HC-One Oval Limited

# Ringway Mews Care Home

## Inspection report

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Date of inspection visit:
20 August 2018
21 August 2018
22 August 2018

Date of publication:
18 October 2018

## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on the 20, 21 and 22 August 2018 and the first day was unannounced. This was the first inspection of Ringway Mews Care Home since it had been bought by HC-One in January 2018. The registered and deputy managers, as well as the staff teams remained the same. Changes had been made at the provider's area manager level and above. The home, under its previous ownership (Bupa), was inspected in June 2017. References throughout this
report to 'the last inspection' concern this inspection.

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

Ringway Mews accommodates 150 people across five separate units, each of which have separate adapted facilities. Three units are general nursing (Lancaster, Halifax and Wellington), one specialises in providing nursing care and support for people living with dementia (Halifax) and one is a residential unit for people living with dementia (Shackleton). Wellington unit also had six 'discharge to assess' beds contracted with the local authority. These were used where people were able to be discharged form hospital but required further assessment of their care and support needs. People were meant to stay on Wellington unit for a period of six weeks whilst being assessed, however some people had lived in Wellington unit for several months whilst a suitable care placement was found for them by their social worker.

Each unit has a lounge, dining area, a conservatory, and a kitchenette. All bedrooms are single with no ensuite facilities. Accessible toilets and bathrooms are located near to bedrooms and living rooms.

There was a registered manager at Ringway Mews. 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.

At our last inspection in June 2017 we found three breaches in regulations because care plans did not always reflect people's current needs, medicines were not safely managed, sluice rooms and cleaning cupboards were not locked and issues identified in internal audits had not been addressed during the registered manager's extended leave.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, responsive and well led to at least good.

At this inspection we found that the home had changed its care files, paperwork and management tools to the HC-One systems. The care plans reflected people's assessed needs and were evaluated each month. Risks had been identified and steps taken to reduce the likelihood of the identified risk occurring. Where

people might have behaviour that challenges, care plans gave details of potential triggers and behaviours.

People in the 'discharge to assess' beds had shorter 7 day care plans to briefly identify their needs. It was not evidenced that these had been evaluated. Two people had lived on Wellington unit in the discharge to assess beds for up to six months but their care plans were still very brief. The HC-One intermediate care plan was to be introduced which would enable more information to be recorded about people's identified needs.

We found continued breaches in regulation because medicines were not safely managed and actions had not been taken when the internal auditing systems had identified there was an issue with medicines re-ordering.

You can see what action we told the provider to take at the back of the full version of the report.

Medicines were found to be out of stock on the first day of a new medicines cycle on one unit. Medicines audits showed this had also occurred on two different units since May 2018. Robust action had not been taken to address the issues with the re-ordering system.

Creams were not always safely managed in the home. Care staff applied topical creams but the nurses signed the medicines administration records (MARs). On one occasion the MARs had been signed as being applied when it was not in the cream basket. Cream labels had become unreadable due to use, increasing the risk of cross infection if two people were prescribed the same cream.

The amount of thickener to be added to people's fluids on one unit had not been accurately transcribed from the speech and language team guidance, resulting in three peoples drinks not being thick enough, increasing the risk of choking.

Action was taken during our inspection to address these issues.

The home was clean and well maintained; however, the secure gardens for each unit had become overgrown. This had been noted in the August area manager visit and an advert placed to recruit a gardener. The registered manager's audit of the general appearance of the home on 17 August 2018 had not identified these areas as an issue.

A new HC-One quality auditing system had been introduced which covered a wide range of areas within the home. Action plans were in place following these audits and an overarching home improvement plan had been written.

All falls, incidents, weights and pressure area sores were recorded, logged on to the 'Datix' computer system and reviewed each month. A falls team had been established to review all falls, look for patterns and ensure steps had been taken to reduce the risk of a re-occurrence.

People living at Ringway Mews felt safe and thought there were sufficient staff on duty to meet their needs. Relatives and staff gave mixed feedback about the staffing levels, with some saying they thought there were enough staff and others saying additional staff were needed. The registered manager used a dependency tool which assessed each person's needs for nursing support and care support. Our observations showed that people did not have to wait too long for support and there was always one staff member present in the communal lounge areas of each unit.

A safe recruitment process was in place. Staff had completed an induction programme when they joined

Ringway Mews. HC-One e-learning was being introduced to the home and staff had started to complete these courses. Annual refresher training in manual handling and medicines administration was in place. Clinical training was organised for the nurses; however, one nurse had been employed for six months and had not completed catheter training.

Staff had regular supervisions and staff meetings for each unit were held. Both were open discussions with staff saying they were able to raise ideas or concerns during these meetings. Staff said they enjoyed working at the service and felt well supported by their unit managers and the deputy and registered managers.

Staff we spoke with knew people and their support needs. Staff said they received information about people's support needs before they moved to the care home.

A FACE capacity assessment tool was used and applications made for a Deprivation of Liberty Safeguard (DoLS) if a person lacked capacity to consent to their care and treatment. The FACE assessments were decision specific; however, on some units these had been photocopied and people's names added. The home had identified that the FACE assessments were not person centred and set an action to review these.

People's health needs were being met by the service. The nursing home team (NHT) visited the four nursing units twice per week. NHT feedback was generally positive, but with variations between the units and individual nurses in the timely request for a re-active NHT visit when someone was unwell.

People's nutritional needs were met. Culturally appropriate food was cooked where required. People's dietary requirements were known and catered for. People told us they enjoyed the food and had a choice of meals.

People living in the care home had advanced care plans in place detailing their wishes in the event of their death.

A planned activity programme was in place. This concentrated on the units for people living with dementia as there were vacancies within the activity co-ordinator team. Activity co-ordinators had been recruited and were completing their pre-employment checks at the time of our inspection.

Residents and relatives meeting were held and a survey had been completed with the majority of responses being positive. Where comments had been raised in the survey the registered manager was due to report on these at the next planned residents and relatives meeting in August 2018.

Ringway Mews had a complaints policy in place. We saw all issues raised had been looked into and responses provided to address the issues raised.

## 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.

Medicines were not safely managed. Medicines had not been available on the first day of the medicines cycle on three occasions since May 2018. Creams had been signed as being applied when not available and their labels were illegible increasing the risk of cross infection.

Risk assessments and guidance to mitigate the risks were in place.

Staff were safely recruited. Observations showed there were sufficient staff on duty to meet people's needs; however feedback form relatives and staff was mixed, with some saying there were enough staff and others saying more were needed.

### Is the service effective?

**Good**

The service was effective.

Staff received the support and training to undertake their role.

Decision specific capacity assessments were in place. The home had identified these needed to be more person centred and we found some had been photocopied from one person to another.

People's health and nutritional needs were being met.

### Is the service caring?

**Good**

The service was caring.

People and their relatives said the staff were kind and caring. Staff knew people's likes, dislikes and needs.

Staff knew how to maintain people's dignity and privacy when providing personal care and prompted people to complete tasks independently.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans reflected people's needs and were regularly evaluated.

Care plans for the 'discharge to assess' beds were brief and there was no evidence they had been reviewed. However; two people had lived on the unit for up to six months.

A reduced programme of activities was in place due to vacancies in the activity co-ordinator team. New staff had been recruited and were completing their pre-employment checks.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

A range of HC-One quality assurance audits had been introduced. A home improvement plan was in place.

Issues with the medicines not being available on the first day of the medicines cycle had been noted on two occasions. However, action was not taken to address this until our inspection.

Staff said they enjoyed working at the service and felt the management team were very supportive and approachable.

Feedback was obtained from people and their relatives through meetings and surveys. Issues identified were to be discussed at the next planned residents and relatives meeting.

# Ringway Mews Care 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 20, 21 and 22 August, the first day was unannounced. On the first day the inspection team consisted of two inspectors, one assistant inspector, a pharmacist inspector and two experts by experiences. 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 experts had experience of services for older people and people living with dementia. One inspector and one assistant inspector returned for the second day of the inspection and one inspector for the third day.

Before our inspection the provider completed a provider information return (PIR). The PIR 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 reviewed the information we held about the service. We looked at the statutory notifications the home had sent us. A statutory notification is information about important events, which the provider is required to send to us by law.

We contacted the local authority safeguarding and commissioning teams. They did not raise any concerns about Ringway Mews. We contacted the Nursing Home Team before and after our inspection. Their feedback is contained within this report. The Nursing Home Team supports people living in nursing homes to access health care and reduce hospital admissions. We also contacted Manchester Healthwatch who said they did not have any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 observed people's mealtime experience and interaction between people using the service and staff throughout the inspection.

During the inspection we spoke with 22 people who used the service, 14 relatives, 15 members of care staff, nine registered nurses, two visiting health professionals, two activities co-ordinators, four hostesses, the registered manger, deputy manager and the HC-One area and quality directors.

We looked at records relating to the management of the service such as the staffing rotas, policies, incident and accident records, five staff recruitment files and training records, 18 care files, meeting minutes and auditing systems.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection we found a breach in Regulation 12 as there were gaps in the cream recording charts, a medicines administration record (MAR) had been signed before administering a medicine and a missing tablet had not been reported as per the homes procedures.

At this inspection we looked at how medicines were managed and found variations across the five units. On Wellington and Anson unit we saw that people did not always have an adequate supply of their medicines. We looked at medicines for 10 people on Wellington Unit and found eight of them did not have one or more of their medicines for periods of between one and four days because they were out of stock. One person's barrier spray was out of stock for 12 days and was still out of stock on the first day of our inspection. If medicines and creams are not available to administer, people's health is put at risk of harm.

One of the out of stock medicines was requested and received on the first day of our inspection and another was in stock but had not been carried forward to the new MAR, so it was not recorded as being available.

We discussed this with the nurse on duty, registered manager and quality director. Following the inspection, we also spoke with the Nursing Home Team (NHT). We were told the medicines re-ordering system had recently been changed. Re-order requests were sent to the NHT, these were checked and sent to the GP for signing. The signed prescriptions were forwarded to the pharmacist and a list of any discrepancies between the requests and prescriptions sent to the home. The list was checked by the home and any medicines required from the missing medicines list followed up by the nurses on the units. When the medicines were delivered they were checked in by the home. This system had been phased in across the home and this was the second month Wellington unit had used this system.

We were told that if the medicines were delivered late or there was an agency nurse on duty they were not checked in at the unit until the weekend before they were required. This meant that any missing medicines could not be chased up before they were needed on the first day of the medicines cycle, resulting in out of stock medicines. The NHT told us that there were variations across the units with the re-ordering of medicines and that, "This is not a new problem as they (the home) aren't always asking for everything that's needed." We looked at monthly medicines audits completed by the deputy manager for each unit since May 2018. On two occasions not all the medicines required were in stock on two different units at the start of the medicines cycle.

The people supported in the 'discharge to assess' beds on Wellington unit were all registered with one GP practice as per the contract with Manchester City Council. However, we were told that this could delay the GP signing any prescriptions as there was only one GP at the practice who did this. We discussed the need for an alternative GP to be able to sign prescriptions for the 'discharge to assess' beds to ensure that they could be obtained in a timely manner.

Following the inspection, a full audit of medicines was completed by the home and any interim prescription requests were submitted. A new medication ordering and receipt report was being introduced to monitor

the ordering process and record the action taken if a medicine was out of stock. Additional checks had also been introduced to ensure oversight of medicines from peers after each medicine round and the registered and deputy managers during their twice daily walk rounds.

All staff who administered medicines were having a supervision with the deputy manager to discuss the findings form our inspection and ensure the actions required were known and understood. Support had also been requested from the provider's medicines management lead to review the systems in place and liaise with the pharmacist.

Creams were not always safely managed in the home. Topical (non-medicated) creams were kept in a basket in the medicines room on each unit. The basket was given to the care staff and they applied the creams before returning the basket to the nurse or senior carer.

The care staff did not make a record of the creams they applied. The care staff told the nurses which creams had been applied and the nurse signed the MARs to state this had been done. However, the nurses did not observe creams being applied. On one unit we saw the care staff return the creams to the nurses in the medicines room but they did not discuss who they had applied creams to. Best practice guidelines state that the member of staff applying the cream should record that they have done so.

The care staff confirmed they did not have any written information to tell them where to apply each persons' creams. They did not have a list of the current creams people were prescribed. This information was held in each person's medicines information kept in the medicines room. The care staff told us they just remembered the information. For one person we saw cream had been signed as applied but there were none in the basket for them. We also saw that some of the labels on creams in the baskets were unreadable as the labels had smudged when being used. More than one person was prescribed the same barrier cream which meant there was an increased possibility of cross infection as the same barrier cream could be used for more than one person. During our inspection all creams were checked and those where the label was unreadable re-ordered.

Some people needed their fluids thickened to reduce the risk of choking and were prescribed a thickener to be added to their drinks. Staff making drinks had information to refer to, to ensure they were made to the correct thickness. We saw that staff made a record of how many scoops of thickener they used in each person's drink.

These records showed that on Halifax unit three people's drinks had not been made to the consistency specified by the speech and language team (SALT). The drinks were not made thick enough which placed people at a higher risk of choking. We discussed this with the registered manager on the first day of our inspection. They completed a supervision with all hostesses across the home to ensure they were aware of the correct number of scoops of thickener prescribed for each person. They told us the number of scoops required had been incorrectly transcribed from the SALT guidelines to the HC-One information sheet. This meant that all people prescribed thickeners should receive their drinks at the consistency prescribed.

Some medicines must be administered 30 minutes before eating. However, we saw some units giving these medicines at the same time as the other medicines that were given with or after food. There was no formal mechanism in place to ensure these medicines were administered before eating. Following our inspection, we were sent a form that detailed the time critical medicines and when they were administered.

The out of stock medicines, management of creams, incorrect consistency of drinks on Halifax and time critical medicines not being administered as per the prescribing instructions was a continuing breach of

Regulation 12 with regard to 2(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff who administered medicines had received medicines training. Annual observations were made of staff administering medicines to check they were competent to do so. If a medicines error was made additional supervision and observations were conducted. This meant the nurses and senior care staff who administered medicines had the training and support to complete this safely.

Medicines classed as controlled drugs were appropriately stored and recorded. A stock check of the controlled drugs was completed every week. This minimised the risk of errors or misuse.

We saw where people were administered their medicines covertly, for example the medicine was added to food or drink without their knowledge, mental capacity assessments were undertaken along with a best interest meeting to ensure the person was receiving them in their best interests.

At our last inspection we found a further breach of regulation 12 as the doors for the sluice rooms and store cupboards containing cleaning chemicals were left unlocked and a sluice machine on one unit had not been repaired in a timely manner. At this inspection we found the sluice rooms were locked on four of the units. On Anson unit the lock on one sluice door did not always engage, meaning the door could be pushed open. The unit manager reported this to maintenance for repair on the first day of our inspection and the registered manager confirmed this had been completed. Store cupboards for cleaning materials were locked.

All the people we spoke with said they felt safe living at Ringway Mews. One person said, "Safe yes, I eat better and sleep better now" and another told us, "I've always felt safe here."

Relatives we spoke with also thought their relatives were safe at the home saying, "[Name] is safe here. I would not take her anywhere else", "Good staff, always a nurse around" and "I feel 'at peace' when I leave that [name] is safe."

Staff we spoke with were aware of the safeguarding procedures at the home. They understood how to report any safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the management team and were confident they would deal with any issues promptly and appropriately. Following a safeguarding incident reflective accounts were written and discussed with the unit managers so that any lessons from the incident could be shared across the home.

Risks to people's health and wellbeing were identified and guidance written to reduce and manage the identified risks. These included the risk of falls, the use of sensor mats and bed rails, choking, skin integrity and malnutrition.

We viewed eight care plans where people might have behaviour that challenges. Clear details of the potential behaviours and possible triggers for the behaviour was recorded in seven of these. One care plan stated the person could become agitated if they were frustrated or their environment was too noisy. Guidelines on how staff would recognise when the person was becoming frustrated and how they could reduce their agitation had not been written. The staff we spoke with knew the triggers for the person's anxiety and how they would support them. Guidelines had been written by the second day of our inspection.

All incidents and accidents were recorded and reviewed by the management team. Antecedent, Behaviour and Consequence (ABC) forms were completed to monitor any incidents involving challenging behaviour. A

falls team had been set up to monitor and review all falls across all units to look for any patterns and ensure steps had been taken where possible to reduce the likelihood of the person having another fall. For example, we saw sensor mats were used to alert staff if a person was getting out of bed and may need support and the use of bed rails was assessed and used where safe to do so to prevent people falling out of bed. Where applicable referrals had been made to the NHT or old age psychiatry for further assessment of the person's needs. 1:1 support had been commissioned following a review of one person's needs which we were told had reduced the number of incidents they had with other people living in the unit.

People told us they thought there were sufficient staff on duty to assist and support them. One person said, "I would say that there are enough staff to give the care you need when you want it" and others told us, "Staff deal with requests within minutes" and "The staff check on you regularly to make sure you're all right."

Feedback from relatives was more mixed, with some relatives saying they did not think there were enough staff on duty. One relative said, "They can be short of staff, mostly at weekends."

Staff views were also mixed about the number of staff on duty, with staff working in the units supporting people living with dementia stating additional staff were required due to people's support needs and behaviours. Nurses we spoke with on some units felt there should be two nurses on duty throughout the day instead of one nurse after 2pm as they had to complete care plan evaluations, deal with new admissions and do assessments for new admissions. One member of staff said, "We don't have time to stop and chat to people, we try, but we can't."

The registered manager showed us the dependency tool used by the home to calculate the number of staff required for each unit. People's dependency level was reviewed each month and the number of hours of nursing and care staff time they needed assessed. Where this changed the staffing levels were also altered as required. Rotas showed there were some days where there were two nurses on duty all day and we were told that one of these would have 'protected time' to complete their paperwork. Nurses we spoke with confirmed this was the case.

Our observations showed that the staff team ensured there was always one staff member in the lounge area, staff responded to people's call bells in a timely manner and that whilst they were busy at key times of the day, were able to meet people's assessed needs. All units had a hostess, with Halifax having two in the morning, whose role was to serve people's drinks, snacks and meals and, if required, support them when they were eating. The domestic staff and activity co-ordinators also assisted over meal times with clearing tables and washing pots. This meant additional staff were available to support people over the busy mealtimes and in a morning the care staff could continue to support people to get up as the hostess served breakfast.

Where required regular agency staff and nurses were used. The registered manager said there were 35 new staff members (mainly part time) currently undergoing their pre-employment checks. These staff would reduce the need for the use of agency staff as they would fill vacancies and also provide cover when staff were on annual leave and training.

A safe recruitment procedure was in place. All pre-employment checks were completed and a full employment history recorded. The reasons for any gaps in employment history were noted. Regular checks were made with the Nursing and Midwifery Council (NMC) to ensure the nurses employed were registered with them.

We found the home to be clean throughout, with no malodours. People and relatives told us the home was

always clean. Staff were seen using personal protective equipment (PPE) when supporting people with personal care tasks. We saw evidence that equipment was maintained and serviced in line with national guidelines and the manufacturer's instructions. Weekly checks were made on the fire alarm and emergency lighting system. Monthly checks were completed out for the call bells system, wheelchairs, window restrictors and people's room furniture. Legionella water checks were completed each month.

Ringway Mews had large grounds. The areas at the front of the units were well maintained. However, the enclosed gardens that people could safely access from the units had not been well maintained, with the grass and shrubs becoming overgrown. We noted this had been identified during the last Home Visit Report by the Area Director on the 5 August 2018. We were told a gardening position had been advertised. On the second day of our inspection a maintenance person had been allocated to Ringway Mews from another HC-One home to complete some gardening work.

Good

# Is the service effective?

## Our findings

All the staff we spoke with felt supported by their unit manager and colleagues. The deputy and registered managers were visible as they completed daily walk rounds of each unit. We were told they were approachable and would listen to any concerns or ideas the staff had.

Staff we spoke with said they received the training and support they needed for their role. People and relatives we spoke with also felt the staff knew how to support them. One relative said, "Staff have got the skills and knowledge (to support their relative) and I can discuss [name's] care with them."

New staff completed a two day induction before shadowing experienced staff for two or three shifts. The induction covered moving and handling, infection control, food hygiene and an introduction to HC-One, its policies and procedures. Each new staff member completed an induction manual, signed off by their unit manager. The induction manual met the care certificate standards, which is a nationally recognised set of principles that all care staff should follow in their working lives.

All staff had recently been enrolled on the HC-One e-learning system and courses were now being assigned to each staff member to complete. These included moving and handling, fire drills, health and safety, safeguarding, food safety and infection control. More courses were due to be assigned to staff once these initial ones had been completed, including specific modules for each job role. One staff member from each unit had completed a 'train the trainer' course in manual handling. They had then run refresher courses for their colleagues in each unit.

Nurses told us their clinical training was up to date, with courses being arranged when required, for example wound care and syringe driver training. However, one nurse who had been employed for six months had yet to complete their training in catheter care.

Training records from when Ringway Mews was a Bupa home showed staff had completed a range of courses including dementia awareness and behaviour that challenges. However newly recruited staff had not completed these courses at the time of our inspection.

Staff were encouraged to enrol on a national recognised course in health and social care when they had completed their probationary period. 105 staff had completed a course at level two or above.

This meant the HC-One training system was being rolled out in stages, with the staff having received Bupa training prior to the change in ownership. However new staff had not yet completed the role specific training, for example dementia awareness or managing behaviours that challenge.

Staff received regular supervisions with their unit manager. We saw that unit managers used a standard form to cover any issues for their unit and added in any additional topics of discussion for each individual staff member. Staff meetings were also held for each unit. Minutes showed staff could raise any topics they wished to discuss during these meetings.

Staff told us they had enough information to meet people's needs, including when people first moved to Ringway Mews. A hand-over was held on each unit between shifts to update staff on any changes in people's health and wellbeing.

A pre-admission assessment was completed by the unit managers or nurses before people moved to the home. This assessed the person's needs and involved the person, their relatives where appropriate and other medical or social care professionals involved in their current care and support. A further assessment was completed on admission to ensure the information held was current.

An initial '7 day' care plan was written from this information, providing brief details of people's needs, including moving and handling, communication and nutrition. Staff told us they were given a verbal handover of people's needs and were also able to read the assessment prior to the person moving to the home.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

HC-One had introduced the FACE capacity assessment tool in July 2018 to assess if a person was able to make a particular decision. Each FACE assessment was specific to one decision, for example for care and treatment, covert medication, end of life care or the use of bedrails. If a person was assessed as not having the capacity to make a decision a best interest decision was documented. This involved the person's family, GP and other relevant professionals as required.

However, we found some units had photocopied a completed FACE assessment and changed the name on the form. This had been done due to the number of FACE forms needed to be completed on each unit but was not person centred. We found one person's form stated they were unable to make a particular decision due to their dementia when in fact they had a learning disability. We discussed this with the registered manager. The home improvement plan from the 17 August noted that the FACE capacity assessments needed to be more person centred and gave a target of 15 September for this to be achieved. FACE forms had been reviewed and completed on an individual basis by the third day of our inspection.

Applications for DoLS had been made where it had been assessed that people lacked capacity to consent to their care and treatment.

This meant Ringway Mews had followed the MCA by having decision specific capacity assessments in place and applying for DoLS, but some units had used generic FACE assessments due to the number of assessments required to be completed in a short space of time, which had been identified and was being addressed by the home.

People and relatives told us medical assistance was requested when it was needed. One person told us, "Yes, I have needed a doctor, and he attended me" and a relative said, "Yes, my mum had a fever and they got the doctor and let me know. They're very good at keeping families informed."

Each person living at Ringway Mews was registered with a local GP practice. The Manchester Nursing Home Team (NHT) made planned visits to the four nursing units twice a week. Re-active visits could also be requested at other times if people became unwell. The feedback we received from the NHT was generally positive, with any plans provided by NHT being communicated between nurses and followed. However, we were told that there were variations between units and individual nurses about contacting the NHT quickly enough so a re-active visit could be made the same day and also some nurses asking the NHT to follow up appointments or referrals, which should be done by the nurses themselves. We discussed this with the registered manager who raised this with the unit managers at their daily meeting.

The residential unit (Shackleton) contacted the person's GP if they became unwell and the district nurse service would visit people when required.

Referrals had been made to other medical professionals as needed, for example the speech and language team (SALT), old age psychiatry or tissue viability nurses.

People who were at risk of developing pressure sores had the appropriate pressure relief mattress. One relative told us that their relative was not re-positioned as often as they should be, however the records we saw showed people were supported to re-position where required.

Staff told us they preferred the new recording sheets now being used as all records for food, fluids, personal care and re-positioning were now on one sheet rather than each record having a separate sheet.

We observed lunch on all five units during our inspection. Tables were neatly laid out and a choice of meals and drinks were available. The hostess on each unit served the food, encouraged and supported people to eat. The activities co-ordinators helped by serving meals and encouraging people. The domestic staff also assisted by clearing the tables and washing up. The care staff provided support for people to eat and took meals to those who chose to eat in their rooms. This meant the meal time was calm and people received the support they required to eat their food.

People said they enjoyed the food at Ringway Mews and had a choice of meals. One person said, "The food is very good, all substantial, three courses at mid-day. I usually eat in the dining room but you can eat where you like" and a relative told us, "Dad eats very well here, better than he did at home."

People's nutritional needs were being met by the service. The chef knew people's dietary requirements, for example soft or pureed food. Each unit provided a list for the kitchen each day detailing people's choices for their meals and any special dietary requirements they had. They also catered for people's individual needs, for example one person was a vegetarian and another needed a gluten free diet. Finger food was also provided for one person. People living with advanced dementia may not want to sit and eat a meal but will pick at food they can eat with their fingers. A relative said, "I can't fault the meals; [name] is a vegetarian and they cope with that well."

The most recent inspection from the environmental health department in March 2018 had awarded the service a 5 (Very Good) rating.

Food supplements were provided where a person had been identified as at risk of losing weight. Where applicable the amount of food and fluids consumed was recorded. One relative told us they had provided coloured plates for their relative to help them to see their food on the plate. However, these had since broken and not replaced. Coloured crockery can help people to maintain their independence when eating as the food stands out against the colour of the plate.

We were also told that cultural diets were catered for. However, at the time of our inspection one person needed halal meat but this was temporarily unavailable as the butcher used to supply halal meat had gone out of business. The chef told us they had made arrangements with a different butcher who was now able to supply halal meat to the home.

The two dementia units (Halifax and Shackleton) had memory boxes outside people's rooms which they or their family, could choose to add personal items to help them identify their own room. Other units had name cards made by the person and the activities co-ordinator on their bedroom doors. These could also include a picture of a themselves or a hobby to enable people to find their room independently. Toilets and bathrooms had dementia friendly signs on them so people could identify them.

The dementia units had a range of items for people to touch and hold. We also saw some people on all units holding a doll or toy. Research has shown that 'doll therapy' can reduce people's anxieties. Staff were heard to be respectful of people's dolls when speaking with them. A family of cats lived on site and accessed the units throughout the day. Visitors were also able to bring their dogs when visiting their relative. People were pleased to see the cats and pets, which provided an opportunity for staff to prompt discussions with people.

Good

# Is the service caring?

## Our findings

The people and relatives we spoke with were complimentary about the kindness and caring nature of the staff team. One said, "Relationships between staff and residents are good; we often have a laugh, it helps the day go by" and another told us, "Yes I am looked after by staff and I'm happy with the care given." Relative's said, "Staff are very approachable" and "Staff are very good, very responsive." Our observations showed people who lived at Ringway Mews seemed relaxed and comfortable in the company of the staff members.

Care files included a communication care plan which detailed how each person communicated their needs and how staff should communicate with them. People's preferences for the gender of the staff supporting them with personal care was also noted and each unit tried to meet these preferences wherever possible, depending on the staff mix on duty. We discussed with the registered manager how the home supported people with one of the protected characteristics, for example race or sexuality. They provided examples of when staff had supported people who identified as lesbian, gay bi-sexual or transgender (LGBT).

People were also supported to follow their faith if they wanted to. People could attend a local church on a Sunday and two local churches visited Ringway Mews to say prayers with people and offer communion.

People said that the staff team knew them well and treated them with dignity and respect. One person said, "I don't have any problems with respect, privacy and so on. They (the staff) always knock before they come in. I never bother with a 'Do not disturb' sign on the door. And they do listen to me" and "Staff treat me with respect." Relatives agreed, with one saying, "The door is always open but the staff still knock and ask to come in."

We saw and heard positive interactions between members of staff and the people they were supporting throughout our inspection. Staff spoke calmly with people to explain what they were doing and provide them with re-assurance. Staff could describe to us how they maintained people's privacy when providing personal care, for example explaining what they were doing, ensuring people were covered and doors were shut. It was confirmed by the people we spoke with that the staff did this when supporting them.

People were prompted to maintain their independence by the staff team. We observed people being prompted to complete things by themselves where possible, for example eating and walking. Staff explained how they encouraged people to do things for themselves where they were able to do so. One person said, "It's possible I could do more, I suppose. I can wash myself down to my legs and they always let me do that." A member of staff told us, "I give them the cloth to wash themselves, let them do their own teeth if they're able to, prompt them, no point you doing it all as it takes it (their skills) away from them."

The staff we spoke with knew people's needs, likes and dislikes. People's current preferences, for example whether they liked to sit in the lounge, stay in their room, watch TV or listen to music were noted in their care files. However, we noted that the new HC-One care plans did not have information about people's life history, for example their family, previous jobs and hobbies. The activity co-ordinators on some units had made a one page list of people's likes and dislikes. We discussed this with the registered manager and

quality director. HC-One used a 'remembering together' booklet to record information about people's life histories. The activities co-ordinators would complete these with the person and their family where relevant, but had not been able to do so at the time of our inspection. Previously a Bupa booklet called 'my story' had been completed for those people who had lived at Ringway Mews prior to the HC-One takeover, which meant the staff had more information about these people's life history.

We were told that where applicable people were referred to an advocacy service. An advocate ensures that decisions made on a person's behalf are in their best interests.

People's care files were stored in the office on each unit and so people's confidential information was securely kept.

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection there was a continued breach of Regulation 9 as care plans did not always reflect people's current care and support needs and had not been regularly evaluated to ensure they were up to date.

At this inspection we found the majority of the care plans had been re-written on the HC-One care planning documentation. We looked at 15 care plans across all five units. We found care plans were in place to inform staff of people's care and support needs. For example, personal care, communication, sleeping, continence, health, mobility, eating and drinking.

Each unit used a 'resident of the day' system, whereby one person on each unit was designated the resident of the day and their care files were evaluated. The care plans we viewed were up to date and reflected people's assessed needs.

We also looked at three care plans for people who were living on Wellington unit for 'discharge to assess.' People were discharged from hospital so their needs could be fully assessed by the local authority social workers and appropriate care and support arranged for them. They were meant to be short term placements, with people either moving back to their home with support or to another care home placement. We saw these care plans contained a range of risk assessments, pre-admission and admission assessments and a '7 day' care plan. This is a short term care plan with brief details of people's needs. It was not evidenced that the 7 day care plans had been evaluated each month, although the nurse we spoke with told us that they had been. The staff we spoke with knew people's needs and said they were given enough information to be able to support people admitted as 'discharge to assess.'

However, one person had lived in Wellington unit since February 2018 and another had lived there for five months. 7 day care plans were still being used. We discussed this with the registered manager and quality director. The quality director informed us that HC-One used intermediate care plans where people were admitted for a short period. These combined the admission assessment, risk assessments and care plans in one document. The intermediate care plans could contain more information about people's care and support than the current 7 day care plans.

This meant that the 'discharge to assess' care plans only contained brief information about people's needs even though some people had been at the home for six months. The intermediate care plans introduced following our inspection would enable more information to be recorded and evidence that evaluations had taken place. We will check these are in place at our next inspection.

Relatives told us they had been involved in discussing their relative's care plans. We were told, "I've had a good discussion about [name's] care with staff" and "Staff considered [name's] preferences and will accommodate them. They've written them in the care plan." As part of the monthly evaluation it was noted on the evaluation sheet whether families had been contacted and what their views were.

Where there was an assessed need we saw that technology, such as bed sensors, were used to reduce people's identified risks. The sensors were linked to the call bell system and alerted the staff when triggered. This meant if a person who was at risk of falls got out of bed the staff were alerted and could provide support.

The staff we spoke with knew people's care needs and could describe the support they required. Staff offered day to day choices to people, for example what they wanted to wear, eat or drink. We observed people being shown plated meals so they could make a choice of which option they preferred. This is important where people have difficulty making a choice when given verbal options or have communication difficulties.

People told us they were able to get up and go to bed when they wanted. On the first two days of our inspection we arrived at 7am. We found there were few people up at that time and observed people being supported to get up and have breakfast when they were ready to do so.

People's cultural and medical needs were met at the end of a person's life. Advanced care plans were in place to document people's wishes at the end of their lives. For example, if they wanted to remain at Ringway Mews or be admitted to hospital, if they wanted ongoing medical treatment or if they wanted the involvement of a priest or other religious figure. People's families and GPs had been involved in these discussions and FACE capacity assessments completed where people were not able to make their own decision about their end of life care. One relative said, "I've had a good discussion with staff on end of life issues."

End of life care plans were developed as people neared the end of their life. Anticipatory medicines were prescribed to manage any pain they may have.

Ringway Mews employed a team of activity co-ordinators to organise activities for each unit. Each unit should have one activity co-ordinator for 20 to 25 hours per week plus an activity manager. However, at the time of our inspection there were two vacancies within the team, with another activity co-ordinator due to leave. Three new co-ordinators had been recruited and were completing their pre-employment checks.

An activities schedule was in place each week, for example sing a longs, arts and crafts, reminiscence and 1:1 chats. More activities had been arranged for the units where people were living with dementia as this was seen as helping to reduce people's agitation by involving them in an activity.

The nursing units tended to have more 1:1 sessions planned as there were more people staying in bed due to their health needs on these units. Monthly events out were arranged, for example a trip to Blackpool or a VE day party. The activities manager also told us they arranged for people to visit the local pub or park when the weather was good and staffing allowed.

The activity co-ordinators also helped out during lunchtime to serve meals and enable the care staff to have more time to support people to eat their meals.

One person said, "I don't do much, mostly watching TV and reading.  But I do like outings, oh yes, singing too" and a relative told us, "Mum likes to sit, listen to music, quizzes and television -  although her hearing and sight are not too good. She loves to dance."

This meant activities were arranged, however these had been reduced due to vacancies within the activities co-ordinator team. New staff had been appointed to these vacancies, which should enable more activities to

be scheduled across all five units.

The home was able to provide information in large print if required. One unit also had a hearing loop in place. A vibrating alarm had been installed on one unit where a member of staff was hard of hearing and a signing interpreter had been provided for training sessions. This meant the home provided accessible information as required.

We saw there was a complaints policy in place. We saw all complaints raised formally or verbally were recorded and had been investigated and responded to. People and relatives we spoke with said they would raise any issues or concerns they had with the staff on duty, the nurse or unit manager. They said that their concerns had been addressed.

Requires Improvement

# Is the service well-led?

## Our findings

Ringway Mews had a registered manager in place. They were supported by a deputy manager. Each unit had a unit manager. Recruitment for a second deputy manager was in progress at the time of our inspection.

At our last inspection in June 2017 there was a breach in Regulation 17 as shortfalls in the care plans had not been addressed and staff training and supervisions had not been completed during the registered managers extended leave.

HC-One had introduced a range of quality monitoring tools and audits since taking over the home. These included twice daily walks around each unit by the registered or deputy manager, weekly dining experience audits, monthly night time visits, monthly audits about the appearance of the home (One Proud Home) and medicines. The area manager did a monthly home visit report, looking at a sample of care plans, medicines checks, records and speaking with people living at the home and their relatives. Quarterly audits for infection control, catering and falls and a quarterly audit by the quality director were also completed. Action plans were formulated from these audits and we saw that these actions were in the process of being completed. An overarching home improvement plan was also in place with the registered manager updating progress on a weekly basis.

A computer programme called Datix was used to record all audits and action plans. The system was also used to monitor any falls, incidents, people's weight, pressure sores, the use of bed rails and any infections across the home. The computer could produce a report so each area could be analysed for any trends or patterns.

A falls team had been set up to review all falls at the home and to ensure any actions to reduce the risk of a re-occurrence had been taken, for example the use of sensors or bed rails. The information was also used to check appropriate referrals had been made to the relevant medical professionals such as dieticians or tissue viability nurses.

At the time of our inspection there was three months data available through Datix. This will increase as the system beds in and so will become more useful to monitor trends in the future.

Monthly health and safety and clinical review meetings were held with the heads of departments to review any issues and agree actions to address them.

However as stated in this report the medicines audits had identified that on two occasions since May 2018 there had not had medicines in stock on the first day of the medicines cycle. We found similar issues during our inspection, which prompted action to be taken. This issue was not on the home improvement plan and a review of the re-ordering system had not taken place when the medicine audits had highlighted this issue.

The One Proud Home audit on 17 August 2018 stated that the grass and plants were okay. However, the area director home visit report from the 5 August 2018 stated the resident's gardens needed some focus as they

were overgrown. The outcome of this was that the position of gardener was advertised. The registered manager also sent an email request on 6 August 2018 to HC-One property helpdesk requesting for contract gardeners to be organised. However; the contract gardeners had not been arranged at the time of our inspection.

This meant the auditing system had identified areas where improvements were required and plans were in place to do this. However, the medicine re-ordering issues had been recognised but no action plan had put in place to remedy the issue. The state of the gardens had been recognised in one audit but not in the One Proud Home audit. The action taken had not resulted in the gardening issue being addressed in a timely manner by HC-One. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

During our inspection the management team at Ringway Mews responded and took steps to address the areas of concern we identified.

People and relatives we spoke with were positive about living at Ringway Mews and the management of the individual units and the home. Comments included, "The manager and the deputy come round nearly every day. Yes, I like it here. Some of us feel thankful that we live here", "This unit is well managed" and "The manager is very approachable and I'm able to talk and discuss issues with them."

Ringway Mews endeavoured to gain the views of the people living at the home and their relatives. Resident and relatives' meetings were held every three months. The attendance at these meetings had increased since our last inspection. A range of topics were discussed including activities, staffing and food.

A residents and relative survey had been conducted in April 2018. The responses had been collated centrally and were positive. An action plan had been written to respond to the comments made on the surveys. These would be presented and discussed at the residents and relatives meeting planned for the end of August.

The staff we spoke with liked working at Ringway Mews and said the unit managers, registered and deputy managers were approachable. Staff meetings were held on a regular basis on each unit. Meetings were held at times which meant night staff were also able to attend. Staff told us these were open meetings and they could make suggestions and raise any concerns they had.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The out of stock medicines, management of creams, incorrect consistency of drinks on Halifax and time critical medicines not being administered as per the prescribing instructions was a continuing breach of Regulation 12 with regard to 2(g) |

**The enforcement action we took:**

CQC issued a Warning Notice to the provider

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Medicine re-ordering issues and the gardens had been recognised but no action plan had put in place to remedy the issues.<br><br>This was a continued breach of Regulation 17 (1) |

**The enforcement action we took:**

CQC issued a Warning Notice to the provider.