Bagshot Rehab Centre Limited

Bagshot Park Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bagshot Park Care Centre provides nursing care and rehabilitation for people with a range of complex needs such as acquired brain injuries. The service accommodates up to 22 people across two separate floors. At the time of our inspection, the service was supporting 21 people.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Although people and relatives told us they felt there were not enough staff, we did not observe any shortages that impacted the care people received. Staff also told us they felt they had enough staff to meet people's need. However, staff were not receiving regular supervision and people and relatives did not always feel agency staff were effective in their roles. We have recommended the registered provider addresses this through additional training and an improvement in supervision frequency. Although people's complex health diagnoses were recorded in care plans, further work was required to ensure staff without a medical background were aware of what this meant and how it affected the person. We have issued recommendations to the registered provider in relation to the Mental Capacity Act 2005 and people's care documentation.

People and their relative's felt unsettled due the number of managers that had been in post over a short amount of time. It is a requirement of a registered service to have a registered manager in place. A new manager had started on the day of the inspection and was in the process of registering with the CQC. We have issued a recommendation to the registered provider in this respect, and acting on feedback from people and relatives in relation to their concerns around the instability of managers.

People and relatives told us they felt safe at Bagshot Park. Staff were aware of their safeguarding responsibility and ensured the environment was clean and free from the risk of the spread of infection. Medicine administration, recording and storage practices were safe, and accidents and incidents were recorded and action taken to prevent reoccurrence. Complaints were recorded and outcomes reached that people and their relatives were happy with.

People were complimentary about the food at the service, due to the chef and kitchen team taking pride in the appearance and quality of the food they produced. Healthy and nutritious diets had resulted in people's health improving. Staff worked collaboratively as part of a multidisciplinary team to rehabilitate people back to a level of independence. Adapted equipment was used as part of this process, with the environment itself being conducive to people's mobility needs.

People and relatives told us staff were kind and caring towards them, respecting their dignity and privacy. People were involved in decisions around their day to day care, with staff allowing flexibility in people's routines to ensure they could take part in activities and events they wished to attend. Activities both in

house and externally were person centred, allowing people to lead as normal a life as possible. Staff were extremely knowledgeable around people's individual communication needs.

Regular audits identified issues which were resolved, and the clinical advisor had informed the CQC of notifiable events. Plans were in place to improve the skill level and development of staff, and close partnership working with external organisations ensured sustainability of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 15 September 2016). Since this rating was awarded the provider has altered its legal entity. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Bagshot Park Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of three inspectors, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Bagshot Park Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was in the process of registering with the Care Quality Commission. This means that once registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. In the meantime, the clinical advisor had been overseeing the day to day running of the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with eight people who lived at the service, six relatives and 14 members of staff including the chef, manager and clinical advisor. We reviewed a range of documents including eight care plans, administration records, accident and incidents records, policies and procedures and internal audits that had been completed.

After the inspection
We continued to seek clarification from the clinical advisor and manager to validate evidence found. We looked at training data and quality assurance records.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated Good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at Bagshot Park Care Centre. One person said, "The individual carers indeed are very good." A relative said, "They talk to [my loved one] and explain what they are doing and this is because she is blind as well immobile from the neck down."
- Staff were aware of safeguarding policies and procedures, and were able to explain what constituted abuse. One staff member told us, "I would always make management aware. I'd go to the police if I needed to or I can whistle-blow." The clinical advisor said, "I'm confident my staff know how to report a safeguarding. We have training and meetings every week so it's always discussed. They understand what should be reported."
- Safeguarding concerns had been appropriately referred to the local authority. Where needed, the clinical advisor had gathered information such as witness statements to support safeguarding investigations.

Assessing risk, safety monitoring and management

- Risks to people were appropriately recorded and managed. One person was at high risk of falls. Staff were safely mitigating this risk by following the guidance in their care plan. This included ensuring the person was supported by two staff when transferring, and their wheelchair which they used for longer distances was set up correctly.
- Another person had a percutaneous endoscopic gastrostomy (PEG) in place to enable them to receive food, fluids and medicines as they were unable to take these orally. Only trained staff carried out PEG administration and ensured it was clean. This was in line with the person's risk assessment.
- People were encouraged to take positive risks. The clinical advisor told us. "We do take risks, that's part of rehab. For example, someone had [an accident] and she wanted to go home to see her family the day after coming here. As a team we did the risk assessment and made it happen. Although it's a risk, we worked very closely with the partner and did a home visit. Other services would probably not have let them. We find ways to make it happen." The person told us it had meant a lot to them as they had a young family and did not want to not be able to fulfil their parenting role.
- Personal emergency evacuation plans (PEEPs) were in place for each person. These advised staff how to support people to leave the building in the event of an emergency such as a fire.

Staffing and recruitment

- During our inspection we observed calls bells being answered in a timely manner and rotas demonstrated sufficient staffing levels were on shift. However, we received mixed views from people and staff about staffing levels. Some people and their relatives felt there were not enough staff, telling us they were "Sometimes a bit thin on the ground". A staff member felt this was not the case and told us, "We do have sufficient staff working here. I am able to step in if needed but very rarely am I needed to do so as I don't

think we are ever short staffed."
● Agency staff were used to cover sickness, holidays and current vacancies in staffing whilst a recruitment drive was taking place. The clinical advisor told us approximately 50% of the current workforce were agency staff. They confirmed in order to ensure continuity of staff, long term agency staff were used where possible. A staff member told us, "Using agency staff isn't an issue as many agency staff have been here a long time and if they are new they work alongside permanent staff." Another staff member said, "I have not seen much change in agency staff recently. Previously we had more working here and I didn't always get to see the same people but now it is more consistent and I think it works better for us as a team."
● Staff had been recruited safely. Recruitment files included references from previous employers, a full employment history, and a Disclosure and Barring Service (DBS) check. This check ensures that people are safe to work with vulnerable people such as the elderly and children.

Using medicines safely
● Practices around medicine administration, recording and storage were safe. Medicine administration records (MARs) were fully completed with no gaps and protocols were in place for as and when medicines (PRN). Handwritten additions to MARs were double checked and signed by two staff to ensure the information was correct.
● Controlled medicines were stored securely, as were medicine trollies when not in use. The temperature of refrigerators storing medicines were checked daily. Correct signage was in place for areas where oxygen was stored.
● Staff administering medicines wore a red 'do not disturb' tabard which other staff respected. There was flexibility with medication timings and provision for people if they were attending a trip, going out with family or attending appointments. Staff told us that although this could result in additional 'drug rounds', this should be the case for people in order for them to live as normal life as possible.
● Nurses received annual competency checks to ensure they were safe to administer medicines. These were completed more often if there were any concerns. The clinical advisor told us, "The nurses have regular competency checks. We manage a lot of tracheostomies (an opening at the front of the neck in which a tube is inserted into the windpipe to help breathing) here so we are always checking. We're known for complex respiratory care."

Preventing and controlling infection
● People were cared for by staff who adhered to safe infection control practices. We observed staff wearing aprons and gloves when preparing to support people with their personal care, and when handling people's food. Gloves and aprons were available to staff members throughout the service.
● People lived in an environment which was clean, tidy and free from malodours. One person said, "The house keeping staff are excellent. They want and do take pride in their work."

Learning lessons when things go wrong
● Accidents and incidents were recorded and lessons learnt to prevent reoccurrence. Documentation of accidents and incidents included information of what had happened, when it occurred and what actions had been taken to prevent it from happening again.
● For example, one person had removed their wheelchair lap strap which had resulted in them slipping out of the chair. Staff now ensured the person had an anti-slip sheet underneath them while in the wheelchair.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- People's legal rights were not always protected because staff did not always follow the principles of the MCA. Mental capacity assessments for specific decisions were not always in place. For example, one person required a lap strap on their wheelchair to keep them safe. Staff told us the person lacked capacity for this decision. However, there was no capacity assessment in place for this. This was despite the clinical advisor telling us, "We've got little posters around the service with the principles on them. They know it's decision specific." We raised this with the clinical advisor who told us they would ensure decision specific capacity assessments were in place. However, when we received copies of new capacity assessments following the inspection they were still not decision specific. We have asked the clinical advisor to rectify this.
- DoLS applications did not always include the restrictions to people, such as the lap strap. However, others were in place. For example, one person required their medicine to be administered covertly (without their knowledge). The appropriate DoLS application had been submitted for this.
- A tracker was in place to monitor the DoLS applications that had been submitted and when these needed to be reviewed and reapplied for. This ensured applications did not expire without being reviewed.
- People told us staff asked for their consent which helped their wellbeing. One person told us, "[Staff] all say, "are you happy for this now?" and if I am not ready I ask if they can call back in half an hour and they do." A relative said, "My daughter is comforted by being asked and explained what is happening."

We recommend the provider and manager ensure decision specific capacity assessments are in place and

DoLS applications reflect the restrictions in place for people.

Staff support: induction, training, skills and experience
● People felt permanent and long-term agency staff were well trained, but did not feel confident in the training of short-term agency staff. One person said, "The permanent staff receive a lot of the employer training, but I think the employers rely on the agency to train the agency staff." A relative said, "They all seem competent; however, the agency nurses are not as confident." Another relative said, "If it is permanent staff it is good or permanent agency it is fine. But the temporary agency staff, whether carer or nurse, is not great." We raised this with the manager and clinical advisor, who said they would address this with additional training and recruitment of permanent staff.

We also recommend the provider ensures short term agency or temporary staff have received the training required to be effective in their role.

● Staff were up to date with mandatory training. This included training in areas such as dignity and respect, nutrition and hydration and moving and handling. We observed them to be competent in these areas on the day of our inspection. Staff were sent a letter reminding them to complete training if this became overdue. The clinical advisor told us, "Training was all e-learning but now everything is face to face for mandatory, with complimenting work books."
● Staff were receiving regular supervision meetings. This meant staff were being giving ample opportunity to discuss their individual personal development and wellbeing.
● Staff told us they received a thorough induction to ensure they were effective in their role. This included completing training and shadowing an experienced member of staff. One staff member told us, "The trainer was so passionate and thorough. Everything was covered and even the difficult subjects such as end of life care were handled well. I shadowed a team leader and he was fantastic. I'm still learning from him. They make you feel you can ask anything and never make you feel you've asked a stupid question."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-assessment checks were completed to ensure the service could meet a person's needs before they moved in. The information gathered included what the person's mobility, nutritional and personal care needs were. These were then used to formulate a full care plan.
● Nationally recognised standards were used to determine people's needs. This included calculating people's body mass index (BMI) and waterlow score. A waterlow score gives an potential risk rating for the development of pressure sores.
● Staff were kept up to date with articles on national guidance around care. The clinical advisor told us, "We send out heatwave information from head office. If anything comes in from the National Institute for Health and Care and Excellence (NICE) we update the staff and keep the information in a folder."

Supporting people to eat and drink enough to maintain a balanced diet
● People and relatives gave us positive feedback on the quality of the food at the service. One person said, "It is good quality and plenty of choice and they can also deliver something for you." A relative said, "The food is amazing here." Another relative told us, "The quality of food is excellent."
● The chef had been shortlisted as a finalist in the Surrey Care Awards 2019. This was due to the pride they took in creating visually pleasing and pleasantly tasting modified meals. A person had submitted a supporting statement for the award nomination which read, "In January of 2019 I was very overweight so I decided I wanted to lose weight. [The chef] came to see me and agreed to help. With her help I have lost 22.6kgs. The meals have been nutritious, delicious and interesting in their variety and I feel that she has gone above and beyond her normal duties by taking a personal interest in my progress." The weight loss

had resulted in the person's breathing improving.

● People's nutritional preferences were noted in their care plans. For example, people's preference of breakfast food and time they liked to eat their meals was recorded. This allowed new and agency staff members to be aware of people's preferences if they were not always able to communicate this to staff. The chef told us, "When someone new comes into the home I will meet with them to discuss what foods they like and dislike. As a kitchen team we know what people's needs are and what they like to eat and what they don't like."

● People had an enjoyable lunchtime experience. Tables were nicely laid and decorated, but people were also able to eat in their rooms if they wished to. People were able to order food that was not available on the menu. The chef said, "People can have what they like to eat, we are always open to any requests that people have and if we can provide it for them then we will."

Staff working with other agencies to provide consistent, effective, timely care

● All staff we spoke with told us there was open communication between the staff, managers, residents and families. This encouraged reporting of individual needs in a timely and effective manner which was evident in the care plans we reviewed. A rehabilitation assistant told us, "If I need to introduce something new in someone's care then we can attend the morning handover to talk with care staff and nurses to put across the changes to people's rehab."

● There was a strong multidisciplinary team presence at the service in order to provide rehabilitation to people. Staff available on site included physiotherapists, occupational therapists and speech and language therapists. Weekly meetings amongst these professionals lead to early and effective communication and care planning. There were clear multi-disciplinary rehabilitation programmes in place for residents under planned timescales, with evaluation dates in place.

● People had access to other external health care professionals such as GPs and dentist. Care records confirmed this and one person told us, "We are all registered with the local practice and [the GP] does a weekly round as well."

Adapting service, design, decoration to meet people's needs

● The building was purpose built to meet people's needs. Corridors were wide and spacious and a lift was available to allow people using wheelchairs to access upper floors.

● Adapted equipment was also in place to allow people to live comfortably at the service. For example, height adjustable tables were installed which could be altered to meet the needs of a variety of people throughout the day. There was access to rehabilitation treatment rooms such as a gym and hydro pool, which were fitted with adaptive equipment to allow people to take part in rehabilitation sessions.

● People's rooms were personalised and reflected their interests. Although people's rooms included their clinical and mobility equipment, people's rooms still looked individual.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

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This is the first inspection for this newly registered service. This key question has been rated Good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People and their relatives told us staff were kind and caring. One person said, "They have empathy and interest and want to treat you as an individual." A relative said, "They are very attentive and nice, inherently kind and this I think is the ethos of this place." Staff were friendly to any relatives or visitors coming in to the building. A staff member told us, "I think it's brilliant families can come when they want and stay however long. (Name)'s husband is often here till midnight and some families come in every day. It's good to get to know them as well."

● We observed kind interactions between staff and people throughout the day. For example, one person was sitting in the lounge. When a staff member entered the room, they went to the person and with warmth and affection said, "It's so lovely to see you. I've been looking forward to seeing you."

● People were dressed neatly and appropriately with clean clothes, and were well groomed.

Supporting people to express their views and be involved in making decisions about their care

● People and their relatives were involved in reviews of their care. Care plans evidenced that discussions had been had with people on a monthly basis. A relative told us, "[Staff] show us [our loved one's] care plan. I sometimes point things out which are incorrect. This has now been changed which is the outcome we wanted."

● Staff included people in day to day decisions around their care. One person's care plan stated they were able to make decisions if staff gave them time to communicate this. A rehabilitation assistant told us, "I encourage people to make their choices over items such as the food they want or the way they want to conduct an activity. If they want to spend time focussing on one part such as their walking then I can adapt the way they are supported to make sure I listen to what they want." The clinical advisor said, "Staff adjust timings of the person's day depending on what they are doing that day. Even when there is covert medicines involved, staff will do it in a very dignified way and in a way that makes them feel in control still."

Respecting and promoting people's privacy, dignity and independence

● People were encouraged to be as independent as possible. Adapted equipment such as specialised cutlery and plate guards allowed people to eat independently. A staff member told us, "We always try to get them to do as much as they want to. If (name) has the correct cutlery he can feed himself. I'd check if he was okay with that but always encourage him." The clinical advisor said, "We show the families around tracheostomy care so they can take their loved ones home. We do a best interests meeting around it. We trained [one person's] mum. She can now take him to an appointment or out for the day by herself. This is to

lead as normal a life as possible."

● Staff protected people's privacy. One person was having a problem with their tracheostomy. Staff members noticed this, and were very supportive and kind when speaking. The staff members then sought advice from the nurse about what might be causing the problem. The person was taken back to their room so they could be assisted discreetly. The clinical advisor told us, "Staff know to inform people what they are doing, keep the doors close, and not to talk about sensitive or clinical things in the corridors. We strongly advocate that." We observed staff knocking on people's doors and asking permission to enter their rooms.

● People's dignity was respected. A relative said, "The door is always shut and curtains drawn (when helping with personal care)." A staff member told us, "If we're supporting a person to transfer don't leave them on the bed with nothing on. We'd use a towel to cover them."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Good.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had personalised care plans and one-page summaries in their rooms which allowed staff to know people as an individual. These included people's likes, dislikes, background and interests. A relative told us, "[Staff] have learnt (all about her) and it is all written down in her room." A staff member said, "They made sure I had time to sit and read through care plans when I started. It gives you a grasp of who people are and their interests. It's lovely when they have all those personal things."
- People received responsive care from staff. For example, people had been supported to attend music events by staff even though they had complex needs. This helped ensure they lived as normal a life as possible. On the day of our inspection, those who wanted to were supported to go ice skating in their wheelchairs at a local leisure centre. he activity involved people from other of the provider's services, which gave people the opportunity to meet and socialise.
- In house activities were also personalised for people. The clinical advisor told us, "We do an interest checklist which takes into account their age and preferences. The groups that are now run for activities are from the interest checklist so we can cater to peoples likes and ages." The activities coordinator recorded who had joined in with activities, if they had enjoyed them, and what support they required to take part. One person told us, "There are things to do and you can have one to one sessions if you are unable to participate in group activities." A relative said, "The activity coordinator comes in to read a story and talk to [my loved one]. Also she comes down once a week to join in with the singing group." A staff member said, "They have live performers and have lots of activities."
- People were supported to practice their faith. Faith ministers visited the service or people were supported by staff to attend local churches. One person told us, "They have a good relationship with the local Church of England. No barriers are put in place irrespective of your beliefs."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Staff were aware of how to communicate with people due to detailed communication care plans. This included how the person was able to signal yes and no if they were unable to verbalise this. A rehabilitation assistant told us, "People have different ways of communicating so it's about taking the time to get to know each person and what they like. How they want to communicate to ensure that I am listening to people and

picking up on what they are trying to tell me."

● Staff persevered in communicating with people who were not able to verbally answer or give hand signals. A staff member explained how they had done this with one person and told us, "We talk assuming he can understand you and look for any reactions. I go through the TV guide with him and look what's on for him. He's interested in movies and sports; definitely anything about Manchester United."

Improving care quality in response to complaints or concerns

● Complaints were appropriately recorded and dealt with in line with the provider's policy. For example, one person and their relative had complained that staff were not quick enough to respond to a call bell when they required urgent assistance. As a result, the clinical advisor had installed an additional call bell with a different sound to the other call bells in the service. This alerted staff they should respond as a priority.

● People and their relatives were pleased with the outcome of complaints they had raised. One person told us. "I have complained and it got resolved". A relative said, "There was a problem and it was also reported by them as well as to the CQC. It was resolved and I was very happy with the outcome."

● Complaints were collated and analysed to check for trends so appropriate action could be taken. For example, where the amount of complaints around tracheostomy care had risen, the clinical advisor had arranged refresher training in this area as well as completing weekly rounds to check the care given and records completed in this area were of good quality.

End of life care and support

● As the service provided rehabilitation care, end of life care was not routinely provided. However, people had end of life wishes recorded in their care plans in case their condition deteriorated.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Whilst care plans included people's complex diagnoses, further information was required so staff members without a medical background were aware what these meant. This would allow both permanent and agency staff to be aware how a person's condition affected them, and what additional support they needed as a result of this. As previously reported, people and their relatives had commented that they felt agency staff were not always knowledgeable around their care needs as a result of their conditions. There was little impact to people due to trained nurses being on site 24 hours a day. However, we raised this with the clinical advisor and manager who said they would implement this.

We recommend health care plans are implemented in people's care plans and room summaries.

● A registered manager had not been in place since May 2019, with a number of short term managers in post since this date. It is a regulatory requirement for a registered manager to be in place. The manager, who was receiving her induction on the day of inspection, confirmed they had started their registration with CQC.

● Action was taken to resolve issues identified in quality audits. Audits were carried on a regular basis in areas such as cleaning and hygiene, care plans and medicines. A medicine audit in August 2019 had identified an oxygen hazard sign was required outside the clinical room. We found this was in place on our inspection.

●The clinical advisor was aware of their responsibilities in ensuring that CQC were notified of significant events which had occurred within the service.

● As part of the service's regulatory requirement, the clinical advisor had ensured the service's previous rating under the previous legal entity was displayed both within the service and on their website.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and resident's opinions of the service were gained on a regular basis in order to drive improvement. Resident and relative meetings were held monthly, and a questionnaire requesting feedback sent to them quarterly. Feedback was generally positive, with the only concern being around staffing levels,

management changes and the skill of agency staff. A relative told us, "They ask me for feedback every now and again. It is normally management that is rated as poor." As already reported, there was an ongoing recruitment drive within the service, and long term agency staff were used where possible to allay people's concerns in the meantime.

● Staff were engaged in the running of the service. Meetings were held with staff members monthly, in which concerns and updates could be discussed. Each meeting had a different theme to improve staff member's knowledge in areas such as mental capacity and safeguarding.

We recommend the provider demonstrates to CQC how they have acted upon concerns around management and agency staff skill by our next inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Whilst people and relatives were positive about the clinical advisor, it was clear they felt unsettled due to a quick succession of managers in a short time frame. They also felt senior management were not always approachable. One person told us, "The previous managers were a mixed lot. Some only last a month. The continuity of managers here is the issue for the running of a successful home." A relative told us, "[The previous managers] have all been pretty useless actually. The upper management … If you challenge [them], you are essentially told to leave. They don't like what they consider, are trouble makers." Another relative told us, "I would give them eight out of ten as the day to day care is very good. Senior management could be better."

● However, staff felt fully supported by the management team. One staff member told us, "I've not meet the new manager yet (as it was her first day) but the other management team are absolutely brilliant, the management totally look after us too. I really can't fault them. They're very caring." Another staff member said, "This is a nice place to work, I can't complain. If there was an identified clinical need for a person, management would provide for that need in a timely manner." The clinical advisor told us, "I feel supported and valued by managers above me."

● Despite the feedback from people and relatives of the instability of the management structure, there was a clear empowering culture within the service which put good outcomes for people at its core. A staff member told us, "I've never worked with a team that's so together. We all have the same goal, to make the residents happy and be as dignified as possible." A rehabilitation assistant told us, "Peoples goals can be different. Long term to maintain disability management and also people who come for short term rehab. Our goal is to make them independent with things such as walking, making food, and preparing them to return home."

Continuous learning and improving care; Working in partnership with others

● The clinical advisor told us of plans that were in place to ensure the sustainability and improvement of the service in terms of staffing. The clinical advisor told us, "I'm looking at doing a healthcare development program. This will instil confidence in the relatives. This is all because nurses are harder to come by." He told us that health care assistants would be trained and supported to progress through training qualifications to a nurse. The clinical advisor also told us, "We've applied for a sponsorship for oversees nurses", which would allow more nurses to be recruited.

● The service had been awarded a tender for neurorehabilitation in the area. This would allow 60 people requiring rehabilitation to receive care at the service for 12 weeks.

● There was further partnership working with external organisations. The clinical advisor told us, "We are part of the registered managers forums. We had a recent safeguarding where I contacted the community pharmacist and head of care for the CCG so that helped form connections. We get a lot of emails from surrey heath for training which we send our staff too."