

Birmingham City Council Kenrick Centre

Inspection report

Mill Farm Road
Harborne
Birmingham
West Midlands
B17 0QX

Tel: 01216750900

Website: www.birmingham.gov.uk

Date of inspection visit:

19 March 2019

21 March 2019

22 March 2019

Date of publication:

09 August 2019

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service: Kenrick Centre is a care home that provides personal care for up to 64 people. At the time of the inspection 50 people lived at the home. The accommodation was established over two floors. On the ground floor there was a residential unit where 25 people lived, and on the first floor there was an enablement service where 25 people stayed at the time of our inspection visits. The aim of the enablement service was to prepare people for independent living following a stay in hospital or life changing event. People stayed at the enablement unit for approximately 4-6 weeks.

The Kenrick Centre also supplied the local community with day centre facilities, a café and a gym which were available for people to use. CQC do not regulate these types of service, so our inspection did not look at this aspect of the Kenrick Centre.

People's experience of using this service

- Risks which affected people's health and wellbeing were not always documented and staff did not always have adequate information to manage and mitigate against risks to people.
- Medicines were not stored or managed safely, which put people at risk.
- Infection control procedures required improvement to ensure people were protected from the risk of infection and cross contamination.
- Staff did not always receive up to date information and training, to ensure they knew how to support people safely.
- Systems of audits did not effectively identify where improvements were needed.
- The leadership and governance of the service required improvement to ensure lessons were learnt, and improvements were embedded and sustained into practice, so that people received a good quality service.
- Care records were not always up to date, and did not always show who should be consulted about decisions regarding people's care and finances.
- People were not always able to participate in activities, interests and hobbies that met their individual needs and choices.
- People told us they felt safe with staff who supported them.
- There were enough staff to meet people's assessed needs across both units.
- Staff had completed safeguarding training and knew what to do if they were concerned about people's well-being.
- People were supported to make daily living choices such as what they wanted to eat, and where they wanted to spend their time.
- Staff were aware people's needs could change, and understood when to seek advice and involve other health care professionals and services when needed.
- Staff knew people well, and knew their preferred ways of communicating, to assist people to make choices.
- Staff encouraged and supported people to be as independent as possible.
- There was a registered manager in post on each of the units at the centre.
- Feedback from people and staff was sought to identify where improvements could be made in the delivery of service.

Rating at last inspection: Requires Improvement. The last report for Kenrick Centre was published on 16 January 2018. CQC had inspected this service on four previous occasions, a rating of Requires Improvement had been awarded on all the previous inspections.

Why we inspected: This was a planned inspection based on the rating at the last inspection. The inspection was also prompted in part by notification of a potential serious incident. At the time of our inspection, we were conducting an ongoing investigation. Whilst this inspection did not examine the circumstances of the incident, we considered the provider's management of risks; staff training, and quality assurance procedures. We may review our findings in more detail when the ongoing investigation is concluded.

Enforcement: The service met the characteristics of Inadequate in two key questions of safe and well-led, with Requires Improvement in effective, caring and responsive.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the provider. The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC.

The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate ●

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate ●

Kenrick Centre

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team: The inspection was carried out by two inspectors, a pharmacy inspector, and two members of our experts by experience team. Experts by experience are people who have experience of using, or supporting someone, who uses similar care services.

Service and service type: Kenrick Centre is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had two registered managers at the time of our inspection visits. Each unit of the home was managed by a registered manager. 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.

Notice of inspection: Inspection site activity started on 19 March 2019 when we initially visited the service and ended on 22 March 2019. The inspection was unannounced on the first and second day. We returned to inspect medicines on the 21 March 2019, and on the 22 March 2019 to continue our comprehensive inspection of both units at the home.

What we did: We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as serious injuries. We sought feedback professionals who worked with the service. We assessed the information we require providers to send us annually that gives us key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection visit: We reviewed eight people's care records, to ensure they were reflective of their needs, and other documents such as medicines records for twelve people. We reviewed records relating to the management of the whole service such as quality audits, people's feedback, and meeting minutes. We spoke with 13 people who lived at Kenrick Centre and three people's relatives. We also spoke with three care staff, three deputy managers, both registered managers, the head of service and a visiting social worker.

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- People did not always have risks to their health and behaviour mitigated by staff, as there were insufficient details in care records and risk assessments to ensure people were cared for safely and consistently. For example, one person had a diagnosis of epilepsy and had a history of seizures. Risk management plans did not state the type of epilepsy, or how staff should support the person when they had a seizure. In addition, one member of staff told us they were unsure whether the person had epilepsy or was experiencing mini strokes. This put the person at risk of not receiving the care they needed.
- Staff did not always act to mitigate risks to people, even when risk mitigation plans and instructions, were available to them. For example, one person had been assessed as having a medical condition which required their leg to be elevated whilst they were in a seated position. We saw staff supported the person to move around, and sit down, without elevating their leg.
- One person used a walking frame whilst moving around, to prevent them from falling, and so that they could maintain their independence. We saw two members of staff assisted the person to walk along the corridor without the use of the walking frame.
- Following our inspection visits the registered managers updated risk assessment for the medical conditions we had identified.

Learning lessons when things go wrong

- Lessons were not always learnt when things went wrong. The registered managers did not always record when incidents occurred. For example, we were told that the week before our inspection, one person had choked on their food, requiring support from staff to stop them choking.
- We looked at the person's choking risk assessments. The risk assessment was insufficient as it did not instruct staff to only provide the person with pureed food. We found the person was still being given solid food. This meant the registered manager had failed to analyse learning from the choking incident, to prevent the person from choking in the future.

Using medicines safely

- Medicines were not always managed and administered safely in the residential unit of the home.
- Two people were administered medicines covertly. Although a doctor had instructed staff to crush the medicines, no documentation from a pharmacist was available regarding the best way to administer the medicine and whether it was safe to crush the medicines. The provider immediately changed their medicines procedures to ensure pharmacy advice was sought when medicines were given covertly.
- Medicines require storage at certain temperatures to maintain their effectiveness and safe use. Some medicines needed to be stored in a fridge between a temperature range, the minimum of the range being 2 degrees. Staff were not monitoring the temperature of the fridge correctly, to ensure it stayed within the acceptable range. A single fridge temperature was monitored daily instead of a range. Daily records

indicated the temperature was frequently outside of the accepted range. No actions taken by staff were recorded and staff did not consistently understand the significance, if the temperature was outside the recommended range.

- Some people administered their own medicines and kept their medicines in their bedroom. Their ability to administer medicines safely was assessed. However, we found procedures were not robust enough to ensure people who administered their own medicines, always stored them safely and securely.
- Auditing procedures and management checks of medicines had failed to identify medicines were not stored and administered safely.
- Some people required medicines to be administered on an as required basis. This meant detailed instructions might be needed by staff, when supporting people who lacked the capacity to make decisions about whether they needed their medicines; or were unable to inform staff when they required their medicine. Detailed protocols were not in place to help staff make these decisions. This meant people were at risk of not always having their medicine to help them control their anxieties and pain.
- Some medicines were prescribed to be administered by a patch. Patch medicine can cause skin irritation, and regular rotation of the site where it is applied to the body is required to minimise the risk. The use of patch charts, to record where the patch was applied on people's bodies was not consistent. Instructions for staff on how the patches should be managed, according to best practice guidance, was not always available.
- People told us staff did not always administer their medicines safely. One person said, "There was one occasion when I took too many tablets, staff gave me the wrong instructions and so I took too many. This made me ill. I take my own medicines now, as staff were doing it wrong. My medicine is meant to be taken half an hour before food. They were giving it to me with food and so I complained."

Preventing and controlling infection

- There were ineffective measures to ensure risk of infection was prevented and/or minimised on the residential unit of the home.
- Staff did not always follow best practice and guidance when supporting people to prevent the spread of infection and cross contamination. For example, staff did not always use protective gloves and aprons when supporting people with personal care.
- Staff did not always wash their hands when they finished supporting people with personal care, before going on to do other tasks.
- Some of the bins located in both units of the home did not have lids in place, to prevent the spread of infection.
- The communal areas of the home were kept clean by housekeeping staff who followed good infection control procedures, such as using colour coded equipment for different types of cleaning and waste removal.

Not ensuring safe systems to prevent people from risk and the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at Kenrick Centre and when staff supported them.
- There were policies and procedures for staff to follow to keep people safe from harm. The provider's safeguarding policy described the different types of abuse people might experience and included information for staff to follow if they suspected abuse.
- Staff had also completed safeguarding training which was refreshed every three years. Staff knew how to keep people safe from potential harm or abuse.
- Detailed records were kept of safeguarding concerns and alerts and where necessary, information was shared with the local authority and the Care Quality Commission (CQC). Concerns had been investigated in a

timely manner.

- There were easy read posters throughout the service, so people knew about abuse, that it was not tolerated, and that they should talk to staff if they had concerns. This showed the provider thought about how to communicate with people about keeping safe.

Staffing and recruitment

- There were sufficient numbers of staff at Kenrick Centre to assist people with their care and support needs.
- The provider had completed robust checks to ensure staff were suitable for their role. These included checking their references and completing checks with the Disclosure and Barring Service (DBS). This meant the provider recruited employees suitable for working with vulnerable people.

Is the service effective?

Our findings

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- The provider did not ensure the MCA was always followed, to ensure people could always express their consent and share their wishes in accordance with the MCA. Where people needed assistance to express their wishes, give their consent, or be involved in discussions about their health, they were not consistently offered support by identified legal representatives and advocates to express their views.
- The provider did not ensure people had mental capacity assessments, best interest's decisions, and evidence of people's legal representatives recorded where appropriate.
- Staff did not consistently understand the principles of the MCA. Staff did not consistently know when it was appropriate to restrain or restrict people's movements. For example, we saw one person who had a diagnosis of dementia being assisted by a member of staff. The person became anxious and began waving their arms above their head. The staff member restrained the person's movements by holding their arms. The registered manager confirmed staff had not been given the permission to restrain people.
- People and staff told us they sought verbal consent from people (where people were able to consent in this way) before providing care and support. One person who could verbally respond to staff questions said, "They always ask me first."

Staff support: induction, training, skills and experience

- Staff received an induction when they started work for the provider. The induction was based on the 'Skills for Care' standards providing staff with a recognised 'Care Certificate'. Skills for Care are an organisation that sets standards for the training of care workers.
- However, staff did not always receive additional or regular refresher training following their induction, for some recognised health conditions, changes in legislation and best practice guidance. For example, care workers had not received training in how to support people with epilepsy.
- Staff in the residential unit had not been offered training in caring for people with dementia since 2014. This was important as people with dementia lived in the residential unit. One member of staff said, "I can't remember doing any dementia training."
- Staff had not received refresher training in Mental Capacity Act since the first quarter of 2015. This means that recent changes to the application of the Act may not be understood by staff.
- The provider maintained a record of staff training, so they could identify when staff needed to refresh their skills. However, the information was not comprehensive, and did not always alert managers when staff

refresher training was due.

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

- We observed how staff supported people at lunchtime. People ate where they chose, either in dining areas, lounges, or their own bedrooms. People told us there was enough to eat and drink. One person told us, "I can get food and drinks at night if I want to."
- Where people required assistance to eat a balanced and nutritious diet, that met their health needs, people had a care and support plan to instruct staff on how they should be supported. However, we found one person who was at risk of choking did not have sufficient information detailed in their support plan to instruct staff on how to prepare their food, to minimise the risk of them choking.
- Most people could make choices about what they ate each day, by selecting daily food choices from a menu. Only two people told us they would like more choice in the food on offer to them. One person told us they would like more choice of pureed food, as this did not always meet their preferred taste.

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

- People were supported in a purpose-built home which met their accessibility needs and provided them with access to local community groups and events.
- Corridors and doorways were wide to accommodate mobility equipment and walking aids.
- People had their own room and could decorate their home with personal items. One person told us, "I have also personalised my room the way I like it. I have my photos and they help to make my room homely."
- The building had a number of facilities that were open to the public and could be utilised by people who lived at Kenrick Centre. These included a café, gym, meeting rooms, and consultation rooms for health professionals and people to meet to discuss their care and treatment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed with the person, health professionals and mental health specialists before they came to live at Kenrick Centre. Assessments included information on people's physical and mental health needs, and how they wanted their support to be provided.
- People who stayed on the enablement unit were assessed for their health care needs by a multi-disciplinary team (MDT) that met weekly to review their ongoing care arrangements. The MDT comprised social workers, managers, occupational therapists, physiotherapists and other health professionals such as doctors and district nurses. The team met weekly to discuss how well people were progressing, and whether they needed additional support, so that they could move on to a more permanent home.

Staff working with together and with other agencies to provide consistent, effective, timely Supporting people to live healthier lives, access healthcare services and support

- People who stayed on the enablement unit were assessed using a 'red to green' system. This system kept a daily track of people's progress during their stay. Staff shared information daily with people on how they were progressing, to reach their goals and move on from the unit.
- Weekly multidisciplinary meetings for people who stayed on the enablement unit meant people's care and support requirements were kept under review.
- There were systems in place, such as daily care records, and regular handover meetings to share information.
- People had access to health professionals such as district nurses. Staff took people to regular hospital, dental and clinical appointments to maintain their health. People confirmed they saw the doctor when they needed to, and one person said, "If necessary I let the carers know when I want to see the doctor."
- The Kenrick Centre housed a number of social and healthcare professionals, which increased their accessibility to people who lived at the home. For example, social workers, physiotherapists and occupational therapists.

Is the service caring?

Our findings

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

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect.

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

- People told us they were involved in decisions about their care. However, some people were unable to verbally communicate well, and make complex decisions. As the registered managers did not consistently keep information about people's mental capacity, and details about who their legal appointees and advocates were, we could not be sure decisions were being made in conjunction with people's representatives.
- People in the enablement unit had weekly meetings with staff at the Kenrick Centre, social workers, and health professionals, to discuss their progress in achieving their goal to be independent and return home, or move to another location. These discussions involved how their care should continue to be delivered.
- The service followed data protection law and people's private information was kept securely. The information we saw was either kept in lockable cabinets in locked offices or on password protected computers.
- People were supported to maintain relationships with those that mattered to them. Friends and families could visit people during set visiting hours in the enablement unit, and at any time in the residential unit.

Respecting and promoting people's privacy, dignity and independence

- Private areas were available for people to spend time together when needed or requested. Staff usually respected people's individual privacy, by knocking on people's doors and asking their permission before entering their room. However, we saw some staff did not always do this.
- Our observations during our visits did not always show people were treated with dignity. On one occasion we saw a person being supported to go to the toilet, and care staff left the door open whilst they supported them.
- People were encouraged to be independent. One person on the residential unit was encouraged by staff to make themselves a drink and help themselves to some fruit. The staff member said, "I really try and encourage people to do what they can for themselves, even if it's the little things." Another said, "We can only ever encourage people. We try to keep them doing what they can for themselves for as long as possible."

Ensuring people are well treated and supported; equality and diversity

- Staff communicated with people in a warm and friendly manner. These responses indicated that people enjoyed the company of staff and each other. Comments from people included; "I think this is a marvellous place. I cannot fault the care that I am getting here", "Staff are good to me. I have a hearing impairment and when I am in bed they tug the blanket to get my attention. They always ensure that the words (subtitles) are on the TV so I can follow the programmes".

- The provider respected people's equality and diversity, and protected people against discrimination. Staff were recruited based on their values and abilities. People and staff were treated equally according to the guidance on protected characteristics. Where people wanted to form relationships outside the home, this was supported.

Is the service responsive?

Our findings

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

Requires Improvement: People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People had care plans and records to show their support needs. Care plans included different topics including physical and health needs and preferences. Care plans were recorded electronically at the home, on both units. They were also printed onto paper, according to the provider's policy.
- People did not always have a full and contemporaneous record of their support needs, and the care they received, as described in the Regulations. Paper care records did not describe in detail how staff should support people to mitigate risks to their safety. Care records did not detail how decisions should be reached, where people lacked the capacity to make all their own decisions.
- Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people receiving care have information made available to them that they can access and understand. Where people had specific disabilities that affected their communication, the provider used some techniques to communicate with people effectively. For example, some documents were available in 'easy to read' formats using large print and pictures.
- Aids were also used by people to support them to communicate. People had smart phones, electronic tablets and computers to access social media to network with family and friends using the provider's Wi-Fi.
- People's personal beliefs and backgrounds were respected by staff. We saw people who practiced religion, were supported to do so. People's cultural choices were discussed with them, so that staff knew how to support them.
- People were encouraged to take part in organised group activities and events around Kenrick Centre. Some activities and events were pre-organised. These included social events, seasonal and religious events, and activities in the community centre. Other people did things alone, such as played games and went out to the local park.
- However, some people told us there was not enough to do, to stimulate and engage them. Comments included; "I just sit in my room and don't talk to people", "There's nothing to do at all here. At night we can only watch TV. I'm often bored. I would like to do more. I do chat with the other residents", "I am just left to read or watch TV, there is nothing else on offer."

Improving care quality in response to complaints or concerns

- People were supported to raise concerns. People told us they felt comfortable raising concerns with staff and managers at the home.
- The provider had a complaints policy and procedure that staff were aware of and these had been provided to people in an easy read format and large print. The easy read and different format information told people how to keep themselves safe and how to report any issues of concern or raise a complaint.
- The service had a complaints log, all recorded complaints had been responded to in a timely way.

End of Life care and support

- where people needed end of life support, the provider had policies and procedures in place to ask them about their wishes and to support them through this difficult time.
- People's end of life wishes were documented. For example, one person had requested to see a priest to receive their last rites and their funeral wishes were documented. Community McMillan nurses and district nurses were supporting the person and their family as they neared the end of their life.

Is the service well-led?

Our findings

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care

- The provider had failed to attain a rating of 'Good' at the Kenrick Centre since July 2014 when we conducted our initial rating inspection of the service. This demonstrated the provider had not responded sufficiently to four previous ratings of 'Requires Improvement' at the home.
- We identified improvements were required in how the provider managed risks to people's safety, in medicines management, keeping care records up to date, and providing staff with the information and training they needed to provide good quality of care.
- The provider's own auditing procedures and quality assurance checks had failed to comprehensively identify where improvements were required. Where some improvements had been identified, the provider had failed to take the appropriate action to improve the service and sustain the improvements.
- Following our inspection visit we asked the registered managers to tell us what they had done in response to our feedback. The registered managers had made improvements to risk management plans, some medicines procedures, and records regarding the monitoring of staff training.
- Following our inspection visit the provider set up an improvement plan, which detailed what they were planning to do to improve the quality of care people received.

Plan to promote person-centred, high-quality care and good outcomes for people.

- The systems in place did not always focus on the individuals using the service, and care records were not always in place to meet people's individual needs.
- The staff training matrix was not comprehensive and was not in a format to support the management team to identify when staff had last received training in certain key areas or when they needed to refresh their skills. This meant people did not always receive care from effectively trained staff. Only 15% of staff who responded to a recent staff survey felt they had completed the training they needed.
- The culture of the home and staff relationships were not productive in generating a culture of learning from mistakes and incidents. Staff provided us with inconsistent feedback on whether the concerns they had raised with managers were addressed.
- There was not a culture of open and honest dialogue, when mistakes were made, to ensure staff reported errors when they occurred.
- Registered managers and staff from the two units did not work together as a team, to ensure they learned from each other and shared good practice.
- Staff told us they did not have supervision meetings with their manager each month. This was in accordance with the provider's previously agreed policy. However, the registered managers told us staff were no longer offered supervision meetings with their manager each month, as the provider's policy had changed. It was clear staff and managers did not always share the same understanding of current policies.

- We asked managers how they supported staff, with checks on their competence, and updating their skills where this was required. A registered manager told us they did not perform recorded spot checks on staff competency to ensure staff had the skills they needed. However, they explained they relied on senior staff who worked alongside care staff each day, to inform them of any training or development needs.

Failure to assess, monitor and improve the quality of the service, meet the regulations, and maintain appropriate and contemporaneous records for each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There were two registered managers employed at the home. Each manager oversaw a unit. Registered managers were supported by deputy managers.
- The registered managers understood their role and regulatory responsibilities. The latest CQC inspection report rating was on display. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgments.
- The provider had notified us of important events as required. This demonstrated the management team was clear about their roles.

Engaging and involving people using the service, the public and staff

- People were supported to complete surveys to capture their views and opinions of the service. All the people who stayed on the enablement unit were sent a survey when they left the home. Surveys were available in an easy to read format.
- In September 2018 a survey had been sent to people to gather their feedback on the residential unit. Seven people had responded, and all were happy.
- However, we looked at a recent staff survey which indicated staff did not always get the support from their manager to consistently deliver good quality care to people. The provider did not have an action plan in place, to demonstrate how staff concerns would be addressed.
- The provider arranged regular meetings with people and staff on each unit. Minutes of meetings were recorded, and actions were reviewed on each unit, to see if changes needed to be made in response to feedback. For example, a staff meeting in the residential unit showed staff had explored learning from a recent death and discussed implementing more activities and stimulation for people.

Working in partnership with others

- The service had links with external services, such as community groups, health professionals and commissioners, that enabled people to engage in the wider community. For example, the provider worked with local community centres and charities to provide activities and interests at their community centre, which was accessible to people who lived at Kenrick Centre. Health professionals were located on site so that people could access health services easily.
- The registered manager on the enablement unit had introduced a tool at the service in April 2018 which was a pilot study at the time of our visits. The tool was designed to improve people's journey through the unit, reducing the amount of time people might need to stay, and to assess daily each person's progress of their recovery. Feedback was provided to people each day on how they were progressing, and when they were likely to be discharged. Daily meetings with social workers, managers, and occupational therapists assessed people's progress. Information from the tool was analysed to detect any trends and patterns, which might delay people's recovery. If the tool is successful, and improves outcomes for people at the service, it may be used by other Birmingham City Council units.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>12(2a,b,c,g) The provider had not ensured care and treatment was provided in a safe way for service users. They had not comprehensively assessed the risks to the health and safety of service users, and were not doing all that was practicably possible to mitigate any such risks. Staff did not always have the skills they needed to care for people safely. The provider did not ensure the proper and safe management of medicines.</p>

The enforcement action we took:

condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>17(2a,b,c,f) Systems and processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Systems and processes were not operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care provided and the decisions taken, in relation to the care and treatment provided. The provider did not evaluate and improve their practice in respect of the processing of quality assurance data.</p>

The enforcement action we took:

Impose a condition