Care UK Community Partnerships Ltd

# Carpathia Grange

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

About the service
Carpathia Grange is a residential care home providing personal and nursing care to 34 people aged 65 and over at the time of the inspection.
Carpathia Grange accommodates up to 62 people across three separate floors, each of which has separate facilities. One of the wings specialises in providing care to people living with dementia, another focusses on people needing nursing care. The premises are purpose built and were commissioned in 2019.

People's experience of using this service and what we found
People were given their medicines as the prescriber intended, and in a way that met their individual needs. We have made recommendations to improve medicines administration.

Staff were safely recruited, and all necessary pre-employment checks were completed. We received feedback from several staff about their concerns that there were not sufficient staff deployed. The registered manager assured us that staffing was within Care UK's dependency tool calculations. We made a recommendation to review the dependency tool to ensure adequate staffing levels had been met.

The provider had a robust infection prevention and control policy and staff adhered to procedures and wore PPE appropriate to the tasks they were completing. The premises were very clean and there were no malodours.

People and their relatives told us they felt the home was safe but if they had concerns, they could speak to staff. Staff were trained in safeguarding and could recognise the signs and symptoms of potential abuse.

Risks were assessed, and reviews and actions taken to minimise residual risks. The premises were safely managed however there were some works required to meet the actions following a fire risk assessment. These were due for completion. Regular checks and servicing of equipment, fixtures and fittings ensured they were safe for use.

Accidents and incidents were thoroughly investigated and learning from them shared amongst the team.

Peoples mental capacity had been assessed and necessary best interest decisions and applications to deprive people of their liberty were made. We noted there were DNACPR's in place that had been issued by GP's and hospital doctors that did not evidence discussion with family members.

Care plans were formulated and reviewed within the first week of people's admission to Carpathia Grange.

Staff participated in an induction on commencing their post at Carpathia Grange and there was a broad range of training courses also completed.

Food and drink at Carpathia Grange was very good and the chef had been praised for their production of meals for people who needed specialist diets. We saw people receiving empathetic and appropriate support with their meals.

The premises were purpose built and were clean and well decorated. There were appropriate signs for people to navigate the building and a good selection of reminiscence areas.

People and relatives believed the care was good at Carpathia Grange and staff were also caring to people's relatives. Dignity and privacy were maintained and when there were concerns about people's dignity or privacy, the provider took steps to explore ways to protect people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported to make choices and lead fulfilling lives. People contributed to their care plans if they were able and learning from day-to-day events was added to care plans to inform staff.

Staff communicated well with people however some communication plans and broader care plans lacked information that may have improved this. Other care plans would benefit from additional details.

There was a busy activities programme and people could choose to participate, have input from staff in their rooms or opt out. There were reminiscence activities throughout the dementia specialist areas of the service.

Complaints and concerns were responded to and a solution found for people. People would raise concerns should they have any and were confident they would be dealt with.

Staff participated in end of life care training and experienced staff worked with new staff to share best practice and experience.

There was a clear structure within the service and staff understood their roles within this. There were several meetings each with specific focus to ensure staff were well informed about relevant issues.

Meetings such as relatives' meetings that would usually have been face to face had been held via Zoom calls during the pandemic. Relatives praised the service for keeping them informed and involved. A regular quality assurance questionnaire informed the provider of their performance and informed future developments.

The registered manager understood their responsibility under the duty of candour and kept relevant persons informed when things went wrong.

Positive links had been forged with local health and social care professionals to enhance the experience of people using the service.

For more details, please see the full report which is on the CQC website at
Rating at last inspection
This service was registered with us on 7 November 2019 and this is the first inspection.

Why we inspected
This was a planned inspection based on our inspection schedule.

Follow up
We will continue to monitor information we receive about the service until we 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?

Good

The service was safe.

Details are in our safe findings below.

### Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

### Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

### Is the service responsive?

Good

The service was caring.

Details are in our caring findings below.

### Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

# Carpathia Grange

**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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors, a medicines inspector, an assistant inspector, a nurse specialist and an Expert by Experience provided off site support. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Carpathia Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. 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
We reviewed information we had received about the service. The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with 16 members of staff including the registered manager, deputy manager, senior care workers, care workers, registered nurses, the infection control lead, quality development manager and the chef.
We reviewed a range of records. These included eight people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with 20 relatives by telephone to obtain their views on the service provided at Carpathia Grange. We emailed requests for feedback to staff members and received six responses and 11 relatives sent emailed feedback when they learned from the registered manager that we had inspected the service.

Good

# Is the service safe?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were safe and protected from avoidable harm.
Using medicines safely
• Electronic Medicine Administration Records (MAR) showed that record keeping, and stock management were well managed.
• Planning and records for people needing support with long term conditions or high-risk medicines was not always consistent. This may put people at risk of receiving a medicine when it was not appropriate or experience side effects that may have a negative impact to their health.
• Staff followed protocols for medicines prescribed on a 'when required' (PRN) basis. However, prior actions taken such as de-escalation techniques were not always clearly documented, nor were outcomes following administration, which may be beneficial in indicating when a review was needed.
•Medicines with a limited expiry once in use; such as creams, liquids and eye drops did not always have opening and expiry information recorded. However, the registered manager had planned actions to address this.

We recommend the provider takes the following actions to improve medicines administration.

The provider should ensure that there is appropriate care planning and record keeping for people who are prescribed high risk medicines and / or for long term conditions.
The service should consistently detail within individuals' records, prior actions to administering 'when required' (PRN) medicines in addition to outcomes and benefits following administration.

• We saw some drinks thickener was stored on a surface in a person's room. We told a registered nurse and they arranged for it to be stored more safely. We were also concerned as a speech and language therapy, (SALT) report advised an incorrect amount of thickener to fluid for this person. The amounts recommended would result in a solid texture when they should be having slightly thickened fluids. The provider followed up with SALT to obtain an updated report and a registered nurse had already noted the error and adjusted the quantity accordingly.
• Some topical medicine administration records, (TMAR) and care plans lacked suitable details. Some stated, apply as described and others used abbreviations that may not be known by non-medical staff.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe at the home. One person said, "Yes, always. If I had any worries, I would find a person [staff member] I get on with and say".
• Staff were trained in recognising the signs and symptoms of abuse and the actions to take should they suspect abuse had taken place.
• A staff member told us, "We look for signs of abuse every day. We make sure they are kept safe. [We] observe behaviour changes and inform team leader or nurse. If I suspect someone may be a victim of abuse,

I go to [the registered manager] and report it."
• The registered manager maintained a detailed log of safeguarding incidents with relevant documents such as timelines, statements and reports for the safeguarding authority. Learning from incidents was shared with the staff team to avoid future reoccurrences.

Assessing risk, safety monitoring and management
• Risk assessments had been completed for all aspects of peoples care and to cover use of the premises. Actions had been taken to minimise risk of harm. People were able to take calculated, positive risks that might enable them to have more fulfilling lives. For example, when not in lockdown, trips to local amenities were frequent.
• Care had not always been taken to ensure people's skin integrity was maintained. One person was cared for in bed and had bedsides up to prevent them from falling out of bed. A risk assessment had been completed as the person liked to undress themselves and swing their legs over the bedsides which could cause friction and skin breakdown. Duvets had been placed over the bedsides to prevent this. However, we observed the person liked to turn upside down in the bed and hang their legs over the hard bedhead where there was no padding. We spoke to a member of staff about this and they said they would raise it with the nurse.
• Premises health and safety checks were mostly completed as required. Checks such as portable appliance testing, (PAT), servicing of hoists and required gas and electrical safety checks had all been completed.
• We noted there were some areas that had not been addressed following a fire risk assessment. Some required actions had been completed while others had not. This was due to the premises still being within a 'snagging period' as the building had only been completed in 2019. The registered manager had requested the works were completed however the contractor had not yet completed them. The registered manager assured us that the contractor would be completing works over the next few weeks. All remedial works that were the providers responsibility had been completed in a timely way.
• Regular checks of firefighting equipment and systems was completed and in the absence of the maintenance person, arrangements had been made for other staff to complete the checks.

Staffing and recruitment
• Staff were safely recruited and all Schedule three requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014 had been met.
• Robust recruitment processes had been followed which ensured only suitable staff were employed. Each staff member had submitted an application form. Their right to work in the UK and any gaps in employment history had been explored by the provider at interview.
• Staff had provided photo identity and had received a clear Disclosure and Barring Service (DBS) check. A DBS check enables employers to make safer recruitment decisions.
• Nursing staff had maintained their professional registration and had a current PIN number allowing them to practice.
• Two staff members spoke to us together. One staff member told us, "We have six [people to assist with eating]. We do feel pushed. We have two carers and a nurse. We have to ask if the nurse can assist us and [one carer] finishes at 2pm. There will be 11 [people] from today. Everyone apart from one [person's care] is a double [two staff members]. The nurse has gone to the 11am meeting. There have been lots of changes since we opened but I still love working here. I love care and the residents." The registered manager assured us that staffing was appropriate as there were three early risers on the nursing floor who were supported by the night staff reducing the number of people requiring support for the day staff.
• Another staff member told us, "There are not enough staff. Two [staff members] for 11 [people], we have one admission today. There's not enough time for chatting [with people] and if one [staff member] is doing the single [care delivery], the other one [staff member] can't do any care. They will do checks and fluids until the other one [staff member] is free." The provider had two staff dedicated to activities and one-to-one

provision in the service who spent time with people and told us that during May 2021 190 one-to-one interactions had been captured on the care system along with 132 group activities.
• Kitchen staff told us they often didn't have time to take a break all day to have something to eat due to being constantly extremely busy and had told the registered manager about this. We raised this with the registered manager, and they showed catering staff meeting minutes detailing instructions to the catering team to take their breaks at suitable intervals during the day, either as a single long break or two shorter breaks.
• Staff members told us some staff left as they were concerned about COVID-19. They had received a lot of support during COVID-19 and said, "[The deputy manager] came in day and night. We all pulled together as a team, across the home. [One staff member] caught COVID-19 and was in hospital. They had lots of support. PPE was okay. We never ran out."
• We asked relatives if there were enough staff deployed in the service. One relative told us, "It's adequate, but it could be better; they don't really have time to sit and talk[to people]. She's bedbound and seems to be a bit lonely in her room". Most relatives thought staffing was adequate, one told us, "Every time I've been there, there seem to be plenty of staff", another said, "As far as we're concerned there's always been enough staff around".
• The provider had a dependency tool used to calculate required staffing levels to meet the needs of people in the service. This had calculated two care staff and one registered nurse or team leader to support people living on the nursing floor of the service. This meant that ten people were supported mainly by two care staff, eight of whom required two staff to provide care support.
• The registered manager assured us that staffing was appropriate as there were three early risers on the nursing floor who were supported by the night staff reducing the number of people requiring support from the day staff. Additionally, at mealtimes, the resident companion and lifestyle coordinator supported on the nursing floor. Following our inspection, an additional staff member has been added to cover the busiest times of the day on the nursing floor.

Preventing and controlling infection
• Staff participated in training in infection prevention and control and during the pandemic the numerous updates were shared with staff through meetings, handovers and by text message.
• Thorough checks were made of all visitors to Carpathia Grange. Health declarations were signed by all visitors and temperatures recorded. Lateral flow tests were also completed for visitors who were not part of a regular testing programme.
• The service was extremely clean, there were no malodours.
• Hand sanitising gel was available at point throughout the home; however, it was not immediately available by some frequently touched points for example at keypads and doors to the stairwells.
• Staff were observed to be wearing gloves, apron and mask when supporting a person who was isolating.
• The registered manager told us they had risk assessed allowing one person who was isolating out of their room to exercise along the corridor. Control measures for this included ensuring other people were in their rooms and a staff presence to clean touch points after the exercise. This was not in line with government guidance however, there had been a robust risk assessment process as the person had frequent appointments meaning they were spending long periods isolating which had a detrimental effect on their mental health.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
• Incidents such as accidents, falls, hospital admissions and infections were recorded and monitored, and the registered manager completed a monthly analysis to look for causes and patterns in incidents.
• Information from the monthly analysis was shared at clinical meetings and measures were devised to minimise future occurrences such as monitoring food and fluids, adding crash mats to peoples rooms who had rolled from their beds and adjusting staffing levels and staggering staff breaks throughout the day.
• A daily '10 at 10' meeting shared urgent information with the team.

Good

# 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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Ensuring consent to care and treatment in line with law and guidance; Supporting people to live healthier lives, access healthcare services and support
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.

• Most people had appropriate mental capacity assessments, and if necessary, DoLS applications had been made. These were still waiting for authorisation by the local authority.
• Where people had relatives with lasting power of attorney over their affairs, the home had checked this and kept records.
• There was not always evidence of best interest decisions or discussion with people's next of kin related to do not attempt cardiopulmonary resuscitation, (DNACPR) documents. We saw DNACPR's that had been written by both GP's and hospital consultants that did not evidence the decision being discussed with anyone.
• The provider had a robust process for assessment and care planning when people were admitted to the service. A staff member told us, "We have an initial care plan for each resident which is built from a pre-assessment and interaction with the individual and their family or next of kin prior to move in, which gives the team an idea on who the person is. Assessments are carried out within a 48hr period of move in to establish risk and abilities". The assessments and care plans were then reviewed after seven days and a 'resident of the day' process ensured that care plans were reviewed and updated each month.
• The provider worked with other agencies such as GP's and district nurses to ensure that people were supported to maintain health and well-being.

• Appropriate referrals were made to SaLT, the older persons mental health team, (OPMHT) and other healthcare professional services as needed and support provided to people to access appointments.

Staff support: induction, training, skills and experience
• Staff participated in a wide range of training courses, some were face to face training, some 'e-learning', online courses. When we inspected, most online courses had high completion rates but some of the face to face training was overdue. Due to restrictions in place during the pandemic, face to face training could not be held.
• Training courses included dementia care, person centred care, health and safety, safeguarding, diabetes and topical medicines. Some training was specific to the staff members job role, for example medicines administration was only completed by staff in posts expected to give medicines.
• A staff member told us, "My induction was very good. I met all the residents on the first 2 days. I was introduced to them and the team. I was also given time to spend with all residents. I was shown housekeeping, kitchen and maintenance things and was shown around the home. I attended all the training that was booked. I also requested more training for my job role and was given this training straightaway". A second staff member had a completely different experience telling us they had a single day of induction and their shadowing shift had, due to the service being short of staff, been spent working mostly without their 'buddy'.

Supporting people to eat and drink enough to maintain a balanced diet
• People received a variety of home cooked food which met their nutritional needs and personal preferences. We saw the daily menu was placed on each table in the dining room, which included various choices and a vegetarian option. For example, Hunter's Chicken, vegetable crumble, jacket potatoes with various fillings, omelettes, salads.
• People were involved in choosing the menus. One person told us they had opportunities to input into the menus. They said, "Once a month we have a meeting. The head chef usually comes and [the registered manager] comes too."
• We observed the lunch meal and saw this was well organised and efficient. People were asked what they would like to eat. Staff described the meals to people where this helped them to make their choices. Staff were attentive and assisted people where required, for example, to cut up their food.
• Food was served directly from the hot counter in the dining room which meant it was served to people hot. The chef told us this also meant it was a safer service as there was less handling of food. We observed staff took people's meals to them where they preferred to eat in their rooms and assisted those who required full support to eat and drink in bed.
• People told us they enjoyed the food. One person said, "The food is good and there's plenty of it." Another person told us, "I can't fault it. It's lovely. Lots of choices. You can choose where you want to eat. I like the social time [in the dining room], and to chat." There were snack baskets in the dining rooms with, for example, rice puddings, fruit, biscuits, chocolate and crisps, which people could help themselves to at any time.
• Relatives were happy with the quality and variety of the menu, one told us, "He's [family member] told me he feels cared for and that he likes the food. He's blind so the food is important to him and that he likes the food has really helped him". A second relative told us, "She loves the food and she's put on weight for the first time ever".
• We spoke to the chef who was very knowledgeable about people's nutritional needs and prepared their food appropriately. For example, a soft, gluten free or fortified diet. No-one at the home had any cultural nutritional needs, but the chef was knowledgeable and told us this would be accommodated if and when required.
• The chef understood the importance of stimulating people's appetites and used creative ways to encourage people to eat. For example, they had recently been congratulated by the provider for their

creative preparation and excellent presentation of pureed foods which we saw was visually pleasing and appetising. We saw an email from the service manager which read, "Excellent and well done! That is the benchmark [for their other homes] so far so well done to you and the team."
• Monitoring of food and fluid intake took place if there was a clinical need to do so, and people's weights were monitored regularly.

Adapting service, design, decoration to meet people's
• The premises were purpose built and were still within the 'snagging' period following commissioning. Décor was clean and attractive and there was a homely feel to the service.
• We saw appropriate signage throughout the premises and there was passenger lift with access to all floors.
• There were very good resources to stimulate people in the dementia specialist areas. We saw resources such as toolboxes and tools, washing line and laundry, and an office area people could access, pick up and use for reminiscence. There was also a 'pub' on the nursing floor and the dining rooms had fully laid tables, similar to restaurants.

Good

# 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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• Relatives were happy with the care their family members received and gave positive feedback about staff. All the relatives we spoke with also commented that staff also cared about people's families. One relative said, "I can't fault their care; it's been a difficult time for them [staff] and we have no concerns. They are being well looked after and treated as an individual person". Another relative said, "The staff are excellent; they have a very caring attitude".
• We saw kind and caring interactions between staff and people and appropriate support was provided. For example, at lunchtime, if people did not know what to choose, staff discretely used 'show plates' to help them choose. Mealtimes were sociable events with staff chatting with people and encouraging interactions.
• Characteristics under the Equality Act 2010 were recognised and needs met. People were treated as individuals and care was person centred and accounted for their needs and wishes.
• Staff received training in equality and diversity and person-centred care.

Supporting people to express their views and be involved in making decisions about their care
• Staff supported people to make day-to-day decisions about their lives such as what to wear or eat.
• People's care records held information about their life before they came to Carpathia Grange so staff could get to know them better regardless of their ability. Knowing information about them helped staff offer appropriate choices and engage more effectively with people.
• People had care plans to support them communicate effectively. People's relatives contributed information to aide staff to communicate with them.

Respecting and promoting people's privacy, dignity and independence
• People were treated with respect and dignity most of the time. We observed staff treated people kindly and with compassion and reassured them when they were confused or disorientated. For example, one person could not remember the way back to their room. A staff member came over and said, "You are in Carpathia Grange [name]. Your room is just there [said the room number and pointed]. Would you like me to help you? Would you like a coffee in the lounge or in your room?" The person was immediately reassured and happy.
• People told us the staff were lovely, helpful and caring. One person said, "[Staff member] is really lovey. He can't do enough for you. He's smashing. I love the place. It's great, lovely, we laugh a lot." Another person said, "They [staff] come in, enjoy themselves. Enjoy what they do. Happy staff. I've been here a few years and I wouldn't move." Another person told us, "The friendliness of the carers is wonderful. They care. We have everything."
• We saw very kind and caring interactions between staff and people. We watched staff and people when they were unaware of us and saw positive interactions.

• At lunchtime we observed a staff member put a cushion underneath a person to help raise them up at the table so they could eat more comfortably.
• We saw one person was cared for in bed and their door was left open so staff could check on them and they could see into the corridor. The person liked to remove their clothing and swing their legs over the side of their bed. This meant their dignity was compromised as anyone passing by could see them in a state of undress. The provider had taken steps to stop this happening and their relatives told us, "[Relative] has a lot of complex needs, but they're always thinking of something different; they don't just carry on doing the same thing, for example, when they kept falling out of bed they got in a special bed so they wouldn't fall out, as well as putting in a falls mat, and when she took to being anxious about her clothes they tried her with a onesie. That one didn't work out, but they're always thinking outside the box".

Good

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

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

• People contributed to their care plans in different ways. Department leads such as the chef would meet with people to learn their preferences which would be added to records and informal learning such as from activity sessions would also be added to care records. Care plans were very person centred.
• We saw some care plans lacked enough details. Information such as how to recognise and provide appropriate care to people living with diabetes should they have hyperglycaemia or hypoglycaemia was not in care plans. We also found a person who had epilepsy did not have a specific epilepsy care plan.
• Care plans for people's pacemakers needed improvement. One person had no care plan for their device, and another had a brief plan. Neither identified the anticipated pulse rates nor what would happen if the rate fell below the expected parameters. Also, there was no guidance on staff actions should the pulse rate be outside of expected limits.

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.

• The provider used different methods to communicate with people and their relatives including written information and use of social media with lots of photos for example.
• Some care plans could be improved to reflect people visual and hearing impairments for example. One person with a visual impairment had very clear and specific instructions about supporting them to eat and communicate but had nothing to advise that they may need items close to them.
• A second person with significant visual impairment and possible hearing loss had nothing in their care plan to inform of their preferred or most effective methods of communication. There is guidance to check hourly as they were unable to use the call bell, but their care plan was also contradictory as it stated elsewhere, they did not wear hearing aids.
• Improvements were needed to clarify how best to support people in care plans, however the impact of this was minimal as staff members knew people well and could communicate effectively with them.
• We saw records in people's rooms alongside repositioning charts and topical medicines records for staff to note a monthly check of hearing aids. These had rarely been completed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• Most relatives were impressed with the activities offered by Carpathia Grange. A relative told us, "The care staff have a good relationship with them, and they seem happy in their world… They have a little friendship group and they told us they engage with the activities. The staff care for their foibles and seem to know what stimulates them. They pick up on what makes them happy, like kissing the grand children's photos". Another relative was also positive about activities telling us, "We've seen them on Facebook, socialising and going into the craft room".
• One relative gave less positive feedback. Their family member had needed to isolate for 14-day periods after hospital stays and had struggled and, due to their visual impairment and preferences, did not enjoy some of the activities. They were concerned their life lacked stimuli, and this was causing them to be depressed. We shared this information with the provider so they could review the person's activities.
• The provider employed a 'lifestyle co-ordinator' who created opportunities for people to enjoy day-to-day activities and social events. We saw this was very person centred and based on people's abilities and interests. The lifestyle co-ordinator told us, "It's been quite challenging as external entertainers haven't been coming in. We do a lot; [for example] making mini gardens with people, exercises, relax and sensory sessions, crafts and painting. We have a risk assessment in place and can use adult paints. We do virtual trips, aimed at people who don't come out of bed. Someone lived in the same place as me so I videoed the journey from home to the shops so they could see what's changed. They saw a photo and said, "I know where that is."
• The lifestyle coordinators or activities staff were very enthusiastic and worked to engage people fully. Having a resident's companion role had a positive impact on people.
• We observed people chatting with the lifestyle co-ordinator. They were relaxed, happy and engaged in conversations with her. There was a lot of laughter and banter and it was clear they valued the relationship they had with her. One person said, "There's my friend" when they saw her. Another person told us, "She's great. She's a sweetie." A third person said, "We always have a good laugh!" People also sat together during self-led activities, chatting, knitting, crocheting and painting. We saw they were friends and helped each other with problem solving. One person told us, "I'm doing diamond painting. I'm the first one to do it." The lifestyle co-ordinator told us, "We need to respect people's wishes. I can remind other staff of people's likes and dislikes. I try to figure out if people don't want to engage and work to include them. We have a bar where they can have a drink, conversations and live the experience".
• There were colourful, fun posters on the notice board for each day's planned activities, such as a word search game called 'Buckingham Palace' where people sat in the coffee lounge and were encouraged to shout out words they could make from the letters. Everyone was enthusiastic and joining in.
• The environment was people friendly and activities were accessible for people to dip in and out of. There was memorabilia around the home that was age appropriate and tasteful. For example, a tool bench, tools and an oil can, a church organ with sheet music, a desk with an old typewriter and a jukebox.
• One person told us," I have a very big room and a lot of my own furniture, pictures, wedding photos. It's cleaned every day. I'm well looked after".
• Relatives felt the provider had made good arrangements to keep them in touch with their family members during the pandemic however there were several concerns that the phone system could be improved. A lack of 'engaged' tone on the phone and at times constant ringing due to the reception desk not being manned had caused some problems as had booking calls in advance.
• Relatives complimented the providers use of various social media platforms, the use of newsletters and online meetings. One relative said, "They've always kept me in touch when something's happened to them and I've attended Zoom meetings for relatives". A second relative told us, "I was impressed with the measures they took over COVID-19 and the way they enabled families to keep in touch. We've been on a WhatsApp group which lets you see each other, and we've been invited to Zoom meetings and had a lot of communications from them by email. There's only been one mobile phone for the home though which has been a bit difficult sometimes. If I had any concerns, I would email the registered manager; she's quick to respond ".

Improving care quality in response to complaints or concerns
• Relatives were happy with the way in which concerns had been dealt with. One relative said, "Whatever I've raised they've acted on and they're very good at communicating out to relatives".
• Another relative told us, "[Deputy manager] had been really helpful with the paperwork and in dealing with any problems. The carers phone every month to update us on how she is".
• We saw complaints raised had been dealt with promptly and throughout the process people had been kept informed and involved.

End of life care and support
• When we inspected no one was receiving end of life care. Staff had been trained in delivering end of life care and some had experience in the area. One staff member told us, "I have supported several residents with end of life care. I feel that the staff do all they can on order to give the individual the end of life they deserve".
• The first person to receive end of life care at Carpathia Grange was during the pandemic and due to the virus and infection control was not as expected. Team debriefs were held and an end of life resource developed including poems to read, oil burners and other sensory items such as massage creams and oils. The resources are still in use and more experienced staff support staff new to care in learning how best to support people.
• We saw that 'do not attempt cardio-pulmonary resuscitation', (DNACPR) forms had been completed for some people and there had been some efforts to discuss end of life care with people.
• Some people had considered advanced care planning, what input they would like should they become unwell. For example, one person wanted 'all treatment and to go to hospital', whereas another person wanted a 'dignified death'. More detail was needed to develop these wishes into advanced care plans, for instance, for that person, what would a dignified death look like?
• We noted that there was a person who had a pacemaker that was not mentioned on their DNACPR form. This is important information that must be included and mentioned in any funeral plans.

Good

# 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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• Overall, there was good oversight of the management of medicines within the service.

• Access arrangements to electronic medicines recording systems did not always provide assurance of a robust audit trail for medicines administration. Since our inspection, individual log ins to the medicines system for agency staff have been arranged by the registered manager.

• Individuals were supported to take their medicines in a way that met their needs.

• There was a clear structure within the staff team and the registered manager and deputy manager had good oversight of the service. Since commencing in post, the registered manager had dealt with difficult issues such as under-performance and excessive sickness absence, an important aspect of their role. This had not been well received by all staff members however, the registered manager was determined that the staff team would be treated fairly and equally and as such, concerns had to be addressed.

• The provider had monthly staff awards, 'Gone the Extra Mile', or GEM awards. Staff were nominated by managers, relatives, people using the service or colleagues when they went the 'extra mile' for people they cared for. This gave an additional recognition from the provider for staff who worked exceptionally well to enhance the lives of people they cared for.

• We received mixed feedback from staff about the management team. Mostly positive, one staff member told us, "The management is fair with employees. They don't have preferences or treat people differently and they act if anyone is not performing or keeps calling in sick [without a reason]. They don't ignore anyone". Another staff member told us, "I have learned a lot of new things and feel supported to learn new things. I can see how fast management adapt to new regulations and make changes. For example, during COVID-19, changes are made very quickly when the pandemic plan is changed by head office. I am made to feel like a valuable asset in the home". A third staff member told us, "She [registered manager] assisted a resident with personal care with a team leader a couple weeks ago. [Registered manager] has very good relationship with resident [name]. Registered manager] never turns [name] away when they have any questions or want to chat. The registered manager has time for residents".

• Other staff told us that management rarely assisted 'on the floor' however short of staff they were, and that staff were not all treated the same.

• The registered manager had a schedule of meetings for each department within the home, for example, lifestyles, catering, team leaders and clinical staff. Minutes showed these meeting were used to discuss issues, identify where and how improvements could be made and recognise and share good practice. There was a clear focus on driving improvements including identifying additional training opportunities for staff.

• Minutes from a recent lifestyle meeting showed staff discussed how to capture people's engagement with daily life and activity opportunities; planning events around Eid and dementia action week, and a memory walk.
• Minutes from a recent catering meeting showed staff had identified some areas for improvement; recording gaps when people were on a high calorie diet and to introduce show plates to help people choose their meals. The registered manager also thanked staff for managing the staffing gaps whilst recruitment had taken place.
• Team leader meetings focussed more on clinical and management issues. For example, at a recent meeting staff had discussed supervisions, call bell monitoring, continence, risk assessments and quality audits.
• Relatives felt the management team were effective and reliable. One relative said, "They've been outstanding, incredibly supportive to my [family member], my sister and myself. From the first it's felt like a family run home and we have a very good relationship with the manager". Other comments included, "I have confidence in the management and if I had any other relatives I would have no hesitation in sending them there", "I do think it's a well organised establishment", and "They've supported us (relatives) really well since went in. [Deputy manager] has been really supportive. We have no issues or concerns, and I would recommend it".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Relatives meetings had been held by video which ensured they continued to have opportunities to raise any issues and keep up to date with the day to day life of the home. A recent meeting had covered COVID-19 visiting and activities. Relatives had been happy with the visiting arrangements. One relative was concerned their family member did not like them wearing a mask, so an alternative face covering was agreed.
• Relatives were asked for their views about the home and the care their loved ones received. A survey had been sent out by an external company covering areas such as the availability of the manager, safety and cleanliness, comfort, personal care, being involved and the attitudes of staff. We saw the feedback was all very positive.
• Some relatives also sent the home messages and emails which were all very complimentary. For example, "Thanks to everyone who made my surprise visit to mum so special……really appreciated. I can see she is loved," and "thanks to the chef who cooked [our relatives] favourite burger and tried to tempt him to eat," and "thanks for the [video] meeting….thanks for keeping us all informed of what is going on in these unprecedented times."

Continuous learning and improving care
• Ongoing audits were completed and areas requiring improvement were identified and dealt with as a result. We noted some areas in need of improvements when reviewing medicines however these had already been noted in the last medicines audit and plans were in place to improve already.
• The registered manager ensured that all care staff had experience of working in the different areas, so they were familiar with everyone living at the service. This meant there was a seamless change when staff tool annual leave or were unwell and care delivery quality was unaffected.
• Regular quality assurance questionnaires were completed and analysed by the provider. This identified areas that were particularly good or that needed attention.
• The registered manager maintained an 'over and above' book detailing when staff members went the extra mile to provide an exceptional level of care to people. Entries included for example, the creation of a remembrance garden and pet therapy sessions.

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

• The registered manager understood their responsibilities under the duty of candour, and shared information with relevant persons when things went wrong. They informed relatives of falls and other accidents or incidents involving their family members and kept them informed with outcomes of investigations.

Working in partnership with others
• The provider worked with other health and social care professionals to ensure people received the best quality support in all aspects of their lives. District nurses supported people using Carpathia Grange as residential care and there were three local GP's working with the service to meet people's healthcare needs. Links had also been forged with the local clinical commissioning group, SaLT and the OPMHT.