

Rutland House Community Trust Limited

# Rutland House Community Trust

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Rutland House Community Trust is a residential care home registered to provide personal care for up to 10 people with a physical disability, learning disability, or autistic spectrum disorder.

Not everyone who lived at Rutland House Community Trust received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. There were eight people living at the home at the time of the inspection, seven received personal care.

### People's experience of using this service and what we found

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led. The service was not always able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

### Right support:

- Model of care and setting maximises people's choice, control and independence

### Right care:

- Care is person-centred and promotes people's dignity, privacy and human rights

### Right culture:

- Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

The home was in a local residential area. However, it was at the end of a side road on a separate gated area.

The home was bigger than most domestic style properties. Yet the size did not have a negative impact on people. We believe this was because the home was under occupied. An increase in the number of people living at the home may impact on the provider's ability to provide personalised care.

The care home was spacious and had two communal areas people could use. There was an additional seating area in the foyer.

The provider had identified the need to refurbish and redecorate the home and were reviewing options available to them at the time of inspection, to ensure this met the requirements of Right support, right care and right culture.

Quality assurance systems and processes had not always been undertaken or identified concerns we found on inspection. We observed occasions where staff wore face masks below their chin in close proximity to people. Improvements were needed to systems and processes to check visitors and staff entering the building did not have symptoms of COVID-19 or had been a close contact of someone with COVID-19.

Staffing levels had not been regularly reviewed to ensure they met the needs of the service. There were not enough staff employed or deployed to meet the needs of the service. This put additional pressure on care staff and meant they did not always have time to spend with people to support them with their social and recreational needs. The provider was experiencing challenges in fulfilling staffing vacancies at the time of the inspection.

Improvements were needed to the providers medicines recording keeping systems. People received their medicines from staff that had been trained in medicines management.

People were not always supported to have maximum choice and control of their lives. However, staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The registered manager was passionate about providing person-centred care and knew people well as they were involved in care delivery. People received support from staff that knew them well. They had positive behaviour support plans in place, which were person-centred. Staff were discouraged from wearing anything that suggested they were care staff, other than the PPE required to keep people safe.

People were supported by staff that knew how to keep them safe from harm or abuse and had been safely recruited. Staff had a good knowledge of risks associated with providing people's care and had received training relevant to people's needs.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

Rating at last inspection

The last rating for this service was good (published 02 March 2019).

Why we inspected

We received concerns in relation to the management of people's falls risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rutland House Community Trust on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to the governance of the service and staffing.

Please see the action we have told the provider to take at the end of this report.

#### Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Is the service safe?**

The service was not always safe.

Details are in our safe findings below

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Rutland House Community Trust

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

#### Inspection team

The inspection was undertaken by one inspector

#### Service and service type

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who lived at Rutland House Community Trust. Some people were not able to answer questions about their experience of the care provided. They were able to tell us about what was important to them to inform the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four members of staff including the registered manager, cleaning and care staff.

We reviewed a range of records. This included five people's care records and three medicines records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies, procedures and quality assurance records. We spoke with two relatives about their experience of the care provided at Rutland House Community Trust and spoke with a fire officer.

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Staffing and recruitment

- The service did not use a dependency tool to assess people's needs and plan staffing levels. This meant they could not be assured safe staffing levels were provided.
- Prior to the COVID-19 pandemic, some people had accessed external activities during weekdays. As a result of the COVID-19 pandemic, and to comply with government guidelines, these had stopped for a period of time and had recommenced on a part time basis. Staffing levels had not been reviewed and increased in response to this change. This meant additional pressure was placed on care staff and people's social and recreational needs were not fully met.
- There were not enough staff employed or deployed to meet the needs of people living at Rutland House Community Trust. The registered manager told us they were experiencing challenges recruiting staff to fulfil vacancies. On the day of the inspection, the registered manager, an administrator and housekeeper were providing care to people as there were not enough care staff available.
- Care staff undertook cleaning and domestic tasks. This meant they did not always have time to spend with people or to support them with their hobbies and interests.

We found no evidence that people had been harmed. However, there were not enough staff employed or deployed to meet the needs of the service. This put people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safe recruitment checks had been undertaken to ensure people were protected from being supported by unsuitable staff.

### Preventing and controlling infection

- We observed occasions during the inspection whereby staff wore their face masks below their chin whilst in close proximity to people. This increased the risk of transmission of COVID-19. We discussed this with the registered manager who took immediate action to address this.
- Staff ensured visitors had a negative lateral flow test, and that professional visitors had a double COVID-19 vaccination prior to entering the care home. However, additional screening checks to ensure visitors did not have symptoms of COVID-19 or had been exposed to COVID-19, were not undertaken in line with government guidance. Following the inspection, the registered manager told us these checks had been implemented.
- The cleaning schedule did not instruct staff to undertake cleaning of high touch areas, such as door

handles and switches throughout the day. We discussed this with the registered manager who told us, they would add this to the cleaning schedule.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

#### Assessing risk, safety monitoring and management

- Most people's risk assessments and care plans had been followed by staff. However, we found care records for one person, did not evidence they had been supported to change position every two hours to assist with the healing of a wound.
- Risk assessments and care plans contained enough information to instruct staff how to reduce people's risks. Staff had good knowledge of people's risks and the support they needed. One staff member said, "[Name] has their food blended and sieved, they have a thickener in their drinks and a speech and language therapy plan." Health professional advice for people's choking risks was fully reflected in their care plans. We observed staff to support people at risk of choking, safely during mealtimes.
- Staff knew what action to take if a person fell. One staff member said, "If a person is on the floor, the first thing you do is check for any injuries or pain, you get help from the shift lead and determine if they need an ambulance or can stand." Records for recent falls evidenced care plans had been followed, people were checked for injuries following falls and risk assessments and care plans were reviewed. A person at high risk of falls, had broken their glasses on the day of inspection. These were repaired during the inspection.
- The fire service had issued a Regulatory Reform (Fire Safety) Order 2005 action Plan in June 2021. The necessary work had been undertaken to achieve compliance with this plan, including the replacement of all internal fire doors. Individual personal emergency evacuation plans (PEEPS) were in place to instruct staff how to support people safely in the event of an emergency. These were reviewed following fire drills to ensure they were effective.

#### Using medicines safely

- There were issues with the electronic medicines administration record (eMAR) system, which meant staff were not always able to record when they had given people their medicines on the eMAR. This meant there were gaps in the eMAR recording. This had been identified by the registered manager. Performance issues relating to recording had been addressed and improvements in recording had been made. A new eMAR system was due to be introduced.
- Monthly medicines audits had not always been undertaken due to challenges with the eMAR system. However, we found daily medicines checks were in place, and the registered manager had identified and was addressing the issues we found. Whilst the checks in place were mostly effective, one person's missed medicine was not identified for 24 hours in October 2021. The registered manager told us monthly audits would recommence once the new eMAR system was in place.
- People's care plans provided detailed guidance, so staff knew when to give people 'as required' medicines. Staff did not administer medicines to people until they had been assessed as safe to do so.
- Best practice for the safe storage of medicines was followed.

#### Learning lessons when things go wrong

- Staff knew how to report accidents and incidents. Records showed accidents and incidents were recorded and were reviewed by the registered manager or a senior member of staff to identify learning.

#### Systems and processes to safeguard people from the risk of abuse

- Staff had received safeguarding training and knew how to identify and report abuse. One person told us, "I am safe here. I talk to them [staff] if I want help and have a bell to call them."
- Records showed safeguarding concerns were reported to the local authorities safeguarding team. A safeguarding investigation was being undertaken at the time of the inspection, following a person falling and sustaining a serious injury.
- Staff felt able to challenge poor practice. They told us if they saw poor practice, they would whistle blow or raise their concerns if needed.

# 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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The providers policies for visiting care homes and new admissions did not fully reflect government guidance relating to the COVID-19 pandemic.
- The provider did not use a dependency tool to review staffing levels to ensure they met the needs of the service. This meant staffing levels had not been reviewed or increased in response to people's changed social needs or to meet the enhanced cleaning requirements relating to the COVID-19 pandemic.
- The registered manager provided care to people when there were shortfalls in staffing numbers. This impacted their capacity to undertake their role as a registered manager.
- Quality assurance systems and processes had not always been undertaken in line with the providers schedule. There were gaps in the completion of fire, health and safety and eMAR audits and an absence of infection prevention and control audits.
- The services quality assurance systems and processes failed to identify some of the concerns we found during this inspection.

Systems and processes were not always in place to demonstrate the quality and safety of the service was effectively monitored and managed. This placed people at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was clear about their role and understood the regulatory requirements. They were open with us during the inspection and responsive to concerns we raised. They took immediate action to address the infection, prevention and control concerns we identified.
- The registered manager was aware of duty of candour responsibilities. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were not always able to be supported with hobbies and interests in the way they wished. One person told us they weren't able to go out as much as they would like as there were not enough staff.
- The manager and staff team were passionate about providing person centred care. People's care plans

reflected their preferences and wishes. One person said, "It's nice here, you can go to bed when you like and get up when you like." A staff member said, "One thing I love, is that the care is person centred. People can do what they want, they are not rushed." We observed staff offering people choices throughout the inspection and providing the care they asked for.

- Poor performance had been addressed and staff were supported to develop. Staff received regular supervisions and felt well supported by the management team. One member of staff said, "The management support here is good. I like the registered manager as she tells you straight."

#### Continuous learning and improving care

- Weekly managers meetings were undertaken to review progress with improvements needed. These informed the monthly 'Trustee' meetings and the services improvement plan.

- The provider was committed to improving the living environment. They had identified the building was 'tired' and required refurbishment and redecoration. This had been put on hold until the internal fire doors had been installed and work to the fire alarm system had been completed, this work was due to conclude the week after the inspection.

- Poor internet connectivity impacted staff ability to access care and medicines records at times. An internet upgrade was booked to take place two weeks after the inspection which would resolve the issue.

#### Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Surveys for staff, relatives and people had not been undertaken during the pandemic. However, a relative told us, "They [staff] always ring us and keep us updated. We have got no complaints whatsoever."

- Team meetings were used to share information with staff and allow staff to provide feedback. A messaging system was also used to keep staff updated of changes.

- Monthly 'keyworker' meetings enabled people to provide feedback on their care. These had not always been undertaken monthly. However, where they had taken place people's views and wishes were responded to. One person had asked for a calendar so they knew when they would see a staff member, they had also asked to attend an event. Both had been actioned.

#### Working in partnership with others

- Staff and the service worked closely with health professionals such as speech and language therapists, occupational therapists, physiotherapists, community nurses and GPs to enhance the health and well-being of people. They liaised with social care professionals to review people's packages of support when their needs changed.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems and processes were not always in place to demonstrate the quality and safety of the service was effectively monitored and managed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  There were not enough staff employed or deployed to meet the needs of the service