The Whitepost Health Care Group

Iden Manor Nursing Home

Inspection report

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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

Iden Manor provides accommodation, personal care and nursing care for up to 51 older people including people living with dementia. The ground floor and upper floors accommodate people with residential needs, and the lower ground floor accommodates people living with dementia and more complex needs. On the day of our inspection, 44 people lived in the service, 24 of whom lived with dementia.

At the last inspection, the service was rated Good. At this inspection we found the service remained Good. We have made recommendations regarding some aspects of the management of medicines.

Medicines were administered safely, although we identified improvements needing to be made regarding the documentation and administration of medicines prescribed 'as required' and of topical creams; and of the monitoring of temperature where some medicines were stored.

Risk assessments were centred on the needs of the individual. Each individual risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. Appropriate steps had been taken to minimise risks of falls for people.

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures were in place to ensure staff were of suitable character to carry out their role.

Staff received essential training, additional training relevant to people's individual needs, and regular one to one supervision sessions.
Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect.

Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. These records help staff deliver care that met people's individual needs.

People were supported to have choice and their independence was promoted by staff who understood the needs of people living with dementia. Staff supported people in the least restrictive way possible and the policies and systems in the service supported this practice.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People told us they enjoyed the food. Staff knew about and provided for people's dietary preferences and restrictions.

People were promptly referred to health care professionals when needed. The activities provided were suitable for people living with memory loss and were in the process of being enhanced.

There was a system of monitoring checks and audits to identify any improvements that needed to be made. The registered manager acted on the results of these checks to improve the quality of the service and care, although their checks had not identified the shortfalls in respect of some aspects of medicines management.

Further information is in the detailed findings below.

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 remains: Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

At our last inspection we found that improvements needed to be carried out in respect of preserving people's dignity. At this inspection we found that these had been carried out.

Staff communicated effectively with people and treated them with kindness and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Iden Manor Nursing 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 carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a comprehensive inspection.

The inspection took place on 14 April 2017 and was unannounced. The inspection team included 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 our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. We also reviewed our previous inspection report, and the Provider Information Return (PIR) that the registered manager had completed. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We spoke with six people living at the service and four of people's relatives. Some people were not able to converse with us due to communication or cognitive difficulties. Therefore we also used the Short Observational Framework for Inspection (SOFI) for these persons. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how care was delivered and how staff interacted with people.

We spoke with five care staff, two nursing staff, a chef, and the person responsible for maintenance. We consulted a local authority commissioner, and a case manager who oversaw a person's welfare in the service, to gather their feedback.

We looked at seven sets of records relating to people's care and their medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and five staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus

and the activities programme. We sampled the service's policies and procedures.

At our last inspection in February 2015, the service was rated Good.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "Oh yes I feel safe' 'I feel secure I suppose' and, "I have bed rails because this helps me with turning over in bed." A relative told us, "Our mum is as safe as can be in this home; we have peace of mind."

The providers had received in January 2017 a fire risk assessment carried out by external consultants which had identified a number of shortfalls such as a number of doors unprotected by self-closers; a lack of fire protection between the maintenance area and staircase above; unsafe glass panelling; more smoke detectors needed; a programme needed for fitting intumescent seals to fire doors; and roof void issues which could present a risk of fire spreading unchecked. Control measures had been taken to ensure people were safe, and actions that could be taken by the maintenance department of the home to implement the recommendations had been done. The report had been discussed during monthly senior management team meetings; quotes for carrying out further works had been requested and remedial works were being scheduled to take place.

Further risks to the service were appropriately addressed and managed. The nurses were fire marshals and the maintenance person was a fire warden. The maintenance person maintained fire emergency boxes, and monitored fire drills. Unannounced fire drills included 'walk-through evacuations', which were well attended by staff. Fire safety training was provided annually by an external fire alarm contractor. People's personal evacuation plans included individual needs in case of an evacuation, and were kept in the nurses' office for handing over to emergency services if necessary.

Repairs were promptly carried out. A care worker who was filling out a form about a shelf needing repair told us they could be sure it would be fixed the next day. The maintenance team had recently been increased by a full time assistant and carried out a daily walk-round of the home. There was an appropriate schedule of weekly, monthly and quarterly testing of fire precautions equipment, water temperatures and flushing of unused outlets, call bells, window restrictors, wheelchairs and bed rails checks. An external contractor for legionella testing had made a recommendation in January 2017 which had been followed up, although the certification to evidence that remedial action had been taken was still pending. Identified faults and repairs were referred to external contractors at once when necessary. There was an annual planner for preventative and planned works. All utilities safety certificates were in date; passenger lifts and hoists were serviced regularly. There was an appropriate level and quality of environmental risk assessments including the grounds, communal and utility areas. There were risk assessments for residents bringing in their own furniture, and control measures included fixing wardrobes to walls if necessary. A business continuity plan was reviewed annually, that included clear instructions on how to manage outages of all utilities and other contingencies.

We identified improvements needed to be made in regard to some aspects of medicines management. Medicines to be taken 'as prescribed' (PRN) were not mentioned in the service's medicines management policy. A person had been prescribed a certain medicine up to three times a day for 'restlessness and agitation'. The nurse told us of their process of elimination of possible causes of distress, and described how

this person may display a particular behaviour to demonstrate their agitation. However there was no written protocol to describe this process or to suggest at what stage of behaviour the use of medicine became indicated. The nurse told us that using the medicine would be a last resort, however the lack of written guidance meant different staff could use different criteria to determine this. In most cases where pain relief medicines were prescribed PRN, there was no protocol in place. There was no guidance to indicate whether people were able to answer enquiries about pain, how they would indicate their discomfort, and no facility to offer pain relief other than at medicines round times. We discussed this with the registered manager who took immediate action. Following our inspection, the medicines policy had been amended to include practice regarding PRN medicines.

Topical creams were shown in the MARs as applied by care workers. However the records seen did not evidence regular application. For example , for one person the MAR showed a particular cream with regular 'C' entry denoting application, however staff had signed for applying cream on three days in January 2017 only, the form used showing the time of application but not the name of cream applied. A body chart for guidance stated 'apply to affected area when required', but did not state or show where was the affected area, and was undated. The nurse told us that care staff knew the person well enough to observe and respond to areas of soreness, which for this person could vary. However when nurses indicated 'carer application', they did not know if or where staff had applied the cream. Care workers' daily notes included whether personal care had included an application of cream, but these did not indicate which cream so could not evidence that use of creams was in line with care plan directions. Following our inspection, the registered manager had ensured that all documentation relevant to topical creams was reviewed for appropriate completion by end of April 2017.

We recommend the provider reviews and monitors all practice, guidance and documentation regarding people's PRN medicines and topical creams, to ensure their safe administration and monitoring. Improvements are to be embedded in practice and sustained over time.

Controlled drugs (CD) were managed safely in the home and administered timely. There was an appropriate system in place for the storage, administration and management of medicines. The head of care undertook monthly CD audits and any medicines errors were appropriately followed up. Two nurses and six senior care workers who had received enhanced training in the administration of medicines undertook medicines rounds and acted as counter-signatories for each other. A nurse told us they did not know if there was a procedure for notifying discovery of a missed entry, and was unable to locate a copy of the medicines policy on the ground floor. A policy was kept in the MAR folder on the dementia unit, and practice seen was largely compliant with the policy. Following our inspection, the registered manager had emailed staff to remind them where the policies were located.

Medicines were kept in two refrigerators in a clinical room, and in a trolley in the hairdressing salon. Although the temperature of both fridges and of the clinical room was monitored, the temperature regarding the trolley storage was not recorded. An external pharmacist had made a recommendation about this after they had inspected medicines in the service and produced a report in January 2017; however this had not been followed up and acted on. Following our inspection, the registered manager had installed a thermometer and set up a monitoring system to check that the temperature for the trolley and the room it was located in was at recommended levels to store medicines safely.

There were sufficient numbers of staff on shift to meet people's needs in a safe way. People told us, "I have a bell pull in my bedroom always answered fairly quickly" and, "The [staff] come as quickly as they can; I am never left here for hours; it all depends what they got going on; sometimes it's five minutes wait sometimes it's a bit longer." Staff confirmed there were enough staff to respond to people's needs and that they had

time to spend with people outside of their tasks. When staff were unable to cover sickness and emergencies, agency staff was used. The registered manager ensured that same agency staff were used for continuity of care. They reviewed staffing levels regularly taking into account people's dependency and needs, and increased staffing levels when necessary, such as when a person had needed one to one staff to attend to their needs; and while the passenger lift was being repaired.

Thorough recruitment and disciplinary procedures were followed to check that staff were of suitable character to carry out their roles. Nurses' registration was monitored by the provider. All processes relevant to recruitment were appropriately documented and fully completed. Newly recruited staff had undergone criminal records checks, had provided full employment history and references. Therefore people and their relatives could be assured that staff were of good character and fit to carry out their duties.

People were protected from abuse and harm by staff who had received safeguarding training and who understood the procedures for reporting any concerns. All of the staff we spoke with were able to identify different forms of abuse and were aware of the service's whistle blowing policy. All staff except one were clear about their responsibility to report any suspected abuse to the appropriate authorities. Following our inspection, the registered manager had scheduled face to face training to embed staff knowledge regarding reporting mechanisms to social services.

Individual risk assessments were in place for people who were at risk of falling, choking, acquiring skin damage; who had bed rails; who displayed behaviours that challenge, and who may experience a decline in their mental health. Control measures to minimise risks were clear, appropriate and followed by staff in practice.

Accidents and incidents were being appropriately monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. The registered manager carried out a daily and monthly analysis of any accidents and incidents to identify any common trends or pattern, documented what actions had been taken, and reflected on their efficiency. Their findings were discussed with the provider at monthly senior management meetings. A comprehensive fall assessment had been carried out when a person experienced frequent falls that included a review of their medicines, of their footwear, of their sight, and of their mental state. As a result, one medicine had been discontinued by their GP and a 'falls mat' had been put in place to alert staff when the person may need help getting out of bed.

Good

Is the service effective?

Our findings

The service remained good. People and their relatives' comments were positive about staff capability. They told us, "All the staff seem to know what they are supposed to do and they get on with it; they seem professional" and, "I know that if I have a problem they'll sort it for me." A relative told us, "The food is very good. I often eat with my sister and I'm sure she is content." A case manager who oversaw a person's welfare in the service told us, "There is good communication with this service, they keep us well informed."

People receive effective care from skilled, knowledgeable staff. Staff received an appropriate induction that included shadowing more experienced staff through a 'buddy' system, until they could demonstrate their competence. Newly recruited staff studied to gain the 'Care Certificate'. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. 50% of care staff had gained or were studying for a diploma in social care at level two and 25% at level three. A leadership and management programme had just been launched for senior staff. All staff received regular one to one supervision sessions and were scheduled for an annual appraisal of their performance.

Care and nursing staff were up to date with essential training that included safe moving and handling, health and safety, equality and diversity, mental capacity, and dementia awareness. They were scheduled for regular refresher courses. Additional training was available and encouraged, such as, record keeping, care planning and palliative care. Further training was selected in accordance to people's specific needs, such as, de-escalation techniques of behaviours that challenge, percutaneous endoscopic gastrostomy (when people have had a feeding tube surgically inserted in their stomach) and oral hygiene. Nurses were trained in syringe drivers (a device used to administer medicines slowly), catheter and wound care, venepuncture (a medical procedure to withdraw a blood sample or for an intravenous injection) and palliative care.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). All appropriate applications to restrict people's freedom had been submitted to the DoLS office as per legal requirements. The registered manager had considered the least restrictive options for each individual.

Consent to care and treatment was sought in line with the law and guidance. Processes were followed by the management team to assess people's mental capacity for specific decisions, for example when a person had declined all assistance with their personal care over a prolonged period of time, and for another who declined taking their medicines. Meetings to reach decision on behalf of people and in their best interests were carried out involving appropriate parties. Care and nursing staff we spoke with were knowledgeable about some of the principles of the Mental Capacity Act (MCA) although they were not aware of how to assess people's mental capacity in practice when simple decisions may need to be made in people's best interests. We discussed this with the registered manager who was a qualified trainer. They told us they had

not been fully satisfied by the completeness of online training and as a result they had started to conduct additional workshops in the home.

People were supported to eat, drink and maintain a balanced diet. Staff sat with people who needed help or encouragement to eat, in the dining room and in their bedrooms. People appeared to enjoy their food, were allowed to eat at their own pace and were gently encouraged when appropriate. The catering staff knew of people's food allergies, specific dietary requirements and preferences. A person told us, "They make sure they know the certain foods I dislike; bread pudding is my worse one so I get something else." The chef obtained daily feedback on what people had eaten and discussed with care staff concerns about anyone's appetite, and how alternative provisions could be made. The chef met individual requests for sandwiches, salads, omelettes and filled baked potatoes as alternatives to the menu. Staff were able to describe to us who needed support, the type of food they favoured and how they liked their food served. People told us, "They come around and ask you what you prefer the day before", "At suppertime the soup is very nice I like to have soup and sandwiches" and, "The food varies, it's not too bad; menus are changed every day; the meat is very tender". Hot and cold beverages were offered to people throughout the day and provided upon request.

People were supported to maintain good health. People were weighed monthly or weekly when there were concerns about their health or appetite and their food and fluid intake was recorded and monitored. They were repositioned regularly in bed when there were concerns about their skin integrity. People were routinely offered influenza vaccinations. Access to healthcare professionals was effectively facilitated. People were referred appropriately to specialised clinics, local GPs, speech and language therapists (SALTs), occupational therapists, dieticians, and a mental health community team. A person had been referred to physiotherapist to assess how their mobility could be improved; another person had been referred to a SALT team when they had a cough which may interfere with their swallowing ability.

The premises had been adapted to meet people's needs, although they dated from Victorian times and the ageing fabric of the building needed attention. For example, woodwork was chipped throughout the home; some fitted carpets were old and loose in places; the main corridors and the bedroom doors in the dementia unit needed to be re-decorated; an orangery had been damaged by stormy weather and its use had been discontinued. We saw several chairs in the main lounge that had become threadbare and needed to be replaced. A local authority commissioner told us, "The home could do with some investment to bring the paint work particularly up to standard, however the home maintenance must be absolutely huge, given the age and size of the property and gardens" and a relative told us, "The place could be amazing, it is so grand and it has so much character, quite a beautiful environment really but it is getting old and starting to look shabby in places, it needs money to be put into it." However, refurbishment and redecoration of the service was being addressed by the provider to mitigate the risks relating to people's health, safety and welfare.

The registered manager showed us that these issues were being addressed, paying attention to the specific needs of people living with dementia. Quotes for remedial work had been obtained, and a re-decoration programme as well as replacement of floorings and furnishings was scheduled to take place shortly after our inspection. Signage had been purchased to be installed after re-decoration had taken place. The provider was considering a possible renovation of the orangery to restore additional leisure space for people and visitors. Each bedroom was large, comfortably furnished, with en-suite facilities. Corridors were wide and included sturdy banisters for people to use when moving around. The dining rooms and lounges were inviting and spacious. There was a hairdressing salon and ample choice of quiet sitting areas throughout the service, and landscaped gardens that included raised flower beds for easy gardening.

Good

Is the service caring?

Our findings

At our last inspection we found that improvements needed to be carried out in respect of preserving people's dignity. At this inspection we found that these improvements had been made.

All the people and their relatives we spoke with told us that they liked the staff and described them as, "Nice people", "Always busy but we are not left alone for too long", "Pretty good; can't complain" and, "Some I prefer to others but on the whole they are quite kind, they chat to me." A person said, "Oh yes I get on with them alright, one or two perhaps I like better; we have a laugh and a joke and they come and see me when they are not on duty." A relative told us, "[X] moved here from another home and this is so much better, they have time for people here. I never have any worries leaving her."

Positive caring relationships were developed between people and staff. People were addressed respectfully by their preferred names, encouraged, praised and appropriately conversed with throughout our inspection. Staff used appropriate banter, particularly in the dementia unit, to engage people in conversations when they appeared withdrawn. However we noted a lack of interaction in the main lounge during mealtimes as staff appeared to concentrate on their tasks rather than on communicating with people. We discussed this with the registered manager who told us this will be discussed at the next team meeting. Additional training for care staff about customer care and communication was scheduled to take place in May 2017. As a member of the housekeeping staff had been vacuuming close to people during activities, the registered manager had ensured the housekeeping staff were provided with the activities plan so they could plan cleaning schedules accordingly and not disrupt people's concentration. The registered manager had introduced a monthly 'dignity day' when people and staff talked about the meaning of dignity, and how it can be promoted in practice. A member of staff told us, "It makes you think about the little things that can make all the difference."

Staff ensured people were comfortable and offered explanations ahead of any interventions, such as when using equipment to help them move around. Staff promoted people's independence and ensured walking aids were provided when necessary. They were encouraged to do as much for themselves as they were able to. One person walked in the grounds independently and was discreetly supervised by staff. People's wishes were respected, such as having a late breakfast or remaining in bed.

People or their legal representatives were involved in decision making about their care and treatment. They participated in initial assessments of needs, care planning and reviews of these when changes occurred. Before any annual review of care plans, each person's family was invited to participate by the nurses, with people's permission when applicable. Some families who lived abroad or who were not available participated via email or face to face via the internet. Two people used computerised devices to connect with their families.

Staff promoted people's privacy and respected their dignity. People could have a bath or shower as often as they wished, although at times they had to wait for staff to be available. A person told us, "I wanted a shower and they told me I may have to wait a little but I got it." Staff knocked on bedroom doors and announced

themselves before entering; people's continence needs were met quickly and in a discreet manner; staff drew curtains on the ground floor and closed doors while helping people with any personal care. A person told us, "When I'm having a bath they put a towel across me."

People could be confident that best practice would be maintained for their end of life care. When people had expressed their wish regarding resuscitation or had made any advance care planning, this was appropriately recorded and acted on. The nursing staff were effectively supported by a local hospice palliative care specialist team who offered specialist guidance when needed. Anticipatory pain relieving medicines were stored for a person who approached the end of their life. This meant that pain management was appropriately planned and delivered.

Good

Is the service responsive?

Our findings

People and their relatives told us that they felt involved in the service and that staff were responsive to their needs. They told us, "If you want something particular the staff would get if for you" and, "The staff know me well and they know what I like." About their preferred routine, people said, "I do what I please; the staff know; I go to bed early I like to see the news at six but at seven I go to bed", I'm a very early riser; my getting up time is agreed with the manager and the staff, I get up at 5 o'clock, I shower on my own every day, and they come and make up the bed at 5.30 it's like being in a parade." About activities, they told us, "We like the entertainment manager; very jolly; nearly every day there is something going on; yesterday it was crossword and quizzes."

People received personalised care. Their care plans were person-centred and included people's likes, dislikes and preferences about food, activities, routine and communication. They included information about their life history in a 'My Life' document, their favourite memories, past occupations, special interests, and people and places that were important to them. A local authority commissioner told us, "The care planning in my view is reasonably good, to the extent that I feel that they over record, as the carers also keep detailed records separate from the main care plans." Although two systems of care planning were used simultaneously and may produce duplicated documentation, this had not impacted negatively in the way that care was informed and delivered. The care plans included specific instructions for staff. Staff were aware of these and implemented these in practice. For example, they followed instructions in people's oral health care plans; knew of people's preferences regarding their routine; that a person wished to be woken up at 4am; that a person liked to get their laundry done on a certain day of the week; that another needed encouragement to participate in activities.

Care plans were reviewed and updated monthly by the nurses or when the need arose, in participation with people when they were able and willing to participate. A formal yearly review was carried out with people's families, legal representatives, local authority and NHS Continuing Healthcare, as appropriate. A relative told us, "We are informed about any significant updates and of the reasons why."

When people were unwell, staff responded promptly to their needs. A person told us, "I have just recovered from a chest infection; they faxed the doctor all the details and he gave me antibiotics for a week, it was all organised on the day." Another person told us how staff had cared for them when they had had an infection. They told us, "The nurses are lovely, they tell the staff what to do and they saw me back on my feet."

The service coordinated with other services such as GPs, occupational therapists, Speech and language therapists, chiropodists, ophthalmologists, physiotherapists, a hospice palliative care team and specialist nurses when people's needs increased. Updated information about people's needs was provided to other services such as hospitals to ensure continuity of care. Staff shifts handovers appropriately described people's individual needs and any recent changes.

Staff ensured that risks of social isolation were reduced. People were occupied with daily activities that took account people's wishes and interests. A programme of daily activities suitable for older people including

those living with memory loss was led by an activity coordinator. Staff encouraged people to attend activities and people who preferred to remain in their room or who were unable to participate were visited by staff and conversed with. A person told us, "I see [named care worker] who often comes and chats with me; he always tries to get me to do the quiz downstairs; I get on with him he is very helpful, bringing me books from the trolley and he is going to get an IPAD for books and movies." The registered manager told us the activities programme was currently being reviewed to provide more meaningful activities informed by people's interests, including people who remained in their bedroom.

We observed an activity session which was a bingo game with large format playing cards, conducted by activities coordinator with some assistance from staff, incorporating afternoon tea and cakes trolley and conversation. People responded to activity coordinator's enthusiasm. A relative told us, "My sister does crosswords and things so she keeps herself amused, but she really enjoys the activities. That man (activities coordinator) works really hard, he's good at what he does and they enjoy it." Books were provided for people and replenished. Special days such as Burns day, St George's day, Commonwealth day, Ascot and Grand National races, Valentine Day, Mothering Sunday and fathers' day were celebrated and used to inform activities or entertainment. There were parties organised by staff, colour themed days and clothes shows. External entertainers such as a pantomime cast, bag pipe player, singers and musicians had visited the service

People and their relatives were involved with the running of the service. There was a resident of the day scheme, when nurses focussed on the person's care and relevant documentation, and when their views were sought about the service. Two senior care staff on both units took responsibility for shopping on people's behalf, when people were not able to go shopping independently. They ensured people had the toiletries and specific treats that they wished. People were aware of how to complain and of the procedures to follow. One verbal complaint about a member of staff had been addressed appropriately; additional training and supervision of this member of staff had been provided. A relative told us, "If we have any problem, we just talk with the manager or the deputy and they make sure it is resolved."

People and their relatives participated in annual satisfaction surveys, the results of which were used to drive improvement in the service. As a result of survey carried out in November 2016, the laundry system had been restructured; menus and the activities programme had been enhanced to include special requests; a person's review of their care planning and provision of personal care had been brought forward to implement improvements. A suggestion box was available and was emptied monthly, although this was seldom used.

Good

Is the service well-led?

Our findings

There was a registered manager in post. 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, their relatives and staff told us they appreciated the registered manager's style of management. People described the manager as, "approachable", "very energetic and organised" and, "very helpful and accommodating. The registered manager was also a registered nurse and worked alongside the staff on several shifts. A member of care staff told us, "It really helps that she is also very knowledgeable as a nurse."

The registered manager was visible in the service. They operated an open door policy and were doing a daily 'walk round' of the premises with staff to check the daily running of the service and update the maintenance programme. They knew each person in the service and were attentive to their individual needs. They carried out regular observations of care practice at different times of the day and had taken disciplinary action when necessary. A person told us, "The manager and I, we have a good rapport, very pleasant; If I've got a problem she will talk with me in private."

The registered manager consistently notified the CQC of significant events and was transparent in their approach. The registered manager kept abreast of any developments relevant to social care and dementia care, researching websites and subscribing to specialised publications. They actively promoted links with the community. They had established connections with a local day centre, a local school to link with their educational scheme, a children choir, and local Child and Adolescent Mental Health Services (CAMHS) who visited the service with children and teenagers. This ensured people in the home had company they could enjoy. In summer, the service held a Fete to which all the community was invited and staff advertised this with posters, leaflets and in Parish magazines. A relative told us, "We look forward to the next 'Wild West' fete; all sorts of people really come together at these events and enjoy themselves."

The service ensured that quality of care was maintained through a quality assurance monitoring system. This included regular audits of dementia care, staff training, care plans, satisfaction surveys, infection control, maintenance, nutrition, tissue viability and falls. When a shortfall had been identified, action plans were written and monitored until completion. For example, as a result of a falls audit and of a tissue viability audit, staff had been provided with clearer instructions about the steps that they should take; several commodes and bed bumpers had been replaced following an infection control audit. However, we found that audits in medicines had failed to identify a lack of protocols for PRN medicines and topical creams; that action had not been taken in response to an external pharmacist audit regarding temperature monitoring. Although since our inspection some action had been taken to address these shortfalls, the relevant monitoring system had not been fully effective in ensuring action was taken at the time when risks had been identified. We recommend that the relevant quality assurance monitoring system is reviewed to ensure that when a shortfall has been identified, action is monitored until completion.

Refurbishment and redecoration of the service was being addressed by the provider to mitigate the risks

relating to people's health, safety and welfare. The provider maintained a health and safety action plan to pre-empt and monitor any risks of roof tiles damage, dampness, and blocked chimneys. A maintenance plan for 2016/2017 identified repairs, redecoration and refurbishment of several rooms, bathrooms and corridors in the home; these were actioned alongside scheduled preventative maintenance works throughout the year. The provider had planned a financial budget that allocated funds to cover the yearly cost of maintaining the premises at Iden Manor. They had a further plan to inject funds for improvements, redecoration and refurbishments of the service in the 2017/2018 financial year.

All documentation relevant to the running of the service and of people's care was appropriately completed and updated. However the state of care records folders was in need of improvement, as several folder arch levers were not functioning properly and allowed for documentation to slip away. Following our inspection, the registered manager had scheduled a plan of action for files to be replaced and re-organised. Policies were bespoke to the service, easily accessible to staff, and continually updated by the registered manager to reflect any changes in legislation. Records were archived and disposed of when necessary as per legal requirements.