Shangri-La Care Services Limited

Shangri-La Residential Home

Inspection report

17 Milvil Road
Lee On The Solent
Hampshire
PO13 9LU

Tel: 02392799859
Website: www.shangrila.uk.net

Date of inspection visit:
10 October 2017

Date of publication:
01 December 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Shangri-La provides accommodation and personal care for up to 26 older people, some of whom live with dementia. Accommodation is arranged over two floors with stair and lift access. At the time of our inspection 20 people lived at the home.

We rated the home 'Requires Improvement' at its last inspection in December 2016. At that inspection we identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. These included breaches of Regulation 9, person centred care; Regulation 11, need for consent; Regulation 12, safe care and treatment and regulation 17, good governance.

At this inspection we found the provider had rectified the breaches found at the last inspection; the home is now rated 'Good'.

There was a registered manager at the home. 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.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

There were suitable systems in place to ensure the safe storage and administration of all oral medicines. However, the system in place to ensure that topical creams were not used beyond there 'safe to used by date' was not robust. This was discussed with the registered manager who told us that they would review the current system and take immediate action to ensure that creams were labelled clearly. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Risks to people had been assessed and completed risk assessments contained detailed personalised information about the person and their circumstances. Risks assessments identified the risks along with the actions taken to reduce these risks. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring.

There was enough staff to meet people's needs and staff had the time to engage with people in a relaxed and unhurried manner. People received person centred care from staff who knew each person well and understood there needs and personal preferences.

Staff had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. Staff followed legislation designed to protect

people's rights and ensure decisions were the least restrictive and made in their best interests.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

Staff developed caring and positive relationships with people and were sensitive to their individual choices, treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were provided with appropriate mental and physical stimulation through a range of varied activities.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs. People and their families were encouraged to provide feedback on the service provided both informally and through quality assurance questionnaires.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

People and their families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

People received oral medicines at the right time and in the right way to meet their needs.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

People had enough to eat and drink and told us they enjoyed the food.

People had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices

and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and focused on individual needs and preferences.

People were involved in planning their care.

People were supported to participate in a wide range of activities of their choice.

Systems were in place to allow people to express any concerns they may have and complaints were recorded and responded to in a timely way.

Is the service well-led?

Good

The service was well-led.

There was a clear management structure in place and staff understood the roles and responsibilities of each person within the team structure.

There was a positive and open culture and the registered manager had developed links with the local community.

The registered manager and provider actively sought feedback from people using the service and their families.

Shangri-La Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and was completed in response to concerns raised about the safety and quality of the service. The inspection was carried out on 10 October 2017 by two inspectors 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.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed the action plan sent to us by the provider following the last inspection in December 2016.

We spoke with nine people living at the home and four family members. We spoke with the registered manager, the deputy manager and five care staff. We also spoke with ancillary staff including a member of the domestic team and the cook. Following the inspection we received additional information from a social care professional and a healthcare professional.

We looked at care plans and associated records for five people and records relating to the management of the service. These included staff duty records, three staff recruitment files, records of complaints, accidents and incidents and quality assurance records. We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At the previous inspection, in December 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. There was a lack of effective risk assessments in place to ensure the safety and welfare of people. The provider wrote to us detailing the action they would take to meet the regulation. At this inspection, we found action had been taken and the provider was meeting the requirements of this regulation.

The registered manager had assessed the risks associated with providing care to each individual. Completed risk assessments contained detailed personalised information about person and their circumstances. Risk assessments identified the risks along with the actions taken to reduce these risks. Risk assessments in place including; falls, moving and handling, the use of bed rails, nutrition and skin breakdown. One risk assessment described clear and detailed information to staff about how to provide care and support to a person who occasionally behaved in a way that posed a risk to themselves or others. This included information in relation to early warning signs and strategies of how these behaviours should be managed by staff. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring.

Risks relating to the building and environment had been considered. Environmental checks had been undertaken regularly to help ensure the premises were safe. These included water, building maintenance and equipment checks. There were arrangements in place to keep people safe in an emergency. Staff were clear about the action they would take in the event of the fire alarm sounding and this was demonstrated when the fire alarm sounding unexpectedly during the inspection. Fire safety checks were conducted weekly and people had personal emergency evacuation plans detailing the support they would need in the event of fire.

People and their family members told us they felt that Shangri-La was a safe place. A person said, "I do feel safe here." Another person told us, "I feel safe and well cared for." A family member said, [My relative] is in safe hands."

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. All staff received training in safeguarding, which helped them identify, report and prevent abuse. Staff told us about how they would safeguard people and actions they would take if they thought someone was experiencing abuse. One staff member said, "I would report concerns to [registered manager], I wouldn't hesitate and know she would listen and act." Another staff member told us, "I would report abuse to the deputy [manager] or [registered] manager, if I was concerned that they were abusing people or not keeping people safe I would speak to the owner, local authority or CQC." The registered manager understood their safeguarding responsibilities and had reported concerns to the appropriate authority in a timely manner when required.

People and their families told us there was sufficient staff to meet people's needs. Staffing levels in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and

unhurried manner. Staff responded to people's needs promptly. Staff we spoke to confirmed there were enough staff to provide appropriate care without being rushed in their duties.

The registered manager told us that staffing levels were based on the needs of the people using the service. They told us that they also used a dependency tool to aid them to ensure that there were appropriate staffing levels in place. This dependency tool took into account the level of support people using the service required and was reviewed six monthly or more frequently if required. The registered manager told us the tool did not consider the size or layout of the building, but they took account of this by listening to feedback from people and staff and observing care and the time it took staff to respond to the needs of people. The registered manager also said, that she considered all of the person's individual needs when calculating the staffing levels and not just their basic care needs. For example one person had a specific lifestyle choice that required additional support. The current staffing levels meant that this person could continue to enjoy this pastime. The registered manager often worked alongside the care staff as part of the care staff numbers. They told us that this allowed them to see any areas of particular pressure. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and agency staff.

The provider had a recruitment process in place to help ensure that staff they recruited was suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed that these processes were followed before they started working at the home. One staff member told us that, "I didn't undertake any direct work with people until my DBS check came back clear." The registered manager told us that staff were also expected to sign a disclaimer during their sessions of supervision to confirm that there were no changes to their DBS status. On viewing one staff's file we noted gaps in the staff member's employment history. This was discussed with the registered manager who was able to explain the reasons for these gaps. This demonstrated that where gaps were identified the reasons for these were investigated by the registered manager. The registered manager agreed to include written information in relation to identified gaps in the staff members file.

There were systems in place to ensure prescribed topical creams and ointments were applied correctly. This included body charts to identify where specific creams should be applied and records completed by care staff to confirm application. However, not all topical creams had an 'opened on' date. This meant staff may not always be aware of when the topical cream would no longer be safe to use. This was discussed with the registered manager who told us that they would review the current system and take immediate action to ensure that creams were labelled clearly.

Medicines were administered by staff that had received appropriate training and had their competency to administer medicines safety assessed by the registered manager or the deputy manager. One staff member told us that they have been trained to administer medications in the last few weeks and they had been signed off as competent by the deputy manager. This staff member also confirmed that their practice to administer medicine was still monitored on a regular basis.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. On viewing the MAR chart no gaps were identified, this indicated that people received their medicines appropriately.

Each person who needed 'as required' (PRN) medicines, such as pain relief had clear information in place to

support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. The registered manager or deputy manager undertook weekly stock checks of medicines to help ensure they were always available to people.

Staff respect people's right to refuse medicines. Where people lack the capacity to make that decision there was a procedure in place for the covert administration of medicines. This is when essential medicines are placed in small amounts of food or drink and given to people. We saw all the correct documentation had been completed correctly, in line with the current legislation that protects people's rights.

During the medicine administration round staff were heard asking people how they would like to take their medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought people's consent. Staff remained with people until they were sure all medicines had been taken.

Good

Is the service effective?

Our findings

At the previous inspection, in December 2016 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. People's capacity had not always being assessed and the Mental Capacity Act was not always considered. The provider wrote to us detailing the action they would take to meet the regulation. At this inspection, we found action had been taken and the provider was meeting the requirements of this regulation.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence.

People and their families told us that staff sought verbal consent before providing care or support, such as offering to provide support to help them mobilise or supporting with personal care. A person said, "I always choose when I want to do something, they never make me do things I don't want to." We observed staff seeking consent from people using simple questions and giving them time to respond. Staff told us how they offered choices and sought consent before providing care. One staff member said, "We will always ask people's consent before we do anything." Another staff member told us, "People always get asked, if they don't want something or want to do something that's fine."

People and their families felt that the staff were well trained. One person said, "They look after me, they know what to do." A family member told us, "The staff are all very adequate." Staff told us they received effective and appropriate training. A staff member said, "I am constantly training, and updating all the time. I have just been signed up to do the medication training course." Another staff member told us, "We get so much training". A third staff member said, "We get lots of training; we are always doing training."

The registered manager had a system to record the training that staff had completed and to identify when training needed to be repeated. There were clear records confirming that staff training was up to date. The

training staff had received included safeguarding, food hygiene, moving and handling, infection control and first aid. In addition, some staff had completed other training relevant to their role, including diabetes, caring for people with dementia and stroke awareness.

Staff new to care were supported to complete training that met the standards of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager told us that they would also ask staff that had worked at the home for a long time questions outlined in the care certificate during their sessions of supervision. This helped the registered manager to ensure that staff understood and worked to expected standards of care.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff, the completion of essential training and an induction handbook. Staff confirmed that they had received induction when they started work at the service.

Staff were appropriately supported in their role. Staff confirmed that they received one-to-one sessions of supervision every three months and a yearly appraisal with the registered manager. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. Staff said, they felt able to approach the registered manager or deputy manager if they had any concerns or suggestions for the improvement of the service. A staff member told us, "[registered manager] is really supportive". A second staff member said, "If I have any concerns I can go to [registered manager] at any time, with no fear. We are really well supported."

People were supported to have enough to eat and drink. Drinks and snacks were offered throughout the day and evening. People and their families were complimentary about the food. People's comments included, "The food is good, we get choices", "The food is quite good" and "I like it here and the food is very nice." People were provided with a choice of food and an alternative was offered if they did not want what was offered. A staff member told us, "The residents mostly like the food; we know what their food preferences are and offer something else if they don't like it." During lunchtime we observed a person who was not eating their meal. A staff member also noticed this and said to the person, "are you alright? Would you like a cheese sandwich instead?" The person said, "Yes" and this was immediately provided. During mealtimes people were encouraged to move to dining tables although if they chose not to this was respected. This helped make the mealtime a pleasant and sociable experience.

Staff were aware of people's dietary needs and offered support when appropriate. For example, one person needed full assistance with their meal and they were supported in a caring and unhurried way. A staff member sat with them and spoke to them kindly about general and personal things that were important to the person; this demonstrated that they knew about the person and their life. People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. Where nutritional risks were identified people were closely monitored to ensure their nutritional needs were met. Where issues and concerns were highlighted appropriate action had been taken by staff. This action included requesting guidance from health professionals and making changes to the menu.

People were supported to access appropriate healthcare services when required. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. Staff knew people's health needs well and information in relation to people's health needs and how these should be managed was clearly documented within people's care files. For example where one person was a diabetic clear

guidance was recorded about management of their diabetes including signs, symptoms and actions staff should take to maintain their health and wellbeing. During the inspection we heard staff describe actions they had taken to ensure people's health. This included obtaining a urine specimen for one person and leasing with the GP to obtain antibiotics.

The environment was well maintained and some measures had been taken to the environment to consider the needs of people living with dementia. For example, signs on toilet doors to make them easily identifiable and colour contrasts for hand rails. Bedrooms varied in size but overall were suitable for their occupants. People visited in bedrooms had access to a call bell system to allow them to request assistance and support where required. People had access to the gardens, which were safe, fully enclosed and provided various seating options.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People and their families told us that the staff were caring. A person said, "The staff are nice, they look after me." Another person told us, "Oh yes, they [staff] do care". A family member said, "[My relative] is very happy here and well cared for." A second family member told us, "[My relative] is very well cared for; they always look clean and well looked after when I visit. The staff are fantastic and so patient." During the inspection the registered manager shared with us some written feedback they had received about the quality of the care provided. One of these was from a healthcare professional which read, "I have been really impressed with the care I have seen." A second piece of written feedback from a family member commented that "all the staff were wonderful at all times and gave us [family] the feeling that [relative] was safe and being cared for in all the right ways."

People were cared for with dignity and respect. One person told us, "I am treated with respect." Staff were heard speaking to people in a kind and caring way and would interact with people in a positive, friendly and cheerful manner. We saw staff kneeling down to people's eye level to communicate with them. We heard good-natured interactions between people and staff, showing they knew people well. Staff were attentive to people, listened to them and understood their personal preferences and needs. For example, one person required support to visit the bathroom. A staff member discreetly discussed this with them and then gentle supported them to access the bathroom while providing on going reassurance and encouragement. On another occasion we saw a person being supported from a wheelchair to a more comfortable chair within the communal area of the home aided by a mobile hoist. This was completed by two members of staff and all done with care and a consideration for the person's dignity.

People's privacy was respected when they were supported with personal care. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We observed staff knocking on doors, and asking people's permission before entering their bedrooms.

People were encouraged to be as independent as possible. At meal times we saw that staff would encourage people to feed themselves and people had access to appropriate specialist equipment where required. We saw people being encouraged to stand and walk on their own using walking aids, such as frames and sticks. Staff did not rush them and allowed people to go at their pace. A care staff member was seen to monitor a person as they used their walking frame to walk to the bathroom. They encouraged the person, reassured them that they were doing well and did not take over. Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example one care plan stated, 'Give me the wet flannel and encourage me to wash my face. If I put the wet flannel back in the sink try and show me what to do'. Another care plan stated, 'I walk fairly slowly with a walking stick but can do this independently.' A third care plan stated 'I am able to brush my own teeth if prompted.' Staff understood the importance of maintaining people's independence and a staff member said, "We will encourage people to be independent."

Staff understood the importance of respecting people's choice. They spoke with us about how they cared

for people and offered them choices in what they preferred to eat and where they wanted to spend their time. A staff member told us, "We always ask people want they want to wear. If they can't tell you we get a few choices of clothing out and show them to them so they can try and choose, it is up to them what they wear." A person told us, "If I want a shower it is my choice when I have it." Choices were offered in line with people's care plans and preferred communication style. Throughout people's care files there were comments about providing choices to people in relation to their care. Comments included, 'I will often eat with my hands, this is my preferred method' and 'I sometimes like to wander, this is my choice.'

People were supported to maintain friendships and important relationships. Care records included details of their circle of support and identified people who are important to the person. All of the families we spoke with confirmed that the manager and staff supported their loved ones to maintain their relationships. People told us, "My family visit regularly and there are no restrictions to visiting times." The added, "My daughter visits me every day, I am very lucky with that" and "My family come to see me, there are no restrictions on visiting." A family member said, "I can visit at any time, they [staff] all know me." Another family member told us, "I'm always made to feel welcome."

People were supported to have a comfortable and dignified death. A healthcare professional commented on how one staff member in particular was "extremely good" with caring for a person at the end of their life and also the persons family. A written comment from a family member read, 'In her last days before she passed away the personal touches she and ourselves received were exemplary. We could not have wished for a better home for her in her twilight years'.

Good

Is the service responsive?

Our findings

At the previous inspection, in December 2016 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The care and treatment of people was not always person centred and did not always meet people's needs in an appropriate way. The provider wrote to us detailing the action they would take to meet the regulation. At this inspection, we found action had been taken and the provider was meeting the requirements of this regulation.

People and their families told us they felt the staff were responsive to their needs. A person told us, "I like it here, I get all the help I need." A family member said, "If they [staff] have any concerns at all about [relatives] health they will always call the doctor and then me". Another family member told us, "Action is always taken [by the registered manager] when needed." A healthcare professional said, "They [staff] do tend to follow instructions on the whole and request assistance when appropriate."

People were provided with appropriate person centred care from staff who understood their needs, views and wishes. For example, a staff member described how one person would not always ask for help because they "don't what to trouble us [staff]". The staff member said, "We will always ask if they need any help and reassure them that we are here to help." Other staff members were able to describe the level of support people required.

Care plans were clear, easy to following and detailed. They provided information to enable staff to give appropriate care in a consistent way. They were individualised and detailed people's preferences, likes and dislikes and how they wished to be cared for. Comments in care files included, 'I [person] usually like to get up between 5am and 7am and watch TV in my room (this is a guideline only)', 'I [person] usually like to get up between 08.30am and 10.00am (this is a guideline only)' and '[person] is able to tell you if they are in pain.' These care files also included specific individual information about people's health needs to help ensure that medical needs could be responded to in a timely way.

Care and support was planned proactively and in partnership with the people, their families and healthcare professionals where appropriate. The registered manager or deputy manager completed assessments of the people before they moved into the home to ensure their needs could be appropriately met. The management team reviewed care plans monthly or more frequently, if people's needs changed. Where people's needs changed actions had been taken to help ensure that effective and appropriate care could still be provided. For example where one person's mobility had deteriorated we saw that discussions had taken place with both the person and their families and the decision had been made to move them to a more appropriate room. Families told us that they were fully involved in the development and reviews of care plans and we saw additional written information confirming this. A family member said, "We are involved in [relatives] care, we are always kept up to date and informed and will attend review meetings."

Staff were kept up to date about people's needs through handover meetings, which were held at the start of every shift. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. Relevant individual

information was provided to staff during this meeting which included information about; changes in people's health needs and where extra support or supervision may be required. During the handover meeting we saw that staff had a good understanding of people's needs and personal preferences; and staff shared ideas and knowledge of how best to provide support to individual people.

People were provided with appropriate mental and physical stimulation through a range of varied activities. The service employed an activities co-ordinator and we saw that care staff had the time to sit and interact with the people living at the home or take them out for walks in the local area. People told us there was enough for them to do. One person said, "I am about to be taken out by [named staff member] in a wheelchair for a stroll in the garden." A family member told us, "They [staff] encourage [person] to paint using special pencils, they display [person's] pictures around his room and in one of the corridors of the home." During the inspection we heard a staff member asking one person if they would like to go for a walk, the person said they would and the staff member said, "Ok we are going to walk down the road to the doctors, is that ok?" The person was happy to accompany them to the doctors.

The activities calendar was displayed around the home;this demonstrated there was a good range of both in-house and external activities. Activities were provided both in groups and individually and were adapted according to the likes and preferences of people on a day to day basis. We observed people being taken out individually, supported to go into the garden and people participating in exercises to music, which was well received by all that took part. Where people declined to take part in activities this was respected by the staff. Activities included reminiscence, games, music, word games, quizzes, films and arts and crafts.

People and their family members told us they had not had reason to complain, but knew how to if necessary. A person told us, "I have no complaints." A family member said, "I know that if I had a concern I could go to the manager, they would definitely do something about it." The complaints procedure was clearly displayed in the entrance hall. The registered manager maintained clear records of complaints. Each concern had been thoroughly investigated and the people involved were updated promptly with the outcome.

Good

Is the service well-led?

Our findings

At the previous inspection, in December 2016 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding the lack of well-maintained records and regarding quality assurance processes. The provider wrote to us detailing the action they would take to meet the regulation. At this inspection, we found action had been taken and the provider was meeting the requirements of this regulation.

People and their families told us they felt the service was well-led. Family members also said they would recommend the home to their families and friends. One family member said, "It is a fantastic home, my [relative] settled from the moment they came in. I can't fault it." Another family member told us, "They [registered manager and staff] are very, very good." A healthcare professional told us, "Shangri-La has improved recently in my opinion."

There was a clear management structure in place, which consisted of the provider, a registered manager, a deputy manager, head of care and care staff. Staff understood the role each person played within this structure and what was expected of them. Staff were aware of the homes values and were clear that people were at the heart of all decisions.

Observations and feedback from staff and family members showed the home had a positive and open culture. Staff and family members all told us they found the management team approachable, easy to talk and felt that they were able to raise any concerns or issues which would be acted on. A family member said, "They always let me know what is going on and keep me in the loop". One staff member said, "The management are fantastic, things have really improved over the last six months and the atmosphere is better." Another staff member told us, "I love working here; [registered manager] is really supportive and will always keep us updated."
Staff confirmed they were able to raise issues and make suggestions about the service and care provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. The registered manager attributed the improvement in staff morale down to the increased staffing levels; the new computerised system for recording information about people's needs and providing staff with more responsibilities to the form of champion roles in areas of the staff's individual interests.

The provider had suitable arrangements in place to support the staff and the registered manager. The registered manager had regular meetings with the provider, which also formed part of their quality assurance process. The registered manager told us that support was available to them from the provider; by the staff team at Shangri-La and that they were able to request additional support from the registered managers of another locations also owned by provider.

The registered manager sought feedback from people and their families on an informal basis when they met with them at the home, during telephone contact, at individual care reviews, which were completed once a month with people and six monthly with people's families and during resident and relative meetings. Formal feedback was also sought through the use of quality assurance survey questionnaires, which were sent

yearly to people, their families, professionals and staff. We looked at the feedback from the latest survey completed in September 2017. Most responses to these were positive and where a concern was raised about the laundry we saw that this was followed up. One comment on a returned quality assurance questionnaire completed by a family member said, 'Issues are dealt with; or an approach agreed pretty much immediately.'

The quality assurance systems in place were effective in assessing where the service required improvement, implementing and sustaining improvements effectively. The registered manager and provider had conducted a range of audits of key aspects of the service. Audits completed included infection control, the cleanliness of the home, medicines management, care plans and accidents and incidents. Where concerns were noted we saw that actions had been taken. For example where an incident, accident or near miss had occurred clear detailed information to the type of incident that had occurred, the cause of the incident/accident and the actions taken to prevent reoccurrence were clearly documented.

There were systems in place to monitor the safety of the environment and the maintenance of the building and equipment. The registered or deputy manager completed a monthly audit of the home to check the safety and cleanliness of the home and ad-hoc unannounced spot checks were completed by the registered manager on specific areas of the home. Health and safety audits were completed which showed that the environment was safe for people to use. This covered window restrictors, flooring, stairs, lighting, equipment, COSHH, fire safety, water temperatures.

Links and been developed with the local community. An open day had been arranged and the registered manager told us that this was to, "Build relationships with others in the community". A tea dance was also being organised. People received visits from the local Brownies group and representatives from the local church. People were supported to attend community events.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. There was a duty of candour policy in place, this required staff to be open with people and relatives when accidents or incidents occurred. The registered manager was able to describe the actions they would take to adhere to the duty of candour policy.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed within the reception area of the home to allow easy access to people, families and visitors.