

Aspire: for Intelligent Care and Support C.I.C

The Limes

Inspection report

Moorfield Close
Swinton
Manchester
Lancashire
M27 0FN

Tel: 01617943042

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This was an unannounced inspection carried out on 09 March 2016.

The Limes care home provides accommodation for a maximum of 30 people. It provides intermediate care (rehabilitation) for 28 people, which is shared with Salford Primary Care Trust and staffed by a Multi-Disciplinary Team. The home also provides two respite beds for people who require short term placements.

The provider, which is called Aspire for Intelligent Care and Support C.I.C Ltd, is a new employee owned social enterprise and is a 'community interest company,' which registered with CQC in June 2015. The service had up until that point been operated by Salford City Council. The 'community interest company' structure is intended to ensure that assets are kept within the company and activities are carried out to benefit the local community. Though Aspire is a new provider, the service is run by the same management team and staff, who were previously employees of the local authority. All staff had the opportunity to purchase a one pound share that had no monetary value, but allowed them to vote at the annual general meeting and have input into how their company was run.

There was 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.

This service and provider have not been previously been inspected by the Care Quality Commission (CQC).

We found the home relied heavily on the clinical assessments that had been undertaken by the healthcare teams such as the MDT or visiting health professionals. These included risk assessments such skin integrity, falls risk and nutritional. Staff were able to confirm that risk assessments had been undertaken and confirmed that these were discussed and documented at handovers. We found no evidence in any of the care files we looked at that risk assessments had been undertaken by the home and there was only very limited written guidance available for staff on how to manage risk for individual people around falls.

Overall after discussions with both the visiting health professional and the MDT team members, we were satisfied that the management of risk was safe, however this was not accurately reflected in care files. Records relating to risk assessments and involving the MDT and District Nurse Team were held separately. We found the MDT, District Nurses and the home were all involved in caring for people who used the service. MDT and District Nurses carried out their own assessments, but the documentation of how it was improving the outcome for individuals was not captured.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), in relation to good governance. We found the service had failed to maintain accurate and complete contemporaneous records for people who used the service.

We spoke with staff to see what supervision, annual appraisals and support they received. Supervisions and appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner. Whilst some staff acknowledged receiving supervision and confirmed that support was always available, a number of staff stated they had not received supervision consistently and could not remember whether they had received an annual appraisal.

One manager told us that each assistant managers had been allocated staff to undertake supervision with and they were currently aiming to undertake this every three months. From speaking to staff and looking at supervision records, this was not currently happening.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, because the provider could not demonstrate the appropriate support and professional development of all staff.

We found there were no management systems in place to review the quality of care files and ensure accurate and complete contemporaneous records were maintained for people who used the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service failed to assess and monitor the quality of service provision effectively.

People we spoke with consistently told us that they felt the home provided a safe and secure environment.

We found the service had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse.

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. During our visit we found there were sufficient numbers of staff on duty during the day to support people who used the service.

We found people were protected against the risks associated with medicines, because the provider had appropriate arrangements in place to manage medicines safely.

The environment within the home was generally clean, but there were areas where the décor appeared to be old and in need of redecoration.

Staff we spoke with confirmed they received an induction when they started working at the home, which included an introduction to the workplace, working systems, policies and procedures, training and development requirements.

Throughout our inspection, we observed staff seeking consent from people before delivering any care or treatment such as medication, support with mobilising, personal hygiene or support with eating.

We have made a recommendation about suitable environments for people living with dementia.

People we spoke with were complimentary about their overall impression with the care and support provided at the home. People who lived at the home described staff as caring and spoke positively about them.

Health professionals we spoke with during the inspection including the members of the Intermediate Care

Team or visiting Health professionals told us that the home responded professionally, efficiently and with good effect for people who used the service.

We found that the service routinely listened to people to address any concerns or complaints. We found the provider had effective systems in place to record, respond to and investigate any complaints made about the service.

Staff told us they enjoyed working at home and that managers were approachable and listened to any concerns they had.

We looked at the minutes from various team meetings including staff and senior team leaders. We saw topics of discussion included rotas, professional boundaries, meal times, medication and falls management.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Not all aspects of the service were safe. We found no evidence in any of the care files we looked at that risk assessments had been undertaken by the home and there was only very limited written guidance available for staff on how to manage risk for individual people around falls.

We found the service had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse.

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. During our visit we found there were sufficient numbers of staff on duty during the day to support people who used the service.

Requires Improvement 

Is the service effective?

Not all aspects of the service were effective. Whilst some staff acknowledged receiving supervision and confirmed that support was always available, a number of staff stated they had not received supervision regularly.

Staff we spoke with confirmed they received an induction when they started working at the home, which included an introduction to the workplace, working systems, policies and procedures, training and development requirements.

There was limited evidence of any written consent that had been obtained from people who use the service or their representatives.

Requires Improvement 

Is the service caring?

We found the service was caring. People who lived at the home described staff as caring and spoke positively about them.

Throughout the inspection, we observed staff interacting with people in a kind and friendly manner. Care was delivered with kindness and consideration for people.

Good 

People confirmed they were treated with respect and dignity by staff.

Is the service responsive?

Not all aspects of the service were responsive. We found the service had failed to maintain accurate and complete contemporaneous records for people who used the service.

People and their relatives told us that the home was responsive to their needs and they were involved in deciding the care they or their loved one's received, however this was not clearly documented in their care files we looked at.

We found that the service routinely listened to people to address any concerns or complaints. We found the provider had effective systems in place to record, respond to and investigate any complaints made about the service.

Requires Improvement ●

Is the service well-led?

Not all aspects of the service were well-led. The service failed to assess and monitor the quality of service provision effectively.

Staff told us they enjoyed working at home and that managers were approachable and listened to any concerns they had.

Staff told us they felt there was a positive culture within the home and that staff worked well together.

Requires Improvement ●

The Limes

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 checked 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 09 March 2016 and was unannounced. The inspection was carried out by two adult social care inspectors and a specialist advisor. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of service being inspected. Their role is to support the inspection. The specialist was a nurse with experience of investigating safety incidents in Secondary Care/Primary Care and care homes.

Before the inspection, we reviewed information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local safeguarding teams, local commissioning teams, environment and community safety directorate, infection control and Healthwatch.

At the time of our inspection there were 27 people living at the home of which two people were receiving respite care. We spoke with nine people who used the service and five visiting relatives. At the time of our inspection, the home employed a total of 50 staff. We spoke with nine members of care staff and the activities coordinator. We also spoke with two registered managers, two assistant managers and a two visiting Health Care Professionals. Staff and management at the home did everything possible to help and support the inspection visit.

We also spoke with three members of the Multi-Disciplinary Team (MDT) of the intermediate care team who were located at the home. The MDT was made up of an Advanced Nurse Practitioner, Physiotherapists, Occupational Therapists, Rehabilitation Technicians and a Social Worker.

Throughout the day, we observed care and treatment being delivered in communal areas that included lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We looked at people's care records, staff supervision and training records, medication records and the quality assurance

audits that were undertaken by the service.

Is the service safe?

Our findings

People we spoke with consistently told us that they felt the home provided a safe and secure environment. One person who used the service told us, "I'd like to think I'm safe. I've had trouble with my foot and the staff are looking after me very well." Another person who used the service said "I've never felt unsafe. I feel safe with the staff and trust them to do the right thing." Other comments from people who used the service included, "Oh yes. The building seems secure and they come when I pull my buzzer." "Yes staff come when I need them and the security feels good, just like at home."

One visiting relatives told us, "She is definitely safe. Was falling previously at home, but that has reduced here. It's good knowing someone can watch her". Another relative said "He is much safer than when he was at home. I feel better now he has 24 hour care."

We looked at a sample of 10 care files to understand how the service managed and assessed risk. As part of the inspection, we also 'pathway tracked' two care files. This is a method we use to establish if people are receiving the care and support they need and if any risks to people's health and wellbeing are being appropriately managed. We found that the Multi-Disciplinary Team (MDT) and home staff undertook a handover of information each morning, which provided all staff with current up to date information about people who used the service including potential risks. This information was written on handover sheets by members of the MDT to ensure it was available to all staff working at the home and provided the most up to date information.

We found the home relied heavily on the clinical assessments that had been undertaken by the healthcare teams such as the MDT or visiting health professionals. These included risk assessments such skin integrity, falls risk and nutrition. Staff were able to confirm that risk assessments had been undertaken and confirmed that these were discussed and documented at handovers. We found no evidence in any of the care files we looked at that risk assessments had been undertaken by the home and there was only very limited written guidance available to staff on how to manage risk for individual people around falls.

We looked at the daily handover sheet completed by the MDT. We noted that for some people the document did provide mobility instructions for staff, but did not give any instructions for personal care/night time needs. Information on the handover sheet did describe mobility requirements and provided some instruction, but this was mainly about the number of staff required for transfers and mobilising using walking frames for short distances and wheelchair for longer distances. No other instructions were available in managing the risk of falls, such as consideration of any visual impairment of the person.

We found there was a 'Care Alert Unit' system in place, which was an infrared system that was used to manage the risk of falls of people who used the service. It was a numbered system where a person at risk would be allocated a number. The member of care staff carried an alert device and was able to respond immediately if the alarm was triggered by the person in their room.

Overall, after discussions with both the visiting health professional and the MDT team members, we were

satisfied that the management of risk was safe, however this was not accurately reflected in care files. Records relating to risk assessments and involving the MDT and District Nurse Team were held separately. We found the MDT District Nurses and the home were all involved in caring for the person who used the service. MDT and District Nurses carried out their own assessments, but the documentation of how it was improving the outcome for individuals was not captured. This would have provided evidential assurance that collectively all risks had been taken into consideration and that the home had brought all that information together in the person's care file.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), good governance. We found the service had failed to maintain accurate and complete contemporaneous records for people who used the service.

The Intermediate Care Team, consisting of MDT provided a service from 7.30 am to 4.30 pm Monday to Friday. If clinical requirements were needed outside of these of hours the home would access advice and guidance by different routes including out of hours 111 service or emergency response.

We found people were also protected against the risks of abuse, because the service had robust recruitment procedures in place. Human resource facilities such as recruitment procedures were contracted out to Salford City Council. We reviewed a sample of personnel files and were able to confirm that staff had been safely and effectively recruited. Records included application forms, previous employment history, interview assessments and suitable means of identification. We found appropriate criminal records bureau (CRB) disclosures or Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained before new staff commenced employment with the service.

We found the service had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. We looked at the service safeguarding process used to manage any concerns and looked at the service whistleblowing policy. This provided guidance to staff on how to report concerns and what action the service would take in responding to such matters.

We spoke with staff about safeguarding procedures and asked how they would recognise any signs of potential abuse. One member of staff told us, "Verbal, physical, sexual and financial abuse can all occur. Stealing people's money or making people feel embarrassed on purpose would be examples of abuse." Another member of staff said "One person was making inappropriate sexual comments to another resident and I reported that as a safeguarding. One person reported their money was missing and I felt that could have been potential financial abuse." Other comments from staff included, "We complete a body map on admission and if I saw some unexplained bruising I would report it straight away." "Speaking to people inappropriately could be classed as verbal abuse and being rough with people is physical abuse. We identify unusual bruises through using a body map."

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. During our visit we found there were sufficient numbers of staff on duty during the day to support people who used the service. One relative told us, "There always seems to be enough around. He is never left on his own." One visiting health care professional said "No concerns, there seems to be enough staff on each floor. Things have improved recently."

We spoke with staff and asked for their opinion on staffing levels at the home. One member of staff told us, "They were very bad in the past, but I've noticed it has improved recently. It is ok at the minute." Another member of staff said "They are much better under Aspire and I have no concerns at the minute. They have recruited new staff and the numbers are going up".

Other comments from staff included, "They weren't good a couple of months ago and we were using a lot of agency. They have improved now though and new staff have started, which has helped". "It feels a bit short at weekends sometimes. This weekend just past there were only four staff in the whole building. They are much better during the week". "The current numbers of staff is fine. I have no concerns about staffing levels. I'm convinced people are safe here and it is a safe environment for them." "The current night time staffing arrangements are fine, no concerns." We found that at night time, one of managers slept on the premises and was able to advise and support staff as required.

We looked at staffing rotas and spoke to the registered manager about how staffing numbers were determined. We were told the service did not use a dependency tool to assist in determining correct staffing levels at the home. The registered manager told us staffing was determined by personal judgement and was based on an assessment of people's needs on a daily basis.

As part of the inspection we checked to see how the service managed and administered medication safely. One person who used the service told us, "No problems with it touch wood. I have it morning, lunch and tea time and I always get it." Another person said "The staff bring me my medication. They stand next to me and make sure I have taken it." On the whole, we found people were protected against the risks associated with medicines, because the provider had appropriate arrangements in place to manage medicines safely.

We looked at a sample of 10 medication administration records (MAR). We found that apart from one medication record we looked at, the remainder had photographs, GP details and people's allergies recorded. This reduced the risk of medicines being given to the wrong person or to someone with an allergy and was in line with current guidance. We were reassured by the assistant manager that this omission would be immediately addressed.

We found fridge temperatures for the storage of certain medicines had been inconsistently recorded with gaps in records throughout February and March 2016. If medicines are not stored at the correct temperatures, this means they could not be safe to use. The assistant manager assured us this matter would be addressed with staff.

Medication known as PRN or 'when required' such as pain relief was supported by protocols. This provided guidance to staff on the safe administration of such medicines. We found the Advanced Nurse Practitioner from the MDT, regularly reviewed people's medication requirements.

During our inspection we observed a meeting involving care home management, MDT staff and a Community Pharmacist. We found that the meeting had been called by the Pharmacist in response to reviewing how services could be improved in order to improve the safety for people who used the service at the home. This meeting demonstrated the effective working relationship between the service and other agencies in an effort to improve the management of medication within the home.

The environment within the home was generally clean, but there were areas where the décor appeared to be old and in need of redecoration. We saw there were a number of hand washing sinks available throughout the building, but a sink on the ground floor did not have any hand towels available to dry hands and a paper towel similar looking to kitchen roll was being used instead. We saw that there was no hand gel available for use throughout the day for the home, although it was noted that members of the MDT had their own hand gel available. We were told by MDT staff that they undertook a hand wash audit throughout the month and reported their findings at home governance meetings. The manager assured us these concerns would be addressed immediately.

Is the service effective?

Our findings

We spoke with staff to see what supervision, annual appraisals and support they received. Supervisions and appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner. Whilst staff acknowledged receiving supervision and confirmed that support was always available, a number of staff stated they had not received supervision consistently and could not remember whether they had received an annual appraisal. One member of staff told us, "I haven't had supervision for some time." Another member of staff said "I haven't had one since joining Aspire. They weren't always that regular under the old provider either."

Other comments from staff included, "I haven't had one yet to be honest and I have been here 18 months now." "I have had a yearly appraisal, but I'm not aware of one to one supervision." "I have had supervision, but I'm not sure how often it should be."

One manager told us that each assistant managers had been allocated staff to undertake supervision with and they were currently aiming to undertake this every three months. From speaking to staff and looking at supervision records, this was not currently happening. One assistant manager told us, "We really haven't the time to conduct supervision with staff and have raised it as a concern with senior management."

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, because the provider could not demonstrate the appropriate support and professional development of all staff.

We looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. Staff we spoke with confirmed they received an induction when they started working at the home, which included an introduction to the workplace, working systems, policies and procedures, training and development requirements. Staff also confirmed they undertook a period of 'shadowing,' where they were able to observe experienced members of staff. Staff were also required to complete the Care Certificate Programme, which provided a comprehensive introduction to adult social care during their 6 month probationary period.

Senior staff were able to confirm they received regular training to support their own individual professional development, which we verified from looking at training records. One member of staff told us, "A lot of in-house training is provided, which is good. I've done health and safety, stoma, medication, safeguarding and infection control. Training is better than with the previous provider." Another member of staff said "The feedback I am getting is that there is a lot in the pipeline. It is certainly improving under Aspire." Other comments from staff included, "Training is good and there is a lot available. I've done training about bowels and bladder and infection control lately. There is enough available. I also done moving and handling and my refresher is coming up." "The training is superb, you can't knock it." "We do regular mandatory training such as first aid, food hygiene, medication, infection control and moving and handling. I definitely feel well trained and supported to undertake my role."

The Advance Nurse Practitioner within the MDT told us they had offered to provide training to care staff regarding clinical issues to enhance the care provision for people in relation to catheter care and this had been agreed with home managers.

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. At the time of our inspection, no one who was living at the home were subject of a Deprivation of Liberty Safeguards (DoLS). In the sample of 10 care files we looked at during the inspection, we found no evidence that people had been subject of mental capacity assessments. The manager said this was because the service relied on information provided by the hospitals in respect of people's capacity, but would ensure this information was recorded within all care files in future.

Staff we spoke with were able to explain the principals of the legislation even though not all had received training in the MCA. One member of staff told us, "I haven't done a training course around it. We must initially presume people have capacity initially and then seek advice if that is not the case." Another member of staff said "I haven't done training. If people have dementia and want to leave the building then a DoLS would be required."

Throughout our inspection, we observed staff seeking consent from people before delivering any care or treatment such as medication, support with mobilising, personal hygiene or support with eating. One person who used the service told us, "The carer came in today and asked if it was ok to wash me." We spoke with staff about their understanding of consent. One member of staff said "Sometimes we get quite challenging people. We need to respect people's decisions and understand that if somebody says no, then it is a no." Another member of staff told us, "I always still ask people first even if they have no capacity. If people refuse personal care then I will respect that. I will encourage to a certain point before seeking advice."

In the sample of 10 care files that we looked at, we found that in nine files there was no evidence of any written consent had been obtained from people who use the service or their representatives. The manager assured us steps would be taken to demonstrate in care files that consent had been formally obtained and documented.

We found people had access to healthcare professionals to make sure they received effective treatment to meet their specific needs. We found the shared care arrangements between the home and inclusive of the Intermediate Care Teams / District Nurses / Pharmacist / GP, were effective in the provision of improved outcomes for people who used the service. People had access to support from external agencies such as dietician services. We found the working relationships between the managers and MDT was good with communications occurring on a daily basis. Electronic communication in relation to sharing information from the Electronic Health Records was effective and staff told us that the system worked well and to the benefit of the people and staffs understanding of the people's progress. We saw that district nurses had good access to the home and that the home had provided an area in the medication room for the nurses to use. District nurses were able to store care records in this room and white board had been installed that was used for information sharing about the people who used the service.

The adaptation and design of the home was generally of a good standard, though was in need of decorating. However, we found the home did not have adequate signage features that would help to orientate people living with dementia. Confused people would find it difficult to locate their individual

rooms or the toilet. We saw little evidence of dementia friendly resources or adaptations in any of the communal lounges, dining room or bedrooms. This resulted in lost opportunities to stimulate people as well as aiding individuals to orientate themselves within the building.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

During our inspection we checked to see how people's nutritional needs were met. On the whole people were satisfied with quality of food provided by the home. One person who used the service said "It's not bad on the whole. I wouldn't say it's top notch, but it will certainly do for me. There are different choices and alternatives." Another person told us, "It's average so far, but I've only been here since Sunday. I asked for bacon and egg today, but was told that is on the menu for Sunday. I wasn't offered the choice."

Other comments from people who used the service included; "The food is very substantial." "The meals are good and are cooked on time." "The food is alright, especially the soup, that's beautiful. There was a choice of sandwiches today and different desserts." "The food is good. I've been told to eat and drink more to help me get better. The staff encourage me all the times." Comments from visiting relatives included, "My relative wasn't eating when she was at home, but is eating a lot better since coming here." "The food looks nice. It certainly smells it as well."

Staff we spoke with demonstrated an understanding of the importance of nutrition and hydration. One member of staff told us, "This is discussed on admission. The kitchen staff have a record of who is on specific diets and then we serve them to people. Some are on pureed and one lady has a kosher diet. I aim to give people plenty of fluid each day and we make a record for everybody." Another member of staff said "I feel we are quite quick at noticing if people are at risk and often refer to dieticians. We add thickener to drinks on advice from the dietician as well. If people are at risk of being de-hydrated then I encourage as much fluid as possible." Other comments included, "I would refer to the care plan about people's nutritional needs. We are also given a rounding sheet each day, which informs us about people's specific diets and any risks. The kitchen have all this information as well."

Is the service caring?

Our findings

People we spoke with were complimentary about their overall impression with the care and support provided at the home. One person who used the service said "It's alright here. I was here a few years ago and have found them to be very helpful. They help me in and of bed and give me my meals. I would recommend it to other people. It helps you get ready for going back home." Another person told us, "Not bad, not bad at all. They take care of us. It's nice, comfortable and very pleasant." Other comments from people who used the service included, "You are given good food, plenty of attention and I think the concept of the place is very good." "I love it here. I really do like it. I'm glad I had the choice to come here." "My overall impressions are that it is very good. They have been very good with me whilst I have been here. They are looking after me."

People who lived at the home described staff as caring and spoke positively about them. Comments from people who used the service included, "The staff I have met so far are very nice. Very nice and very kind to me. I find them to be caring." "The staff are caring and they do their best." "They are ok. They are nice people as well. They have a job to do and they do it well." "There are some delightful ladies who will do anything for you." "The staff are alright and seem very good. You can have a bit of fun with them. They are very caring and very polite." "The staff are brilliant. They are caring and make sure I am not worrying about anything."

We spoke with visiting relatives about their impression of the home and staff. One visiting relative told us, "I think it's a bit run down, but the staff are good and kind. Our relative seems a lot better than when she first came in." Another relative said "I think he is fine here and it seems very nice. The building is a bit tired and dated though." Other comments from relatives included, "The staff are very friendly". "Nothing seems to be too much trouble for the staff here."

Throughout the inspection, we observed staff interacting with people in a kind and friendly manner. Care was delivered with kindness and consideration for people. Staff showed genuine concern for people's wellbeing and were not just performing a task. People looked clean and well groomed. Staff knew people and there was a friendly atmosphere between staff and people living at the home.

People confirmed they were treated with respect and dignity by staff. Comments from people who used the service included, "Since I have been here I have been treated very well." "The staff are never rude to me in the slightest and we have a bit of fun as well." "There seems to be a general culture of respect here." "They don't make a fool of you or anything like that, which shows respect." One visiting relative told us, "They are very pleasant with her and always knock on the door before coming in."

As part of the inspection we checked to see how people's independence was promoted. We asked staff how they aimed to promote people's independence. People told us that they were encourage to be independent as part of their rehabilitation. Comments from people included, "I am a very independent person. I'm due to go home soon and the staff let me do as much as I can for myself." "It is very much encouraged here. It's a rehabilitation unit so they do as little for me as possible, which is how it should be." "I don't like to move, but the staff encourage me to and remind me I won't get better unless I try." "I make my own bed and clean my

own room when I can".

Staff we spoke with recognised the importance of encouraging people to be independent as part of their rehabilitation. One member of staff told us, "Talk to them and encourage them, they can still do things themselves. I always remind them they won't necessarily be here that long and will be going home soon and need to do things themselves." Another member of staff said "People are here for rehabilitation so I encourage people as much as possible as their goal is to go back home. One lady buzzes for us to help her onto the commode, but sometime when you get there she has done it herself so it's important to remind her of that." Other comments from staff included, "I always observe what people can and can't do themselves. I try and do less for people the longer they have been here to get them ready for going home."

It was clear from observations and discussions that people were able to make choices and were involved in decisions about the care they received. Though people told us they were involved in making decisions about their care and were listened to by the service, this was not always documented clearly in care files. We found staff were respectful of people's choices and opinions. One member of staff told us, "Sometimes people wear clothes that aren't appropriate. I always point it out to them, but if they don't want to change that is their choice. I always see if people would like to stay in bed in the morning and let them get up when they want." Another member of staff said "I always offer people a choice of different clothes to wear. Sometimes people want me to wash certain parts and they do the rest so I'll ask and see what they prefer." Other comments included, "If I'm in people's room and they are getting dressed I offer them the choice of me either staying in the room or stepping outside. Communication is important so we know what people want."

The home made available quality assurance questionnaires in the reception area for people to complete in relation to the quality of care provided. We looked at several returns, which provided positive comments of services provided. A comments box was also located in the reception area.

Is the service responsive?

Our findings

Health professionals we spoke with during the inspection including the members of the Intermediate Care Team or visiting Health professionals told us that the home responded professionally, efficiently and with good effect for people who used the service. They reported that there was always a staff member available to assist if assistance was required at any time. One visiting health care professional described that there was a mind-set that the home was a rehabilitation place and that staff would always raise any issues of concern. They also described the working environment as open and friendly.

People and their relatives told us that the home was responsive to their needs and they were involved in deciding the care they or their loved one's received, however this was not clearly documented in their care files we looked at. One person who used the service said "Since I came in on Sunday they have met all my requirements fully." Another person told us, "It's fine for me here. The staff are doing everything I want."

As part of this inspection we looked at a sample of 10 care files. We found that care plans did not always accurately reflect people's current needs.

We found that not all care files contained information such as pre-admission details from the Acute Hospitals, or referral forms if the person had been referred to specialist services. All of the care files we looked at varied in content with limited or concise detail provided by the home. Individualised concise care planning by the home were difficult to find although this appeared to be addressed by the intermediate care unit and visiting health professionals. Care files were minimalistic and did not reflect fully the concise personalised picture of the person's needs or outcomes of risk assessments. We saw no evidence that any reviews of care or risk assessments had been documented within care files.

One file we looked at related to a person who was registered blind. Part of their treatment requirements was to have frequent changes of dressings. The care file contained limited information as to how this action was to be undertaken by staff. Although a body map was completed, the detail on the form did not indicate who had identified the areas of concern on the body map or what actions the home would take in updating the care file following care provided by district nurses.

The care file of this person also lacked information relating to an admission sheet that the home had completed, a photograph of the person, detail of next of kin or advocate, assessment of mental capacity, consent form, standard risk assessment forms, cognition / mood and preferences and choices. In one section of the file contained details of a Personal Profile, which detailed preferred name, what interests and religious requirements. It did not state who had completed this form and the detail given was not in-depth with only short answers to the questions. There was no indication of any family involvement in the completion of this documentation.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), in relation to good governance. We found the service had failed to maintain accurate and complete contemporaneous records for people who used the service, which has been referred to elsewhere in this

report.

The handover of information at the beginning of the day involving all staff and members of the MDT was informative. This gave the most up to date position of every person's needs for that day. We observed a health professionals meeting during our inspection, which provided a positive insight into medicines management with the home. The home were very supportive of the visiting health professionals who come into the home on either a daily basis or at regular intervals to assess further the treatment or care of people and to support them on their road to recovery.

During our inspection, we checked to see how people were supported with interests and social activities. We found that the home had an activities co-ordinator, who worked three hours each day over a five day period. One person who used the service told us, "They have sing along and various different performers. They do try quite hard to keep us entertained." Another person said "We did some Elvis Presley singing recently and there is plenty for us to do." A visiting relative told us, "They have a karaoke machine, which is always out. They were doing healthy heart and hips today and lots of people were taking part."

During our visit we observed people who appeared to be responsive to the activity of the day held in the first floor lounge area. Music was being played and the people were singing along and appeared to be really enjoying themselves. An activities board displayed what activities were available on each day, such as healthy hearts and hips.

The activities coordinator told us it was difficult to arrange outings as numbers were needed in advance for bookings. They felt that three hours a day was insufficient to ensure people were properly stimulated, however they organised both group and individual activities.

We found that the service routinely listened to people to address any concerns or complaints. We found the provider had effective systems in place to record, respond to and investigate any complaints made about the service. Comments from people who used the service included, "I have a poster on my wall informing me of how to make a complaint. I've never made one though." "I've never made a complaint, but think if I did, it would be handled appropriately."

Is the service well-led?

Our findings

At the time of our visit, the registered manager had had been in post since September 2015. 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.

The provider, which is called Aspire for Intelligent Care and Support C.I.C Ltd, is a new employee owned social enterprise and is a 'community interest company,' which registered with CQC in June 2015. The service had up until that point been operated by Salford City Council. The 'community interest company' structure is intended to ensure that assets are kept within the company and activities are carried out to benefit the local community. Though Aspire is a new provider, the service is run by the same management team and staff, who were previously employees of the local authority.

Staff told us they enjoyed working at home and that managers were approachable and listened to any concerns they had. The intermediate care team members told us that they felt they had a close working relationship with all members of staff and management at the home. They described that managers were always available if they needed to discuss care planning needs for people. Visiting health professionals told us they felt listened to by care home staff and managers. Staff told us they felt there was a positive culture within the home and that staff worked well together.

One member of staff told us, "The manager is still fairly new and is finding her feet. I feel I can approach her to raise issues though." Another member of staff said "Really good. Seem nice and friendly and open to listening to anything we have to say." Other comments from staff included, "The change to Aspire has gone smoothly. No concerns." "You can be open and honest with managers and they do listen if you have any concerns."

We found the service undertook a limited number of audits and checks to monitor the quality of services provided. One assistant manager told us that medication checks were undertaken daily, however these checks had not been recorded. We saw that regular checks of fire safety equipment and fire drills were undertaken. We found no evidence to indicate any audits undertaken by the home with regard to infection prevention and control or environments. However, the intermediate care team explained how they fed into the home's quality assurance processes by undertaking hand wash and nurse bell audits. These findings were reported to a Governance Meeting, which was held once a month and involved care home staff and the intermediate care team leads. Infection prevention and control was standing agenda item at this meeting.

We found no systems were in place to review the quality of care files and ensure accurate and complete contemporaneous records were maintained for people who used the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service failed to assess and monitor the quality of service provision effectively.

There was an accident-reporting book, which included forms that had been completed if an accident had occurred. A computer record was generated, which included other services within the company group. There was no written evidence seen of actions taken as a result of the incident either in the book or on the computer record. We were told by managers that the computer record generates an overall picture to the management team. The management team would in turn audit, analyse and act upon the results. Actions required would be considered at the home Governance Meeting involving managers of the home and the intermediate care team.

We looked at the minutes from various team meetings including staff and senior team leaders. We saw topics of discussion included rotas, professional boundaries, meal times, medication and falls management.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found the service had failed to maintain accurate and complete contemporaneous records for people who used the service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the provider could not demonstrate the appropriate support and professional development of all staff.