N. Notaro Homes Limited

La Fontana

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
La Fontana was a residential care home that was providing personal and nursing care to people aged 65 and over. At the time of the inspection there were 65 people living there.

People's experience of using this service and what we found

People lived in a home where quality audits were carried out but were not always effective in ensuring improvements were made. Shortfalls identified at this inspection had not been identified and addressed by the provider's own quality assurance systems.

Systems and processes in place to protect people from the risk of abuse were not fully effective. Staff knowledge and responses to the needs of those living with dementia needed further developing. People had behaviour care plans in place, however the records in the care plans were not up to date. There were not individualised interventions or strategies to help alleviate people's anxiety or behaviours that challenged.

Accidents and incidents were reviewed to help identify themes and trends. Audits had not identified under recording of these incidents and it was not clear if all unexplained injuries were recorded, investigated and reported.

Improvements were required into the induction to new staff at the service. There were a number of staff who did not know people well. Some staff and relatives raised concerns in regard to staff being employed who had limited understanding of the English language. Although there were sufficient staff on duty there was a high use of agency staff in the home, including agency nurses. We found the agency staff had not always had their identity and skills checked before they started work at the service.

A recommendation made at our last inspection in regards medicine management had mostly been met. There have been improvements to the way people's medicines were managed since our previous inspection. However, some further improvements were needed to the way information was recorded about people's medicines, further improvements were needed for medicines prescribed to be given 'when required'.

Systems were in place to ensure people were protected from the risk of the spread of infection. The service was able to demonstrate when infections had occurred. Current and national guidance was followed.

A recommendation made at our last inspection in relation to the service revisiting guidance relating to the Mental Capacity Act 2005 in relation to supporting people to make decisions, had not been met. Where people lacked capacity to make decisions or give consent, staff did not always act in accordance with the Mental Capacity Act (MCA). Mental capacity assessments and best interest decisions had not been fully completed in line with the principles of the MCA. DoLS applications were out of date.

There was a risk people may not be protected from harm because staff lacked the specialist knowledge and skills to care for people living with advanced dementia and complex needs. Although some new staff praised their induction others told us they felt they needed more guidance.

People had their nutritional needs assessed. Pictorial menus were observed on tables. People told us they enjoyed the food at La Fontana. Throughout the inspection staff were observed offering people regular drinks and snacks in a caring way.

People lived in a comfortable home which was well-maintained and regular checks were carried out to promote people's safety. People had bedrooms where they could spend time in private or with visitors. There were ample communal spaces and garden areas for people to use.

Throughout the inspection we observed kind and respectful interactions between staff and people using the service. People told us staff were kind and respected their privacy and dignity. Visitors said they always felt welcomed at the home and staff kept them informed about the care of their loved ones.

Each person who lived at the home had a care plan, but these lacked details and were not person centred. Daily records were called 'wellbeing checks. They did not give a true reflection of what the persons needs were. The provider had a new on-line care system in place and told us the care plans were a 'work in progress.'

The provider had a complaints procedure and people and their relatives told us they were aware of the process to make a compliant. However, there were shortfalls in the recording of complaints.

There were shortfalls in the oversight of the service. Although there had been improvements in notifying CQC of incidents and safeguarding alerts. The provider quality assurance systems did not identify and rectify previously identified breaches of regulation, ensure the quality of service provision and mitigate the risks to people.

Rating at last inspection: The last rating for this service was requires improvement (published 15 February 2019). Following this inspection, we imposed conditions on the provider's registration. These required the provider to carry out specified audits and report on the outcomes of these audits to CQC each month. At this inspection there had not been enough improvement made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the safe welfare of people using the service. A decision was made for us to inspect and examine the risks.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, caring, responsive and well led sections of this full report.

Following the inspection, we have been informed that all staff have undergone training on 'Behaviours that Challenges'.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for La Fontana on our website at www.cqc.org.uk.

Enforcement
We identified eight breaches of regulations in relation to person centred care, consent, safe care and treatment, safeguarding, good governance, fit and proper persons employed, staffing, receiving and acting on complaints. Please see the action we have told the provider to take at the end of this report.

Following the inspection, the Care Quality Commission (CQC) took enforcement action by varying conditions already imposed on the providers registration. This required the provider to provide CQC with a monthly report outlining actions and progress towards making the required improvements.

Follow up
We met with the provider on 03 December 2019 to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

La Fontana

Detailed findings

Background to this inspection

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

Inspection team
The inspection was conducted by three inspectors and an Expert by Experience with experience of care of older people and those living with dementia, on the first 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. On the second day a pharmacist inspector also attended the inspection to inspect medicine management.

Service and service type
La Fontana is a care home and is registered to provide nursing and personal care and support for up to 75 older people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information, we had received about the service in the time since our last inspection. This included details about incidents the provider must notify us about, such as allegations of abuse, and serious accidents and incidents. We sought feedback from the local authorities who commission services from the provider. Usually the provider is asked to complete a provider information return. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. However, on this occasion the provider was not asked to complete a provider information return as we brought the inspection forward due to the concerns we had identified in our monitoring of the service.

During the inspection-
During the inspection, we spoke with 24 people who used the service, to ask about their experience of the care provided and with 15 visiting family members.

Some people using the service were living with dementia or illnesses that limited their ability to communicate and tell us about their experience of living there. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us and share their experience fully. We observed staff providing support to people in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether they were comfortable with the support they were provided with.

We spoke with 23 members of care staff including the quality compliance manager, registered manager, head of care, four nurses, and the chef. We reviewed a range of records about people's care and how the service was managed. This included looking at 11 people's care records and a sample of electronic medicines records. We observed administration of medicines and checked storage arrangements, policies and procedures, medicines audits and records. We spoke with six members of staff about medicines. We reviewed records of meetings, staff rotas and staff recruitment files. We also reviewed the records of accidents, incidents, complaints and quality assurance audits the management team had completed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were in place to protect people from the risk of abuse, however these were not fully effective. A number of people we met demonstrated behaviours that challenged the service related to their dementia, for example verbal and physical aggression to staff and each other. One person had thrown a heavy item, placing people and staff at risk. Another person received an injury from being hit by another person. Staff told us they found it difficult to manage people behaviours and had not received any training in regards interventions. This meant incidents were not being appropriately managed as staff did not have the skills and knowledge to support people at these times.
- There was a risk that people may not be supported safely. Staff told us, and records showed some people found it difficult to be supported with personal care. One person's behaviour chart stated on four occasions in June 2019 they had become 'agitated' whilst receiving personal care. The persons records stated the care had continued even though the person remained 'aggressive'. One member of staff told us, "Sometimes it is difficult to support people with personal care. We just have to try and calm them and get on with it. I am sure that is why there is so many unexplained bruises."
- People were not always protected from harm because staff had not received training to support behaviours that challenge. Staff were able to describe initial steps they took to try to calm people, however they lacked the knowledge and a consistent approach or the next steps if their initial steps were unsuccessful. This meant people were at risk because staff did not have the correct skills to support them.
- People had behaviour care plans in place, however the records in the care plans were not up to date. For example, one person's behaviour charts had not been completed since 14 May 2019 whereby the persons daily records reported unpredictable behaviours were continuing.
- Since the inspection we have also been notified of concerns being raised about possible neglect of a person due to poor moving and handling practice. This is being investigated by the provider and local authority safeguarding team.

Failure to protect people from the risk of abuse was a continued breach of Regulation 13 (Safeguarding) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations

At our last inspection the provider had failed to ensure risks to the health and safety of service users was assessed and mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management. Learning lessons when things go wrong
● Where risk assessments were in place staff were not always following guidance. For example, one person had been assessed as needing a soft diet, including thickened fluids. We observed the person eating a bowl of dried snacks which was not in accordance to the guidelines in their care plan. This meant the person was at risk of choking. We asked the registered manager to follow up on this concern.
●There was a risk that people may not have their needs met safely when required because equipment was not available at all times. Staff informed us they did not have the correct amount of equipment to move people safely. Staff told us people shared slings and hoists which meant they "Had to wait until one became vacant". One member of staff told us, "Sometimes they are being used in a different unit, we have to wait and go and get one". We discussed our concerns with the registered manager who informed us this issue had now been addressed as they had recently purchased new slings and hoists.
● Records relating to recording of incidents needed to be improved. Staff were required to record and report incidents to nurses when they occurred, and nurses would then record them onto incident forms. There was a risk that incidents were not always recorded. For example, we observed one person with bruises to their arm. There was no record of the bruising, although a member of staff told us they were not new bruises. They agreed these should have been recorded in the person's care records.
●We observed one person being aggressive towards staff during our inspection. This was not recorded as an incident or on the person's behaviour chart. Staff informed us 'this was a daily occurrence'. This meant incidents were under reported therefore opportunities to identify daily risks related to challenging behaviour were being missed and measures not put in place.
● Care plans and risk assessments were not always updated to reflect people's changing needs and to manage risk to prevent the reoccurrence of the incidents. For example, one person was recorded as having five incidents where they hurt staff and people in June 2019. Their care plan stated they needed 'constant supervision' to avoid the risk of harm to others. On both days of the inspection we observed the person unsupervised. Following the inspection, the provider informed us the care plan had been updated, as the person did not need to have constant supervision.
● Although accident and incidents were monitored to identify themes and trends, under reporting meant opportunities to identify risks, and themes relating to managing challenging behaviours were being missed. Without analysis of these there were limited opportunities to learn lessons and change or improve care provided to people.

Shortfalls in the assessment and management of risk was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Since our last inspection improvement had been made to monitor risk when people were cared for in bed in regards the monitoring of mattresses and bedrails. Some people had bed rails in place to prevent them falling. Risk assessments had been carried out. We observed that the documentation in place informed staff of the required distance between the mattress and the top of the bed rails.

Staffing and recruitment

●Recruitment procedures did not ensure people were supported by staff with the appropriate experience and character. The provider used agency staff to undertake shifts where there were gaps which other staff could not undertake.
● There was not a robust system to ensure agency staff had an induction when they came to the home, or identity checks to ensure they were the correct agency staff member. We found the agency staff had not always had their identity and skills checked before they started work at the service.
● The provider's recruitment process was not always followed. We reviewed five recruitment files for new staff. We found gaps in employment history in three files, including evidence of suitability checks. This meant there was a risk that unsuitable staff may be employed.

Shortfalls in staff recruitment procedures was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● During the inspection the home was adequately staffed, although there were sufficient staff on duty there was a high use of agency staff in the home, including agency nurses. People were supported with their physical care needs in a timely manner
● We received mixed comments from people and their relatives with regards to the staffing levels in the home. There had been a high turnover of staff, however the provider was using agency staff to ensure the correct staffing levels were adhered to. Comments in regards staffing included, "Enough staff? I would say so, yes. Not as a rule, any long waits". "Yes, enough staff. I'm not waiting I just go and get it". "They've lost so many staff in the last three months". The registered manager told us they were actively recruiting but still had vacancies for both nursing and care staff.

At our last inspection we recommended that improvements were needed to some aspects of medicines management including the recording of external creams 'when required' medicines and competency checks of nursing staff. We found improvement were still required in regards 'when required 'medicines.

Using medicines safely
● Following our last inspection, we found there have been improvements to the way people's medicines were managed.
●Further improvements were needed for medicines prescribed to be given 'when required'. Protocols to guide staff when these might need to be used had been introduced since our previous inspection, but these were not available for all 'when required' medicines prescribed for people. Where they were available they had not always been updated to include changes to the way these medicines were prescribed after a medication review had taken place. They did not contain individualised information about when they might need to be used for each person, or how to decide how much to give if a variable dose had been prescribed.
●Medicines were stored safely. The home used an electronic recording system for both care records and medicines administration. The system used for medication administration scans bar codes and this identifies if the wrong drug is being prepared. This reduced the risk of medicine errors.

Preventing and controlling infection
●Systems were in place to ensure people were protected from the risk of the spread of infection. The service was able to demonstrate when infections had occurred. Current and national guidance was followed. People were protected against the risk of the spread of infection because staff received training in good infection control practices.
●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 minimise the risks to people. Sanitising hand gel and hand washing facilities were available throughout the home.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection we found some people had restrictions in place. We made a recommendation that the service revisits guidance relating to the Mental Capacity Act 2005 in relation to supporting people to make decisions. The provider had failed to comply with this recommendation.

● At this inspection we found unauthorised restrictions remained. For example, a person who lacked capacity smoked but was restricted to having a cigarette every two hours. Although a risk assessment was in place in regards the smoking, no best interest documentation was in place to show how the decision to limit the cigarettes had been reached. The person was overheard on numerous occasions throughout the inspection reminding staff their 'two hours was up'. This meant that people were at risk of unnecessarily restrictive practice.
● Where best interest decisions had been made on people's behalf there was no record that people who knew them well had been consulted. For example, one person had moved rooms with the agreement of their family. The registered manager had not ensured the family members had the legal rights to make decisions for the person. A best interest process had not been followed. This meant there was a risk that

people who did not have the legal right to make decisions for people were granted this status.
●Deprivation of Liberty safeguards and key requirements of the Mental Capacity Act were not fully understood. Where people lacked capacity, evidence was mixed in regards best interest decision and consulting family. For example, one person had no mental capacity assessment on record, however the person had a DoLS in place.
●DoLS applications were out of date. A health professional informed us they were not kept up to date by the service in regards DoLS application and who still required them. The registered manager was unable to tell us how many people had DoLS or if there were any conditions attached to the DoLS. This meant the registered manager was unable to monitor whether the service was complying with any DoLS authorisations.

Failure to ensure people were not at risk from unauthorised restrictions was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience.
● People did not always receive effective care by staff who had the skills to support them with specific needs. Staff completed a four-day induction course and had mandatory training updates periodically. Although some new staff praised their induction others told us they felt they needed more guidance.
● Staff training had not been kept up to date in line with the provider's guidance. For example, staff members were overdue safeguarding and moving and handling training updates. One member of care staff had worked for the organisation for over six months and had not received any moving and handling training. This had been raised with the registered manager, but appropriate training had not been arranged.
● People's care plans stated they needed support from skilled staff because of their complex needs linked to dementia. We found staff had only completed basic dementia awareness training, so lacked the specialist knowledge and skills to care for people living with advanced dementia and complex needs.
● Where people displayed behaviours that challenged the service, staff had not received behaviour support training to manage these situations in positive, proactive ways. We reviewed six behaviour care plans which stated that people behaviours needed 'a prompt and skilled' response that might be outside the planned interventions. Staff informed us they had not received any specialist training in supporting people with their behaviours. Comments included, "There are a lot of incidents that don't get recorded." "We are used to seeing people with bruises, they hurt each other. We just do our best." "I would like more training to help people". The quality and compliance manager told us, "There needs to be more dementia training and behaviour training for all staff". They informed us they would address this issue with immediate effect.
● New staff who had not worked in the care sector prior to employment at the service were shown basic manual handling techniques by staff whose training was out of date. We discussed our concerns with the registered manager who arranged an update in training for staff with immediate effect.
● The feedback received from health professionals in regards the service supporting people with dementia stated, 'Staff lack knowledge of assessment of people with dementia. This links to a lack of training and creativity'.

Shortfalls in staff training, skills and experience was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Assessments were completed before people came to live at the home and involved people and their families. The service used evidence-based assessment tools to assess risk of falls, pressure ulcer risk, risk of malnutrition and dehydration.

Supporting people to eat and drink enough to maintain a balanced diet

● People had their nutritional needs assessed. Risks to people's complex needs in regard to food and fluid had been identified. People were observed being supported to eat a healthy diet. The chef told us, where needed, meals were fortified to ensure people got the correct nutrition.

● Lunch time was observed on both days of the inspection. People who required assistance, were given protective clothing to wear. They were supported in a caring and unhurried manner. They were helped at a pace led by the person. Carers were seen to be attentive and engaged with people they were helping with smiles and patience.

● People were offered two choices of meals. Pictorial menus were observed on tables. People told us they enjoyed the food at La Fontana. Throughout the inspection staff were observed offering people regular drinks and snacks.

●The chef had a good understanding of how to support people on modified diets, such as those who needed a softer diet due to swallowing difficulties.

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

● People's physical health needs were monitored by trained nurses. Nursing staff provided support to people to manage long term health conditions and responded to emergency medical situations.

● Health professionals told us that interactions had 'improved', they told us there seemed to be 'more warmth' towards people living at the service and staff seemed more 'relaxed.'

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

● People's bedrooms were personalised and reflected people's preferences and choices.

● Communal areas were kept clean and uncluttered to reduce the risk of people tripping. 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. Bedrooms on the ground floor had patio doors leading out onto the home's gardens and grounds.

Supporting people to live healthier lives, access healthcare services and support

● People were supported by local health professionals.

● Care files contained records of when healthcare professionals had been involved in people's heath and care needs and any advice or action required.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement.

This meant people did not always feel well-supported. Cared for or treated with dignity and respect.

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

● People had mixed views and experiences about the care they had received by the staff. One relative told us they were concerned about night care support. Another relative told us they were concerned about their relative having unexplained bruises. They said, "Nobody can account for them." Others were concerned in regards the changes to staff.

●People told us staff were respectful. Interactions were generally positive however, we saw examples of dignity not always being promoted and respected. For example, staff referred to people who needed support with meals as 'The feeders'. Another member of staff was calling everyone 'Darling'. Staff were often heard trying to encourage people to remain seated and 'have a cup of tea', although staff did not sit and talk to people for a meaningful time.

●Care plans showed what people could do independently. We observed one person restless and bored. Their care plan stated they liked to help make drinks. Staff told us it was easier if they made them their drinks. On the second day of the inspection we observed the person helping staff with drinks, and they appeared much happier.

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

●People were observed being offered choice, for example staff looked at the menu with people to ensure they had a choice of food. Care records held information about how to support people with choices.

●We observed staff to be mostly kind and caring towards people, with one staff member telling us, "I have worked here a long time and know people well. I care about them."

●Comments from relatives included, "I'm in every day. I can visit when I want. I'm very much made to feel welcome. The staff tell me if there is anything major happening. Overall the staff are very kind".

Respecting and promoting people's privacy, dignity and independence

●Throughout the inspection we observed kind and respectful interactions between staff and people using the service. Knowledge of individual needs was demonstrated by staff.

● People told us they felt respected, and their privacy and dignity were respected. Comments included, "Yes. They close doors and keep me covered. Yes, they are gentle". "Oh yes, they respect me".

● People looked clean and well presented. Nails looked clean. People who needed clothes protectors were offered these at meal times.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Records lacked detail and were not person centred. Daily records were called 'wellbeing checks'. These were not person centred and did not give a true reflection of what the persons needs were. For example, the record for one person stated, 'resident observed, no issues, washed, clean, cream applied, repositioned, wet pad changed.'

●The provider had a new computerised on-line care system in place. Care plans were updated by nurses, and care staff entered details of care provided via a computer tablet. We discussed the quality of the care plans and records with the registered manager, and clinical lead. They acknowledged some of the care plans needed improvement. They told us the care plans were still being adapted and they were a "Work in progress".

● People were involved in the planning of their care. However, some records we viewed stated that people had received a review of their care needs. We did not see any evidence this had been discussed with people or their relatives in a formalised way. Some people told us that they did not receive a review of their care needs and were not asked about changes in their needs. This meant the care and support provided may not be reflective of people's needs.

●Charts were in place for staff to complete following each episode of care; however, the records were generic and not person centred. For example, when a person had been supported with personal care the records only showed that personal care had been received. It did not give any details, such as whether the person had received a shower, bath or if oral hygiene had taken place.

● Improvement had been made in regard to the recording of bowel movements. Staff monitored people's bowel movement and informed the nurses of any concerns. However, there was a concern that any issues may not be personalised for people. For example, the minutes of the staff meeting in May 2019 informed staff all people must be given laxatives if they had not opened their bowels in 24 hours. This guidance to staff did not reflect people's personal bowel patterns and would not have supported people to receive person centred care.

●The minutes of the staff meeting in May 2019, informed staff they must support people with a shower. If the person refused they must 'insist' after three days. This meant people may receive given care that was not person-centred or was against their wishes. A staff member told us, "In the care plans it states three days for bath or shower, since our last meeting we are supposed to give people a bath or shower every day".

● There was limited social stimulation for people. People, relatives and staff told us there were not enough things to do, to keep them occupied. Comments included, "There is nothing for them to do. Supposed to be something every day. Staff need to sit and talk to them a bit more".

● People sat in the same place throughout the day on the first day of our inspection. One person sat from 11:28 till after 15:19 in the same seat. Staff spoke with this person when they assisted them with a drink or food only.
● At the time of the inspection there was no designated activity coordinator, which meant there were long periods where there was not much going on for people. The recording of activities was poor and did not give a true insight into activities which had taken place, for example activities recorded included, going out for a cigarette, watching television, talking to staff. One person's records showed there had been incidents of aggression. The person's care plan stated that the person needed to engage in meaningful activities which prevented them from becoming aggressive.

Shortfalls in the planning and delivery of person-centred care was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where there was a group activity, for example, an external entertainer on the first day of the inspection, it was evident people enjoyed the social interaction and benefitted from it. The registered manager told us plans were in place to recruit new activity coordinators.

Improving care quality in response to complaints or concerns.
● The provider had a complaints policy, however we found this was not always adhered to in regards the recording of the complaints. The registered manager told us "There is no complaints we have a notice on the notice board to tell people how to complain in the reception. We have not received any complaints". However, the minutes of the staff meeting in May 2019 informed staff two complaints had been made, and four relatives informed us they had made complaints but had not received any formal acknowledgement of their complaint.
● The registered manager later showed us an email response to an outcome of a complaint. However, they had not recorded their investigation into the complaint. They informed us they had not considered it as a complaint as they had "Dealt with it." There were no formal records of complaints recorded at the time of the inspection, although people and staff told us they had made complaints as some personal items were missing". This meant that there was a risk that complaints were not dealt with in an open and transparent and timely manner.
● The compliance and quality manager informed us the complaints policy should always be adhered to. The provider complaints policy states 'All complaints must be recorded'.

Shortfalls in the monitoring of complaints was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●Information was available in different formats; the activity programme had been completed with photos showing the activity that had taken place.
●Several rooms had memory boards outside of rooms to prompt conversation on times past or present.

End of life care and support
●People were supported to have a comfortable, dignified end of life. When a person's health declined staff

worked with local health professionals such as GPs, local hospice services to ensure they had all the support and equipment they needed to keep the person comfortable and pain free.

- There were improvements in end of life care plans, which prompted staff to explore people's preferences and choices in relation to end of life care. Any advanced decisions people had made, for example about resuscitation or preferred funeral arrangements were recorded in end of life plans.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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

At our last inspection the provider had failed to assess and monitor the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 relating to the governance of the service.

Following our last inspection, the Care Quality Commission imposed a condition on the providers registration to send us monthly reports. The provider had submitted monthly reports, but these were brief and had not been used to drive the improvements needed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems in place to monitor the service had not been totally effective and missed opportunity to improve the quality of service that people received. The providers quality and compliance audit in May 2019, failed to identify the issues found at this inspection in regards risks and regulatory requirements.
- Systems in place to monitor incidents were not effective. For example, they had not identified all incidents as they were not all being reported, and staff needed to receive additional training to manage incidents related to behaviours that challenged the service.
- There was a management plan in place to drive effective improvement and prioritise actions. However, this was not effective. For example, risks remained in regards people hurting each other and staff. The provider had failed to introduce measures to reduce or remove these risks within a timescale that reflected the level of risk and impact on people using the service.
- Provider audits did not identify the shortfalls and ongoing breaches in regulation found at this inspection.
- New staff, who had not worked in the care sector prior to employment at the service were shown basic manual handling techniques by staff whose training was out of date. We discussed our concerns with the registered manager who arranged an update in training for staff with immediate effect.
- The head of care held a number of responsibilities but did not have time to do them due to working as part of the nursing team. This meant that there was a lack of senior support over three units of the home. The registered manager told us plans were in place to make the head of care supernumerary, and to appoint a new deputy manager.

Shortfalls in assessment and monitoring the quality of the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We found improvements in regards to systems being in place for ensuring people had the correct pressure relieving mattresses. Mattresses were checked on a regular basis to ensure they were at the correct setting for the person's weight. We reviewed two records which showed the checks were part of staff daily routine, although the people were of low weight, the mattresses were correctly set, and staff were working in partnership with others in regards their care.

●At our previous inspection 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. At this inspection reporting had improved.

● The provider had displayed their CQC assessment rating at the service and on their website.

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

●The leadership of the service did not guide staff to understand the importance of adopting an equality diversity and human rights approach. Meeting minutes demonstrated that the registered manager put guidelines in place which did not consider people's individual needs and preferences. One person's care plan stated that staff must 'come back later' if the person did not wish to receive personal care. The person's care records showed that although the person was recorded as being aggressive whilst being supported with personal care, the care continued. A member of staff told us, "If people don't want support we can't force them. But we are told they have to have the support, or the system is out." This meant there was a task-based approach to supporting people rather than a person- centred culture focused upon people's needs.

● There was a low level of staff satisfaction and staff told us there was a division within the team. Staff told us there were often communication issues within the team, which made it difficult for them to work with each other. There were a number of staff who did not know people well. Some staff and relatives raised concerns in regards staff being employed who had limited understanding of the English language. Comment included, "(Registered manager name) does not listen they can become defensive and changes the subject". "Managers don't say thank you, they put lots of pressure on us". "Very difficult and frustrating as I don't feel I can give adequate care. There are two nurses that will help. We try to keep people safe, but they do hurt each other, it is difficult as we try our best."

The service continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

●We discussed the governance arrangements in place at the service and arrangements with the registered manager and the compliance and quality manager. The compliance and quality manager told us, they were aware of some of the issues identified in this inspection including the concerns about the language skills of some staff, the shortfalls in the care plans, best interest decision process and lack of activities and training for staff. They informed us they would be addressing all issues raised and "Would learn from this inspection and improve the reviewing of the service".

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

● People and their relatives were routinely involved in decisions about the service. We reviewed two residents' meetings held in March and June 2019. Issues were raised in regards the turnover of staff, and high number of agency staff and lack of activities. Relatives told us they felt able to discuss their concerns but did not know the registered manager well.

●Staff meetings were held, and staff confirmed they felt comfortable talking up at the meetings. Daily handovers were held by the nurses leading the shift, who ensured the care staff were made aware of any issues to follow up.

Continuous learning and improving care

●The service was meeting its registration requirement to submit monthly action plans. Care plans had been updated, however we found shortfalls in how care was delivered, and the support people received.

● Improvements had been made in relation to submitting statutory notifications. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

Working in partnership with others

● There were improvements with the service working with other providers. However, feedback about how the service worked in partnership with others was mixed. Comments from other health professionals included, "(the registered manager) becomes defensive when there are issues. They do not listen and often change the subject". Another told us, "The registered manager remains cooperative and supportive of our enquiries. Staff at La Fontana were very welcoming and supportive of when we visit the home". A further professional told us they were not kept up to date by the registered manager. Working with others was an ongoing area for development.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems in place to ensure people received person centred care were not fully effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The service failed to gain consent of the relevant person for care and treatment and was not acting in accordance with the principles of the MCA 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems in place for reviewing and recording complaints were not fully effective

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not always followed to ensure the correct checks had taken place before staff started working at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

The service failed to ensure staff had appropriate training, support and development to enable them to carry out the duties they were employed to perform

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk associated with people's care and the environment was identified and assessed. The provider had not ensured staff followed risk assessments. The provider had not ensured timely action was taken and risk reduction measures introduced to minimise known risk.

The enforcement action we took:

Notice of proposal to impose a condition 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 People were not protected from abuse and improper treatment because systems and processes designed to monitor people's safe care and treatment were not effective. This exposed people to harm from neglectful care.

The enforcement action we took:

Notice of proposal to vary a condition 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 provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured quality monitoring systems mitigated risk relating to the health, welfare and safety of people using the service. The provider had not ensured, timely, improvements to the service provided had been made and sustained.

The enforcement action we took:

Notice of proposal to vary a condition on the providers registration