Birmingham City Council

Kenrick Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 04 and 16 October 2017. This was an unannounced inspection.

At the last inspection in December 2016 the provider was rated as requires improvement in two out of the five areas we inspected against; whether the service was safe and well- led. This was because medicines were not always managed effectively to reduce any associated risks to people and the systems in place to assess and monitor the quality of the service were not always used to identify where improvements were needed.

During this inspection, we found that some improvements had been made; however further improvements were required.

The Kenrick Centre is a purpose built centre which is designed to accommodate up to 64 people across two separate services. On the first floor there is an enablement service which provides support for up to 32 people for up to four to six weeks following discharge from hospital. The purpose of the enablement unit is to provide a further period of recovery and assessment to prepare people for their return home or identified placement. The ground floor is registered to provide accommodation and personal care for 31 people. At the time of our inspection 56 people were living at the service. Changes were required to the registration of the service to reflect that people were receiving accommodation and personal care as part of the enablement service on the first floor. The provider has been informed of this and we await applications to make the necessary changes to their registration.

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. There were two registered managers in post at the time of our inspection, one on each of the two units whom were responsible for running the two services separately and independent of the other.

The service was not consistently safe or well-led because the management team had not always fulfilled the responsibilities of their role. The provider's quality assurance systems had failed to identify the shortfalls found during the inspection and some of the improvements required at the time of our last inspection had not been made. These included issues related to the safe management of medicines within the home as well as sufficient oversight of auditing practices such as fridge temperatures and Deprivation of Liberty Safeguard (DoLS) authorisations.

We have made a recommendation about the management of medicines within the home.

Some people felt that more staff were needed to meet their needs in a timelier way. The provider was in a period of transition whilst staff from other locations were being transferred over to work at the Kenrick Centre. Staff shortages were managed using agency staff that were deployed on a regular basis to promote

consistency.

Most of the people we spoke with felt safe living at the home and were protected from the risk of abuse and avoidable harm. The provider had effective systems in place to ensure that staff were recruited safely, received the training they required and were aware of the safeguarding processes in place.

People were cared for by staff who had been trained to meet their needs and who obtained their consent prior to supporting them. People were offered choices on a daily basis which included meal preferences. This meant that people had food that they enjoyed and any risks associated with their diet were identified and managed safely within the home.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary.

The service was caring because people were supported by staff that were helpful and caring. Staff had taken the time to get to know people including their personal histories, likes and dislikes. People were also cared for by staff that protected their privacy and dignity and respected them as individuals.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible. Most people felt involved in the planning and review of their care.

People had the opportunity to engage in activities within the home, but these were not always specific to their individual interests. People were supported to maintain contact with people who were important to them and visitors were welcomed at any time.

There was a structural approach to the leadership within the home and staff reported to feel supported by the management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Not all people living at the home could be confident that they received their prescribed medicines as and when required.

Not all of the people living at the home were confident that there were always enough members of staff available to meet their needs when required. However, agency staff were deployed to meet any short fall and the provider had safe staff recruitment processes to keep people safe.

People were protected from the risk of harm and abuse because the provider had effective systems in place and staff were aware of the processes they needed to follow.

Most people felt safe and secure living at the Kenrick Centre.

Is the service effective?

Good

The service was effective

People's rights were protected because key processes had been followed to ensure that people were not unlawfully restricted.

People received care and support with their consent, where possible.

People received care from staff who had received adequate training and had the knowledge and skills they required to do their job effectively.

People's dietary needs were assessed and monitored to identify any risks associated with their diet and fluid requirements and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff that were helpful and caring.

People received the care they wanted based on their personal preferences and dislikes because staff spent time getting to know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Good

The service was responsive.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

People were supported to maintain positive relationships with their friends and family.

People were actively encouraged and supported to engage in activities within the home; however these were not always specific to people's individual interests.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team had some systems in place to assess and monitor the quality and safety of the service. However, these were not always effective in identifying shortfalls found during the inspection.

There was a leadership structure in place and staff felt supported by the management team.

Kenrick 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.

This unannounced inspection took place on 04 and 16 October 2017. The inspection was conducted by two inspectors and an Expert by Experience on the first day and one inspector returned on 16 October 2017 to complete the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience involved in this inspection had experience of caring for an older relative who used regulated services including care homes.

As part of the inspection we looked at the information that we hold about the service. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also requested feedback from the local authority and Healthwatch with their views about the service provided to people at the Kenrick Centre. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. We also referred to information that had been shared with us by members of the public.

During our inspection, we spoke with eight of the people who lived at the home. We also spoke with or received information from seven relatives and nine members of staff including the provider's Nominated Individual (an appropriate person who has been nominated by the organisation to represent them and have oversight of the management of the regulated activities being provided to people), both registered managers, two of the unit deputy manager's, three senior carers and three care assistants. Some of the people living at the home had conditions, such as dementia which meant they could not clearly tell us their experiences of the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us, as well as general observations of day to day living within the home. We reviewed the care records of seven people to see how their care was planned and looked at the medicine administration processes overall but in greater detail for 13 people. We looked at training records for all staff and at three staff files to check the provider's recruitment and supervision processes. We also looked at records which supported the

provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that people had not always received their medicines as prescribed, in particular, their prescribed creams and eye drops. At this inspection, we found that improvements had been made, but other areas were found to be requiring improvement.

At our last inspection we found that where people were receiving their medicines covertly (for example, disguised in food) within their best interests, no written management plans were in place to support this practice including details of how or when this should be reviewed. At this inspection we found that whilst some improvements had been made, further improvements were required. For example, we saw that procedures had been followed to ensure that people, who were receiving their medicines this way, were doing so within their best interests because the provider had sought the appropriate authorisations to provide care in this way. However, there was no evidence to show that the provider had sought advice from the relevant professionals, such as a GP or Pharmacist, which gave details and guidance on how medicines should be administered safely in this way. We discussed this with one of the deputy manager's on the residential unit who acknowledged the benefits of having this information available to staff. We also fed this back to the registered manager of the residential unit on 16 October 2017, who advised that since our last inspection they had discussed this with their dispensing pharmacist and had been advised that the pharmacists' required further training on providing this support to care homes before they were able to meet this request.

We also found on both units, that protocols were not in place for people who required their medicines on an 'as required basis', often termed 'PRN' protocols. PRN protocols support staff to make a decision as to when and sometimes how, to give people their prescribed 'as required' medicines. This information is particularly important for people who are unable to tell staff if or when they require the medicines, such as for people living with dementia. Following our inspection site visit, the registered manager for the enablement unit sent us a copy of a PRN protocol that they had developed in response to our feedback.

We observed a medicine administration round on both units. Observations we made on the residential unit confirmed concerns that had been shared with us by people residing on both units, stating that staff did not always ensure people had taken their medicines when were administered to them by staff. A relative of a person living on the residential unit said, "Sometimes they [staff] bring them [medicines] when [person] is eating and they leave it on the side and don't supervise they are taken". Another relative we spoke with on the residential unit told us, "I have come in and found tablets on the floor under the bed; they don't watch that [person] has taken them and I have had to take them [medicines] to staff to dispose of". One person we spoke with who was staying on the enablement unit explained, "I was in the toilet and my medicines were just left on the side, I thought that was careless. After they [staff] said, 'did you take them?' but they wouldn't know if I hadn't!" We discussed this universal concern with both of the registered manager's. They advised that all senior staff have been reminded of the importance of ensuring people take their medicines before walking away and that this will be monitored closely going forward.

A relative we spoke with and records we looked at showed that the provider had not always ensured that

medicines were available to people in a timely manner. This included two incidents whereby antibiotics were unavailable and we found that one person's pain relief was unavailable at the time of our inspection visit. Whilst there was no evidence that this person had experienced a negative impact as a result of this delay because their pain was being managed by another medicine that was available to them, the provider should have ensured that systems and processes in place meant that medicines were available to people in a timely way. The registered managers explained to us that there had been issues with the previous dispensing pharmacy and as a result they had changed pharmacies and were hopeful that these issues would now be resolved.

Other people we spoke with and observations we made on both units showed that on the whole, people received their medicines as prescribed. One person said, "They [staff] bring it [medicines] when I need it. I was getting in a mess at home even with the blister packs". Another person told us, "Yes, they give it [medicines] to me". A third person stated, "Medicines are very good here, the staff do what they need to. If I need medicines [pain relief] they give it. I talk to them [staff] about my medicines and I know what they are all for". We saw staff offering people their medicines and explaining to people what the medicines were for in an attempt to reassure people and gain their consent to take their medicines as prescribed.

We saw that medicines were kept secure on the residential unit, within a locked medicine trolley which was also securely stored within a locked treatment room when not in use. On the enablement unit, we found that medicines were stored differently and were mostly kept in peoples individual rooms and most people had access to their medicines unless there was an identified risk. We discussed the risk of having lots of people visiting the service and potentially having access to medicines with the registered manager.

We recommend that the provider considers current guidance on managing medicines in care homes and take action to ensure that the safety of medicine management is enhanced within the home.

We received mixed reviews about the staffing levels within the service. Whilst people and staff on the residential unit were mostly positive about the staffing levels, with comments such as, "I think there is enough staff, they are just a bit rushed at busy times" and "It's [staffing levels] ok, just certain times can be rushed", people on the enablement unit reported to be more concerned about the number of staff available. One person said, "The staff are lovely but they are very short staffed, particularly at certain times like hand-over [when there is a change-over of staff from one shift to another and information is shared between them]. I have had to wait for long periods of time on occasions; they [staff] do rush to you, but it's clear they are too busy". Another person told us, "There is not enough staff; they do seem short but someone always comes when I buzz". A third person stated, "I suppose not [enough staff], not when they are really busy". Records we looked at including complaints and staff meeting minutes also raised concerns about staffing levels within the home. There appeared to be a consensus both on the residential and on the enablement unit that there had been an over-reliance on agency staff in recent months. We discussed this with the registered managers. They explained that closures in some of the Provider's other locations meant that staff recruitment was on hold, because staff were being transferred over to the Kenrick Centre from these other services. Both registered managers were hopeful that this would have a positive outcome for people and staff on both of the unit's within the home. Feedback we received from the commissioners at the local authority informed us that since our visit, they had observed a number of staff from another location had started to work at the Kenrick Centre and this was 'going well'. They told us, "We spoke to a member of staff [who had moved over to the Kenrick Centre] and they were enjoying their new role. I consider the staffing ratios to be more than adequate".

We found that the provider had robust recruitment procedures in place for both permanent and agency members of staff. This ensured that only staff who were trained and checked for their suitability to work with

people were deployed to work within the service.

Most of the people we spoke with on both units were happy with the care they received and felt safe living at the home. Comments we received included, "Everyone is well looked after", "Can't fault the place", "I feel safe here", "We [people] get what we need" and "Oh yes I'm very safe, it's fantastic, they [staff] all help as much as they can". This was with the exception of two people and one relative who explained that their sense of safety and security had been compromised when another person who lived at the service had entered their bedrooms during the night. One person who was staying on the enablement unit said, "I feel safe most of the time but I have had a man come in to my room five times; he has dementia so he can't help it, but it is frightening". Another person told us, "I did feel safe, but last night I had two visits from a man [another person who was residing on the enablement unit]. I was asleep and I had to tell him to go away. Staff did apologise and acknowledged I'd had a traumatic night". Staff we spoke with were aware of these incidents and explained that some people living with dementia can become disorientated and will sometimes 'wander' in to other people's rooms. We found that these incidents had been repeated and three people (that we had spoken with) had been affected.

We discussed this with the registered manager on the enablement unit and asked what systems or processes were in place to prevent this from re-occurring. They explained to us that staff were aware of this person's care needs and were monitoring the situation closely, particularly at night. They advised that they would request support from the Occupational Therapists' within the enablement team to consider what else they could do, such as implementing sensor detector mats, to further reduce the risk of this reoccurring.

We saw that people had access to call alarm pendants which meant that should they require assistance, and were able to do so, they could press the button [buzzer] to summon staff support when they needed it. People and relatives we spoke with and observations we made showed that staff were particularly vigilant in ensuring that people wore these pendant alarms or had access to the alarm buzzers within their bedrooms.

Throughout the inspection we saw that people looked relaxed and comfortable in the presence of staff. We saw that staff acted in an appropriate manner to keep people safe. For example, we saw that one person needed support to walk to the dining room; staff provided support and reassurance to the person to give them the confidence to walk to the dining room to join their friends for a meal.

People and relatives we spoke with were confident that people were protected against the risk of abuse. We found that staff had received training on what action to take to keep people safe from the risk of abuse and avoidable harm. Staff we spoke with were aware of the different types of abuse and were able to explain what the reporting procedures were. One member of staff told us, "We are trained to look for abuse and how to report it" Another member of staff said, "I'd go to the Senior on duty of the deputy [manager] if I was concerned". A third member of staff explained, "I have no concerns about abusive practice here at all. If I did though, I'd have no hesitation to report it to [Registered Manager] or any other manager that I could find; I'd even report it myself if I thought I needed to". This meant that staff had the knowledge and the skills they required to identify the potential risk of abuse and knew what action to take.

People we spoke with were confident that staff had the knowledge and skills they needed to keep them safe in an emergency. One person we spoke with said, "There is a list of staff who know first aid, so they know what to do in an emergency". Staff we spoke with were able to tell us about how they would recognise if a person was physically unwell or were experiencing pain and they knew what action they needed to take in an emergency. One member of staff told us, "If a person falls, we would check them over for any injuries and if we were unsure, we would always call the paramedics before moving them or assisting them up". Another member of staff said, "Some people can't tell us if they are feeling unwell, but we ask them directly if they

are in pain, or if we notice that they don't seem themselves, we have to just use our judgement and act in their best interests".

We saw that information specific to peoples' individual care needs and any associated risks were recorded in their care plans and/or risk assessments, ensuring that staff had the information they required to care for people safely. Staff we spoke with were familiar with people's individual care needs including those that posed as a risk to their health and well-being. For example, staff were aware of people who were at risk of choking, falls and who required pressure-relieving care to prevent them from developing sore skin. They were able to tell us what action they took to support these people and to minimise these risks, such as adhering to specialist diet plans.

We also found that emergency policies and procedures within the home were regularly reviewed and updated and staff had a good knowledge and understanding of these. For example, we saw that the building was well maintained with regular maintenance and safety checks including, fire safety. The registered manager of the residential unit told us, "We make sure that we are constantly improving to promote the safety of people, for example, since the Grenfell Tower fire disaster a few months ago, we have now changed our fire drills from six monthly, to quarterly and we have introduced this new 'coding' system to ensure that staff are fully aware of people's individual fire or safety evacuation needs and plans".

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. We found that on the whole staff were able to tell us about people's capacity to consent to the care that they were receiving and that people were being cared for in the least restrictive ways possible. Where people were deemed to lack the mental capacity to consent, applications to deprive the person of their liberty within their best interests had been sent and some of these had been authorised, whilst others were awaiting assessment by the local authority.

People we spoke with on both units told us and observations showed, that staff gained consent before providing care to people, offered people choices about the help and support they required and gave reassurances about what it was they were going to help the person with. One person said, "Staff always ask us what we want and need". Another person told us, "They [staff] speak to you about everything. It's nice to be asked what you need and be listened to". A third person we spoke with stated, "I am involved in all decisions, they encourage and advise; they always ask before doing anything". Staff we spoke with were able to give examples of how they promoted consent and independence as much as reasonably possible, in all aspects of the day to day care and support they provided to people. One member of staff told us, "It's important that we get consent as best we can and give people choices. We have people [living here] with dementia but we still ask and show them options to help them to make choices. If they can't, we make sure we get to know their likes, dislikes from speaking with family or reading their assessment or from our observations and make choices for them in their best interests".

People, relatives and staff we spoke with were confident that most of the staff working at the home had the knowledge and the skills they required to care for people safely and effectively. One person said, "Oh yes, they [staff] are very good at what they do". Another person said, "They [staff] seem like they are skilled". A third person explained, "I can't fault most of them [staff]". A relative explained to us, "The general level of staff is fantastic, most of them are very skilled and do a good job". Another relative confirmed this and told us, "The permanent staff are fine and a lot of them go above and beyond". A member of staff we spoke with told us that they were required to do a lot of online learning which they described as 'okay'. They also said that some of the agency staff were not always as committed to the job as the permanent staff but they were hopeful that this would be rectified as new staff from the provider's other locations were due to join the service.

We found that there was a mix of knowledge and skills within the staffing team. For example, we asked a

permanent member of staff [employed by the provider] about their understanding of the Mental Capacity Act 2005. They were able to give us a sound explanation of what this meant and how they applied it within their work. However, we asked the same question of an agency member of staff and their knowledge of this topic was poor. We asked how the provider monitored the practice of agency staff and were told that they received confirmation from the employment agency about the level of training that the agency staff had received before they accepted them to work at the home. They ensured that the same agency staff were deployed within the home on a regular basis to promote consistency and that their practice was monitored through observations. Any issues would be addressed with the staff members directly and fed back to the agency where necessary.

Staff we spoke with and records we looked at confirmed that staff received the training and support they required from the provider. We saw that staff engaged in regular discussions and meetings with senior staff, including supervision and appraisals to support their development. We also found that staff meetings were held to promote effective communication systems between management and staff. On the residential unit, these meetings were used as an additional opportunity to support staff development. We found that the registered manager of this unit had been innovative and creative in thinking of ways in which they could promote staff engagement in learning and development opportunities. We saw that staff members had been given topics related to their work for them to research and were asked to facilitate a training session by way of presenting their findings to their colleagues within team meetings. Topics included clinical and operational aspects of their work from epilepsy, dementia, and stroke conditions through to bullying and harassment, data protection and stress management. It was also commendable that the senior staff on the residential unit had all been supported to achieve their NVQ Level 5 which demonstrated the provider's investment in the development of its staff.

People we spoke with told us that they had a good choice about what and where they ate and they enjoyed the food prepared for them. One person told us, "The food is good" Another person said, "The cook is very good; I definitely know when she is off, the standard slips [laughs]". A third person commented, "There are [meal] choices and it's [food] always nice and hot and plenty of it". Staff we spoke with and observations we made showed that people had a choice from four meal options and were supported to go to the hot food trolley to make a choice about what they would like to eat. One member of staff told us, "People who are able are asked to come to the trolley and choose what they would like [to eat]. For people who aren't [able], we show them the options, usually two at a time, so not to overload them with choices".

We found that meal times on both units were pleasant, relaxed and social events. Tables were laid with cutlery, napkins and condiments. Drinks were readily available and people could either help themselves or be supported by staff. People were given the choice as to where they wished to eat, either in the dining room, lounge area or in their rooms. One person told me, "I choose to eat in my room and that's ok here". People received the right amount of support to eat and drink in accordance with their care needs and specialist diets and preferences were accommodated. For example, we saw people eating soft diets in keeping with recommendations made by a speech and language therapist (SALT) and other people's cultural and dietary preferences were met such as vegetarian diets.

We found that people had access to doctors and other health and social care professionals as required. One person said, "Yes, [we see the doctor]. He is coming to see me tomorrow". A relative we spoke with said, "The Doctor comes and so did the Optician recently". Records we looked at confirmed that people were supported to maintain good health and to attend any medical appointments they were sent.

Good

Is the service caring?

Our findings

People and relatives we spoke with on both units were positive about the caring attitude of the care staff and the relationships that were formed between them. One person we spoke with told us, "The staff are lovely, they are all very nice and caring". Another person said, "They [staff] are kind. For example, one of them guided me to the bathroom and left the light on for me so it was easier for me to go again". A third person stated, "Up to now they have all been [kind and caring], I haven't come across otherwise". Another person told us that staff go out of their way to support them. They gave us an example whereby if staff were going shopping whilst they were off duty, they will bring things back for them. They said, "I've asked them to look out for some nail varnish for me as I like to paint my nails". A relative we spoke with told us, "They [staff] always call her by name and have a laugh and a joke".

People and relatives we spoke with complimented the homes 'lovely atmosphere'. We saw and heard people laughing and joking with staff which contributed to a vibrant and friendly ambience on both units. Staff were seen to interact with people with warmth, compassion and familiarity. We saw that staff adapted their communication and interaction skills in accordance to the needs of individual people. For example, we saw staff coming down to people's eye level before speaking with them and offering reassurance touches to express kindness and compassion. It was clear that people had developed trusting relationships with the staff that were providing care to them.

People we spoke with told us that staff took the time to get to know them and staff understood their histories, likes, and preferences. One person said, "They [staff] know what I need and what I like". A relative we spoke with told us, "Yes, they know her. If she is upset they will put music on to help settle her". Staff we spoke with were able to tell us about different people's individual care needs. For example, one member of staff we spoke with was able to tell us what level of support individual people required and provided us with examples of people's interests and how they liked to spend their time. This was confirmed through speaking with people and observations we made.

Everyone we spoke with told us and we saw that staff promoted their independence. One person said, "Yes they [staff] encourage me to be independent but they will also tell you if you're pushing yourself too much". A relative we spoke with told us, "They [staff] encourage her to do as much as she can for herself. She still goes to the bathroom unaided and they will encourage her to visit the lounge for company". Another relative said, "It's good, they are encouraging her to walk".

Everyone we spoke with told us that staff treated them as individuals. One person told us, "It's great here, I am treated as an individual". People also confirmed that they were treated with dignity and respected their privacy. One person said, "They always knock before they come in". Another person explained, "They [staff] are always respectful, they always knock and never barge in". A third person told that staff protected their privacy at all times, for example, when using the shower. Relatives we spoke with confirmed that they had no concerns about the way privacy and dignity was maintained within the home. One relative said, "It's very good, she always looks well kempt and looks like her".

We found that people and/or those who were important to them were encouraged to get involved in the planning of their care. Everyone we spoke with told us that staff had spoken with them about the care and support that they or their loved one required. Records we looked at showed that people had access to advocacy services to support their participation within the care planning process, if they required it. An advocate sees to ensure that people, particularly those that are most vulnerable in society are able to have their voice heard on issues that are important to them and defend and safeguard people's human rights. They ensure that people's views and wishes are genuinely considered when decisions are being made about their lives.

Good

Is the service responsive?

Our findings

Most of the people and relatives we spoke with told us that they were involved in the review of their care. One person said, "I am very much involved". A relative told us, "We [person and relative] ensure we are involved". Another relative explained that staff always spoke with them or other members of their family (as appropriate) and involved them in any decisions about the persons care. Some people we spoke with could not always recall being actively involved in a discussion or having had their care reviewed, but told us that staff would often 'share' their care plans with them to make sure they were 'okay' and to gain their consent, where possible. Records we looked at showed that care plans and risk assessments were regularly reviewed and updated.

People and relatives we spoke with and records we looked at, showed that the provider asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One person told us, "They [staff] do have [residents] meetings". Another person said, "I'm not one for meetings but I have opinions". A relative said, "I'm usually at work when they [staff] hold the meetings but there was a questionnaire".

We saw that the provider had a complaints policy in place and forms were available for people and/or visitors to provide their comments, compliments or complaints about the service provided. We found the provider recorded compliments and complaints and where necessary, these had been responded to. We found that some complaints were on-going and had been for some time, including one related to the enablement unit. We discussed this with the registered manager. They explained this had been passed to a senior manager and they were in the process of responding to the complainant.

Everyone we spoke with told us they knew how to complain by way of speaking with staff. However, not all of the people we spoke with were familiar with who the registered managers were, particularly on the residential unit. Nevertheless, people and relatives were confident that if they had an issue, they could speak with any of the staff and these issues would be resolved.

We saw some people were engaged in self-directed activities that they enjoyed. For example, we saw people reading, listening to music and watching television. People also had access to some organised activities such as knitting club, singing for joy and exercise classes. However, we were told by some of the people and relatives we spoke with that more needed to be done by way of activities and stimulation. Records we looked at showed that this had been raised with the provider by people who used the service and their relatives previously, back in April 2017 and again in August 2017. We fed this back to the registered managers on both units. Feedback we received from the local authority during a recent quality monitoring visit explained that since our inspection, the registered managers had, 'Recognised that the frequency and diversity of resident activities needs to be evaluated and that this process was ongoing'. We will monitor the improvements in this area at our next inspection.

We saw that people were supported to express their individuality and staff were aware of how they could promote equality and diversity within the home. One person we spoke with said, "We are treated as

individuals here". We saw that people's bedrooms were personalised with their belongings and we were told that this made them feel like 'living here is like home from home'. Whilst this was more evident on the residential unit, one person we spoke with on the enablement unit said, "Even though I am only here for such a short time, I have some of my photos out to make it feel more homely". Staff we spoke with told us that the personalisation of rooms enabled them to get to know people better. One member of staff said, "It's nice to see photos of people and their families and it gives us a good talking point".

People's diverse cultural and spiritual needs were respected within the home and this extended to staff too. For example, we found that any special dietary requirements were accommodated such as for people who required halal meats and there was a designated room that people, staff and visitors could use to pray. We explored thoughts, attitudes and practices around sexuality within the home. We found that whilst individual staff were open minded, they explained that this was not something that was actively discussed within the home. One member of staff said, "I'll be honest, I am not aware of anyone from the LGBT (Lesbian, Gay, Bisexual, Transgender) community [living here], which I suppose, is unusual given the high turn-over of people we have [on the enablement unit]; but there aren't any prejudices". The registered manager of the residential unit explained to us that sexuality is considered as part of the initial assessment process and the provider is looking at ways that they can ensure people feel comfortable to express themselves in all ways. They said, "We work hard to respect equality and diversity here. We recently celebrated black history month, we enjoy and recognise Diwali, we accommodate requests for changes to shift patterns at Eid, and we hold bible classes. We are looking at more ways to demonstrate our inclusivity to LGBT".

Requires Improvement

Is the service well-led?

Our findings

During the planning of our inspection, we noticed that there were some changes required to the provider's registration to this location. We discussed this with the provider's Nominated Individual (a person that has been nominated by the provider to manage the service on their behalf) back in October 2017 and asked them to submit the relevant applications to remedy this as soon as possible. We followed this request up again in November 2017 but we have not yet received these applications at the time of completing this report.

The provider was required to have a registered manager in place as part of the conditions of their registration. There were two registered managers in post at the time of our inspection, each individually responsible for one of the two units. This meant that the conditions of registration for the service were being met. A registered manager has a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is ran. We found that both units were run separately; the registered managers explained that they felt that this worked well because the units were very different to the other. Some aspects of the service were managed jointly with a greater degree of oversight by other management teams deployed by the provider, including the maintenance and risk management systems and processes concerning the building. This included the governance of fire safety, electrical, and gas equipment as well as the structural and cosmetic maintenance of the building.

At the time of our last inspection, we found that some improvements were required to the management of the service to ensure safe and quality care was provided to people and maintained. This included the governance of medicine management and record keeping particularly in relation to ensuring people had individualised and detailed risk assessments and care plans. Whilst some aspects of the management oversight systems had improved, we found that further improvements were still required. We continued to find that there were a number of audits in place to assess the quality and safety of the care provided to people, but these had not always identified some of the shortfalls we found during the inspection.

On the residential unit we found that fridge temperatures continued to be recorded as too high (or not at all) for the safe storage of medicines. There was no evidence that these records had been monitored for completion or accuracy in order to identify if or what action had been taken to remedy this issue. We also found on both units that the recordings of fridge temperatures in the communal kitchenette areas were inconsistent and also failed to identify when or what action had been taken when the temperatures were noted to be too high. One member of staff said, "Not all staff bother to check the temperatures and to be honest nothing is done when it's too high anyway". We also found that the system for monitoring people's Deprivation of Liberty Safeguards authorisations had failed to ensure that new applications had been submitted in a timely way. When authorisations end, the provider cannot lawfully continue to deprive a person of their liberty. If the provider considers that a person will still need to be deprived of their liberty after the authorisation ends, they need to apply for a further authorisation to begin immediately after the expiry of the existing authorisation. Best practice guidance states that a provider needs to apply for a further authorisation far enough in advance to ensure that it is received before the existing authorisation ends. This ensures that the provider is not unlawfully providing care to a person in a way that deprives them of their

liberty. We looked at four people's DoLS authorisation records and found that they had expired before a new application had been submitted. This meant that there had been a period of time whereby people had been receiving care in a way that deprived them of their liberty, without the provider having the appropriate authorisations in place to do so. We fed this back to the registered manager at the time of our inspection. Following our feedback, the registered manager of the residential unit advised that a new 'DoLS tracker' system had been implemented to ensure that applications were submitted in a timelier manner to ensure that they were providing care to people lawfully. We have received feedback from a commissioner from the local authority who has confirmed that during a recent quality monitoring visit to the service, they have seen evidence of 'a more robust DoLS renewal tracking system' since our inspection site visit on 4 October 2017.

We found that on both units there appeared to be an over-reliance on the computer systems for the monitoring of the service. For example, the auditing of medicines were mostly reliant on the assumption that data had been recorded correctly on the computer system and that this would alert staff to any medicine errors. However, we found that staff could not always account for the quantities of medicines in stock, particularly liquid medicines. The registered managers on both units agreed that a more robust monitoring system was required for these medicines in particular. Another example was the monitoring of other aspects of care such as how the registered managers would monitor if a person had not eaten or drank enough or how they would look for people who were considered to be a high risk for weight monitoring purposes (under or over weight). We saw that this was possible because the computer system was capable of running quality monitoring reports which would evidence that the information stored on the data system was being used to monitor safety and to drive improvements within the service. However they explained that this was not always done as the provider was working towards becoming a 'paperless' service. Nevertheless, we discussed how these reports could be saved electronically and that the analysis of these reports and any accompanying action plans (and the review of these actions comparatively) would demonstrate greater oversight of the service provided to people. Since our inspection, we have been told that the provider had implemented a new quality monitoring system which reflected the key lines of enquires that CQC look at as part of the inspection process in order to enhance the governance of the service. We have also been told that a new fridge monitoring system and the management oversight of this system had been implemented.

Overall, we found that both units had their own areas of strength as well as areas that required improvement. We asked what systems were in place to promote consistency across the leadership of the two services and whether the registered manager's cross-audited each other's quality monitoring practices. We found that all quality monitoring records and practices were kept separate. We fed back to both of the registered managers that despite the two services being managed separately, there would be great benefit in them sharing good practice and working collaboratively when addressing any shortfalls so that there is consistency across the site.

We found that both units had a clear management structure in place which included a registered manager, multiple deputy managers, and senior carer's. Most of the staff we spoke with were positive about the leadership within the service and reported to feel listened to and supported. Where there were exceptions to this, staff acknowledged that there had been lots of changes within the wider provider which had had an impact upon the management of the Kenrick Centre, which the management team could not influence. For example, low staffing levels had been managed with the use of agency staff which had caused some inconsistency to the running of the service. Staff we spoke with recognised that this had been a challenge and had been stressful but were mindful that these decisions were made at a provider level opposed to being the responsibility of the registered managers.

Staff we spoke with were aware of the provider's whistle-blowing policy. Whistle-blowing is the term used

when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. One member of staff told us, "I have no issue with bringing concerns up; I'd report them to the managers or CQC if I had to".

The registered managers were aware of the requirements of the Duty of Candour regulations and explained how this meant that they would be open, transparent and share information about incidents in the home with people that used the service, relatives and professionals. Throughout the inspection we found both of the registered managers to be open and honest in our discussions and any information we required was provided. This was also true of their co-operation with us when processing any other enquiries or notifications that have been submitted to us concerning the services provided to people at the Kenrick Centre.

Since our inspection site visit, we have received a comprehensive response to our feedback from the registered managers which detailed what action the provider plans to take to address the issues identified as part of the inspection process. Information we have received from the local authority, following their commissioner's quality monitoring visit to the two services showed that some of these actions were already underway and improvements have been made since our inspection site visit. We will continue to monitor the provider's compliance in accordance with the conditions of their registration and will check the progress at our next inspection.