Apex Care Centre Limited

Apex Care Centre

Inspection report

Ruskin Road
Mablethorpe
Lincolnshire
LN12 1BP

Tel: 01507478856
Website: www.careplushomes.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook a comprehensive inspection on 15 and 16 August 2018. The inspection was unannounced.

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

The service is registered to provide accommodation for up to 40 older people or people living with a dementia type illness or a physical disability. The service is made up of five individual units each accommodating eight people. Two of the units provided a secure environment for people living with a dementia type illness. The other units provided accommodation for people with both nursing or residential care needs. There were 38 people living in the service during our inspection. Three people were in hospital.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection of Apex Care Centre in May 2017 we found five breaches of the regulations and the service was rated 'Requires Improvement'. This was because the registered provider failed to notify CQC of issues relating to the safety and welfare of people living in the service, had failed to ensure that people received their medicines in a safe timely and consistent manner, did not ensure that security systems were working in a safe and effective manner, had failed to maintain effective systems and processes to assess, monitor and improve the quality of the service and had not ensured that sufficient numbers of suitably skilled and experienced staff were employed.

Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, "is the service safe" and "is the service well-led" to at least good. On this inspection we found that the provider had ensured that people were kept safe and free from the risk of harm, and that effective systems and processes were maintained to assess, monitor and improve the quality of the service. At this inspection we found that improvements had been made and the service was now rated "Good".

Systems and processes were in place to keep people secure and safe from the risk of harm and abuse. People had their medicines administered safely by trained and competent staff. The service was clean and staff followed safe infection control practices.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider followed the guidance in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People had their care needs assessed and their care was planned in line with up to date guidance and legislation. There were enough staff on duty to provide people with care and support. staff were trained appropriately and had the knowledge and skills to carry put their roles. People were provided with a balanced and nutritious diet and had access to a range of healthcare services.

People were cared for by kind, caring and compassionate staff. People and staff had a good relationship and the service had a homely atmosphere. People had their privacy and dignity were respected.

Staff supported people to spend their time as they wished and to maintain their hobbies. People had an advanced care plan to protect their wishes at the end of their life to achieve a comfortable, dignified and pain free death.

People spoke highly of the care they received and the attitude of staff. Staff enjoyed working at the service and were proud of their achievements. The provider had introduced a robust approach to monitoring the quality of the care people receive. The registered manager was respected by people and staff alike.

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 safe and the premises were secure.

Medicines were ordered, stored, administered, recorded and disposed of safely by competent staff.

There were sufficient number of staff on duty to keep people safe from harm.

The service was clean and staff followed safe infection control practices. Lessons were learnt when things went wrong.

Is the service effective?

Good

The service was effective.

Some areas of the service would benefit from improvements to the environment to make it more dementia friendly.

Staff had the knowledge and skills to deliver effective care.

People received a nutritious, varied and balanced diet.

Staff supported people to access their GP, dentist and optician.

The provider complied with The Mental Capacity Act 2005 and Deprivation of liberty safeguards.

Is the service caring?

Good

The service was caring.

People were cared for by kind, caring and compassionate staff.

People were supported to maintain contact with family and friends.

Staff treated people with dignity and respect and supported their independence.

Is the service responsive?

Good

The service was responsive.

People received care that was person-centred and individual to their needs.

There were systems in place to manager complaints.

Systems were in place to promote a comfortable, pain free and dignified death.

Is the service well-led?

Good

The service was well-led.

There are robust clinical governance systems in place.

Notifiable events are reported to CQC.

The registered manager is approachable.

Staff have access to up to date policies, procedures and care guidelines.

Apex Care Centre

Detailed findings

Background to this inspection

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

The inspection was prompted in part to follow up on the breaches of regulations we found on our inspection on 17 May 2017.

This inspection took place on 15 and 16 August 2018 and was unannounced.

The inspection team was made up of one inspector and an assistant inspector.

Before our inspection we gathered and reviewed other information we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams and the local clinical commissioning group.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us. We spoke with the registered manager, the provider, the deputy manager, one registered nurse, a senior carer, four members of care staff, the kitchen manager, the cook, the housekeeper, the laundry assistant, two activity coordinators and nine people who lived at the service. We also spoke with four visiting relatives.

Before our inspection we requested a Provider Information Return (PIR). A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this to help inform our inspection plan.

We looked at a range of records related to the running of and the quality of the service. These included three staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager had

completed. We also looked at care plans and daily care records for eight people and medicine administration records for five people who lived at the service.

Good

Is the service safe?

Our findings

At our last inspection in April 2017 we found the provider to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure that people received their medicines in a safe, timely and consistent manner. At this inspection we found that the provider had made significant improvements and was no longer in breach of regulation 12.

On this inspection we looked at medicine administration records (MAR) for five people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. For example, one person had time specific medicines to ensure they achieved their optimum mobility and manual dexterity. Another person who had capacity to make their own decisions, did not like to be observed when taking their medicines and had a care plan to support their request. We spoke with this person who told us that they took a lot of medicines and said, "They give me my tablets then they go. I do not want them standing over me when I take them. I have signed a disclaimer." Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer their medicines safely. We noted that one person had recently been discharged from hospital with prescribed antibiotics. A short-term care plan in place to ensure these were administered safely. We observed a member of staff administer medicines and they enquired if it was suitable for the person to take them at that time or did they would want them to return later. For example, when one person was eating their evening meal.

Overall, we found that staff had been re-trained and assessed as competent to administer medicines safely. New systems had been introduced to monitor that medicines were ordered, stored, recorded, administered and disposed of safely.

At our last inspection in April 2017 we found the provider to be in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure that security systems were working in a safe and effective manner. At this inspection we found that the provider had made significant improvements and was no longer in breach of regulation 15.

At this inspection we found that people living in Apex Care Centre were safe and secure. Regular call bell checks had been introduced and undertaken by a qualified engineer. Any errors in the system identified by staff were reported immediately. New electronic key pad door entry systems had been fitted to entrance doors and magnetic locks have been fitted to fire doors that would be released in the event of a fire. These measures had ensured that the security of the service was effective.

Staff could tell us about the improvements made to the security of the service since our last inspection. One member of care staff said, "People in the dementia unit are safe. We have codes on the doors." A record was maintained of all regular safety checks carried out on the premises. In addition to the security systems, safety checks were also performed on fire safety and utility systems such as electrical items and gas appliances.

At our last inspection in April 2017 we found the provider to be in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure that sufficient numbers of suitably skilled and experienced staff were employed to meet people's needs in a safe and consistent manner. In addition, systems for determining the level of people's dependency were not effective. At this inspection we found that the provider had made significant improvements and was no longer in breach of regulation 18.

At this inspection we found that the registered manager and provider had undertaken a full review of all staff roles and responsibilities, and an ongoing recruitment programme had been introduced. We observed and duty rotas confirmed that there were sufficient numbers of staff on duty to keep people safe and meet their care needs. The register manager told us that the number of staff on duty varied from day to day, depending on the current behaviours and care needs of people. For example, one person who was unsettled and at risk of harm to themselves and towards others had two staff on duty to look after them. Staff told us that most of the time there were enough staff on duty and that sickness was covered by bank staff. We found that to ensure people were familiar with staff who cared for them, that the same bank staff were used in the dementia units to maintain continuity.

We saw that good infection control practices were adhered to. All staff had attended infection control and handwashing training, had access to policies and procedures that reflected national guidelines and had access to personal protective equipment. Standards of cleanliness in the home were regularly assessed by a senior member of staff or the infection control lead. The housekeepers completed daily records of cleaning duties undertaken. All areas of the home were clean and there were no unpleasant odours.

Staff were aware of how they would keep people safe from harm, and were able to identify signs of abuse and escalate their concerns. One recently appointed member of care staff said, "I wouldn't force them to do something against their will. If I saw someone being treated roughly I would tell [name of registered manager] or a senior. We can phone CQC or whistleblow. There are numbers in the admin office and the staff room for safeguarding." Safeguarding and whistleblowing were standard topics for discussion at recruitment interviews, clinical supervision sessions and at shift handovers.

Systems were in place to identify and reduce the risks to people living in the service. People's care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage risk. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. We saw that one person who had been assessed at high risk of choking, had been reviewed by a speech and language therapist. This ensured that they received an appropriate diet and staff had the skills to assist them at mealtimes and keep them safe.

The provider had robust systems in place that ensured accidents and incidents were thoroughly investigated and audited. All staff were trained on how to access an electronic accident and incident report form that was completed at the time of the event. The provider and registered manager had direct access to the system and regularly reviewed the reports. The registered manager discussed the incidents with all staff at team meetings. Staff were made aware of the outcomes of investigations and how things could be done differently in future to prevent a reoccurrence. A similar robust process was in place to log, monitor, report and learn from safeguarding incidents.

When one person had acquired tissue damage to their skin, the registered manager and supporting community healthcare professionals undertook a Root Cause Analysis (RCA). The RCA was an in-depth investigation of all the possible causes of the breakdown of the person's skin. Lessons were learnt, and

changes to practice put in place to reduce the risk of a reoccurrence. The lessons learnt and new practice initiatives were then shared by the community tissue viability team throughout the county.

We found that the registered manager and provider had acknowledged our feedback and the rating of 'Requires improvement' from our last inspection and had made improvements to the safety of people who lived in the service. Following this inspection, we have rated this domain 'Good'.

Good

Is the service effective?

Our findings

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 with appropriate legal authority. 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.

Prior to our inspection we requested and received information from the local authority mental capacity team about the number of current DoLS authorisations granted to people living in the service. Eight people were currently being lawfully deprived of their liberty. A request for a DoLS authorisation had been requested for one person and before their best interest and mental health assessments had been carried out, there underlying health condition improved. This had a positive impact on their cognitive ability. The registered manger immediately notified the local authority mental capacity team and the request was withdrawn. This meant that the person would not be unlawfully deprived of their liberty. Therefore, we found that the provider was working within the principles of the MCA.

Care staff were aware how to obtain consent from people when providing personal care. One staff member said, "It doesn't matter whether they have dementia or not, I always ask them what they want to eat, help them make a decision." We found written evidence that consent had been obtained in individual care files.

Before a person moved into the service the registered manager undertook a full assessment of their physical, social, psychological, cultural and spiritual needs. Risk assessments and care plans were developed in accordance with their needs and preferences and regularly reviewed. When a person moved into the service for a short-term respite stay or as an emergency they also had their needs and preferences assessed.

Where able, people had a say in the recruitment of new staff. On day one of our inspection one person who lived in the service was actively involved in the interview panel for new care staff. This helped the person achieve a sense of involvement in the appointment of suitable care staff to deliver effective care and support to people who lived in the service.

Newly appointed staff undertook a period of induction to prepare them for their role. The duration of this depended on their role and previous experience. One member of care staff shared their experience of their

induction with us and said, "I was shown around and had training in my first week. I have shadowed four shifts and have a few more next week. I've been given an induction book and I hope to start the care certificate soon. I'm on a three-month probation."

The registered manager had recently introduced lead roles for key topics such as mental capacity act and tissue viability. Other staff were supported by the local authority as ambassadors for safeguarding, nutrition and infection prevention and control. They attended regular meetings were kept up to date with best practice national guidance. Other key roles would be identified through clinical supervision sessions.

The service had a designated staff training room and a senior member of staff had completed 'train the trainer' programmes for The Mental Capacity Act 2005, Deprivation of Liberty Safeguards and Infection, Prevention and Control. The registered manager had gained a certificate in education to teach learners over the age of fourteen years. The registered manager had not been in post long and was looking at innovative ways to train and develop their staff to effectively meet the needs of the people who lived in the service. They shared with us their plans to develop the training room into a care skills laboratory and provide in-house training pertinent to the needs to people in their care. We looked at the staff training matrix and saw that staff had attended mandatory training in key areas such as health and safety and infection control. In addition, some staff had undertaken training in topics relevant to their roles and level of responsibility, such as diabetes awareness, palliative care and neurological disorders. We looked at individual training records for three members of staff. We found that newly appointed staff were enabled to undertake the Care Certificate, a 12-week national programme that covered all aspects of health and social care.

We looked at the training room and saw that staff had access to policies and procedures and up to date national guidance on a range subjects relevant to all aspects of care in the service. A monthly policy focus had been introduced. The current topic was oral healthcare and the topic planned for the following month was confidentiality.

All staff received regular supervision sessions from the registered manager or a senior member of nursing or care staff. The sessions were focussed on the needs of the people who lived at Apex Care Centre and were supported by national guidance. For example, recent sessions included the principles of the mental capacity act and effective handwashing. We saw that records were maintained and areas for improvement and professional development were identified. Staff also received an annual appraisal on their performance, career aspirations and professional development from the registered manager.

People told us that they enjoyed their meals and were provided with a good choice. One person said, "The food is nice. I get lots of choice. I can't' complain." People were provided with a varied, nutritious and balanced diet and were offered a choice of main course. There were always alternatives to the main course, such as salad and baked potatoes. We saw that hot and cold drinks and finger snacks were offered between meals, such as homemade cake, fresh fruit and freshly made sandwiches. All fresh food was locally sourced and bread and milk were delivered daily.

We spoke with the kitchen manager, who was a qualified cook. They told us that they used fresh produce that was locally sourced. They made their own soups, sweet and savoury pies, cakes and desserts. This enabled them to fortify foods with cream, butter and milk to support people at risk of weight loss. The kitchen manager and their team were aware of individual likes and dislikes and food allergies. The catering staff ensured that people were provided with a choice that supported their dietary preferences and requirements. For example, reduced sugar, gluten free and textured diets.

People who had poor appetites, recent weight loss or assessed at risk of developing malnutrition or

dehydration had their food and fluid intake recorded. The kitchen manager kept a record of the previous six-months menu choices.

The kitchen manager told us that they took small steps to encourage people who had lost interest in food to enjoy their meals, and said, "If a person is on a soft diet, we serve all the items separately on their plate to make it look appetising. If a person is only able to use one hand, we cut their food small and provide a plate guard. It can take new people three or four days to settle as moving in can be very upsetting. We involve their families a lot at this stage." Overall, the catering team were committed to ensuring people were provided with a nutritious and balanced diet to suit their needs and preferences.

Nursing and care staff shared information at shift handovers about individual care needs to maintain continuity of care. One staff member said, "We share what the next team on duty should do." In addition, staff had a daily diary and communication book.

Some people were living with a progressive neurological disorder. We noted that staff recorded when signs of deterioration were observed and immediately referred the person to the appropriate healthcare professionals to support their well-being and maintain their independence. For example, the Parkinson Disease Nurse Specialist and the local branch Parkinson Disease Society.

Staff supported people to access their healthcare professionals, such as their GP, dentist and district nurse. Furthermore, when people were admitted from hospital to Apex Care Centre they continued to be seen by their physiotherapist, occupational therapist and speech and language therapist. This support provided a seamless service and ensured that people continued to rehabilitate and reach their optimum level of independence.

Care staff accompanied a person when they attended an hospital outpatient or GP appointment and if this was at lunchtime the cook provided the person with a packed lunch.

We observed the lunchtime meal in the main dining room used by people from both the nursing and residential units and the dementia unit. People who lived in the dementia unit were segregated from others by a solid partition. The meal servery was situated on the non-dementia side. Although people living with a dementia type illness could hear voices on the other side of the partition, they could not see what was happening and they were excluded from the friendly banter. We discussed the negative impact this could have on them with the registered manager and provider. The provider agreed to remove the partition and open the dining room up to ensure that it was fully inclusive to people with varying abilities and disabilities.

We discussed the environmental development plans that had been identified to improve the wellbeing of people living in the dementia units. The communal lounge had roof windows that did not provide much daylight. In addition, there was no direct access to the gardens from this area. Following our inspection, the provider sent us photographs that showed that work had begun to provide people with access to a secure, tactile garden. This would provide people with an outside area that was safe and would offer sensory stimulation through plants with different textures and aromas. Furthermore, work had begun on extending the lounge and installing a large window with views of the garden.

We observed areas where individual needs had been identified and the environment had been adapted to accommodate them. For example, one person was a keen gardener. However, they had become dependent on their wheelchair to get about. Their bedroom had direct access to the garden and a ramp had been built to enable them to access the garden independently when they wished to. In addition, raised beds had been built and the person was now able to follow their hobby. We chatted with them about their garden and they

told us, "The staff helped me with my garden. It is really nice. I have always had a good garden and I am out [in it] every day."

We found that the registered manager and provider had acknowledged our feedback and the rating of 'Requires improvement' from our last inspection and had made improvements to the safety of people who lived in the service. Following this inspection, we have rated this domain 'Good'.

Good

Is the service caring?

Our findings

We found that people were looked after by kind and caring staff. We observed that staff and people knew each other well and were at ease in each other's company. We witnessed lots of friendly banter. People told us that the staff who looked after them were kind and caring. One person told us how staff had helped them settle in and said, "They are very pleasant." Another person said, "They [staff] are nice. Everyone talks when they come past." One person's relative told us, "[name of person] is very content. Staff look after her well." Care staff told us that they would recommend the service to family and friends. One member of care staff said, "I would recommend the home because I feel confident that people get what they want in the home and staff are nice." Another member of care staff said, "The home is inviting, friendly and caring."

Some married couples lived together in Apex Care Centre. We saw that staff were considerate of the past life they had spent together and put systems in place to enable them to continue to live as a married couple. For example, rather than have individual bedrooms, they were supported to share one bedroom and have the other room as a sitting room. We saw that each had a bed that suited their care and mobility needs, for example one person had a profiling bed and their spouse had a divan bed. One couple we spoke with told us that they were well looked after and said, "We are very well looked after, it couldn't be better. The people [staff] look after us. We have our privacy. They bring us hot chocolate when we go to bed at night." We saw that their lounge was furnished with personal items, they could watch television together and had the facilities to make a cup of tea.

People were supported to maintain contact through social media with family and friends who were unable to visit them. Several people had their own mobile phone or laptop and could use these whenever they wanted to. Staff supported other people to use communication equipment owned by the service to keep in touch with family and friends through phone calls and Skype. The deputy manager was praised by the registered manager and provider for going above and beyond the call of duty. They had reunited one person who had become estranged from a close family member. A meeting was arranged and they got together after many years.

People were supported to lead their lives in their chosen way. The protected characteristics of the Equality Act, such as age, sexual orientation and gender, were embraced rather than treated as barriers to people leading their lives in their preferred way.

People were enabled to record their life story in a booklet called, 'this is me', and share their story with staff who cared for them. This helped staff have the knowledge and understanding of the person's previous life events, including their childhood, careers, relationships and children.

People's care records were stored safely, ensuring the information within them was treated confidentially. Records were locked away from communal areas to prevent unauthorised personnel from accessing them. The registered manager was aware of the requirements to manage people's records in accordance with the Data Protection Act and the General Data Protection Regulations (GDPR).

If a person wanted some private time and did not want to be interrupted, they placed a 'do not disturb' sign on their bedroom door. We saw that staff and other people who lived in the service respected their wishes not to be disturbed. There was also a 'family room'. This was a quiet space where people could meet with their relatives and friends away from the chatter and activity in shared areas.

Except for one member of staff, we observed that people were treated with dignity and respect by staff. This staff member spoke to people living with dementia in a raised voice and in a childlike manner. Rather than address people by their preferred name they called them by terms of endearment, such as sweet and sweetheart. We noted that most people were unaware when they were being addressed. This lack of personalisation did not promote dignity and respect. We shared our concerns with the registered manager. Following our inspection, the registered manager raised the concerns with the member of staff and professional development plans and supervision were put in place.

However, we observed other staff treat people with dignity and respect. We saw when staff spoke with a person that they sat down beside them, made eye contact and held their hand. One member of care staff said, "I treat them all is if they were my mum, how I would want my parents looked after. Treat them with respect."

Good

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting a people to live well and maintain their optimum level of independence and well-being. Registered nurses and senior care staff were responsible for writing the care plans. Care staff told us that although they were not involved in writing care plans they found them easy to follow. One member of care staff said, "Care staff do the daily care notes and food and fluid charts. They [care plans] are easy to follow and informative. Another member of care staff said, "They are kept up to date."

People told us that they were involved in the care plans and that their care was personalised. One person told us, "I have seen my care plan. I am asked what I want when it comes to my care. They ask me every day when I'm ready to get up."

People where able, were given the independence to live their life as they wished, in the least restrictive way possible. For example, one person walked to the nearest shop each morning to buy a daily newspaper. They had a health condition that would require urgent treatment if they suddenly deteriorated. Therefore, they carried their mobile phone with them at all times and a card with information about their health condition and treatment. This reassured the person and staff that should the person have a medical emergency in the community that they would receive appropriate and timely treatment.

Although there was some structure to the activity programme, the activity coordinators took a flexible approach. Activities and pastimes were easily changed at short notice if people requested an alternative to the programme. Some male residents attended a club called the 'men's shed' at the local library. One person played the organ in the local church. We spoke with the activity coordinators who had recently been appointed to post. They told us that they were focussed on making the activities person-centred. One activity coordinator said, "We take the residents out and we are trying to get the community involved, like the church and local school." We noted that there was an activity coordinator on every day, including weekends.

The registered persons ensured people were protected under the Equality Act 2010 and they had a knowledge of the Accessible Information Standard, which applies to people who have information or communication needs relating to a disability, impairment or sensory loss.

Information on making a complaint was included in the Service User Guide and Statement of Purpose. We also saw a copy on display in the main reception area. This guided people on how to make a complaint to the provider and if they were unhappy with the outcome there was information on how to contact the local authority and the Local Government Ombudsman (LGO).

The provider and registered manager were open to feedback from people, their relatives and staff. There was a letter box outside the registered manager's office. We saw that this was used to share concerns and

suggestions. One person told us that they knew how to make a complaint, but did not need to and said, "I have no problems." Another person said, "I have no issues with this place, it's nice and I wouldn't change anything." A third person told us, "I wouldn't be here if I had an issue with the home. I've had the odd problem, but the carers are nice and they go the extra mile."

We looked at the complaint log and saw that complaints were fully investigated and responded to in a timely manner. The registered manager had used all available records to inform their investigation and outcome. For example, we saw that reference had made to a person's plan of care, medicine administration record and daily care notes. In addition, the registered manager had spoken with nursing and care staff.

Staff and supporting healthcare professionals communicated with each other and worked in partnership with the person and their family when planning their end of life care. We saw that measures were in place to promote a comfortable, pain free and dignified death. For example, one person's GP had prescribed anticipatory drugs to be used when needed to keep the person comfortable and pain free at the end of their life.

When a person was near the end of their life an extra member of staff was rostered on duty to comfort and support the person so as they would not die alone.

Good

Is the service well-led?

Our findings

At our last inspection in April 2017 we found the provider to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to maintain effective systems and processes to assess, monitor and improve the quality of the service. At this inspection we found that the provider had made significant improvements and was no longer in breach of regulation 17.

A programme of regular audit was in place that covered all key areas such as health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff at team meetings and daily handovers. The registered manager, area manager and provider maintained regular contact to share identified weaknesses and develop actions to address.

At our last inspection in April 2017 we found the provider to be in breach of regulation 18 Registration Regulations 2009. This was because the provider had failed to notify CQC of issues relating to the safety and welfare of people living in the service. At this inspection we found that the provider had made significant improvements and was no longer in breach of regulation 18.

At this inspection we found that the registered manager and provider had submitted the notifications that they are required by law to submit to CQC.

It is a statutory requirement that a provider's latest CQC inspection report is clearly displayed at the service and on their website. This is so that people who lived in the service and those seeking information about the service can be informed of our judgments. The rating from the previous inspection was displayed in the main reception area and on their website.

The provider had a philosophy of care on display that gave out a positive message that Apex Care Centre was more than just a care home, it read, 'Our residents do not live in our workplace; we live in their home.'

The registered manager delegated responsibilities to their heads of department. For example, we noted that the kitchen manager was empowered to lead their team. They were responsible for undertaking the kitchen audits and caring out appraisals with their team. They told us, "I address any staff issues as they happen. However, I would tell the manager if important issues were disclosed by staff."

We found that he registered manager was approachable and had adopted an open-door policy. People, their relatives and friends and staff could approach the manager at any time. The registered manager told us, "They can meet privately and can pop into the office at any time." In addition, the registered manager held a regular 'manager's tea party'. This was an informal get-together, where people and their family and friends could meet with each other and the manager and chat over a cup of tea, sandwiches and cake.

Staff spoke highly of the registered manager and were full of praise for the positive change that had taken

place. One staff member said of the registered manager, "Very approachable, changed for the better since [name of registered manager] came. It's nice, the care is better." Another member of staff said, "The registered manager is changing things for the good." It was noted that the registered manager was a visible leader and undertook a 'walkabout' of the service every day. The key benefit of this was that people got to know the registered manager, and the registered manager got to know them. Staff told us that they liked to see the registered manager walkabout.

Every morning the registered manager held a 'head of department' meeting. This was attended by heads of department and other senior staff on duty such as the registered nurse, a senior carer and an activity coordinator. Together they shared current information about people who lived in the service, any maintenance work and events. This meant that all departments had insight into the daily needs of people who lived in the service and priorities of the day to keep people safe and well cared for.

People and their relatives were invited to give their feedback on the service through an annual survey. We looked at the results from survey undertaken in March 2018. The survey covered key areas such as, food and nutrition, personal care and support and leadership within the service. We found that the responses were predominately positive.

Staff had a say on the running of the service and attended regular meetings chaired by the registered manager or their deputy. We looked at the minutes from a recent meeting and saw that there was discussion around staff rotas, training and security. We also saw that the registered manager used this forum to share best practice and give positive feedback to their staff.

The registered manager was building relationships within the local community. For example, children from a local nursery school come into the service once a week. We learnt that people and the children join in activities together, learn from each other and benefit from the visits.

The provider and registered manager worked in partnership with other agencies to promote good practice within the service. For example, the provider was a member of the Lincolnshire Care Association (LinCA). LinCA provides members with regular newsletters, workshops and networking to enable them to keep up to date with current best practice initiatives. The service had been approached by LinCA to pilot a new medicine management policy for Lincolnshire. This pilot will start in September 2018 and the registered manager has been asked to share their experience at a national conference. The policy reflected National Institute for Clinical Excellence (NICE) best practice guidelines.

The service had achieved the competencies to be an authorised placement for associate nurses studying at a local university.

We found that the registered manager and provider had acknowledged our feedback and the rating of 'Requires improvement' from our last inspection and had made improvements to the safety of people who lived in the service. Following this inspection, we have rated this domain 'Good'.