N. Notaro Homes Limited

La Fontana

Inspection report

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13 September 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of La Fontana on 12 and 13 September 2018.

La Fontana is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

La Fontana provides accommodation for up to 76 older people who need nursing and personal care. At the time of the inspection there were 69 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.

Although people who were able to, told us they felt safe living in the home, the systems in place to protect people from harm needed to be improved. There were frequent incidents involving people becoming anxious and physically challenging to other people. These incidents were not always being reviewed to identify factors that could prevent further incidents from occurring. Care plans and risk assessment were not always updated following incidents.

Risks to people were not always being identified and management plans put in place to mitigate risks. Staff told us at times they were using unplanned restraint for one person during personal care. Staff had not received all of the training required to ensure they felt confident to manage incidents.

Some improvements were required to the processes in place where people lacked the capacity to make decisions for themselves.

People's care plans were of mixed quality, were not consistently person centred and some contained contradictory information. Some of the plans lacked specific details of people's communication needs, and preferences for how they wanted to be supported.

The provider had not notified the Care Quality Commission and the local authority of safeguarding incidents in line with their legal responsibility. The governance systems had not been fully effective in improving the quality and maintaining the safety of people. A new governance system had been introduced and had not been fully embedded to demonstrate its effectiveness.

Staff knew how to recognise and report abuse and felt confident concerns would be acted upon. Staff told us they felt supported in their roles.

Medicines were stored and administered safely. Some improvements were required to the recording of external creams, 'when required' medicines, and the competency checks of nursing staff.

We received some mixed feedback from people and relatives regarding the staffing levels in the home, there were enough staff available to meet people's needs. The provider had procedures in place to ensure that suitable staff were recruited.

There were systems in place to protect people from the risk of infection. There were a range of checks in place to ensure the environment and equipment in the home was safe.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

People's nutritional needs were assessed and their weights were monitored where required. Our observation of the mealtime experience was mixed. People commented positively about the food, although some said it was repetitive. The registered manager had plans in place to review and update the menu.

People were supported to access a range of healthcare professionals. The home maintained links with the local community.

People and their relatives spoke positively about the staff supporting them. Staff described how they supported people in a way that promoted their privacy and dignity. Staff spoke positively about the people they supported.

There were a range of activities on offer for people to take part in. Records demonstrated some people's social needs were not consistently met. People, their relatives and staff had the opportunity to provide feedback on the service.

Relatives, staff and health professionals commented positively about the management of the service.

We have made two recommendations to the service. One in relation to the service revisiting guidance relating to the Mental Capacity Act 2005 in relation to supporting people to make decisions. The second recommendation identifies that improvements are made to aspects of medicines management, including the recording of external preparations, 'when required' medicines, and the competency checks of nursing staff.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not fully safe.

People's medicines were stored and administered safely, the recording of some medicines needed to be improved.

Risks to people were not always identified and mitigated. The systems in place did not fully protect people from the risk of harm.

Staff said they had sometimes used unplanned restraint when supporting a person.

There were sufficient staff to meet people's needs. Staff were recruited safely.

People were supported by staff who knew how to recognise and report abuse.

People were protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff did not receive all of the training required to meet people's needs and to keep them safe.

Where some decisions were made for people in their best interest, these were not always completed in line with the Mental Capacity Act 2005.

People saw appropriate health care professionals to meet their specific needs.

People received adequate nutrition and hydration. Our observation of people's mealtime experience was mixed.

Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of the staff supporting them.

People told us they were supported in a way that promoted their dignity and respect.

Most of the staff working for the service knew people well.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans were not consistently person centred and detailed.

People's care records were not consistently completed.

People had access to a range of activities, we found some people's need for occupation, stimulation, and activities were not always met.

People felt confident to raise any concerns with the staff.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The governance systems to monitor and improve the quality and safety of the service people received were not fully effective.

The provider had not notified the Care Quality Commission of all incidents in line with their legal responsibility.

People were supported by staff who felt able to approach their managers.

The service had links with the local community.

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.

This inspection was carried out by two inspectors and an expert by experience on the first day and three inspectors and a medicines inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. When the service was last inspected in August 2016 the service was rated good.

Prior to the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, tell us what the service does well and the improvements they planned to make. We reviewed other information that we had about the service including safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with a dementia and were not able to tell us about their experiences. 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.

We spoke with six people who used the service and six people's relatives or visitors. We also spoke with 16 members of staff. This included the registered manager, the deputy manager, the clinical lead, the administrator, activity coordinator, kitchen staff, housekeeping staff, nursing staff and care staff. We also requested feedback from three visiting health professionals.

During the inspection, we looked at 11 people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records relating to food and fluid consumption. We reviewed records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit

reports.

Requires Improvement

Is the service safe?

Our findings

The service's approach to risk assessment needed to be improved. Although the care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition, other risks had not been assessed. For example, one person was being assisted by staff to eat a pureed diet using a syringe. This method carries a risk of choking, but there was no choking risk assessment in place. Although the GP had been involved in the decision to use the syringe, there was nothing documented to demonstrate that speech and language therapist (SALT) advice had been sought. Additionally, a member of care staff we spoke with who had just assisted the person, told us they had not been trained to use a syringe this way and had not been informed of what to do in the event the person choked. We discussed this with one of the nurses who told us they assumed care staff had been trained to carry out the procedure. The registered manager told us the nurses were responsible for showing staff how to support the person. We discussed the lack of SALT input and the lack of choking risk assessment and plan with the nurse and the deputy manager. They contacted the GP and arranged for the person to be reviewed by the SALT team and said they would complete a risk assessment and write a choking plan.

When people had been assessed as being at risk of pressure sores, the plans informed staff of any pressure relieving equipment in place. However, the correct settings of air mattresses in use were not documented and the plans did not always specify how often staff needed to change people's positions. We looked at all of the air mattresses in use with the clinical lead. Six of the eleven mattresses were set correctly; the other five needed adjusting. Although there was a process in place for staff to sign to confirm they had checked the mattress was set correctly, this was not being followed. By not being correctly set there was a risk people lying on them would not benefit from the pressure relieving qualities.

Additionally, staff had not always recorded when they had assisted people to change their positions. Although night time records showed position changes regularly took place, the daytime records did not. By not recording repositioning there was a potential risk of staff not knowing how long a person had been in one position, increasing the risk of people developing pressure ulcers. The registered manager confirmed at the time of the inspection no one in the home had pressure ulcers.

Some people had bed rails in place. Risk assessments had been carried out; however, the documentation in place did not inform staff of the required distance between the mattress and the top of the rails. The medicines and healthcare products regulatory agency (MHRA) recommendations are for a minimum distance of 220 millimetres between the mattress and the top of any rails in order to reduce the risk of harm to people. The guidance informs staff to avoid, "mattress combinations whose additional height lessens the effectiveness of the bedrail and may permit the occupant to roll over the top." The provider's bedrails policy did not include this recommendation. Together with the clinical lead we looked at the beds of twelve people who had an air mattress in place with bed rails. Only one of the beds we saw complied with the above guidance and some of the others had distances of just 130 millimetres. Staff were not aware of the recommended guidance. The lack of knowledge was evident in one plan because staff had documented, "Since [person's name] is nursed on an air mattress the bed becomes too high leading to the use of bed rails and bumpers for safety while in bed." This meant there was a risk that people could roll over the top of the

bedrails because the overlay mattresses in use reduced their effective height. During the inspection staff took action to address this.

We also found the homes fire register detailing the names of people, their room numbers and their mobility needs was out of date. Out of the 69 people living at the home 25 entries on the register were incorrect. This meant in the event of a fire the fire brigade would not have the correct information in order for them to evacuate people.

There were systems in place to analyse and review each incident or accident that occurred in the home. These systems needed to be improved. Staff recorded and reported incidents when they occurred. Staff told us incidents were reported to the nurses, who would then ensure an incident form was completed and the registered manager would then receive a copy of this. We found incident were not always reported on incident forms and reported to the registered manager. We also found where incidents occurred; care plans and risk assessments were not always updated to prevent the reoccurrence of the incident. For example, one person had an incident where they became anxious in their wheelchair resulting in a tear of their skin. This was reported on an incident form to the registered manager; however the person's care plan had not been updated to identify this as a specific risk.

This was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other plans, when risks were identified the plans provided some guidance for staff on how to reduce the risk of harm to people. For example, when equipment was needed to move people safely, hoist and sling details were documented. When people used mobility aids to get around, these were also documented.

The systems in place to protect people from harm needed to be improved. For example, some people living in the home, due to their specific needs, at times experienced anxiety and confusion. This could lead to physical incidents towards other people and staff. Records demonstrated these incidents were occurring frequently for some people. During August 2018 one person had been involved in eleven incidents where they had become physical with other people. These incidents resulted in people being harmed or being placed at risk of harm. Although the person's care plan included some guidance for staff to follow if the person became anxious, it did not detail any proactive measures to prevent incidents from occurring. The care plan had also not been updated following the eleven incidents in August 2018 with the specific details of the incidents and actions staff should take to prevent further incidents. This meant people were placed at risk of being harm due to the levels of incidents and lack of action being taken to prevent this. Staff however were able to describe how they supported the person when they became anxious and we observed them doing this in a discreet and reassuring way.

Although staff had taken some action by involving health professionals to review the person, the incidents were not always being reported to the registered manager. This meant the incidents were not being reviewed and analysed and actions identified to prevent further incidents. Additionally, safeguarding alerts were not being raised with the local authority and notifications were not sent to the Care Quality Commission. The registered manager told us they would report the incidents to the safeguarding team, they also demonstrated they had sought further input from the specialist dementia service, updated the persons care plan and put further measures in place to ensure people were safe.

Staff told us, another person had recently become very anxious when they supported them with personal care. They said at these times the person would hit out at the staff supporting them and that on occasions four members of staff were needed in order to ensure the person's hygiene needs were met. Some of the

staff we spoke with were confident with supporting the person at these time. Others described it as being, "Very hard." We asked the staff what support four of them provided during one episode of care and they all described a form of restraint whereby two members of staff would hold the person's hands and arms in order to prevent them hitting staff members. There was no risk assessment or guidance in place stating that the person could be restrained at these times. Although there was a plan in place, there was limited information for staff on how to support the person during episodes of aggression. Additionally, records showed that when the person had become agitated, staff had continued to provide support, rather than attempt to de-escalate the situation. This contradicted the guidance in another section of the plan. We discussed this with the registered manager who told us they were not aware of staff using restraint. They confirmed they would raise a safeguarding alert for the person and arrange for further input from the specialist dementia team that would include offering staff advice and training on how to manage these incidents.

This was a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were happy with the way staff supported them with their medicines. One person told us, "Staff give it to me." Another Commented, "I don't worry, staff give it to me."

Nursing staff administered medicines and recorded this on electronic medicines administration records (MARs). A sample of 20 people's MARs showed that people were given their medicines correctly in the way prescribed for them. Staff demonstrated how the electronic stock control and recording system worked. People received their medicines in a safe and caring way. The records showed why 'when required' medicines had been prescribed. We checked records for four people who were prescribed sedative medicines for agitation or distress. There were details in their care plans around managing behaviours but only one person's plan included person-centred details to guide staff as to when it would be appropriate to give a dose for this person.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective. There was a policy and system in place so that some non-prescription medicines were available to treat people's minor symptoms in a timely way.

There were separate charts in place for recording the application of creams or other external preparations. There were body maps and guidance in place for how staff should apply these. Staff recorded the application of these products on daily charts, however we saw two people's charts where they were prescribed more than one preparation, but the records didn't specify which had been applied. Managers explained that a new electronic recording and care planning system was about to be introduced which would address this issue.

Nurses told us they had received training on the use of the medicines system and were checked as competent to administer medicines safely as part of their induction. However there were no records kept of these checks. There were detailed policies and procedures, and information to guide staff on looking after medicines safely. There was a reporting system so that any errors or incidents could be followed up to help prevent them from happening again. Monthly medicines audits were being completed and issues identified. We saw that the most recent audit in August had picked up that not all 'when required' medicines had written care plans in place around their administration.

We recommend that improvements are made to some aspects of medicines management including the

recording of external preparations, 'when required' medicines, and the competency checks of nursing staff.

People who were able to told us they felt safe living at La Fontana and with the staff supporting them. One person told us, "I just feel safe. There are people all around. I like it here, people are nice." Another commented, "Yes, everyone is friendly, and I have a bell to call them." One person commented they felt uncomfortable with other people entering their bedroom, they said staff had taken action to prevent this from happening. Not everyone could tell us if they felt safe, but we observed they looked comfortable and relaxed with the staff supporting them.

One relative told us they thought their family member was, "Safe and well looked after." However another commented they had concerns about the incidents involving some of the people living at the home and the impact this may have on their family member.

Staff told us they completed training on how to protect people from avoidable harm and abuse, and staff spoken with confirmed the correct action to take if they suspected abuse. One staff member said, "I know the residents well and would know if something wasn't right. I would report it straight away and I'm confident the right action would be taken. I know I can report anything straight to safeguarding, I have never had to." Another commented, "All bruising is reported to the nurses, we check people daily. I am happy they would take the right action. I know I could contact the Care Quality Commission, we have training about this and it is discussed in team meetings."

We received mixed comments from people and their relatives with regards to the staffing levels in the home. One person told us, "Yes, I think there are enough staff." Other comments included. "They are a bit slow sometimes. They can't help it they have others to see to" and "Not enough staff in the mornings." Relatives told us, "Staffing levels are adequate", "It's 50/50, sometimes staff appear stressed", "There are a shortage of staff to give personal care" and "Sometimes there does not appear to be anyone about when I come in."

Staff thought there were enough staff available to meet people's. Comments from staff included, "Yes, there's enough staff. The staff aren't stressed or rushing", "We usually have enough staff. Staff pick up extra shifts if someone goes off sick or we can use agency", "Most of the time there are enough staff" and "Staffing is good here."

Our observations were that there were enough staff available to meet people's care needs. On the second day of the inspection one area of the home was short staffed by one staff member due to staff sickness. We observed this impacted on the level of social interaction people experienced during the morning.

We discussed the calculation of staffing levels within the service with the registered manager. They told us that currently no formal dependency assessment or tool was used. Staffing levels were currently calculated by knowledge of people's needs, observations around the service and feedback from people, the relatives, and staff. The registered manager confirmed the staffing levels in the home and we saw the staffing rotas were consistent with this. We reviewed the staffing rotas which demonstrated the majority of shifts were covered with permanent staff, staff confirmed where shifts were covered with agency staff, regular agency staff were used.

The provider had procedures in place to ensure that only suitable staff were recruited. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are

barred from working with vulnerable adults.

There were systems in place to ensure people were protected from the risk of the spread of infection. The provider employed a team of housekeeping staff to maintain a clean home. Staff had access to, and wore, personal protective equipment such as disposable gloves and aprons which also helped to minimise risks to people. Sanitising hand gel and hand washing facilities were available throughout the home.

There were a range of checks in place to ensure the environment and equipment in the home was safe. Safety reviews and regular servicing of utilities such as electrical checks, water checks, checks on equipment and regular fire alarm testing and drills were carried out.

Requires Improvement

Is the service effective?

Our findings

Where people lacked the capacity to make specific decisions the Mental Capacity Act (MCA) Code of Practice was not consistently followed. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Mental capacity assessments had not always been completed in full. For example, one person had been assessed for their capacity to consent to a textured diet and thickened fluids. The assessment had not been completed correctly because staff had not documented the discussions they had with the person in order to assess their understanding. Another person's capacity to consent to receiving a liquidised diet via a syringe had been assessed in November 2016 but speech and language therapist's input had not been sought as part of the decision making process. Staff had signed to indicate the decision had been reviewed every three months. A new capacity assessment had been completed on 15 August 2018, and was an exact duplicate of the original assessment. This did not demonstrate that the person's capacity had been fully reviewed. Additionally, in this instance, the risks associated with this procedure were not documented within the assessment or within the best interest decision making process.

We looked at the plan for one person who smoked. A risk assessment had been carried out and in order to prevent the risk of harm, the plan guided staff to supervise the person when smoking. Staff looked after the person's cigarettes. The plan stated the person should be offered a cigarette every two hours. The person had not been assessed for their capacity to consent to this and there was no best interest documentation in place to show how the decision to limit the cigarettes had been reached.

Several people had bedrails in place but people had not been assessed for their capacity to consent to these. Room sensors were in use but again, peoples' capacity to consent to their use had not been carried out.

We discussed the lack of MCA assessments with the registered manager who told us during their last CQC inspection they had been informed that they did not need to keep MCA assessments and best interest decisions in people's care plans. They demonstrated MCA assessments and BI decisions had been completed in the past for some aspects of people's support. We were not able to corroborate this information.

We recommend that the service revisits guidance relating to the Mental Capacity Act 2005 in relation to supporting people to make decisions.

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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The

deputy manager maintained a log of DoLS applications. One person's DoLS applications had been authorised by the local authority, however we had not been notified of these in line with the provider's legal responsibilities. The registered manager told us they would send the notification to us retrospectively.

Although staff commented positively on the training they received we found training to safeguard staff and meet the needs of some people at the service had not been provided. One person commented they thought the staff lacked training in supporting people when they became anxious. Staff told us they had received training in Dementia and the Quality and Performance Manager told us this training including supporting people when they became anxious. However, staff did not feel they had enough training to support people during incidents when they occurred. We discussed this with the Quality and Performance Manager who told us they would arrange for specific training and support to be given by health professionals visiting the service as this had been successful in another of the provider's homes.

Staff received an induction when they commenced employment. This provided them with the basic skills and training needed to support people who lived in the home. Staff told us the induction included a period of 'shadowing' experienced staff and reading people's care records. One staff member said, "The induction was ok, it taught me about the home and was enough for me. I felt I could have asked for more." Another commented, "The induction was enough for me."

One nurse was new in post and told us their induction was, "Thorough." They said, "I spent a week with the deputy manager, completed my mandatory training the following week, then spent time with the clinical lead and worked across all of the units. I felt supported during the process and wasn't under any pressure." The induction programme was linked to the Care Certificate. The Care Certificate standards are recognised nationally to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff were also positive about the on-going training they received. Comments included; "The training here is very good" and "We have enough training to do the job." Nurses told us they had access to training and development in order to meet their professional registration requirements. One nurse said, "We are all going to be doing mandatory training in a block over a few days. I'm due mine." The nurses also said they had access to professional development. Comments included, "We have access to external training. I've done end of life training at the local hospice" and, "If nurses want extra training we can arrange it externally. We also access Somerset Clinical Commissioning Group courses and get a lot of support for training from the Intensive Dementia Support Service team."

Staff training records demonstrated staff received training in subjects such as; safeguarding, health and safety, infection control, moving and handling people, fire safety and dementia awareness. Some staff required refresher training in some subjects and the registered manager confirmed that dates had been set for this.

Staff told us they had regular supervisions (one to one meetings) with their line manager and felt supported in their role. One staff member told us, "I have supervision with one of the nurses, they are ok and I feel supported." Another commented. "Supervision is fine, they ask if we have any problems and if they can help, its supportive." All of the nurses we spoke with said they felt well supported in their roles. They said they had access to supervisions and also gained support from the clinical lead and the deputy manager. One nurse said, "I feel very supported. The deputy and clinical lead are easy to talk to and approachable." Another nurse said, "I do feel supported here. The deputy manager is so good, very supportive."

People's nutritional needs had been assessed and people's weights were monitored. However, the guidance for staff within care plans was not always clear, on occasions was contradictory and had not always been updated to reflect the person's current needs. People's food and drink preferences had not always been included. For example, in one person's plan staff had documented the person should have a specific texture 'E' diet. However, in another section of the same person's plan it was written that they should have a different texture 'C' diet. This meant there was a risk they may not receive the correct textured diet. In another person's plan it was written that they were having two types of dietary supplements but records from a GP visit on 06 June 2018 stated that one of these had been stopped. Another entry on 05 September 2018 stated the second supplement had also been discontinued by the doctor. The care plan had not been updated to reflect this. We discussed this with the nurse who told us they would ensure the care plans were update to reflect the correct information.

Some people were having their food and fluid intake monitored. Charts we looked at had been completed, but the level of detail was mixed. For example, on one person's food intake chart, staff had written, "All lunch" and "All pudding." There was no information on exactly what the person had eaten which meant it would be difficult to assess whether the person had received a nutritionally balanced diet. This was relevant because the person had a history of weight loss and had been assessed as having a high risk of malnutrition. Although fluid charts did not have a target intake written on them, people's daily intake had been totalled and the charts we looked at showed that people had their hydration needs met. We saw and heard staff throughout the inspection offering people drinks. For example, on one occasion we saw a member of staff take a cup of tea to one person and say, "Hello [person's name]. I've brought you a lovely cup of tea." The person smiled and said, "Oh thank you."

One person was receiving most of their nutritional needs via a percutaneous endoscopic gastrostomy (PEG). The regime was documented and the service had sought advice from the dietician when needed.

Our observations of the lunchtime experience was mixed. We saw staff put plates of food in front of some people and did not always tell them what it was. We saw that although several people sat at dining tables staff did not always serve the whole table in one go. This meant that sometimes people were eating while others were sat watching. People were not always offered a choice of gravy; for some it was put straight onto their meals. We saw one person eating slowly and their remaining food was on the edge of the plate. They didn't have a plate guard in place and we had to ask staff to put one on so that the rest of their food did not fall off. Also some people were supported with plastic disposable aprons to wear during lunchtime rather than personalised aprons or more discreet napkins.

We also saw positive examples of staff assisting people to eat. Staff told people who was going to support them, what their meal was, if they were happy with this and asked if they would like gravy and condiments. Staff sat alongside the person and chatted and encouraged them as they ate. We heard them ask, "Is it nice?" and "Would you like some more?" Condiments were available on the tables. Although the service was not using coloured plates, which is recommended by the Alzheimer's Society for people living with a dementia, the crockery contrasted the colour of the table mats. This makes it easier for people living with a dementia to see the plate. There was also a pictorial menu available on the dining tables which we observed staff using during the inspection. The food looked and smelt appetising. One person told us, "It's very nice." Other comments from people included, "There is sufficient choice", "It's not as good as it used to be. But there is always something else", "Very enjoyable. I have a good appetite" and "It's a bit repetitive lately."

We spoke with the one of the chefs. They told us staff provided a list of people's dietary requirements, such as textured diets and diabetic diets to the kitchen. They said although there were no vegetarians using the service at the time that they were able to cater to people's needs.

They said, "We've had people on gluten free diets before. It's not a problem." They told us the menu was a four week rotating menu that had been in place for at least six years. The registered manager confirmed they were about to change the menu to a seasonal menu. The chef said the kitchen staff were able to meet people's additional requirements. They told us, "For example, we used to just do scrambled eggs at breakfast, but now we do boiled, fried and poached. We do our best to give people what they want."

People had access to on-going healthcare. The GP visited weekly and we saw that when needed nurses contacted the GP for advice or asked them to come and review people. People also received support from other care professionals, such as speech and language therapists, optician, chiropodist and support from the Intensive Dementia Support Service where required. Care files contained a record of when healthcare professionals had been involved in people's heath and care needs and any advice or action required. A health professional commented that staff made appropriate referrals and followed the guidance they gave.

The environment was designed to meet the needs of people living with a dementia. It was spacious, 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. There was a 'sun room' in the home where old style shops, ice cream vendor and items were displayed, that provided a 'memory lane'. We were told activities and events were held in the sun room. People had a 'memory box' on the wall next to their own door containing photographs to help them remember and identify their room. We found some of the pictures were bunched up in the boxes which could prevent people from seeing them. There was signage on toilet and bathroom doors to enable people to orientate to these rooms. 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.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. Comments included; "Yes they are caring, I have a bit of a laugh with them", "They are mostly caring", "Everyone is approachable. They are just like us" and "The majority of them are kind." Relatives told us staff were "Very kind" and "Very caring, with a personal approach."

We saw many positive interactions between people and staff. For example, we saw a member of staff knock on one person's bedroom door and say, "Good morning [person's name]. How are you? You look really well this morning." On another occasion we saw a member of staff take a drink to one person in the lounge area and say, "Is it ok if I sit here with you? I've come to help you have a drink." We also observed staff interacting with people positively when they were becoming anxious, offering to get people blankets if they were feeling cold and suggesting a person they may be more comfortable having a nap on their bed.

There was a pleasant atmosphere. People appeared relaxed around staff, they were generally smiling. We saw one member of staff reading the newspaper to one person. Another member of staff walked with one person to the lounge and asked, "Where would you like to sit? Can you see the television from there?" and "Which channel would you like on?" On another occasion we saw a member of staff gently wake somebody who was sleeping in a chair and say, "Hello [person's name]. Sorry to disturb you. I wondered if you'd like a cup of tea or coffee?" We observed one person who had one to one staffing, the staff member was very attentive towards the person, talking to them, offering reassurance and holding their hand to offer comfort.

The majority of staff we spoke with know people well and were able to tell us about their life histories and what was important to the person. Some of the newer staff were unable to recall the information but knew there was information relating to this in people's care plans. Life history documents were in place which provided staff with information on people's lives before they moved to the service. These were used to record information relating to the person's life history including their previous occupations, family details and their hobbies. Information such as this is important when supporting people who might have dementia or memory loss.

People told us they were supported in a way that promoted their dignity and respect. One person told us, "They never make me feel self-conscious." Other comments included, "I've no concerns with staff. We are respected" and "They try and cover me up." We observed staff knocking on people's bedroom doors before entering. Staff described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains, ensuring 'care in progress' signs were displayed on people's doors and explaining what they were doing whilst providing personal care.

On one occasion we overheard staff discussing the personal care they were about to deliver in front of other people and staff. We fed this back to the registered manager who told us they would remind staff to ensure people's needs were not discussed in front of others. Staff also occasionally referred to people as 'feeds', meaning they require assistance at mealtimes, which did not demonstrate respect for the person discussed.

Staff spoke highly of their roles. Comments included, "The care here is really good. The staff are very good at

their jobs and work well as a team" and "The care here is good, I know good care takes place." The clinical lead said, "I am always on the floor, always visible, always watching and listening. This way I can monitor the care people get."

People were involved in most day to day decisions about their care and support. However one person told us they did not have a choice over the gender of carers at night because sometimes there were only male carers available. We discussed this with the registered manager who told us rotas were planned with a mix of male and female carers and the rotas we saw confirmed this. They told us the deputy manager and clinical lead were responsible for completing the allocations for staff and they had a good knowledge of people's preferences. They said they had not received any complaints relating to this and they would make enquiries relating to this. They also said they would ensure this was discussed at the next residents meetings to gauge people's feedback.

Staff described how they supported people to be involved in their care and decision making as much as they were able to. One staff member commented, "The residents choose when they want to get up and go to bed, where they spend their time, their meals, choice of clothes and if they want to watch a film or TV. Even if they can't [verbally] tell us we always ask them, we look at their expressions and can tell if they are happy." During the inspection we observed some people chose to stay in their rooms; whilst others chose to spend time in the communal areas.

The service kept a record of compliments they received. We reviewed a file that contained written feedback to the service to express their thanks. Relatives told us they were made welcome when they visited the service. One relative told us, "I come in every lunch time to help feed my relative; I'm part of the furniture now. They are kind to me." A health professional also commented that staff made them feel welcome.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan that was personal to them, however we found the care plans were of mixed quality, were not consistently person centred and some contained contradictory information. Some of the plans lacked details of people's choices and preferences for how they wanted to be supported. For example, personal care plans did not always detail whether gentlemen preferred a wet or dry shave, or whether ladies liked to wear jewellery or make up. Although plans contained guidance such as, "Help [them] achieve their expected standards [of hygiene]" there was no explanation of what this was.

People's life histories had been documented, but social care plans did not always inform staff of things people liked to do. For example, in one plan the guidance was for staff to "Offer books and magazines" but didn't specify what type of books or magazines the person preferred. In another plan it was written for staff to "Put on music", but did not inform staff which type of music the person liked to listen to.

Although staff were knowledgeable about people's communication needs, communication plans did not always provide unfamiliar staff with enough detail to ensure people could voice their needs. For example, in one person's plan staff had written, "Limited communication. Can answer yes and no." The guidance for staff was to, "Use short sentences, make eye contact, use a calm voice and monitor body language" but did not specify what body language they should be observing for or what it might mean. Another person's care plan stated they were unable to communicate verbally, but were able to express a range of moods through 'nonverbal' language. There was no description of the 'nonverbal' language the person used. The care plan stated the person could become frustrated when "Carers do not understand them" and that staff should give the person "Time to express their needs and moods through nonverbal language." There were no details of how they may express their moods, what this meant and what staff should do in response. In another person's plan however, some further detail was included because staff had written, "When nervous, upset or needs to communicate, will rock [their] body" and "Words can be muddled."

The handover sheet we were provided with stated one person was prone to urinary tract infections. The care plan for this person made no reference to this. Instead it was written, "Encourage at least two litres per day." The plan had been reviewed three monthly and on each occasion staff had documented, "Care plan relevant."

The standard of documentation was not always good. Some of the terminology used by staff did not evidence a person centred approach to care and support. For example, in one plan staff had documented the person needed 'toileting' and in another person's falls record staff had written the person was 'creamed.' Plans had not been reviewed when people's needs changed which meant the information within them was not always accurate or up to date.

There were charts in place for staff to complete following each episode of care; however, these did not show that people received all aspects of care each day. For example, we looked at the charts for one person with the clinical lead. There was no record of the person being supported with their oral hygiene on the first day of the inspection. Staff had not always written when they had applied topical creams or lotions. As detailed

in the safe key question, staff had also not signed to confirm mattresses were set correctly and there was not always a record of people's positions being changed during the day.

There were 'bowel' charts in place for staff to record when people had their bowels opened. We looked at the chart for one person which showed they had not been to the toilet for one week. A member of care staff said this information had been "Handed over" every day. We asked the nurse what action had been taken and they said the person had been given a softening medicine and would have some prune juice too. We expressed our concern that one week was a significant length of time to go without seeking medical advice for this issue, and the nurse told us it had been recorded on the handover to call the GP that day.

Nurses told us they checked the monitoring charts throughout their shifts, but the consistently poor standard of documentation did not show that the checks being carried out were effective.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other care plans we reviewed contained information relating to people's needs and how staff should support them. We looked at the plan for one person who was an insulin dependent diabetic. The plan detailed the insulin regime the person was prescribed. There was also information for staff on how to recognise the signs and symptoms of hypo or hyperglycaemia and the actions they needed to take if either happened. We looked at one person's wound care plan. There was a photograph of the wound in place and the dressing plan was detailed.

We discussed the quality of the care plans and records with the registered manager. They acknowledged some of the care plans needed improvement. They told us they were waiting for a new computerised care planning systems which was about to be introduced and they had a date set for October 2018. The Quality and Performance Manager told us this had been introduced in one of the provider's other homes .They said this had been successful in ensuring comprehensive care planning and recording of care delivery.

The deputy manager and the clinical lead both said they were confident that the electronic care planning and delivery system the service was due to implement would improve the quality of documentation and provide them with real time information on how people's needs were being met.

The service was accredited with the gold standards framework. The Gold Standards Framework in Care Homes (GSFCH) is a programme to improve end-of-life care in nursing homes by offering staff training and a framework to help identify, assess and deliver care. Although there were advanced plans in place and 'thinking ahead' plans, these had not all been completed in full. Having this information in place enables people and their families to inform staff of any special wishes around how they want to be cared for at the end of their lives. This includes information such as whether people wish to be admitted to hospital and if they have any spiritual preferences. We discussed this with the clinical lead who told us they were working with the nurses to make the discussions around of life care easier and more person centred.

People told us if they had any concerns they would either speak to staff or the nurse in charge. One person said, "I would speak to the nurse in charge, or any of them really." Another person said they hadn't had any concerns and a third said where they had raised concerns these had been acted upon and responded to. We reviewed the complaints records and noted there was one on-going complaint that had been responded to in line with the provider's policy.

People who were able to told us they were happy with, and aware of the activities on offer and had the

choice if they wanted to participate or not. One person told us, "I know about them and can join in if I want." Other comments included, "I can't fault the activity co-coordinators they are really good" and "I like the musical events." Relatives commented, "The activities very good, especially the trips", "I use the garden and the animal petting with my relative" and "The activity co-ordinator is spread a bit thin."

The provider employed an activity coordinator who had two activity assistants supporting them. During the inspection we observed the activities coordinators taking people outside for walks in the garden, sitting with one person supporting them to knit, and arranging a sing along which people and relatives appeared to enjoy. We observed picture boards of previous activities which included: singing, a folk singer, a story teller, musical entertainers, crosswords, painting, garden parties, cheese and wine, mini bus outings to pantomime, garden centres and a pub lunch which was arranged twice monthly. We also observed staff sat with people, talking to them about day to day happenings.

The activities coordinator explained how they individualised activities to meet people's preferences. They said when people arrive at the home they ask them and their relatives what they enjoy and they build their activities around this. They gave an example of how one person liked maths, so they sit with the person and do maths with them. The registered manager told us a priest was available to attend the home when requested.

Although people and relatives commented positively about the activities on offer, records demonstrated some people's need for occupation; stimulation and activities were not consistently met. For example, we reviewed one person's records who was unable to independently mobilise or verbally request support, they were therefore reliant on staff to support them with their social engagement and stimulation. The person's records demonstrated they had been involved in seven activities during August 2018 and five activities in July 2018 with some of these being recorded as "Enjoyed spending time in the lounge." Whist some staff said they regularly spend time with people chatting and engaging with them, others said they were busy supporting people with their care needs, and they did not always have time to spend with people.

Requires Improvement

Is the service well-led?

Our findings

There were a range of systems in place to monitor and improve the quality and safety of the service. These included audits relating to medicines, infection control, nutrition, maintenance and the food safety. Whilst we found some of these audits were identifying shortfalls in the service and the action required to remedy them, they were not identifying all of the concerns we found during this inspection.

The systems in place to monitor care plans had not ensured all areas where people were at risk were identified. We found areas where people were placed at risk and there were no risk assessments in place. The systems in place to monitor records had not identified where there were gaps in recording people's care needs. The auditing systems were not effective in ensuring the fire register was up to date. The systems in place had not ensured pressure relieving mattresses were set correctly and bed rails were within the recommended guidance to prevent people from falling out of bed.

The systems in place to monitor incidents had not identified these were not all being reported to the registered manager or the need for staff to receive additional training to manage incidents. They had also not ensured that all care plans were accurate and updated following incidents, or that relevant safeguarding alerts had been raised.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the governance arrangements in place at the service and arrangements with the registered manager and the Quality and Performance Manager. The Quality and Performance Manager told us the provider had introduced an electronic governance system. The system encompassed the service undertaking a self-assessment against the Key Lines of Enquiry (KLoE) inspected against by the Care Quality Commission during a comprehensive inspection. All incidents, accidents, care plans, records, and training formed part of the new electronic record. This system allowed continual monitoring of incidents and accidents within an individual service within the providers group.

The registered manager told us they had recently started using the new system and this had not been fully embedded into the service. They were confident once this was in place it would be effective.

The Care Quality Commission (CQC) had not been notified of all safeguarding incidents and one Deprivation of Liberty Authorisation in line with legal requirements. Providers are required by law to notify CQC of specific incidents, this is so that we can ensure the correct action has been taken. We discussed this with the registered manager who reassured us all further relevant incident would be reported to us in line with their legal responsibility.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Some people knew who the registered manager was and some didn't. One person commented, "I can't fault

the deputy manager." Relatives told us, "The manager and deputy are approachable" and "They are approachable and supportive."

All staff spoke highly of the registered manager, the deputy manager and clinical lead. Comments included, "I can discuss anything with [registered manager]. [They] are very open and will always take time to listen. Very approachable", "[Clinical lead] is so approachable and helpful" and "I know [deputy manager] is always by my side and supporting me."

The registered manager was also a registered nurse and they kept their knowledge and skills updated thorough on-going training. The registered manager told us they were supported by the provider's senior managers, who provided them with supervision and were available for support if needed. They also attended the provider's managers meeting which was an opportunity to share good practice and learning. The Quality and Performance Manager told us in the managers meetings included learning and sharing opportunities to discuss on-going compliance issues in each service.

The registered manager maintained a regular presence in the home. They had knowledge of the people who lived at the home and the staff who supported them. They told us they spent time in all areas of the home which enabled them to constantly monitor standards.

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "We talk about any issues, we can have our say." Another commented, "Staff meetings are ok, we talk about any problems and are improving all the time." Nurses said they also had regular clinical meetings with each other and attended the staff meetings with all members of the team. Meeting minutes demonstrated meeting were used to discuss items such as, record keeping, choice making, care delivery, reporting information, encouraging independence, safeguarding, dignity and respect.

Staff commented positively about working at La Fontana and the staff team. Comments included, "We are like a family, a very nice team and treat each other equally" and "The staff are all friendly, Staff also said they felt valued by the provider. Comments included, "I feel very valued. The senior management team are very friendly and always ask how I am when they visit" and "I do feel valued, yes."

The home maintained links with the local community such as; the local school, churches, pubs and garden centres. The registered manager told us how they had recently arranged a coffee morning for relatives and people from the local community in Martock. The purpose of the meeting was to discuss dementia and offer advice and support to people's relatives. The registered manager invited a speaker from the Alzheimer's society to attend the meeting and deliver a presentation. They told us they planned to hold similar coffee mornings quarterly throughout the year.

There were a range of systems in place for people and their relatives to give feedback on the service. This included a survey covering areas such as the staff, the environment, cleanliness, the meals and overall satisfaction. We reviewed the results of the latest survey completed by relatives which demonstrated overall feedback was positive. We also reviewed an online feedback survey completed by people's relatives and visitor and noted the feedback received again was very positive.

Resident and relatives meetings were also held to enable people to discuss matters relevant to the home. Relatives told us they felt listened to. On relative said, "The meeting was advertised well, I felt listened to." Another commented, "I brought up a concern and they acted on it." We reviewed the minutes of the latest meeting and saw items discussed included, staffing arrangements, the menus, activities and the cleanliness of the home. Action points were created as part of the meeting records.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of all safeguarding incidents and DoLS applications in line with their legal responsibility. Regulation 18 (1) (2) (e) (4) (b)

The enforcement action we took:

We issued a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users was not always assessed and mitigated. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

We placed conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and process to safeguarding service users were not fully effective at protecting service users from harm. Care and treatment for service users was provided in a way that involved restraint. Regulation 13 (2) (4) (b)

The enforcement action we took:

We placed conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the service were

not fully effective. Accurate, complete and contemporaneous records were not kept in respect of each service user. Regulation 17 (1) (2) (a) (c)

The enforcement action we took:

We placed conditions on the providers registration