HICA

The Anchorage - Care Home

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

The Anchorage – Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. This inspection took place on 31 May and 5 June 2018 and was unannounced.

The Anchorage – Care Home is registered with the Care Quality Commission to provide personal care for up to 40 older people who may have physical disabilities and dementia related conditions in one adapted building. The main area, known as The Anchorage, accommodates older people who may have a physical disability. There is a separate wing, known as The Haverstoe unit, which provides support to older people living with dementia. The Haverstoe unit bedrooms are all contracted by the Clinical Commissioning Group and supported by NAViGO, a Community Interest Company and a not for profit social enterprise that emerged from the NHS, to run all local mental health and associated services in North East Lincolnshire. People there are jointly supported by the service and NAViGO along with input from professionals from the Clinical Commissioning Group. There were 39 people using the service at the time of this inspection.

At the last inspection in January 2015 the service was rated overall as 'good' with one section rated 'outstanding'. At this inspection the service was rated overall as 'outstanding'.

The service had a registered manager who has been registered for the past seven and a half years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager's wealth of experience, competence and knowledge ensured the service was exceptionally well-led. They effectively used quality monitoring and assurance systems to continuously improve the service, understood their legal and registration responsibilities, maintained supportive working relationships with others and ensured the secure and consistent completion of records and documentation.

The staff were outstandingly caring. People, their relatives and visiting professionals, without exception told us that staff were consistently caring and compassionate. The staff fostered, championed and facilitated a person-centred culture. They respected people's rights, privacy, dignity, diversity and independence.

People received an outstandingly responsive service. Staff found imaginative ways of supporting people to meet their needs through effective care plans. Support overwhelmingly reflected people's preferences and cultural needs. People were supported to experience an extensive range of activities, pastimes and occupation. Complaints were positively responded to so that outcomes for people were satisfactory. People's end of life care was extremely responsive to their individual wishes.

The safety of people, staff and visitors was actively maintained using risk management systems. Safeguarding referrals were promptly made to the responsible investigating body. Suitable numbers of staff were recruited and deployed to meet people's needs. The provider and staff safely managed medicines and the control and prevention of infection.

Staff were trained, skilled and competence assessed to carry out their roles. People's nutritional and healthcare needs were met. People's rights were upheld through adherence to the Mental Capacity Act and associated legislation. Advocacy services were accessed for people that required them. The premises were suitable for providing support to people and particularly those living with dementia or physical disability.

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.

People were safely supported with regards to their safety, risk management, the premises, staffing, medicines and infection control.

Is the service effective?

Good

The service was effective.

People received effective care that took into consideration their complex care needs, rights, nourishment, hydration and environment.

Is the service caring?

Outstanding

The service was exceptionally caring.

Without exception, people, relatives and stakeholders told us the staff were extremely caring and compassionate. People's diversity, privacy, dignity and independence was completely respected.

Is the service responsive?

Outstanding

The service was exceptionally responsive.

The provider found imaginative ways to ensure people's care and support met their needs and took account of their preferences and wishes. Concerns were very positively addressed and end of life care was extremely well delivered.

Is the service well-led?

Outstanding

The service was exceptionally well-led.

The culture and atmosphere was extremely positive and inclusive. Quality assurance was very effective and there was a strong commitment to continuous improvement.

The registered manager had a wealth of experience, competence

and knowledge and used it effectively to provide an excellent service.

The Anchorage - Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on 31 May and 05 June 2018 and was unannounced.

One inspector carried out the inspection. Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also received feedback from local authorities that contracted services with The Anchorage – Care Home and reviewed information from people who had contacted CQC to make their views known about the service. This information was used in the planning of our inspection.

We received a 'provider information return' (PIR) from the provider. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We carried out 45 minutes of a Short Observational Framework for Inspection (SOFI) in one of the lounges, which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people that used the service, two relatives and the registered manager. We spoke with five staff that worked at The Anchorage – Care Home and a member of the organisation's quality team. We looked at care files belonging to four people that used the service and at recruitment files and training records for four staff. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems that were implemented. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms.

Good

Is the service safe?

Our findings

People told us they felt safe living at The Anchorage – Care Home. Staff protected people from avoidable harm and abuse, with systems and technology in place to monitor incidents. Staff were trained in safeguarding people from abuse and demonstrated good knowledge of the procedures to support this. People and staff were comfortable raising safeguarding concerns and responses to these were sympathetic.

Staff were very skilled in recognising risks or unsafe situations, for example, with interaction and relationships between people. Staff carefully monitored the people likely to be involved in these situations and made good use of resources, such as sensor mats to be aware of people's location and specific medication to help them manage anxieties.

People were encouraged to manage their own positive risk taking wherever possible to ensure they were in control of their lives. Information about risk was shared in staff handovers, meetings and during supervision.

Protective measures were in place as required for people's safety and to promote their human rights. Situations were handled using the least restrictive option, for example, where a person refused personal care that was essential for their continued health and wellbeing, staff followed the principles of 'Respect' training and techniques they had completed with the organisation's trainers.

The culture was open and transparent. Current best practice was adhered to and staff used their learning to drive improvement. The registered manager led a best practice culture by ensuring models of best practice were followed. For example, the registered manager and staff followed dementia care practices, trends and policies as influenced by guidance such as that in NICE (National Institute for Health and Care Excellence) guidelines. They adhered to medical advancements in treatments for stroke, Parkinson's or diabetes and the registered manager ensured information was shared across the service.

Safeguarding systems, processes and practice protected people from abuse and avoidable harm. Where a person behaved in a way that challenged other people staff managed the situation in a positive way that protected people's rights and dignity. Support to people in these circumstances was regularly reviewed. Staff were astute and recognised people's anxieties, reassured them to alleviate those feelings and referred them to professionals for assessment in a timely manner.

The premises and equipment used was regularly monitored and maintained for people's safety, with regards to fire precautions, utilities, windows, hot water and the passenger lift. Profiling beds, safety rails, crash mats, hoists, sensor mats and emergency call bells were available and used effectively and safely. Accidents and incidents were recorded, analysed and learning from them was used to avoid repetition. We saw that staff used equipment correctly to ensure people's safety. People could store valuables in a lockable facility in their bedroom and had a key to their bedroom if they wished, which offered them security.

Sufficient numbers of trained and qualified staff were available on duty to meet people's needs and respond to any unforeseen circumstances. Staffing levels were reviewed and changed according to a used and tested staffing matrix dependency tool completed each month, which helped with production of rotas. Checks on staff absence were undertaken, with 'return to work' interviews and supervisions sessions carried out and dispensations given for attending health checks, so that staff felt supported. Staff told us they saw The Anchorage – Care Home as a good place to work where their safety as well as that of the people that used the service was promoted and protected.

Recruitment systems and procedures were robust and made sure that staff selected were right for the job. Appropriate Disclosure and Barring Service and other security checks were completed. We evidenced in recruitment files that staff completed thorough checks before they begun working in the service. We also saw that new starters completed a questionnaire so that the registered manager could identify a staff member's knowledge base and know the areas of training they needed to build on.

Staff responsibility for the management of medicines was safe and met good practice standards described in relevant national guidance, including standards in relation to controlled drugs and non-prescribed medicines. People were involved, where possible, in regular medicine reviews. Medicines, held in monitored dosage cassettes, were stored correctly and administered and disposed of safely, as the culture among the staff was that they had a shared responsibility towards people's safety. Support from healthcare professionals such as the district nursing services was accessed for invasive treatments.

Staff managed medicines well and handled problems that arose with, for example, late delivery, keeping stocks synchronised or people refusing to take their medicines. This included chasing up GPs or the dispensing pharmacist and encouraging people, so they were not at risk of missing the medication prescribed for them.

Staff followed correct procedures as specified by NICE regarding anyone taking medicines covertly. Sometimes people were given medicines covertly if they refused them and were unable to understand the importance of taking them. Self-medicating was encouraged for homely remedies where people were assessed as being able to manage them safely.

The service managed the control and prevention of infection well. The premises were clean and hygienic. Staff received training in this area and their competence was checked through observations three times a year; five times for new staff. They understood their responsibilities and maintained high standards of cleanliness and hygiene. Designated staff were infection control 'champions' with responsibility to identify inappropriate or inadequate care practice and challenge it. They were also trained to be trainers of infection control and prevention. The Clinical Commissioning Group infection control 'Essential Steps' were followed and concerns about wellbeing in relation to hygiene were shared with the appropriate agencies.

The catering staff had good food hygiene training and experience and they followed required standards and good practice. Their latest kitchen audit showed excellent results.

Good

Is the service effective?

Our findings

People told us the service was effective at meeting their needs. They said, "I never want for anything" and "The food is very good. I get all the help I need." Visitors said, "Staff were magnificent with my [relative's] demanding needs. I know where to come when it's my turn" and "The staff are simply wonderful and have no agendas."

Care and support was planned and monitored to ensure consistency, in line with current guidance, legislation and best use of technology. People' needs were robustly assessed and regularly reviewed and reference was made to external services where necessary, such as those for health care and support with technology. People's quality of life and care outcomes were good because staff effectively applied their learning to provide the outcomes people wanted.

Staff were competent and skilled to carry out their roles, which we evidenced through discussions with them and viewing their training records. Training was provided by the organisation's training department or external bodies and covered a wide range of care areas. Supervision and appraisal of staff was effective at motivating them and enabling their professional development.

People were actively involved with meal provision and exercised genuine choice regarding food and drink. This was well presented in a pleasant environment and we saw there was opportunity to graze with finger-foods all through the day. Discussion with the staff revealed that people were provided with meals that respected their religion, culture and dietary preferences. People, especially those with complex needs, were protected from the risk of poor nutrition, dehydration and swallowing problems that affected their health with support from dieticians and speech and language therapists.

Mealtimes were relaxed and unhurried and there were sufficient staff to support people when they required it. There were menus on tables to inform people of the options. The registered manager undertook meal time observations to ensure people had good experiences and changes could be made to improve any shortfalls. A result of seeing that staff practice had been hurried and congested around the service hatch and trolley, meant that staff were allocated specific tasks at meal times so they used their resources efficiently and more effectively. It had resulted in calmness, happiness for people and a more productive process whereby everyone now ate well.

Staff practice followed clear guidelines and was consistent with regards to cross-sector working with other organisations. People were involved in their move between services, for example, on admission to and discharge from hospital patient passports and palliative care patient handover forms were used.

People's health and wellbeing was effectively monitored and any concerns were identified so that they could be given the right information in the format they required and be supported to return to good health. For example, 'The Well Pathway for Dementia' was used to discuss people's general health issues and to focus on particular needs, such as hydration, which was considered by all staff as most important. Efforts to keep people hydrated were very effective. Patient passports were consistently and effectively used to

ensure health needs were understood across services.

Everyone had access to the secure gardens or outdoor space that was safe and risk assessed. There was ample space to meet family and friends in private if people wished to, as well as somewhere to hold activities and entertainment. The addition of a new conservatory on the Haverstoe unit since out last inspection had greatly enhanced the environment there. This met the needs of people living with dementia and enabled them to access the garden safely or experience the garden while staying indoors. The whole of The Anchorage – Care Home was designed to be dementia-friendly, with décor and signage being appropriate for everyone.

Technology was available to assist staff in the effective support of people with physical needs and those living with dementia, so that they maintained independence while ensuring their best interests. These included items such as sensor mats, personal computers and television loop systems. Humberside Independent Care Association (HICA) had piloted virtual reality headsets in another service and was soon to distribute these across the organisation to offer people experiences of, for example, attending a musical concert in a concert hall, sightseeing in a famous city or being at a funfair.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making specific decisions on behalf of people who may lack the mental capacity to do so for themselves. The legislation 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 these decisions, any made on their behalf must be in their best interest 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 interest and legally authorised under this legislation. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We found the service was working within the principles of the MCA and any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of these processes and requirements, having received training in them and their awareness was tested with the use of a questionnaire from time to time.

Where people lacked capacity for specific decisions they were given information in an accessible format of their choice and family, friends and advocates were involved in helping them to understand as much as possible. One person fully accepted they needed to be supported with daily living and although they had capacity to understand this they expressed their dislike of being in care. They were not given access to codes for key pad locked doors and this was arranged using a DoLS authorisation.

People were fully involved in decisions about their care. Mental capacity assessments were comprehensively completed and involved people, their families and other professionals where necessary. People were asked for their consent with all aspects of the service delivery and this was recorded and signed for, with regards to, for example, taking photographs, handling medicines, receiving personal care and sharing confidential information with other stakeholders as necessary. Where people living with dementia sometimes refused personal care and became anxious they were supported using 'Respect' techniques (strategies put in place under the best interest route) whereby trained staff managed people's care using least restrictive methods.

Outstanding ☆

Is the service caring?

Our findings

People and their family members told us they found the staff to be extremely caring, kind and compassionate and that relationships within the service were positive. People told us they felt listened to and knew how to seek help. People said, "The staff are amazing. They have all been very helpful again today" and "We get brilliant care. I am very happy with it. The staff are excellent." Visitors said, "My [relative] is cared for in bed now and if in pain, carers are lovely with them. Staff are so gentle when they need to change position. Just being here and with the staff makes their life special", "One hundred percent caring environment. A great job is being done" and "My [relative] is so happy. I call it 'Mum's hotel'."

People were respected and valued as individuals and empowered by exceptionally caring staff who shared the responsibility of their care. There was a strong, visible person-centred culture. For example, staff knew about people's individual nuances and so anticipated their needs and wishes. We saw a staff member recognise the early signs that a person was restless and the staff gave them a snack, which provided satisfaction and also distraction. People's families expressed in their thank you letters to staff what the caring approach they received felt like. Their comments included, 'My [relative's] welcome made them feel like a long-lost friend', '[Name] finds it so comforting being here', 'My [relative] has had a lovely day during our visit. We can see they are happy and get on so well with the staff' and 'My [relative] has been here for three years and you have made their life fantastic. Your genuine love for them shows through.'

Staff ensured that people were always treated with kindness and demonstrated real empathy. Evidence of this came through our Short Observation Framework for Inspection (SOFI), where people were seen to be treated very kindly by staff that demonstrated they fully understood people's feelings, moods and anxieties. For example, we saw people were given lots of attention throughout the observation. They were spoken with, their hands held when they were unsettled and calming music was offered and provided. We saw staff encouraged people to other parts of the room and engaged them in an activity or conversation when they got uncomfortably close to others. There were staff 'champions' for dignity, dementia and diversity. These roles meant staff challenged inappropriate or inadequate care practice and encouraged excellent practice through challenge, discussion and sharing of knowledge.

Staff demonstrated the right skills to get to know people well and had time to spend with people throughout the day. They used people's preferred means of communication to interact with them and to provide support with, for example, personal care, nutrition, personal safety and entertainment. One person used a 'picture exchange communication' system to make their needs known and this had given them their independence back. Being understood also improved their emotional wellbeing. Others used specific behaviour or signals to make their needs known, which staff learned to interpret and were quick to acknowledge. Easy read questionnaires were also used to seek views.

The relative of anyone receiving respite care at The Anchorage – Care Home was given a Carers Support Network leaflet to enable contact with the group once the person returned home.

Good communication among staff was aided by a variety of methods: a weekly planner for noting

deprivation of liberty safeguards and 'do not attempt cardio-pulmonary resuscitation' arrangements, traffic light monitoring for pressure care, nutrition and mobility, procedures and protocols for covert and 'as required' medicines, attending staff meetings and following 'dementia pathway care planning'.

Staff treated people consistently as individuals with past lives and supported them to re-live certain experiences, like taking one person back to a shop where they used to work and enabling another to have constant occupation by helping fold laundry, as they used to work in a launderette. These experiences helped people to recall memories and remain calm when they felt moments of anxiety because of living with dementia.

Staff were quick to respond to any changes in people's needs, like when one person appeared unusually upset. Staff took time to find out what was amiss, provided a comforting hot drink and a snack, kindly reassured them and helped them resume their usual demeanour.

Staff recognised and anticipated when people needed help from them or their families with decisions about care and support and maintained open and honest relationships with everyone. Staff provided support that was particularly sensitive, like knowing who the important individuals were or remembering the significant events in people's lives. They were exceptional at helping people to express their views so that everyone understood people's needs. Advocacy services were accessed where needed, but staff also advocated for people in their relationships with other services. They also pointed people and families in the right direction if outside help was needed, for example, from social services or health care professionals. We saw examples in documentation where all these were regularly accessed by people.

Staff were particularly skilled in exploring and resolving conflicts and tensions. They used the key working system, which operated under a team structure, to get to know and share information about people, their needs and anxieties. This meant they identified when potential conflicts might arise and used diversion techniques to help avoid them or calming language to dispel them. Key working was audited and analysed each month to identify trends and needs.

Everyone with a stake in people's care was given time, information and the support they needed to provide compassionate, person-centred care to them. This included making sure routines, rotas, training and staff supervision and appraisal arrangements were appropriate to empower stakeholders.

People were treated with dignity and respect without discrimination. This was at the heart of the culture and values demonstrated at The Anchorage – Care Home and was embedded in everything the staff did there. All staff completed training in maintaining people's dignity and six staff 'dignity champions' noted and reported on how well staff treated people throughout their working day. People with or without the ability to communicate were involved in decisions about the environment and their personal spaces reflected their individual decisions and choices in respect of, for example, their cultural and support needs.

Recruitment of new staff, their training and support underpinned the values of kindness, compassion, respect dignity and empowerment. The registered manager stated that the job application for a care worker was designed to highlight their value base and that they looked for caring values in new staff at the interview stage. This was borne out when we observed staff holding people's hands and speaking with them to give reassurance. Staff smiled a lot, sang with people and encouraged conversation and activity or occupation. Staff were generally very attentive and always supporting people in a compassionate and caring way.

Staff developed trusting relationships with people and family members, which enabled them to recognise and know about when people were distressed or in discomfort. Staff were extremely tuned in to people's

needs and the observations we carried out in one of the lounges showed the extent of staff intuition and ability to recognise needs, particularly in those people living with dementia. For example, one person appeared to be wary of another entering the personal space where they sat, but staff explained that the person on the move was the vulnerable one in that particular situation.

People's choices were fully respected, including when they moved around the service, the time they got up or went to bed, whether they joined in with activities and when they received personal care from a staff member of their choosing. We saw that people stayed in bed if they wished, three or four because they just wanted extra rest, one because of illness and three because they were no longer mobile and required full support in bed.

Staff respected people's privacy and dignity and maintained confidentiality of information, supplying details to other stakeholders and professionals on a need to know basis only. An equality, diversity and human rights approach to supporting people's privacy and dignity was embedded in the service. We saw that all interactions were discreet, respectful and reflective of needs.

Outstanding ☆

Is the service responsive?

Our findings

People told us staff responded extremely well to meeting their needs and had exceptional skills as well as excellent understanding of their social and cultural needs, diverse values and beliefs. They said, "Staff often facilitate our activities and entertainment", "We have really good staff that know when and what we need help with" and "Our needs for personal care, with moving around and eating well are met by all staff." They also said, "We have plenty to do to occupy ourselves" and "I really liked the Time Care person, who talked with us about all sorts." Visitors said, "The staff are an absolute credit to the home" and "I know that [Name] would be lost without the staff here."

Visiting professionals said the service provided person-centred care and achieved exceptional results. For example, with preventing pressure damage, maintaining excellent hydration and offering occupation/entertainment. They said, "I am now used to very good practice here. There is a new 'normal'" and "Very supportive staff. Impressive activities." Written feedback they gave about the service included, 'Staff are always very helpful. The care provided is so good', 'Really positive meeting the staff and manager and I look forward to my next visit' and 'Always welcomed.' With regards to the support a person received from staff in respect of the easing of a contracture of the person's knee joint, the physiotherapist stated, "I want to emphasise what excellent work this is by the Haverstoe team. I have never seen this type of improvement for this type of patient in this type of setting in my career as a physiotherapist!"

People, their families and advocates were involved in compiling people's care plans that were based on the SCIE (Social Care Institute for Excellence) person-centred guidance made available to staff. This meant people received the support that best suited their wishes and met their needs. SCIE had filmed the service last year and interviewed the registered manager to showcase how person-centred care was at its best.

People's diverse needs were considered on the grounds of the protected equality characteristics. One person with a physical disability that smoked had been bought fire retardant bedding and curtains, a self-extinguishing bin and prescribed non-flammable topical creams so they could independently and safely smoke by the patio door of their bedroom. Their choice and preferences were listened to and restrictions had been removed. This also improved their decision making opportunities. Another person with visual impairment was supplied red crockery, which improved their coordination and meant they kept their independence.

Care plans were based on people's lives, goals, skills, abilities and how they preferred to manage their health. They were regularly reviewed against people's changing needs and incorporated the implementation of forward thinking care delivery. For example, the staff had signed up to a Clinical Commissioning Group 'quality framework domain' on oral hygiene and were extremely committed to delivering and achieving.

Staff empowered people to make choices so they were in control and maintained their independence. Staff encouraged activities, relationships and community links so that people were not isolated. One person that spent a lot of time in their bedroom and only sought company in the evenings when communal areas were

quieter, often had staff sit with them to prevent any isolation. Pet therapy was accessed to aid wellbeing. One person held a 90th birthday party to which family, friends and everyone at The Anchorage – Care Home was invited. Afterwards they remarked they had drank a little too much, but slept extremely well. They told people about it for weeks. Where people experienced barriers to accessing services, staff made reasonable adjustments and action was taken to remove the barriers in relation to communication and access needs.

Activities were innovative, met people's individual needs and followed best practice guidance, so that people lived as full a life as possible. For example, children from a local child-minding group often visited to join people and delight them in baking sessions: a mince pie competition took place across the organisation at Christmas. Staff recalled how one person living with dementia had come alive at the sight of a little girl and sang a whole song to her. The person often remembered the event by looking at photographs that were taken.

Staff brought babies in after their maternity leave for people to see and hold. One person often displayed their anxiety. Their love of children and animals enabled them to find meaning, purpose and satisfaction from watching the children and holding babies, as well as caring for life-like dolls and soft animals at other times. Staff found this person behaved as if lost when they were not caring for a child or animal and laughed and smiled much more when they were.

Another person cried a lot and so the staff implemented a 'Play List for Life', which was a compilation of their special and favourite music to be played for them using headphones any time at their request. This person used to sing in pubs in their younger years and so spent many precious moments with a family member singing to old Elvis songs and both had taken comfort, joy and pleasure in sharing this 'Play List' together. The person only cried occasionally now. These examples showed staff went the extra mile to find out what people did in the past, evaluated whether it could be accommodated and made it happen.

Interactive dementia friendly reminiscence environments known as 'Rempods', were hired to offer people the experience of past lifestyles. These were exchanged as people grew over-familiar with them. Once a month the service held a 'cruise day' involving entertainment and food from countries around the world. Flags were flown, music played, people dressed for dinner and entertainment was provided that reflected the country at which the 'imaginary' ship had docked.

People that found them comforting or useful had individualised 'twiddle muffs' containing items that they or family members had specifically requested and one person had 'bubble tubes' in their bedroom. 'Time Care' a reminiscence facilitating company visited and enabled people to discuss the times and places they remembered.

A person that used to do ballroom dancing was one of the guests at the organisation's SHINE ball last year. They said, "It was a dream come true to dance again in black tie." SHINE is the organisation's strategy for making a difference to people's lives through activity, interest, achievement and maximising potential for service users and staff. A ball is held each year to celebrate achievements.

A senior physiotherapist that provided services on the Haverstoe unit was part of a choir run by the local falls team staff that visited to sing to people. A local scout troop was booked to visit the service and maintain a regular contact to achieve one or more of the scouting badges by helping people. Shoes and clothes party-plan events were often held.

The provider complied with the Accessible Information Standard, which sets out a specific approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of

people with disabilities, impairment or sensory losses. They achieved this by assessing and identifying and then managing people's individual communication needs.

There was use of technology to assist people and staff in the management of people's communication needs and physical disabilities. For example, access to computer internet programmes enabled people to see and speak to family members living abroad, which gave them peace of mind their loved ones were safe and well and pleasure from the interaction with them. One person always became excited the day they were contacting family and said, "I live for that day." They usually spoke about nothing else until the next time they went on-line.

People's concerns were confidentially and sensitively investigated and lessons were learnt, shared and acted on. People and their families were given information about how to raise any concerns and give feedback about their care. They said they knew the procedures, which were open and transparent and felt confident their complaints would be taken seriously, explored and responded to in a timely manner. HICA procedure is that other managers in the organisation investigate complaints, to ensure impartiality. Learning from complaints was used to improve the service and staff gave examples of how they had done this.

Staff ensured that people and their families were empowered, involved, listened to and informed in developing their care plans with regards to their preferences and decisions for end of life care. The process included support from appropriate professionals, where necessary.

Staff understood people's diagnoses and had the skills to assess and support their physical and learning disability and dementia care needs. They had all completed training in end of life care. People's wishes were known and respected, as with one person following illness and assessed as having capacity, but unable to swallow. They made a definitive choice to remain at the service, refusing foods and supplements, but accepting fluids. Staff met their every need and wish with regards to maintaining hydration. This was underpinned with use of the North East Lincolnshire Council palliative care patient handover form, which was a consent document that ensured people stayed at the place of their choosing during their final days.

Staff had the skills to support people particularly in relation to their diverse needs on the grounds of protected equality characteristics, and had knowledge about, for example, people's religious rituals and customs for end of life support. Staff had knowledge of different faiths, for example, Jehovah's Witness, Jewish, Muslim and Christian. They understood what people expected from them at the end of their lives. They also had access to a document titled 'What If', which detailed people's wishes.

Staff made sure people's dignity and comfort were maintained by ensuring people had access to appropriate equipment, nourishment and medication and received the personal care they needed to keep them free from pain and discomfort. Staff consulted professionals about a dignified and pain-free death and facilitated the receipt of anticipatory medicines that district nurses could administer at short notice.

Staff skilfully supported relatives and friends in an emotional way, as well as practically, after a person died. A sign in the form of praying hands were posted at the entrance following a death in the service. Staff always attended people's funerals as a mark of respect and to give family emotional support. One family member, in thanking staff, said they were now able to listen to their relative's favourite music again. An after-death analysis was conducted to ensure relatives were treated respectfully and supported and these were checked each year to identify and amend any common issues.

Outstanding ☆

Is the service well-led?

Our findings

People and their visitors told us the service was very well-led and they received great care. They said, "The manager is marvellous and runs the home so well", "I am always impressed by how well the place is managed, as we get to know what is important" and "This is a brilliant home and very well run."

The service was consistently well-led and managed with the registered manager attending meetings with the local clinical commissioning group (CCG) to keep up-to-date with current practice on the medical and treatment needs of the people and those particularly living in the Haverstoe unit. The service had consistently met and been awarded the CCG's Gold Standard Quality Framework for three consecutive years. It also won a North East Lincolnshire Council (NELC) health and social care award in 2017 and had two other staff members in the finals at this award event.

The registered manager was also involved with 'Attends Together' a strategy in place for the protection of people via a multi-disciplinary information sharing group. They attended the annual FOCUS Dementia Conference, the Dignity Champions Network and subscribed to an NCFE (a national education awarding organisation) newsletter about quality care to stay informed on new learning opportunities for staff.

The leadership, governance and culture promoted high-quality person-centred care. The registered manager understood their governance responsibilities with regards to legal requirements and conditions of registration and ensured quality performance, risk and regulatory requirements were monitored and mitigated.

The provider was required to have a registered manager in post. At the time of this inspection the manager had been registered for seven and a half years, which meant they were well-established. They were aware of the need to maintain their 'duty of candour', which is the responsibility under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to be honest and to apologise for any mistake made.

The management style of the registered manager was empowering, positive and passionate. The registered manager was well supported by the organisation's senior management, who facilitated the completion of an annual check on their governance abilities. Results of this were relayed to staff who understood the requirements of the action plan put in place afterwards. For example, they had been made aware of and contributed to the improvements in practice for infection control and prevention, the development of care plans and a survey on physical disability equipment, in the last year.

The registered manager engaged with staff, people and other stakeholders in their daily management of the service. They shaped the culture by promoting the organisation's visions and values. They monitored staff practice against these values in supervision. Staff were aware of the visions and values and strategic goals of the service. They said, "I follow the SHINE principles and always know what is expected of me." and "We have excellent systems in place for supervision and monitoring of our practice." Equality and diversity were actively promoted and any workforce inequality was acted on so that staff felt they were treated equitably.

Quality was defined from the perspective of people that used the service. Quality assurance arrangements were robust and identified areas for improvement. The service operated a post-admission survey with people's family a few weeks after people took up permanent residence, to give them an early opportunity to comment on care and shape care delivery to their expectations. People had commented, 'My [relative] was made very welcome right from the start', '[Relative] has settled in so quickly and really likes the staff' and 'I really like being here. My room is lovely and everyone is so friendly'.

Annual feedback was sought from people and their families about service delivery using satisfaction questionnaires, which this year had shown an increase in satisfaction on the previous year's results. A comments book, monthly 'resident/relative's meetings' and impromptu discussions were also used to gain views. The registered manager demonstrated the action taken in response to feedback received. Improvements had been made to the dining experience for everyone, the conservatory had been added to the Haverstoe unit and activities and entertainment was now appropriate for all. The HICA organisation produced a bi-monthly newsletter that went to people and their families, to provide them with information about how services and individuals were doing.

An annual quality improvement plan was produced, which followed CQC's Key Lines of Enquiry. Audits were completed regularly to assess service and staff performance and a new management audit tool had recently been implemented. Accidents were entered on the organisation's shared network and an analysis of the information was carried out each week. Internal infection control audits were used to inform housekeeping staff of areas for improvement and an infection control audit, for example, competed by the local authority early in 2018 revealed a very high achievement against expected standards, which compounded the good work completed and monitored throughout the year.

Audits were carried out on the management of medicines each week and the dispensing pharmacy completed six monthly medicine audits, with the latest one being carried out in April 2018. The service recently took part in a CCG medicines waste pilot, where the wastage in prescribed medicines amounted to only £69 for the whole year. The CCG reported that 'Excellent procedures and practice were followed.' Care plan and pressure care audits were monthly and an action plan was put to the front of a file for staff to address any shortfalls and seek advice and support from such as specialists, for example, in tissue viability. Staff received memos with praise for their hard work.

Staff told us they were respected, valued and supported and their voices were heard and acted on. They received constructive feedback about their performance from the registered manager and senior staff in memos and supervision sessions. It was the manager and senior staff's responsibility to account for the actions, behaviour and performance of staff and to ensure staff knew what was expected of them.

People, their families and staff were meaningfully involved in how the service was delivered, as their diverse views and opinions were sought through a comments book, care reviews and user meetings. The service used a "You Said, We Did" approach and one of the changes made was for staff to sit with people in communal areas to complete their diary entries.

Staff encouraged links with local community resources such as scout groups and retail businesses to raise the profile and help the public better understand the needs of people living with dementia.

The registered manager worked openly and collaboratively with other agencies and organisations by building good relationships and keeping in contact with their officers and workers, sharing information and listening to and acting on advice when it was offered. The same officer with Humberside Fire & Rescue Service visited and completed a general fire safety check four years ago and was also contacted in relation

to a person's safety needs in 2017. These relationships supported care provision, service development and joined-up care for people.

Data protection was appropriately managed and the service was registered with the Information Commissioner's Office. The registered manager was aware of the new data protection legislation recently introduced by the European Union.