Bupa Care Homes Limited

Ringway Mews Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Ringway Mews Care Home on 12, 13 and 14 June 2017. This was the first inspection of Ringway Mews Care Home since it had been re-registered with the Care Quality Commission in January 2017. The re-registration had taken place as a business entity to reflect changes to the providers named responsible people. This did not create any changes to the overall registration of the home. The home, under its previous legal entity, was inspected in May 2016. References throughout this report to 'the last inspection' concern this inspection.

Ringway Mews Nursing Home is owned by BUPA Care Homes. The service consists of five 30 bedded units; Lancaster, Shackleton, Anson, Halifax and Wellington. Wellington had recently been re-opened and fifteen people lived there at the time of our inspection. Each unit specialises in either nursing or residential care. Each unit has a lounge, dining area, a conservatory, and a kitchenette. All bedrooms are single with no en-suite facilities. Accessible toilets and bathrooms are located near to bedrooms and living rooms.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Shortly after our last inspection the registered manager took an extended period of leave, returning in February 2017. During their leave the home had two different relief managers.

The clinical service manager (CSM) for the service had moved to the position of unit manager shortly before our inspection. Two CSM's had been recruited to support the registered manager, both of whom were due to start working at the service shortly after our inspection took place.

At the last inspection we found two breaches of the Health and Social Care Act 2008 because additional care plans were not in place for some people's identified needs and the audits completed by the service had not identified the issues found during the inspection or issues that had been identified had not been actioned. At this inspection we found similar issues; however an improvement plan was in place for the service and all care plans were in the process of being re-written.

A new breach with regards to medicines was identified during this inspection. You can see what action we have told the provider to take at the end of the full version of this report.

Daily and weekly medicine monitoring sheets were in place on each unit to check that all medicines had been administered as prescribed. New cream charts had recently been introduced for care staff to sign when they had applied any creams. However these were not consistently completed so it was not possible to tell if the creams had been applied as prescribed. We identified a missing tablet on one unit. Bupa procedures for reporting and investigating this had not been followed. The registered manager initiated these procedures when we informed them of what we had found.

People and their relatives told us they felt safe living at Ringway Mews and that the staff knew their needs well. They also said staff were respectful, kind, caring, supported them to complete some tasks themselves and offered them day to day choices, for example about what they wanted to eat or wear.

A robust process was in place to recruit staff suitable to work with vulnerable people. New staff undertook a week's induction and completed training, including safeguarding vulnerable adults, commensurate with their roles. Staff said they felt supported by the unit managers. Supervisions and staff meetings were held where staff were able to contribute to discussions about the service.

People and their relatives thought there were enough staff on duty to meet people's needs, although one person said they had to wait longer at night time. Staff on one unit thought they needed more staff or a hostess to help with people's meals and the night staff on another unit thought they needed more staff to support people to go to bed. The registered manager used a dependency tool to calculate the staffing levels for each unit. This was updated weekly to take account of any changes in people's needs. We were told the staffing on one unit had recently been increased as people's needs had changed.

All areas of the home were clean and there was no malodour on any of the units. A carpet cleaner had been purchased since our last inspection to ensure carpets could be thoroughly cleaned whenever required. Procedures were in place to prevent and control the spread of infection.

A new breach with regards to premises and equipment was identified during this inspection. You can see what action we have told the provider to take at the end of the full version of this report.

We noted on three units the doors to the sluice rooms and cleaning cupboards were not always locked. The registered manager was aware of this and had previously brought it to the attention of the staff that these doors should always be locked so people did not have access to chemical products kept in these rooms. One sluice in one unit had not been operational for over six months at the time of our inspection. A new sluice machine was on order and it was installed the week after our inspection.

Regular checks were made of the firefighting equipment. Equipment was serviced and maintained in line with the manufacturer's instructions.

Care records were in the process of being re-written. Support was being provided by central Bupa staff to the unit managers, nurses and senior staff so they gained the skills to write care plans to the required standard. We noted that some people's care plans did not include guidance for staff to follow when people had been assessed as being non-compliant with care or having behaviour that may be seen as challenging. Risk assessments were in place, including how the service mitigated the identified risks. Relatives said they had been involved in their loved ones care plans.

Daily notes made for each person were seen in their care files. However on Shackleton unit these were written in the early afternoon and so did not contain any details of events during the afternoon or early evening before the night shift started.

People were supported to maintain their health and nutritional intake. Records were kept were appropriate of what people had eaten and drunk. We saw referrals to relevant health professionals were made, for example to the Nursing Home Team, district nurses and GP's.

We saw people were supported to make advanced decisions about the care they wanted at the end of their lives. Four units had been accredited by the Six Steps programme for end of life care and support. Staff from

the unit that had recently opened had been enrolled for the Six Steps training. We saw that one person who was receiving end of life care did not have a specific end of life care plan for staff to follow. The information was written in the evaluations of the care plans so was not easily accessible for staff.

We found the service was working within the principles of the Mental Capacity Act (2005). New capacity assessments were being introduced, with associated best interest decision forms for each decision needing to be made on a person's behalf.

Activities were arranged on each unit and monthly trips were organised, for example to Blackpool or the zoo. Fiddle items and dolls for doll therapy had been purchased for two units. Staff said this gave people living with dementia something to handle and fiddle with, which had reduced their anxiety.

Staff said they enjoyed working at the service and that they received support from the unit managers, CSM and registered manager. Some senior staff expressed they had felt 'vulnerable' during the registered manager's extended leave. The feedback from the Nursing Home Team was that the home had missed the registered manager whilst they had been off work.

We saw that during the registered manager's extended leave staff training had not been provided, supervisions not done and actions from our last inspection and internal audits not completed. Since their return the registered manager had addressed these issues. A home improvement plan was in place and support for re-writing care plans had been secured from the Bupa central team.

Bupa has a number of quality assurance audits in place, including monthly care plan audits, medicines audits, monthly area manager audits, quarterly health and safety and infection control audits. Actions from these audits are now being completed.

Systems were in place to record, investigate and respond to any complaints made to the service. All accidents and incidents were reviewed by the registered manager. A number of statistics were compiled for monitoring purposes, for example falls, pressure sores, nutrition, medicines errors, the use of bed rails and hospital admissions. This meant any trends or patterns of behaviour could be identified and action taken when necessary to keep people safe.

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.

New cream charts had been introduced, however care staff were not always signing it to show the cream had been applied as prescribed. A missing tablet had not been reported as per the Bupa policy. People received their tablets and liquid medicines as prescribed.

Sluice rooms and store cupboards were not kept locked which posed a risk to ambulant people living at the service as they may access cleaning chemicals. A sluice on one unit had not been working for at least six months. As a result we noted commodes had to be emptied and cleaned in bathrooms. This increased the risk of cross infection.

A safe system of staff recruitment was in place. Staff received training in safeguarding adults and knew the procedure for reporting any concerns.

Care records included information about the risks people may face and guidelines for staff in how to mitigate the risks.

Is the service effective?

Good

The service was effective.

New capacity assessment documentation was being introduced. Where people did not have capacity, best interest decisions were recorded for each decision made when they lacked capacity.

Staff received the induction and training to meet people's needs. Staff felt supported by the unit manager. Supervisions were now taking place; but had not been completed regularly when the registered manager was on extended leave.

People received appropriate health care and referrals were made to health care professionals when required.

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 well.

Relatives were able to visit whenever they wanted to and could have meals with their loved ones.

People's care needs at the end of their lives were recorded but were not easily accessible in one end of life care plan. Other medical professionals were involved in people's end of life care as appropriate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect a person's current needs or provide guidance for staff when supporting people who were non-compliant with their care.

Care plans were in the process of being re-written for all people living at Ringway Mews. The unit managers, nurses and senior carers were being supported by central Bupa staff to improve the content and consistency of the care plans.

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

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

Is the service well-led?

Requires Improvement

The service was not always well led.

A registered manager was in place as required by the service's registration with CQC. Two Care Service Managers were being recruited to support the registered manager.

During an extended period of leave taken by the registered manager supervisions had not been completed, training had not been kept up to date and audits had not been acted upon.

The service and each unit had an improvement plan in place. Support for the unit managers from central Bupa personnel was in place to improve the quality of the care plans.

Staff said they enjoyed working at the service. They said the registered manager, unit managers, nurses and senior care staff were approachable and supportive.

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 12, 13 and 14 June 2017 and was unannounced. The inspection team consisted of three inspectors and two experts by experience on the first day. 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. One inspector returned for the second and third day.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.
We contacted the local authority commissioning and safeguarding teams, the local Healthwatch board and the Nursing Home Team. The Nursing Home Team supports people living in residential and nursing homes to access health care and reduce hospital admissions. No one raised any concerns about Ringway Mews.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 23 people, nine relatives, the registered manager, two unit managers, four nurses and 13 care staff. We observed the way people were supported in communal areas and looked at records relating to the service. These included 10 care records, five staff recruitment files, daily record notes, medication administration records (MARs) on each unit, maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

All the people who used the service and their relatives we spoke with said they thought Ringway Mews was a safe place to live. One relative told us, "I feel so relaxed knowing that she (mum) is safe."

At our last inspection we made a recommendation for current best practice guidelines to be followed in regard to having topical cream charts for staff to sign when they had applied any creams and body maps to be consistently used across the different units at Ringway Mews.

At this inspection we found body maps were used in all units to clearly identify where any creams needed to be applied. We noted that new cream charts for the care staff to sign when they had applied any creams had been recently introduced in May 2017 and were in the process of bedding in. This meant that it had taken the provider 12 months to implement these charts. We saw that on three units there were gaps in the recording on the cream charts. On some charts no signatures had been entered for the day and others one signature had been entered when the cream was prescribed to be applied twice each day. This meant it was not possible to ascertain if the person had had the cream applied as prescribed.

We checked the medication administration records (MARs) on all five units. We saw all had been fully completed. A daily and weekly check of MARs was completed which checked that all the medicines had been correctly signed for.

We checked the quantity of medicines held by the service corresponded to the amount recorded on the MAR. We found that on four units all the quantities were correct. However on Wellington unit we saw a note on one person's MAR that one Atorvastatin tablet was missing. We checked all the other medicines for this person and found one additional Metformin tablet in the packet. We asked the unit manager and nurse on duty about this. We were told that they had seen the note made by an agency night nurse about a missing tablet but did not know how it had occurred. The incident had not been reported to the registered manager as per Bupa policy. We were later told the Metformin tablet had been signed as administered on the MAR when in fact it had not been given to the person. The metformin was administered after we had checked the quantity. This meant the amount of metformin tablets held was correct, however the MAR should only be signed when the medicine had been administered as it is a record that the person has taken their prescribed medicine. We had received a notification from the registered manager of a similar incident in April 2017 where the MAR had been signed but a tablet had not been administered from a blister pack.

We discussed this with the registered manager who immediately raised an incident report for the missing tablet. They also said they would speak with the nurse who had signed the MAR chart before administering the metformin tablet and further competency training checks would be completed.

We saw guidelines were in place for when any 'as required' medicines and creams were to be administered. On four units these included details of how the person would inform staff, either verbally or non-verbally through facial expressions or behaviour, that they required a PRN medicine. On Lancaster unit we saw five PRN protocols that did not provide details as to when the PRN medicine should be administered. For

example one protocol stated to administer 'in the person's best interest' and another did not accurately record the prescribing instructions. We were told these PRN protocols had been reviewed and updated during our inspection.

We noted creams, eye drops and liquid medicine bottles were dated when opened, however not all creams had been dated on Halifax unit. The unit manager told us they would speak with the care staff who applied the creams to ensure that all creams were dated when opened in future. This is important as they can lose their efficacy after being open longer than the manufacturer recommends.

We found the gaps in the cream charts records, the signing of the MAR before administering a medicine and the lack of reporting of a missing tablet was a 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 not being deprived of their liberty.

People at risk of choking due to swallowing difficulties were prescribed 'thickeners' to add to their drinks to reduce this risk. Charts were in place for the care staff or hostess (a staff member who assisted at meal times) to sign whenever they added 'thickeners' to any drinks. Guidelines for the consistency of drink each person required were kept with the charts. This meant people were receiving thickened fluids as prescribed.

We saw risks to people's health and wellbeing were identified, including the risk of falls, moving and handling, pressure ulcers and malnutrition using the Malnutrition Universal Screening Tool (MUST). We saw these were regularly evaluated.

Appropriate care plans were developed to mitigate the identified risks, for example guidance on moving and handling. Where required, assessments for the use of bed rails to prevent a person falling out of bed had been completed.

We looked at the rotas and staffing levels on each unit. We saw the agreed levels of staff for each unit were adhered to, agency staff being used when required. When necessary staff were asked to work across different units to ensure the correct skill mix was in place or so that several agency staff were not working together on the same unit. People and relatives we spoke with told us they thought there were sufficient numbers of staff on duty to meet people's needs. One person said, "Enough staff? Oh, yes" and another told us, "They are busy, but I don't have to wait long." One person told us they had to wait longer at night for the care staff to respond when they used their call bell.

Most staff we spoke with thought there were enough staff each day to meet people's needs, although they could be busy at key times of the day, especially in the morning. Staff noted that having a hostess on the unit to serve people's meals enabled them to continue supporting people to get up or assist people with their

meals which they said was a big help. We noted on Halifax unit one person had been assessed as requiring one to one staff support 24 hours a day and another person had one to one support for 12 hours each day. We saw these hours were provided as part of the rota.

At night there was a senior member of staff designated as 'site cover.' Their role was to respond to any issues across the service, for example staff sickness, an accident or incident. An agency nurse we spoke with explained how the site cover had supported them when one person became unwell and needed an ambulance to be called. This meant that the service had contingency plans in place with access to an experienced staff member if required at night.

Staff on one unit, Shackleton, said they did not have the support of a hostess. The night staff on another unit, Halifax, said they felt there needed to be more staff at the beginning of their shift as there were usually 10 – 15 people awake in the lounge when they started their shift, most needing two staff to support them with their personal care when they went to bed. The rota showed there was one nurse and two care staff on duty at night, with an additional staff member for the one to one support noted above.

We spoke with the unit manager on Halifax unit and the registered manager about these comments. We were shown a dependency tool used by Bupa to determine the staffing levels required. This was updated weekly to ensure if anyone's needs changed they were reflected in the staffing levels. The registered manager told us they did have flexibility on the staff numbers and could increase them from what the dependency tool indicated if there was good reason to do so. Both the registered manager and unit manager said they felt there were sufficient staff on duty and stated they had not been approached about the need for more staff. The registered manager told us, confirmed by staff, that the rota had been increased for Anson unit recently due to an increase in the needs of the people living on the unit. The registered manager also explained they had recently visited Halifax unit in the early hours of the morning and spoken with the staff on duty at that time. This showed the staffing levels were regularly reviewed and adjusted when required.

From our observations we saw there were sufficient staff on duty to meet people's needs, although staff were busy at key times, for example in a morning and at meal times. Call bells were responded to appropriately and staff were able to spend time with people at quieter times, for example after lunch.

At our last inspection we noted there was a malodour in the lounge area of Shackleton unit. At this inspection no malodour was present in any of the units. The domestic staff we spoke with told us a carpet cleaner was available to use when required. This was usually used by night staff when people were in bed as it left the carpet wet. However at the time of our inspection not all night staff had been shown how to use the machine. The registered manager completed a daily walk around all the units. One of the areas they checked on was if there was a malodour on any of the units. This meant the service had taken steps to ensure any issues with malodours were identified and dealt with.

All areas of the service looked clean and tidy. People and relatives told us they thought the home was clean. We were told, "Yes, the home is clean. It's a nice place." The housekeepers we spoke with had a daily schedule for cleaning each unit. Our observations during the inspection showed that staff used personal protective equipment (PPE) such as gloves and aprons appropriately when carrying out tasks. The head housekeeper did a daily walk round and checklist and completed an internal infection control audits every three months. This included checking the staff's handwashing technique, use of PPE and a visual check of 10% of the bedrooms. An action plan was written following the audit. The action plan from May 2017 had been annotated with what had been done following the audit.

We noted during our inspection some store cupboards, containing cleaning products and toiletries, and sluice rooms were left unlocked on three of the units. This meant people who were ambulant may gain access to chemicals or clinical waste. We saw that notices had been issued to remind staff that they were to ensure these rooms were always locked and this issue had been noted in an audit done by the Bupa area manager in May 2017. This meant the management of the service were aware of this issue and had taken steps to remind staff of their responsibility to ensure the store cupboards and sluices were locked. The area manager told us the next step would be to take disciplinary action against staff who left these doors open. This may help ensure people are kept safe from having access to chemicals and clinical waste. We will check this at our next inspection.

One of the two sluices on the Lancaster unit was not working. We were told this had been ongoing for over six months. Repairs had been completed for the drains and a new sluice machine was on order. We were informed that the sluice had been installed the week after our inspection; however the repairs had taken a long time to complete. During this period staff had been using one of the bathrooms to dispose of offensive waste and clean commodes. We were also told that for a period of about a week the second sluice had also broken in March 2017. This meant all commodes had to be emptied and cleaned in the bathrooms. This increased the risk of cross infection.

The unlocked sluice rooms, cleaning cupboards and length of time to complete repairs on the sluice room were a breach of Regulation 12, with regard to 2(d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place to ensure staff were safely recruited. We looked at five staff personnel files, including one nurse, who had been recently recruited. We found that they contained application forms detailing their full previous employment histories, with any gaps in employment explained. Appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. All the files contained two references. The nurse's registration with the Nursing and Midwifery Council was checked to ensure they were registered to practice as a nurse. We noted that the registration was checked on an annual basis. This meant a system was in place to recruit staff that were suitable to work with vulnerable people.

Staff were aware of what may constitute abuse and the procedures in place to protect people from harm. Staff were clear that they would report any concerns to the unit manager, the nurse or senior carer on duty and were confident they would act on their concerns. All staff had received training in safeguarding vulnerable adults.

Incidents and accidents were recorded and monitoring put in place following an incident or fall. They were reviewed by the registered manager. We saw the incident forms contained details of what had occurred and what action had been taken by the staff. The manager noted on the forms if the local authority safeguarding team and the Care Quality Commission had been notified of the incident. All incidents and accidents were entered into the Bupa computer system. A monthly report was produced which could be used to highlight any trends in falls or incidents.

Where applicable a member of the central Bupa support team would undertake an investigation into an incident, speaking with any staff and people involved and looking at records such as daily notes or MARs. A report with recommendations was then written. Risk assessments were reviewed following an incident or fall. Where applicable the service's disciplinary procedure was followed.

This meant the registered manager had an overview of accidents and incidents and steps were put in place

to reduce the likelihood of them re-occurring.

We checked the systems that were in place to protect people in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) were in place for all people who used the service and a copy was kept by the main door to each unit in a 'fire file'. These plans were brief and detailed if a person was independently mobile, required support from one person or would require two people to evacuate them as they were not mobile. Any changes to the PEEPs had been handwritten over the printed copy, which may have caused some confusion in the event of an emergency. We spoke with the registered manager about this. The PEEPs were printed off each week from the latest occupancy list on the central Bupa computer. This meant any handwritten changes made would be updated on the printed copy the following week.

We saw the fire procedure document in the fire files were out of date. There was no contact sheet for relevant phone numbers in the files. We were told the service had two main fire files, one in the office and one on Anson unit, which contained all the contact numbers, plans of buildings and up to date fire procedures. All the fire files had the required information in them on the second day of our inspection.

We were shown a fire risk assessment that had been completed by an external contractor for each unit in September 2016. The actions noted in this assessment had been completed.

The service had a business continuity plan which contained contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak or power failure.

Records showed the equipment within the home had been serviced and maintained in accordance with the manufacturer's instructions. The service held records of weekly and monthly tests completed for the fire alarm, fire extinguishers and the water systems. Monthly checks on all wheelchairs were also completed monthly. This should help to ensure that people were kept safe. Fire drills had been held for two units in April 2017; however we did not see records of fire drills for the other three units.

Good

Is the service effective?

Our findings

Everyone we spoke with spoke highly of the staff team. One relative said, "They (the staff) have a good knowledge of mum."

A new member of staff told us they had completed four days of training when they joined the service. Courses undertaken included moving and handling, safeguarding, mental capacity, infection control and health and safety. They then worked alongside experienced members of staff so they could get to know people and their needs.

All the staff we spoke with said they had regular refresher training. Records we saw confirmed this. We noted that the training offered by the service had reduced during the registered manager's extended leave. Since their return to work the training matrix had been reviewed and we saw the staff training was now up to date. Staff told us they had completed courses in dementia awareness and challenging behaviour. They said this had assisted them to understand and support the people at the service living with dementia.

Records showed 59 staff had achieved a nationally recognised qualification in health and social care. The registered manager said the service encourages staff to enrol on these courses. Nurses completed clinical training and a two day clinical course had been booked for June 2017. This included catheter care and wound care.

This meant staff received the training to provide effective support to people living at the service.

Staff told us they had supervisions with their unit manager; however they were not clear how often these were. Some told us it was every three months and others every six months. One unit manager told us they undertook supervisions when there was an issue they needed to discuss with staff, either as a group or individually. Records showed that supervisions had not regularly been held when the registered manager was on their extended leave. Since their return we saw all staff had received two supervisions, one being a group supervision as a staff team. All staff told us that they were able to speak with the nurses and unit managers whenever they needed to. Unit managers told us they were able to speak with the registered manager, who had an open door policy.

This meant staff had the support they required to undertake their roles.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

From the care plans we viewed we saw new mental capacity forms were being introduced. These clearly assessed a person's capacity to make decisions. If a person was assessed as not having capacity, best interest decisions forms for each separate decision to be made were completed, for example consent to a person's care and treatment, safety in bed (use of bedrails or sensor pads), use of a hoist.

Care files that had not been updated had an older version of a capacity assessment; however separate best interest decisions were not recorded. All the mental capacity assessments were being updated as part of the update of all the care files.

Where people had been assessed as not having capacity to consent to living at Ringway Mews a DoLS application had been made to the relevant local authority. We saw the registered manager regularly contacted the local authorities for an update on the progress of the DoLS applications. Where DoLS had been authorised by the local authority a copy was filed centrally and in people's individual care files.

This meant the service was working within the principles of the MCA and were in the process of documenting clear best interest decisions made on people's behalf where they were unable to make the decision for themselves.

Staff explained to us how they provided people with day to day choices, for example what they wanted to wear and what they wanted to eat. We saw staff asked people if they wanted support before they provided it. For example one staff asked, "Which drink do you want? You can have them both if you like." A resident told us "They always ask first, they never force you to do anything." This meant staff sought people's agreement and consent before providing care or support.

We noted when we arrived at 7am there were not many people who had already got up. Staff were clear that people were only supported to get up when they woke up and wanted to do so. Night staff on Halifax unit explained there were usually 10 to 15 people in the lounge area when they started their shift. A relative said, "My mother likes to stay up watching TV in the lounge. One night she fell asleep in her chair and didn't want to go to bed. The staff made her comfortable, gave her a blanket and she slept in her chair like she would have done at home." This showed people were able to choose when they went to bed and when they got up.

We observed the morning handover between the night shift and the incoming day shift on three units at the service. The nurse or senior carer gave an update on each person living at the unit. The information was also written on a handover sheet for reference. This provided the staff starting their shift with brief details of each person's wellbeing and if they needed any additional observations or support due to being unwell or a change in their needs. The unit manager in one handover said to a nurse they would provide a full update for a person who had been admitted whilst they had been on annual leave. We did note that not all day staff were able to listen to the whole handover as people were asking for support. The day shift nurses or senior carers said they would ensure that all staff were updated with the information provided during the handover.

This meant staff were provided with up to date information about each person's wellbeing so they were able to provide the appropriate support and continuity of care; however they may not receive this at the start of

their shift if they had to support people during the handover.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the food and had a choice of meals each day. One person said, "The food is very good, I can have a salad or jacket potato if I don't like what's on the menu." The care records we looked at all contained a risk assessment regarding people's nutritional intake using the Malnutrition Universal Screening Tool (MUST). Where people were at risk they had been referred to a dietician or the Speech and Language Team (SALT). Appropriate food supplements were prescribed and offered. Regular checks were made on people's weight. We noted people were provided with aids to support them to eat and drink independently, for example cups designed with angled sides so they were easier to tip and drink from. Where applicable, food and fluid charts were kept to record what people had had to eat and drink each day.

Staff we spoke with were knowledgeable about people's dietary requirements. However one person told us their relative required thickened fluids but staff had given them ice cream after a meal which could have increased the risk of the person choking as the ice cream melts. They said they had raised this with the staff team.

We spoke with the deputy chef who showed us how they recorded any special diets on a whiteboard, for example soft or pureed meals. Each unit provided a list for the kitchen each day detailing people's choices for their meals and any special dietary requirements they had. The chef was aware of two people who were vegetarian and provided meals appropriate to their wishes. We were told one person had asked for more Caribbean style food. The chef explained how they added extra spices into this person's food to try to meet this request. Cultural diets, for example halal meat or a kosher diet had been provided in the past; however no one currently living at the service required this at the time of our inspection. The most recent inspection from the environmental health department in December 2016 had awarded the service a 5 (Very Good) rating.

Each person was registered with a local GP. The service was supported by the nursing home team (NHT). The NHT visited each unit every week and the unit managers and nurses could refer people to the NHT if they became unwell. We received positive feedback from the NHT about each unit at Ringway Mews, stating the care staff new the health needs of people well and followed any guidelines they were provided by the NHT staff.

We saw that referrals were also made to occupational therapists and district nurses when required. We saw that people at risk of developing pressure sores had the appropriate pressure relief mattresses in place and records were kept of when people were supported to re-position. A relative told us, "If [name] needs a doctor, the staff always ring to let me know" and another told us, "I have no worries at all about the staff getting whatever professional help is necessary." This meant that people's health needs were being met by the service.

We noted the units had recently been re-decorated. The two units, Halifax and Shackleton for people living with dementia had authentic transfers on each bedroom door that made them look like the front door to a house or flat. A memory box was also situated outside the room for photographs or mementoes significant to the person living in the room. This can help people living with dementia orientate themselves within the unit and find their own bedrooms. People and their families could choose whether they wanted to use the memory box or not. However we did not see such items on the other units, where there was only a small name plate on each door to assist people to identify their own rooms. There was also a lack of 'dementia' friendly signs which can also help orientate people within the unit. We recommend that best practice guidance for providing dementia friendly environments are followed for all units at the service.

Two units (Halifax and Shackleton) had a range of fiddle toys, fiddle muffs, dolls (for doll therapy) and other items that people living with dementia could handle. These items can be useful to occupy or distract people living with dementia, reducing their anxiety and agitation. We were told these were a pilot scheme and may be purchased for other units in future.

We noted throughout the inspection that pets were allowed on the units. A family of cats lived on site and were let into the units. Staff brought their dogs into the service as well. The people we saw responded well to the presence of these pets and they gave an opportunity for staff to prompt discussions with people.

Good

Is the service caring?

Our findings

Everyone we spoke with said the staff were caring and kind. People told us, "The staff are fantastic" and "Yes, the staff are very good to me." A relative told us, "The staff are definitely kind and caring, and they have a laugh as well" and another said, "The staff are so lovely with mum."

The staff we spoke with knew people's needs and were able to describe to us the support people needed and their likes and dislikes. Staff understood the principles of person centred care, explaining this involved treating each person as an individual, being flexible and that support should be tailored to each person to meet their needs and choices.

Each person had a 'My Story' document which detailed the person's family, jobs they had done and hobbies they enjoyed. We found these had not always been completed. The registered manager told us that many people did not have any family who visited, which meant they were unable to establish the information if the person was not able to tell staff themselves. People also had a 'lifestyle' document which stated what the person liked to do, for example one person's lifestyle document stated they liked to sit in their wheelchair rather than transfer to a chair, go out with a personal carer each week and attend church services. We saw from the care file daily notes that these preferences were supported and the chosen activities took place.

This meant, wherever possible, staff were provided with the information about people and their lives to be able to form meaningful relationships with them. A relative said, "They (care staff) have a good knowledge of mum."

Throughout our inspection we observed and heard kind and respectful interactions between staff and the people they were supporting. Staff explained how they maintained people's privacy whilst providing support and that they informed people about the support they were going to provide so people knew what the staff doing. One person said, "The staff respect me; they always use my full name." Relatives told us, "Yes, they give mum privacy when changing her, for example" and "They change her clothes when needed and always dress her very nicely."

We saw staff encourage people to eat, drink and mobilise independently where appropriate. Staff also described how they encouraged people to retain their independence by allowing them to complete any personal care task they are able to do for themselves. One person said, "The staff help me be independent every way they can. I get people to help me with different things when I need. I like it here." A relative told us, "They encourage mum to do things for herself and stay active, like have a good wash every morning."

We saw visitors were welcomed at the home. They could visit at any time and were able to share a meal with their loved one if they wanted to.

In each person's care file we saw a future decisions plan. People's wishes for their care at the end of their lives were recorded, for example if they wanted to stay at Ringway Mews or be admitted to hospital. We saw

the Nursing Home Team (NHT) were involved in assessing people's capacity to make any advanced decisions and people's family were also involved in the discussions. Where agreed a do not attempt cardiopulmonary resuscitation (DNACPR) was in place.

At our last inspection in May 2016 we were shown a 'your future' document that we were told Bupa were going to introduce across the home. This was a comprehensive advanced planning document to encourage discussions with people and their family, where appropriate, about their end of life care. We did not see this in people's care files at this inspection.

We saw four units had been accredited with the Six Steps end of life care programme. The Six Steps is a nationally recognised programme for supporting people and their families about making advanced decisions about the care they want at the end of their lives and their wishes after death. Named staff on the recently opened Wellington unit, were being enrolled on the Six Steps programme.

We looked at the care file for one person on Shackleton unit who was at the end of their life. We saw that their care had been regularly reviewed by the GP, dietician and physiotherapist. However the person's care needs for their end of life care had been added to the evaluation section of their current care plans, rather than updated the actual care plan. For example, in the "senses and communication" section it was noted "[name] can communicate all their needs verbally. Wears glasses for all purposes and can use the nurse call bell" and in "choices and decisions over care" it was noted "[name] likes to stay in their comfortable chair during the day, where they choose to eat all their meals." This was no longer the case. A more accurate assessment of their current needs was recorded on the plan of care evaluation sheets in each section. This meant the information on the person's current needs and how staff should meet them was in the care file but not easily accessible to the staff team. A staff member we spoke with was very knowledgeable about the person's current care needs.

We discussed this with the registered manager, who acknowledged that a specific end of life care plan would more clearly be able to reflect a person's current support needs at the end of their lives. They said they would raise this within Bupa.

This meant people's wishes at the end of their lives were recorded and people's end of life care needs were assessed, but this was not easily accessible for the care staff.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection at Ringway Mews we found a breach of the Health and Social Care Act Regulations as additional care plans had not always been completed to guide staff in how to meet people's needs. At this inspection we again found care plans that did not fully reflect the support people required to meet their needs.

We looked at ten care files across all five units. Each file contained a pre-admission assessment of need, written after speaking with the person, their family where appropriate and any professionals, for example hospital staff and social workers, involved in the person's care. Staff told us they were given a verbal handover of information from the unit manager, nurse or senior carer before the person moved to the service. They said they read the care file when they had the opportunity to do so. All the staff we spoke with told us they had sufficient information about a person's needs when they moved to the service to be able to safely support them.

A set of care plans and risk assessments were completed when the person moved to the home. Clear timescales for the completion of the documents were in place.

We were told, and saw, that the care plans were in the process of being re-written. This was due to findings at the last CQC inspection and from Bupa's own audits that had identified short falls in the care plans, including a lack of clarity on what tasks people were able to complete for themselves, what they required support with and ensuring needs recorded in one section of the care file were reflected in other, related, care plans.

Some of the care files we looked at had been re-written and others had not. We found in one care file on Anson unit that had been re-written that the 'mental health and wellbeing' care plan noted the person 'can be non-compliant with personal care.' The evaluations for this care plan stated '[name] can still be challenging at times.' We looked at the washing and dressing care plan and found that the non-compliance and challenging behaviour was not mentioned in this plan. This meant there was no guidance for staff on how to support the person if they were non-compliant with their personal care.

On Halifax unit staff told us that one person now required two staff to support with washing and dressing and three or four staff when they had a bath or for personal care if they were agitated. This person's care file had not been re-written. We saw a behavioural assessment had been completed stating the person may reverse their sleep (i.e. sleep during the day and be awake at night), sleep in the lounge rather than in their bed and invade other people's personal space. A protection plan was in place advising staff to guide them away from others if they were too close to other people.

However the washing and dressing care plan stated the person required one or two staff to support them. If the person was non-compliant then staff should leave the person and return a few minutes later to try again. A best interest decision for personal care also stated staff should leave the person and return if they were being non-compliant and the least restrictive practice for a basic level of cleanliness should be used. Staff

told us that on occasions they had to hold the persons hands when providing personal care as the person would not always allow staff to change them if they had been incontinent. This was not recorded in the care file. This meant staff had developed a system of working that involved physical contact with the person in order to meet their needs for cleanliness that was not contained within the care plans. The unit manager told us that it was very rare for three or four staff to be needed; however the staff said this was now a regular occurrence, especially when supporting the person to have a bath. Any support provided that requires physical contact in order for the support to be delivered needs to be assessed and documented to ensure the support is in the person's best interest.

Separate behavioural support plans, which would provide guidance for staff when the person was agitated, had not been written for either of these two people.

We also noted that not all sections of the care plans had been regularly evaluated. This meant it was not clear whether the care plan wholly reflected the residents' current needs. The service had a system where one person in each unit was the 'resident of the day.' This meant all care plans should be evaluated and the activities officer would spend time with the person to find out what activities they would like to do. We were told that if an agency nurse was on duty or there was an incident on the unit the care plans may not be evaluated that day, but this should be noted and completed the following day.

This was a continuing breach of Regulation 9 (3)(b) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We were told assistance to re-write the care plans was being provided by the Bupa Quality Assurance Support Manager (QASM) and a Bupa 'Admiral' nurse. They were in the process of working with the unit managers, nurses and senior care workers to improve their skills in writing care plans. The QASM and Admiral nurse audited the re-written care plans and made recommendations for any changes required. We saw the audits showed the quality of the plans was improving. This would mean once the care plans had been re-written the senior team at Ringway Mews should be able to maintain the quality of the care plans in the future as they would have the skills to do so.

From the care files we viewed we saw that the re-written care plans included more detail about what people were able to do for themselves and where they required support from the staff team.

Each care file had a 'My Portrait' form at the front of the file. This was a one page summary of a person's support needs in each area covered by full care plans and was a good introduction to each person's needs for the care staff.

Where appropriate we saw relatives were involved in their loved ones care plans. Relatives told us they were kept informed of any changes in their loved ones health and wellbeing. One relative said, "There is a good dialogue with senior staff here."

We saw daily notes were written for each person detailing the support they had received that day and general information about their health. These records were dated, timed and signed by the care staff writing them. However on Shackleton unit we saw that the daily notes were written after lunch during the day and so did not contain any information about the afternoon, tea time or evening before the night staff started their shift. This was also noted at our last inspection. This meant that information relating to the needs and support people required may not have been fully recorded. We were told, and saw, that the service had provided training and support for staff to improve the recording of the daily notes.

Relatives we spoke with said they had been involved in agreeing their loved ones care plans. We were also told the staff kept them informed of any changes in their loved ones health or wellbeing. One relative said, "There is a good dialogue with senior staff here."

The service had five activity officers working a total of 80 hours per week between them. We saw a programme of regular activities was arranged, such as quizzes, bingo, other games and art and craft sessions across the units. One activity was arranged for each unit each day. People were also able to go to activities in different units if they wanted to. A monthly trip was arranged, for example to Blackpool and Chester Zoo. People told us they enjoyed the trips out. The service had links with the local church and we saw three nuns visiting people to say prayers with them if they wanted to. We were told people went out to the local park or for lunch when the weather was nice.

Each unit had access to a garden area, some of which had raised beds. The grass areas were well maintained, however some of the raised beds were overgrown. We were told on Halifax unit a garden shed had been purchased so one person was able to bring their gardening tools from home and potter in the garden.

The service had a formal complaints procedure in place. Any complaints received were investigated and responded to. Any actions taken, for example if staff had a supervision or training following the complainant, were noted. A log of all complaints received was kept so that any trends in complaints or complainants could be monitored.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place as required by their registration with the Care Quality Commission (CQC). Since our last inspection in May 2016 the registered manager went on an extended period of leave, returning to work in February 2017. During the registered manager's extended leave the service had two different relief managers in place.

The service had a clinical service manager (CSM), who had moved to the role of unit manager the week before our inspection. Two CSM's had been recruited who were due to start work shortly after our inspection. Their role was to support the registered manager, unit managers and complete a series of audits of the service.

Bupa have a substantial number of audits for their services, including daily walk rounds by the registered manager or CSM, monthly care plan audits, monthly medicines audits, monthly area manager audits, quarterly health and safety and infection control audits. There were also six monthly visits by the estates service (checking on the repairs of the buildings), catering service and a six monthly assessment review tool.

However, as noted in this report, during the registered manager's extended leave issues highlighted at our last inspection were not addressed, for example short falls in care plans and cream charts. The six monthly assessment tool completed in December 2016 noted that actions from the area manager's monthly audits had not been completed. During this time we also saw that supervisions had not been completed and training had not been arranged. Feedback from some senior staff was that they had felt 'vulnerable' when the registered manager was on extended leave as there had not been consistency of support from the two relief managers.

The feedback from the Nursing Home Team (NHT) also stated that 'the Home really missed [registered manager] when she was on leave' and that they were re-assured that the registered manager dealt with any issues that the NHT brought to their attention.
This meant that during the registered managers extended leave there was a breach of Regulation 17 (1) with regard to (2)(a)(b) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

Since the registered manager had returned to work these issues had been addressed. It had been identified that the care plan audits that had been completed by the CSM had not been robust enough to highlight the short falls that the external audits found. The registered manager had obtained the support of the Bupa Quality Assurance Support Manager (QASM) and a Bupa 'Admiral' nurse to support the senior staff to improve the quality of the care plans, including the mental capacity and best interest plans. Training was now up to date and supervisions were being completed. New cream charts had been introduced.

The two new CSM's would receive training from experienced CSM's at other Bupa homes and would support the registered manager to have a robust auditing system.

A Home Improvement Plan (HIP) was in place for the home. This had been devolved to each unit so they had

their own improvement plan. The plan included ensuring medicines checks were completed daily and weekly. New people moving to the service had all the necessary care plans in place within 72 hours, supervisions were completed and care plans were re-written to the agreed schedule.

This should support the service to meet the requirements of Regulation 17. We will check the progress of this at our next inspection.

The registered manager showed us how they monitored trends of falls, pressure sores, nutrition, medicines errors, the use of bed rails, hospital admissions, accidents and incidents across all units through a Bupa computer system. All details are put into the computer system and graphs and tables of the data are produced.

The registered manager held daily meetings with the unit managers, chef, maintenance and head housekeeper. These were used to share information about any issues on the units.

Quarterly health and safety and quality assurance were held to discuss and address any issues highlighted in the audits and any maintenance issues across the service.

Staff told us regular team meetings were held for each unit. They said they were able to contribute to these meetings and raise any concerns or issues they may have. We also saw regular resident and relatives meetings were held.

We saw surveys were conducted by a central Bupa department for relatives and staff. Results were collated centrally and sent to the registered manager who responded to any points raised.

This meant the service sought people's views on the home and responded to the issues and requests made.

Staff were positive about working at the service and said that the unit managers, nurses and senior care staff were approachable and would listen to them when required. Staff said, "We work well together as a team," and "There is a high standard of care here, together with a general positive ethos." Another member of staff commented, "There is a positive feeling around the place, particularly since the registered manager has returned to work."

The feedback from the NHT was positive about the registered manager and unit managers, although they noted that some units did not always run as well when the unit managers were not present.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not always reflect a person's current needs or provide guidance for staff when supporting people who were non-compliant with their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Gaps in the cream charts records, the signing of the MAR before administering a medicine and the lack of reporting of a missing tablet. Unlocked sluice rooms, cleaning cupboards and length of time to complete repairs on the sluice room.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance During the registered manger's extended leave actions from CQC's previous inspection and from Bupa's internal audits were not addressed, supervisions had not been completed and staff training had not been arranged.