must have misunderstood a previous directive from the company in relation to the use of some care documentation that was no longer to be used.

We found that confidentiality of information was not protected. On both Anson Unit and Lancaster Unit we found that information about people’s care needs was displayed on the notice boards in the staff offices. Visitors were able to access the offices and see the information displayed. Additional records, such as personal care charts, observational records and food and fluid monitoring sheets were also seen in the dining areas on three of the units we visited. Whilst this information was easily accessible to staff, information about people was not kept confidential from visitors.

This was a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Confidential information in respect of people’s care was not securely maintained.

We looked at how people were supported to maintain their autonomy and independence. One staff member from the Halifax unit told us, “99% of the residents are unable to make their own decisions, but we offer them choices.” A second staff member said, “We offer choice, we show people two meals so they can make a choice, we encourage them to go to the hairdressers, go on trips and we try to do activities in groups or individually.” Another staff member said, “We offer choice, I find that hand and body language helps residents to understand sometimes and show the residents pictures.” Further comments included; “We maintain dignity, offer choice, show patience, and show residents what we mean, for example; taking towels and shampoo to residents when a shower or bath is being offered”.

We looked at how staff cared for people in a respectful and dignified manner. We found staff knew people’s individual preferences and personalities and treated people with kindness. Interactions between people and staff were pleasant and friendly. We saw people ask for support when

Requires improvement

Is the service caring?

needed and staff responded appropriately. Those staff we spoke with were able to tell us how they would promote people's privacy and dignity when offering care and support.

Following the inspection a member of the Nursing Home Service told us, "The staff at the home are caring and show empathy to the people in their care. The residents are treated with dignity and respect. The care staff on Shackleton unit are outstanding in their approach and know everything about people – true holistic care."

Requires improvement

Is the service responsive?

Our findings

We looked at the care plans for 14 people on Anson, Lancaster and Halifax Units. We saw that a pre-admission document was completed prior to admission. It was then identified the level of support people required. For example; grade one meant people were able to manage their own care and had some independence; whilst with grade four meant people needed a higher level of physical and emotional support from staff. Assessments reviewed on the Lancaster unit were incomplete. For example, on one assessment there was no information regarding the person well-being, risk of falls, skin integrity, weight and routines. Therefore it was unclear how accurately the level of need could be determined if relevant information was not available.

We saw little evidence to show that people who used the service, or their relatives, had been involved in the development of their care plans. However people's relatives were contacted and kept informed about any changes in their family members health and well-being. One staff member told us, "The families are very supportive of their relatives and us [staff]".

We found care plans did not contain enough information to show how people were to be supported and cared for. The care plan for one person made no reference to the fact they were receiving 'end of life care'. There was no information about the care of their mouth, pressure area care or the pain relief required. Despite this person previously having repeated urine infections there was no information about the care of their urinary catheter.

We saw that one person had recently sustained an injury following a fall. There was no information in their care plan to guide staff on the care that was required for their injury. On a third file we found a photocopied 'Do Not Attempt Resuscitation' (DNAR). Original documentation would need to be provided to ensure people's wishes are respected.

The care plans of two people who were fed artificially with a food supplement by a tube into their stomach, did not contain enough information to guide staff on some aspects of the care that they required. We were told both people received 'mouth care' but there was no information in their care plans and no mouth care equipment in their rooms. There was no information in one of the care records to show how much food supplement the person was to receive. The other record showed that the person had not received any food supplement for nine days. Staff told us the records were not accurate as the person had been receiving their food supplement.

The care plan of a person who had a specific medical condition did not contain any information to enable staff to identify when the person was becoming ill and needed emergency treatment. There was also no information about the specific medication that was available to treat the emergency should it arise. To reduce the risk of people receiving unsafe or inappropriate care, information must be in place to guide all staff in the care and treatment required in an emergency.

We looked at 14 care charts in relation to the care delivered to people on Anson Unit and 10 on the Lancaster unit. We found forms were poor photocopies and were not easy to follow. On Anson unit nothing had been recorded on the charts for several days. When asked, staff on the unit told us that the charts were not up to date and that people had received the care required.

We saw that food and fluid charts were also completed for people assessed at nutritional risk. Records seen on the Lancaster unit were incomplete and did not detail the time or amount of food and drink provided. Some entries just made reference to 'pureed diet'. It was unclear what this included. Without clear and accurate information there was no assurance people were receiving adequate nutrition and hydration to meet their needs.

We found care records were not accurate and did not reflect the care and treatment that was required or provided. This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at Ringway Mews have varying needs and abilities. We were told that some people were able to make their own decisions about how they spent their day, whilst other people had some level of confusion or lived with a dementia. We saw some people chose to spend their time with others in the lounges or dining room, whilst others preferred the privacy of their own room.

We looked to see what activities were provided for people. Not all the people living at Ringway Mews were able or wanted to join the activities provided. Designated activity staff were provided to support each of the units. We were told that regular group and one to one activities were

Requires improvement

Is the service responsive?

provided. However on Lancaster and Halifax units we saw no structured or meaningful activities being provided during the inspection, other than a brief game of bingo with a small group of people. Staff spoken with on the Halifax unit told us "We have 20 hours a week; activities are usually in the mornings as the unit becomes very noisy and unsettled in the afternoons." We were told the activity worker on Lancaster unit was not in work therefore a worker from another unit was working across both units.

We saw music being played through the television. One person told us they had newspapers delivered, which enabled them to follow the football news. Three people we spoke with said they preferred the privacy of their own room, relaxing and watching television. A further person showed us their art work, which they enjoyed doing. There was a programme of trips or events posted on the notice boards on each unit. Each unit was allocated five places each. These included two trips to Blackpool in July and October, a visit to Coronation Street and a summer fair. People spoken with said these were well attended.

A member of the nursing home service told us, "The activities/trips for the residents have improved and I know this is an area identified to continue. The music therapy on Halifax has been an excellent intervention."

We looked at what systems were in place for the reporting and responding to people's concerns. We discussed with the registered manager issues which had been raised with us prior to the inspection. Whilst the registered manager was aware of some of the concerns, other matters had not been brought to her attention. The registered manager showed us their complaints record. We saw that seven issues had been brought to her attention. Records included the action taken and relevant correspondence. The registered manager told us they had an 'open door policy', should anyone wish to raise anything with her and worked closely with people, their families and commissioning team, where necessary to resolve any matters raised. We saw a number of compliment cards had also been received about the quality of care offered to people.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place who took responsibility for the overall management of the service. The registered manager was supported in her role by a regional manager, clinical services manager (CSM) and unit managers.

Most of the staff we spoken with felt supported in their role. We were told the registered manager "Deals with any problems straight away", "Morale in the home is good" and "Home Manager is supportive and approachable". A senior member of staff told us "I have 100% confidence in the manager, she is proactive, her door is always open and she's has been very supportive towards me".

Following our inspection a member of the Nursing Home Service told us, "In my opinion the service is well led. The manager is motivated, has a visible presence and is up to date with the service. I am always able to meet and speak with her and she is very open to improvements and recommendations to improve patient care". Adding; "The response time and actions of the staff is efficient and strives to be individualized and holistic at all times. Any changes no matter how small are usually promptly communicated to one of us".

We looked at how the registered manager and clinical service manager were monitoring the quality of the service provided. We saw audits were completed in areas such as; medication, mealtime experiences, respect and dignity and safeguarding. Other areas of the service were monitored such as staff training and development, health and safety and the environment. A daily 'walk around' was completed and provided an overview of the needs of people living at the home, such as hospital admissions, complaints and concerns, pressure care and weights. The registered manager also carried out a night visit on the 3 June 2015. This involved a check of all units and explored areas such as medication, the environment, records and routines.

Whilst routines checks were being completed, shorfalls identified during the inspection had not been identified. We were informed that the medication and care planning system had recently been introduced. It was acknowledged by the management team that staff needed further training to develop their understanding on how to complete the documentation so that records were accurate and complete.

We were told a quality matrix 'circle' was completed and forwarded to the organisations quality monitoring team. This included information about deprivation of liberty safeguards, pressure sore, falls etc. We were told this helped to target areas where improvement where needed. The registered manager said that a recent issue had been identified in relation to falls on one particular unit. This had resulted in a review taking place and an agreement to increasing staffing so that sufficient levels of support where provided.

We found systems to assess and monitor the quality of the service were not sufficiently robust enough to identify the areas of concern found during the inspection. People need to feel confident that the home is being effectively monitored and managed so that they are protected against the risk of unsafe or inappropriate care and support. This meant there was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw opportunities were provided for people, their visitors and staff to comment on the service and share ideas. The manager strived to involve and inform people as much as possible. Weekly staff updates and newsletters were provided. There was also a 'visual management board' displayed for staff which informed them of progress within the home as well as any events and any improvements planned. We also saw records to show that meetings were held with the laundry team, heads of departments, care staff and registered nurse's meetings as well as occasional resident and relative meetings. Bupa also provided the 'Global People Survey'. This is an annual feedback survey which provides staff with the opportunity to have their say about the service.

Prior to our inspection we reviewed our records and saw that events such as accidents or incidents, which CQC should be made aware of, had been notified to us. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

Prior to and following our inspection we contacted the local authority commissioning team, Nursing Home Service and NHS safeguarding team for their views about the service. We were not made aware of any issues or concerns about the standard of care and support provided for people living at Ringway Mews.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's health and welfare were not protected because risks to their health and safety were not always identified. Risks that were identified were not regularly assessed. In addition the provider did not do all that was reasonably practical to mitigate the risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance An accurate, complete and contemporaneous record of the care and treatment provided was not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Confidential information in respect of people's care was not securely maintained.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found care records were not accurate and did not reflect the care and treatment that was required or provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to assess and monitor the quality of the service were not sufficiently robust enough to identify and manage areas of improvement so that people were protected against the risk of unsafe or inappropriate care and support.