N. Notaro Homes Limited

La Fontana

Inspection report

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Website: www.notarohomes.co.uk

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 9 August 2016 and was unannounced.

At the last inspection on 16 and 22 July 2015 we found there were breaches of legal requirements. We asked the provider to take action to make improvements to: People's food choices and the support they received at meal times; the accuracy and completeness of care records; the effectiveness of their quality monitoring system; and the deployment of sufficient numbers of suitably qualified staff. We received a provider action plan stating the relevant legal requirements would be met by 28 February 2016. At this inspection we followed this up and found the actions had been completed, although some further improvement was needed to ensure people's care records were consistently up to date. We have also made a recommendation about best practice in relation to dementia care.

People's mealtime experiences had improved greatly and there were more regular staff employed to meet people's nursing and personal care needs. Management was more visible around the home and the registered nurses were far more active and effective in providing support and leadership to the care staff.

La Fontana provides accommodation for up to 76 older people who need nursing and personal care. At the time of the inspection there were 74 people living at the home. The majority of people were living with a dementia and many had complex nursing or other support needs.

The service had 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.

The registered manager told us the service philosophy was to provide a high standard of care, meet people's needs and provide a safe environment. People and their relatives told us the service was responsive to their needs and the registered manager was open, accessible and approachable.

We observed staff supported people in a caring and considerate way and they had a good understanding of each person's needs and preferences. A person who lived in the home said "The staff are nice and caring and on the whole they are patient and respectful". A relative said "The best thing about this place is the care and attention they [staff] give to the residents. I would recommend this home; it's just like a big family".

People told us they felt safe and secure. A person who lived in the home said "There are always staff around and they are there within minutes if anything happens". A relative told us they felt well informed about changes in their relative's needs and felt their relative was being cared for safely.

There were always three qualified nurses on each day shift to ensure people's clinical care needs were met. The service also worked in close partnership with other local health and social care professionals to meet

people's health and wellbeing needs.

People received their medicines safely from registered nurses and people were protected from the risk of infection. The home's environment was spacious, clean and bright throughout with lots of natural light.

The home had good facilities for people living with a dementia, including secure spacious gardens, a reminiscence room with traditional shop displays and its own animal farm. People, relatives and other members of the local community were invited to various events at the home, including: open days, Alzheimer's days, fetes and other celebrations. This encouraged social interaction with the community and helped to raise awareness of dementia care.

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.

There were sufficient numbers of suitably trained staff to keep people safe and meet their needs.

Risks were identified and managed to help people remain safe.

People were protected from abuse and avoidable harm.

People received their medicines safely from registered nurses and people were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

People received care and support from staff who were trained to meet their individual needs.

People were supported to maintain good health and to access external professionals when specialist advice was needed.

People's nutritional needs were met, including any special dietary needs.

The service acted in line with current legislation and guidance when people lacked the mental capacity to consent to aspects of their care.

Is the service caring?

Good

The service was caring.

People were supported by caring, friendly and considerate staff.

People were treated with dignity and respect and were encouraged to be as independent as they were able to be.

People were supported to maintain continuing relationships

with their family and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Progress had been made, but further improvement was needed to ensure people's care records were consistently accurate and up to date.

People received care and support that met their nursing and personal care needs. However, more emphasis was needed on providing personalised dementia care.

People, relatives, staff and other professionals were supported to express their views and these were taken into account to improve the service.

Is the service well-led?

Good

The service was well led.

People were supported by a visible and accessible manager and a dedicated and motivated staff team.

The service had a caring and supportive culture focused on promoting the health and well-being of the people who lived in the home.

The provider's quality assurance systems helped to ensure the quality and safety of the service was maintained and improved.

La Fontana

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 took place on 9 August 2016 and was unannounced. It was carried out by two 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. Their area of expertise was as a family carer for a person with dementia.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The service was last inspected on 16 and 22 July 2015 and we found there were a number of breaches of legal requirements. The service received an overall rating of 'Requires improvement' at that inspection.

Many of the people who lived at La Fontana were unable to fully express themselves, or to fully understand verbal communications, due to their dementia or other health conditions. We therefore spent a lot of time observing the care and support practices in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with 15 people who lived in the home, nine visiting relatives and 21 members of staff. The staff included three qualified nurses, 14 care staff, the activities co-ordinator and activities assistant, the chef and kitchen assistant. We also spoke with the registered manager, the deputy manager and briefly with the provider's operations manager who visited the home for a feedback session at the end of the day.

During the inspection, we looked at records which related to people's individual care and to the running of the home. These included seven care plans, food and fluid charts, medication records and some of the provider's quality assurance records, including staff training, complaints and incident files.

Good

Is the service safe?

Our findings

At our last inspection we found there were not always enough suitable staff deployed to consistently meet people's needs. We required the provider to take action to make improvements. At this inspection we followed this up and found the necessary actions had been completed and the staffing situation was much improved. The use of agency staff had significantly reduced and they were now only used to cover short notice absences. Additional members of staff had also been recruited but were awaiting satisfactory employment checks and references before they could start work.

At this inspection, there was enough staff to keep people safe and to meet their needs. During the day time there were 20 members of care staff, including staff providing one to one staff support, and three qualified nurses (one to cover each of the three units). At night, there were either two nurses and 11 care staff, or three nurses and 10 care staff. The service also had a team of domestic, laundry and kitchen staff. The registered manager and deputy manager were additional to the staffing levels detailed above. One of the qualified nurses had been appointed to a new position of head of care to assist the deputy manager with the day to day clinical supervision of the service. Once all the nursing vacancies were filled this post would also be supernumerary to the day time staffing levels on two days a week.

People told us they felt safe and secure. One person who lived in the home said "I've never seen staff be unkind to anyone. There are always staff around and they are there within minutes if anything happens". Similarly another person said "There are always staff around and I've never seen anyone treated badly". A relative told us they felt well informed about changes in their relative's needs and felt that their relative was being cared for safely.

People were kept safe because risks were well managed. We observed staff cared for people in a safe manner, for example: supporting them when walking; ensuring footrests were used when using a wheel chair to prevent damage to their feet; and using appropriate manual handling techniques when using hoists or supporting people to stand. People were moved safely and their dignity was maintained. The service had a planned equipment maintenance programme and regular testing to ensure equipment was safe for people to use.

Staff demonstrated a good knowledge of people's risks. For example, there was a person who became distressed at times; staff knew to speak to them calmly and to distract them by walking with them. Some people's care records identified a need for one to one staff support and we saw this was provided. Staff were also seen safely supporting people who were at risk of falls. Information was recorded on how to reduce the risk, including ensuring people always used their walking aids and the staff remained observant.

Risks of people becoming dehydrated or malnourished were reduced because the risks were assessed and action taken to minimise it. People's food and fluid intake was recorded and monitored when they were at risk. Action was taken if the levels of food or fluid were not maintained to an acceptable level. A nurse told us they would contact the person's GP and also ensure staff were informed at each hand over to encourage the person to eat or drink.

Staff were provided with the information they needed to deliver safe care to people. This was done through the verbal hand over sessions and a summarised personal care folder kept in each person's room. This provided an overview of a person's needs and risks to enable staff to care for the person safely. It recorded information such as, the daily care staff provided, observations, and repositioning intervals. Staff told us they found these personal care folders helpful, as a quick reminder, and they were particularly useful for new staff or agency staff.

Air mattress pressures were checked and recorded to ensure they were correct for the person's needs, and records were made when people were repositioned. Records showed the home had a low incidence of pressure sores. Care staff told us it was their job to complete the records accurately and to report any concerns or other issues to the nurses.

Staff received training in and had a good knowledge of safeguarding people from abuse. They described how to recognise abuse and gave good examples of types of abuse. They described how and where to report any concerns and were confident this would be dealt with quickly.

The risks of abuse to people were also reduced because there were effective recruitment and selection processes for new staff. Staff described their recruitment which included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks a person's criminal history and their suitability to work with vulnerable people.

Records showed incidents and accidents were investigated and action plans put in place to minimise the risk of recurrence. As far as we could ascertain, the service met its statutory obligations to inform the local authority safeguarding team and the Care Quality Commission of all notifiable incidents.

Staff knew what to do in emergency situations. People's files contained personal emergency evacuation plans which described the measures staff had to take to support them to remain safe. For example, in the event of a fire, the information described the nearest exit route and/or safest place for the person to go to. It also stated whether or not the person needed support with a hoist and whether they used a wheel chair for mobility.

There were service continuity plans in the event of an emergency situation, such as a fire or utilities failures. In-house maintenance staff and external specialist contractors were employed to carry out fire, gas, and electrical safety checks to ensure the environment was safe. The registered manager and the provider's senior management team also carried out regular health and safety checks. The service had a comprehensive range of health and safety policies and procedures for staff to follow.

Since our last inspection, the service had introduced a new electronic medicines administration system. The new system was still being embedded into the service but appeared to be working well. It enabled staff to more accurately monitor people's medicines, for example, it recorded the last time the medicine was administered, and any missed doses or errors. There was a hand held computer which showed a photograph of the person requiring the medicine, so staff could easily identify it was the right person. The system also recorded and gave a warning signal if staff attempted to administer a person's medicines at the wrong time of the day.

We observed one of the nurses undertaking a medicines round. They gave people their medicines in a safe, considerate and respectful way. We saw the nurse used their professional knowledge to assess a person, with limited verbal communication skills, as being in pain and encouraged them to take their 'as required' pain relief medicine.

The electronic medicine administration records were accurate and up to date. Medicines were stored safely and there were suitable arrangements for medicines which needed additional security or required refrigeration. The provider had an appropriate medicines policy and procedures. A GP visited the home every week and reviewed people's prescriptions, including 'as required' medicines, to ensure they were up to date and appropriate.

People were protected from the risk of infection and there were effective infection control measures in place. There were sufficient supplies of personal protective equipment (PPE) for staff to use, located around the premises. We observed staff wearing protective aprons and gloves when providing personal care and when preparing or handling food. There were also notices around the home advising staff about maintaining a safe level of hand hygiene.

We observed the home was well maintained, clean and tidy throughout. There were clear housekeeping schedules and we observed regular cleaning of the premises during our inspection.

Good

Is the service effective?

Our findings

At our last inspection we observed people were not always offered reasonable food choices and some people were not given appropriate support with eating their meals. We required the provider to take action to make improvements. At this inspection we followed this up and found people's mealtime experiences had significantly improved.

We observed people were being cared for effectively in line with their documented care plans. However, we found one exception to this general rule. We observed a person who required oxygen through a nasal tube to assist with their breathing. Their care plan identified they had oral hypersensitivity and an oral desensitisation programme was in place. When we visited them in their room, we observed the person's mouth and lips were very dry. It was late morning, but their daily care record did not show they had received any mouth care. There was also limited information provided about their pressure area care and repositioning. We asked a member of care staff about the person's mouth care and were told "I've not done it, it is for the nurses or senior carers". We checked the person's records again mid-afternoon and there was still no evidence of mouth care and the person was still positioned on their back. We spoke with a nurse who checked the daily care charts and at this point provided the mouth care. Contrary to what the care staff member had said, the nurse told us any member of staff could undertake the mouth care. When we asked about the re-positioning the nurse said "she doesn't really go on her side".

We fed back this information to the registered manager and the deputy manager (who are both registered nurses). They said they would take immediate action and revise the person's care plan to state the mouth care must only be provided by a qualified nurse and the repositioning frequency would be increased from twice daily to every three hours.

People's views about the food varied from "The food is really good" to "It's good but not brilliant". Everyone said they could ask for an alternative, if they wished, but mostly they were happy to have what was available. A relative told us their family member "Needs a fortified diet. Their meals are quite substantial and they get good portions. The roasts are really lovely".

People were supported to have sufficient to eat and drink and to maintain a healthy diet. Care records demonstrated people's nutritional needs were assessed and they were supported to drink and eat in line with their preferences and assessed needs. Some people were prescribed food supplements and others required food and drink at a specific consistency to help them swallow and avoid choking. We observed people at risk of choking had thickeners for their drinks which staff understood how to use. Care staff recorded people's food and drink intake in their daily records. For example, if a person did not eat one of their meals this was recorded and brought to the attention of a nurse.

We observed the lunchtime experience in each of the home's dining areas. There were pictorial menus on each table, along with condiments and napkins. Menus provided a choice of two meals as well as alternatives, such as salads and jacket potatoes. The choice on the day of inspection was shepherd's pie or fish mornay, served with creamed potatoes and seasonal vegetables. People appeared to enjoy their meals

and very little food was left on their plates. We observed one person, who did not want either of the menu choices, had an appetising savoury buffet selection delivered to their room.

To help people living with a dementia understand the meal choices, staff plated a small sample of each meal to show people what the choice was. People then either said or pointed to their choice. However, we observed the crockery used in the home was a pastel colour rather than a vibrant primary colour. Contrasting colours are known to assist people with a dementia.

We observed staff sat down to be at eye level with people whenever they spoke with them or asked them a question. Staff were caring, gentle and patient in their approach and the way they encouraged people to eat and drink. For example, we heard one member of care staff say "Don't worry my love, just eat what you can". Staff were cheerful and chatty with people throughout the lunchtime period.

There were sufficient numbers of staff to support people appropriately and in an unhurried way. We observed some people received one to one staff support, some were supported by their relatives and others were able to eat their meals unassisted. Some people had their meals taken to them on trays to their own rooms. A relative told us their family member sometimes sat outside on the garden furniture to eat their meals, when the weather was nice.

The chef told us the menu choices were discussed and agreed at the monthly residents and relatives meetings with the registered manager. They were provided with "a list from the office" of people's individual food preferences and any special dietary needs. For example, soft or pureed meals were prepared for people who had swallowing difficulties. Portion sizes and calorie intake was controlled for people who needed to lose or gain weight. People who were at risk of malnutrition or dehydration received fortified diets. There were also special diets for people with diabetes or gluten free requirements.

People and their relatives told us the service was effective in meeting people's health and personal care needs. One person who lived in the home said "They [staff] all know their stuff" and another person said "Everyone seems very efficient, I haven't had any problems". A visiting relative said "We're getting our real mum back now. She was quite poorly but she's come on a lot since coming here".

People's needs were fully assessed prior to moving to the home and then regularly thereafter. This ensured people's changing care needs were understood and met. Appropriate equipment was also in place as needed. For example, people at risk of pressure damage to their skin had specialist pressure relieving equipment and the home was equipped with assisted bathing facilities for people with mobility needs.

People were supported to maintain good health and wellbeing. A number of people had complex physical and/or mental health needs and some required one to one staff support. There were always three qualified nurses on each day shift to ensure people's clinical needs were met. A local GP visited the home on a weekly basis, and also at other times as requested. A dentist, optician and chiropodist also visited regularly. People's care records described their health needs and any risks associated with them. Information was provided on the action needed to maintain their health, including regular access to external health care professionals when needed.

Newly appointed staff completed an induction programme where they worked alongside more experienced staff. During this time staff were provided with a range of training which included mandatory and service specific training. The Care Certificate had been introduced as part of the induction programme. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. We spoke with a number of relatively new care staff and most said the induction training was

good although one member of staff felt they "had been thrown in at the deep end".

Staff received training to ensure they had the knowledge and skills to provide effective care in line with current best practices. This included mandatory training, such as: safeguarding, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, first aid, infection control, fire safety, moving and handling, and understanding dementia. Person specific training was also provided to meet people's individual needs, including caring for people with diabetes and communication strategies for people who were unable to speak or could not fully understand verbal communications.

Training records showed staff were up to date with their mandatory training. The provider also supported staff with continuing training and development, including vocational qualifications in health and social care. The nurses told us they attended nurses meetings three times a year and they received support with their professional revalidation requirements.

People received care from staff who felt supported by senior care staff, the qualified nurses, the registered manager and the organisation. Staff attended monthly team meetings and received one to one supervisions every couple of months, where they discussed what was going well and areas for development. Staff also told us the nurses were "around more" if they needed help or advice.

Staff received training and had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found staff knew how to support people to make decisions and knew about the procedures to follow where a person lacked the capacity to consent. This ensured people's rights were protected. Care plans recorded discussions with people's relatives and any decisions made in their best interest. This included Do Not Attempt Resuscitation (DNAR) decisions.

Assessments about people's capacity to consent to living at the home had been completed. DoLS applications had been completed for people who were unable to consent to this and for those who required constant monitoring by staff to keep them safe from harm. Three DoLS authorisations had been granted but the majority of applications were still awaiting decisions. The authorisations granted were within the date of expiry and the service was complying with the stated conditions. This showed the service followed the requirements in the DoLS. There were also associated risk assessments and best interest decisions documented in people's care plans.

The environment was spacious, clean, airy and bright with lots of natural light. The home was organised into three separate care units, each with its own nursing station, lounge and dining area. People had a 'memory box' on the wall next to their own door containing personal items to help them remember and identify their room. All bedrooms were on the ground floor and each room had patio doors leading out onto the homes well maintained and secure gardens and grounds. People had their own door keys where they were assessed as safe to do so. Visitors told us their relatives enjoyed being taken for strolls around the grounds and visiting the home's animal farm.

Good

Is the service caring?

Our findings

We observed people were cared for by considerate, caring and patient staff. Staff went to people's eye level whenever they communicated with them and spoke in a clear and kind manner. One person who lived in the home said "The staff are super, I've had no problems with any of the staff". Another person said "Yes the staff are nice and caring and on the whole they are patient and respectful". A relative said "I don't think you can fault them, they are very kind. [Their relation] is happier than I've seen them for a very long time".

We spoke with another relative pushing a person in a wheelchair around the gardens. They said "The best thing about this place is the care and attention they [staff] give to the residents. The carers are so loving, even if a resident is 'playing up'. Their privacy is always considered and they are treated with dignity and respect at all times. I would recommend this home; it's just like a big family". During the afternoon of the inspection, there were a lot of visiting relatives and staff were very welcoming towards them. A relative told us the staff were always caring, welcoming and kind.

People looked well cared for and were appropriately dressed in clean clothing. They looked relaxed and comfortable with the staff who supported them. The atmosphere in the home was very calm and cheerful. We noticed birthday balloons and a banner on one person's door and later in the day a birthday cake was presented to them. Staff said they always did this on people's birthdays.

We observed many examples of staff demonstrating a caring and compassionate approach. For example, we heard a member of staff ask a person who used a walking frame if they wanted to go for a walk. They patiently assisted the person to stand up and adjusted their dress for them as it had risen up. They asked where the person wanted to go and then reassured them saying "You carry on you're doing well". We also observed a senior care worker ask a gentleman who was sitting alone at a dining table "How are you doing. Do you want another drink?" The person declined and then stood up and started picking up the knives and forks from the table. The senior care worker gently persuaded him to leave the cutlery for later, saying "You are a lovely man, aren't you" he responded to this with a big smile.

People were encouraged to make their own decisions, as far as they were able to. We observed staff offered people options to choose from and then acted on the person's wishes. Staff also appeared to have a good understanding of each person's needs and preferences. Each person had a named nurse and a key worker who took particular responsibility for ensuring the person's needs and preferences were understood and acted on by all staff.

Staff were trained to communicate with people in ways they could understand. Staff were patient and persevered, without rushing people, to ensure they understood people's wishes. Where necessary, people were assessed by a speech and language therapist who advised and supported staff with relevant communication techniques. Where people had limited understanding or communication skills the views of close relatives, or other people who knew them well, were also taken into consideration.

We observed people were able to choose where to spend their time without any unnecessary restrictions.

They could spend time in the company of others in the various lounges and other communal areas of the home, or they could choose to spend time in the privacy of their own rooms. One person said "I can watch events on the TV in my room or in the lounge, it just depends, I can decide if I want company or not".

Staff respected people's privacy and dignity. Personal care was provided in the privacy of people's ensuite bedrooms or in the home's assisted bathrooms. Staff ensured doors were closed and curtains or blinds drawn, as necessary. If someone knocked on the door while personal care was in progress, staff said they always checked who it was and covered the person before opening the door. Staff respected people's privacy by knocking on people's doors and waiting until they were invited in. Throughout the inspection, we observed staff assisted people in a discrete and respectful manner.

Information about people's end of life preferences, and any spiritual or religious beliefs, was recorded in their care plans. The service was accredited by the National Gold Standard Framework (GSF) which is a national scheme for ensuring high standards in caring for people at the end of their lives. We were told when a new person moved into the home they had a 'what I want for the future' meeting within two weeks of their arrival. People's relatives were also involved when it was appropriate to do so.

The provider supported people to practice their spiritual and religious beliefs where this was important to them. For example, some people were supported to attend local church services and local clergy visited the home to provide pastoral care for people who requested this.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found inconsistencies between people's personal care records and their detailed care plans and the frequency of care plan reviews. Staff also relied mainly on verbal communications about people's needs and preferences rather than the documented care records. This increased the potential for errors and omissions when providing people's care and support. We required the provider to take action to make improvements. At this inspection we found some actions had been completed but further improvement was still needed. We also found examples of personalised dementia care, but as a specialist care home for people with dementia, more could be done to embed this approach throughout the home.

A relative of a person who lived in the home said "Care plans are pretty comprehensive but there are some voids and discrepancies. They have upped their game but I still find issues".

We found a significant improvement in care records and the timeliness of care reviews since our last inspection. The monthly reviews of care plans were mostly up to date and records relating to incidents, such as falls, were clearly recorded and assessed. If changes to care were needed the care plan was updated accordingly. For example, one person who had experienced a 'mini-stroke' had a mobility reassessment and their care plan was updated to reflect the person's changed needs. Initially, they needed two care staff to assist them with transfers and a wheelchair to assist with their mobility. Over time, their mobility improved and the care records showed they were now independently mobile again. The person's daily care records, including fluid and food intake charts, were up to date and consistently completed. However, some of the person's other reviews and reassessments were overdue by a month or more. These included pressure care, communication, and behaviour reviews.

Conversely, another person's monthly care reviews and monitoring records were up to date but we found inconsistencies in their daily mouth care records and there was a lack of clarity about which staff members were responsible for this task. This was rectified immediately when we brought it to the attention of the registered manager and their deputy. The registered manager told us that once all of the newly recruited nursing staff were in post, the deputy manager would be additional to the rostered number of nurses on duty five days a week; and the head of care additional to the rostered number of nurses on two days a week. This would enable them to carry out more frequent spot checks and audits of care plans to ensure greater consistency across the home.

People's needs were assessed prior to moving to the home to ensure the service could provide the necessary care and support. Each person had a comprehensive care plan based on their assessed needs. This was kept in the nurses' station where the allocated nurses had quick access to it. People also had a personal care folder in their rooms which summarised their needs and contained forms for staff to record daily notes about the care provided.

Care plans provided the necessary information for staff to enable them to respond to people's individual needs. The records were divided into sections covering all areas of need, including: communicating; moods and emotions; deciding; spiritual; friends and family; keeping safe; eating and drinking; dressing; sleeping;

pressure care; and coping with pain. Under each section a narrative was recorded about the person's need and how staff should meet it.

People and their relatives told us the service was responsive to their needs and people had choice about how they spent their days. People told us "I do what I want to do and when I want to do it"; "Everything I've requested I've been given. As far as I can tell everyone is looked after well"; and "When I need help normally they come within about five minutes, they're very efficient". A relative said "When we have any issues, everything we say is followed through. [Registered manager's name] always says don't leave with any grievances, report them to me".

On the whole, staff provided care in a positive way and they cared a great deal about the people who lived in the home. However, some of the staff appeared more task focussed, meaning they did things for people; rather than being people focussed and doing things with people. When staff adopted a people focussed approach it made people feel more valued and respected as they were treated as individuals. Whereas the task focussed approach can have a negative impact on people's self-esteem as they are treated impersonally and simply as another job that needs doing.

All staff received training in dementia care but only some of the staff applied this knowledge in a thoughtful way. Those staff saw every daily task or activity as an opportunity to engage with people socially and tried to chat to people about things they had read in the person's 'life story'. The life story provided a brief history of the person's life experiences, including family, career and other important memories for them. The deputy manager was very person centred and had good ideas about improving the experience of people living with a dementia. The new head of care was also highly motivated and keen to expand their knowledge and understanding of dementia care. As a specialist care home for people with a dementia, we felt the service needed to do more to ensure a consistently good person centred approach was adopted by all of the staff.

We recommend that the service consider the published guidelines on current best practice in relation to the specialist needs of people living with a dementia.

People would benefit from greater stimulation if the service focused more on utilising people's life history to plan activities that people enjoyed and were interested in. We observed some good examples of this, but it was not the norm. For example, one person had an interest in fashion; staff knew this and had created a suitcase with materials for the person to touch and look at. Another person's care plan stated they liked to go out into the garden; the person told us "I do a bit of gardening and I can go outside when I want through the patio doors". However, some of the care staff talked about 'activities' as if this was a separate task to perform. They did not seem to appreciate that all tasks, including personal care, provided opportunities to engage with people socially.

The service employed three dedicated activities staff to help with activities and to manage the home's farm animals. The activities coordinator and the two assistants worked different shifts to ensure cover throughout the week. A weekly list of activities was displayed in each of the home's three units. The activities coordinator told us these lists provided "ideas and guidelines" and there was an expectation that care staff would be involved with people's activities. They said a 'rummage box' was available in each unit for people to use. These boxes included dementia friendly 'twiddle mitts' which are mitts, with items sown on them, for people to interest themselves with. However, we did not see the rummage boxes or twiddle mitts in use during the inspection. The activity coordinator said, unless staff were around to observe, they did not use them in case people tried to eat them and might choke.

Most of the activities we observed were carried out by the activities coordinator or the assistant. Although in

one unit we observed people had soft puzzles, pens and colouring books on the tables. We also observed care staff singing and shaking rattles with people during the afternoon. On the day of the inspection the activity coordinator engaged six people in poetry and sing songs in one unit and a similar number playing bingo in another unit. The activity coordinator also talked about how they used the gardens for those interested; and gave an example of growing tomatoes with people who enjoyed this. However, they said they had limited time and it was challenging to provide activities that would be suitable for everyone in such a large home. For this reason, it was important for all care staff to be involved with activities.

The home had excellent facilities including secure, well-kept grounds and gardens, an animal farm, and a reminiscence room with 'old fashioned' traditional shop displays. The room contained an ice cream stall and the lighting could be changed to simulate sunshine. Although the registered manager said these facilities were used regularly, we saw little sign of this on the day of the inspection. Some of the visiting relatives' comments also contradicted what we had been told. For example, one relative said they had been shown around the reminiscence room when they first looked around the home, but they had never seen anyone use it since their family member moved in to the home. On the day of inspection it was sunny and warm but we saw very few people using the gardens. Also during the day we were told the activity coordinator and the assistant had to escort a person to a hospital appointment. During this time there did not appear to be anyone available to enable people to visit the animal farm. It appeared that people were not being given regular access to these facilities, which would have been beneficial to them.

People contributed to the assessment and planning of their care, as far as they were able to. People's views were sought and it was recorded where people were unable to make certain decisions about their care. In these cases, staff consulted with people's close relatives and other professionals involved with their care. The service arranged monthly resident and relatives meetings to discuss the general running and other aspects of the home. Notes of previous meetings recorded discussions about menu choices, redecoration and refurbishment, and social events and activities.

People, relatives and staff told us the nurses, managers and senior care staff were all accessible, approachable and responsive. They said they could go to the registered manager or their deputy and they would resolve any issues or complaints appropriately and promptly. A relative said "It's a good thing we feel we can raise any concerns and they do follow them through. I've never been made to feel bad about having said something". A person who lived in the home said "I would be happy to raise a concern or make a complaint if I needed to. The manager is very approachable".

The provider had an appropriate policy and procedure for managing complaints. The policy included agreed timescales for responding to people's concerns. In the last 12 months the service had received one formal complaint. The provider had taken appropriate action to resolve the issues and had advised the complainant about the next steps if they remained dissatisfied with the outcome.

Good

Is the service well-led?

Our findings

At out last inspection, we found improvements were needed in the supervision and support provided to staff. Our overall impression was there was a lack of visual leadership. We were told the nurses' role was to lead the shifts but they did not appear to have the necessary skills or understanding to do this effectively. We required the provider to take action to make improvements. At this inspection we followed this up and found effective action had been taken to improve the management and supervision of staff. A person who lived in the home said "It seems to run quite smoothly here and there's always somebody around. I'm quite happy here".

At this inspection we observed the nurses directing care staff and senior carers to support clients appropriately. For example, care staff were asked to assist people when they appeared to be getting anxious or distressed. We heard nurses reminding staff to encourage people to have a drink and to record this in their fluid intake charts. All three nurses were very visible on the floor and staff approached them for clarification and advice when required. Care staff told us they always reported any issues or concerns to the nurses. If they noticed any changes in people's needs they noted these in the person's daily care records and then brought this to the attention of the nurses.

Staff spoke positively about the registered manager saying he was around the home a lot and they felt able to talk to him and to the deputy manager about any concerns. A member of staff said "We get on well with the manager and feel supported". Staff also said they were well supported by the nurses and the senior care staff. A member of care staff said "It's all about team work, we are like a family". The nurses and senior care staff had a clear understanding of their respective roles and responsibilities. We heard senior staff and nurses directing care staff throughout the day. Care staff spoke positively about how the service had improved over recent months, saying there were more regular staff around the home, including the nurses. They said staff worked in each of the three units to ensure they got to know people across the home and not just in one unit. They said this helped with staffing cover and also it meant people became familiar with all of the staff and felt more comfortable knowing who they were.

Relatives said the registered manager was open, accessible and responsive. One relative said "He is around all the time. You can just knock on his door, he is very approachable". We observed the registered manager was very visible around the home throughout our inspection. People, relatives and staff told us this was his normal style and approach.

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The registered manager told us the service philosophy was to provide a high standard of care, meet people's needs and provide a safe environment. People were to be treated with respect and dignity and offered choice. He wanted a happy working environment for staff and to involve people's families and other professionals as part of their care team.

Staff training and development was used to promote these values and they were reinforced at staff meetings, shift hand overs and one to one staff supervisions. The approach was also supported by the

provider's policies, procedures and operational practices.

The staffing structure and the lines of reporting and accountability were much clearer than at our previous inspection. The care staff reported to the nurses and they reported to the deputy manager and ultimately to the registered manager. The registered manager and deputy manager were visible around the home and provided clear leadership. The nurses led the shifts and the nurses and care staff understood their respective roles and responsibilities. All levels appeared to be motivated and focussed on meeting people's care and support needs. Decisions about people's care and support were made by the appropriate staff at the appropriate level.

The provider used an electronic online system to monitor staff satisfaction. Every member of staff had access to the system and was invited to answer questions on a quarterly basis about their working experience and whether they felt valued. Staff were free to complete this anonymously or identify their names. Any issues were then flagged up for discussion at team or individual meetings, as appropriate. If a home's score fell below set thresholds, the manager had to send a report and action plan to address this to the provider. Recent results showed a high staff satisfaction score at La Fontana. Our observations and the comments from staff during the inspection showed staff morale was high.

On the whole, the provider's quality assurance system was effective in ensuring people received good quality care in a safe and homely environment. This included monthly in-house audits of key aspects of the service, such as: medicines, nutrition, wound management, significant incidents, health and safety and the environment. The provider's quality and performance manager also carried out a full unannounced service review of the home every two to three months. The provider's operations manager and the home's owner also visited the service on a regular basis.

Following these audits and reviews, the registered manager prepared and implemented an action plan to address any issues or areas for improvement. For example, additional staff training or supervision was arranged to address any practice shortfalls. A new head of care post had recently been created to support the deputy manager with care plan checks and audits and to help improve the consistency and accuracy of record keeping. These examples showed the service learned from experience and took action to improve the service.

To the best of our knowledge, the registered manager had notified the Care Quality Commission and other statutory authorities of all significant events and notifiable incidents, in line with their legal responsibilities. We observed the service kept up to date records and investigated incidents. The registered manager promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

People and their relatives were encouraged to give their views on the service through day to day discussions with staff and management, care plan review meetings, monthly resident and relatives meetings, and the provider's annual satisfaction survey. Relatives told us they were made welcome when they visited and management and staff actively encouraged their involvement and views.

The registered manager and deputy manager participated in a range of forums for exchanging information and ideas and fostering best practice. These included service related training events, conferences and relevant online resources. The registered manager attended the provider's home managers meetings and various multi-agency meetings with health and social care professionals. The service had achieved the National Gold Standard Framework (GSF) accreditation for caring for people at the end of their lives. These

various methods helped the service to keep up to date with the latest and best care practices.

Staff supported people to participate in a range of social and leisure activities within the home and in the local community. The service held various events such as open days, Alzheimer's days, fetes and other celebrations to involve people, relatives and others in the life of the home.

The service worked in close partnership with local health and social care professionals. More specialist support and advice was also sought from relevant professionals when needed. We saw records of multi-agency meetings and support in people's care plans. This cooperation helped to ensure people's health and wellbeing needs were met.