

Rutland House Community Trust Limited

Rutland House Community Trust

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

About the service

Rutland Community Trust is a residential care home providing accommodation and personal care to 9 people at the time of the inspection. The service can support up to 10 people.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Right Support:

Staff supported people to achieve good outcomes. There were clear communication systems within the service to support this.

People were supported to have maximum choice and control of their life and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care:

The care people received was tailored to their individual needs. Staff treated the person with dignity and respect and promoted their right to privacy.

Right Culture:

The culture within the home empowered people who used the service. The staff team promoted inclusive practices which supported people to live a full life, their rights and aspirations were promoted.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 08 December 2021)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 15 November 2021. Breaches

of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve staffing and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to good based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. However, we found no evidence during this inspection that people were at risk of harm from this concern. Please see the Well-led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rutland Community Trust on our website at www.cqc.org.uk.

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good ●

The service was well-led.

Details are in our well-led findings below.

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 Health and Social Care Act 2008.

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 carried out by 1 inspector.

Service and service type

Rutland House Community Trust is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rutland House Community Trust is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had submitted an

application to register.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with two people who lived at Rutland House Community Trust. Some people were not able to answer questions about their experience of the care provided. We observed the support they received to help us understand their experience of receiving care.

We spoke with 3 members of staff including the manager, and 2 care staff. We spoke with a relative of a person who used the service. We reviewed a range of records. This included 2 people's care records and medicines records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has changed to good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

At our last inspection the provider did not have 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- There were enough staff on duty to meet the needs of people who used the service. People's assessed needs were used to ascertain the numbers of staff required to meet their needs in a safe and person-centred manner.
- People who needed one to one staff support received this support at the required times.
- The provider followed safe recruitment practices. They completed relevant checks which assured them staff were suitable to work with people who used health and care services. These include disclosure and barring checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- People were safe. There were protocols within the service to promptly identify any changes or concerns to people wellbeing. These protocols included systems to bring concerns to the attention of senior staff and report to relevant agencies.
- Where possible, people were empowered to identify and report any concerns they may have about their care and safety to the manager. We saw that the manager responded satisfactorily by investigating concerns raised and taking relevant actions. One person told us, safety is one of the areas they discussed in their regular catch-up meeting with the manager.
- Staff understood where people required support to reduce the risk of avoidable harm. There were protocols in place with other agencies which provided advance information on the support people who need to be safe when out and about in the community. For example, there were protocols in place with the police to ensure people's safety when out in the community.

Assessing risk, safety monitoring and management

- People's care records included assessments of risks relating to the care and support they received. They included information and guidance for staff on how to provide support which minimised those risks.
- The protocols for managing risks promoted people's rights. Their freedom and rights to make choices

were not restricted.

- The service followed positive behaviour management practices. People could access and update their own care records to record their feedback on the care they received and their emotional state. The manager and staff used this to tailor support which was responsive to people's current emotional needs.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
- Where decisions were made on a person's behalf, this was done collaboratively with other people involved in their care. This was done in accordance to good practice which ensured decisions were in the best interest of people.

Using medicines safely

- People received their medicines as prescribed. Care plans included information and guidance on how staff would provide safe medicines support. Only staff who had received medicines training administered people's medicines. This helped to ensure risks from medicines were reduced.
- Protocols for the administration of medicines followed good practice guidance. Staff recorded the support they delivered in Medicines Administration Records. The manager maintained oversight of the records to ensure the support people received was safe.
- Medicines were stored in line with best practice guidance.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. This was because maintenance works were needed to improve the seals in the communal shower areas. Following our visit, the manager told us completed improvement works including changing damaged floors.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

There were no restrictions to visiting. People's family and friends were supported to visit them. There were protocols in place to minimise the risk of spreading infections during visits.

Learning lessons when things go wrong

- There were systems in place to use concerns and incidents that occurred at the service to improve people's experience of care and support.

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 our last inspection we rated this key question requires improvement. The rating for this key question has changed to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

At our last inspection the provider did not always have systems and processes 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- The provider had made improvements to the oversight of staffing levels and updating the policies in relation to updates in government guidance regarding COVID-19. However, we saw further improvements were required in maintaining safety requirements of the premises such as updating shower areas and floors. The manager told us there were planned improvement works to the building.
- There was a new manager in post. The manager had submitted an application to become the registered manager of the service. The manager was experienced in managing care services and spoke to us about their plans for improving the service. Following our inspection, the manager was successfully registered.
- Staff spoke highly of the support they received from the manager. They told us they had easy access to the manager for support and guidance when required. A staff member told us, "[Manager] is very supportive and makes me feel empowered in my role."

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 provider and the systems within the service demonstrated the service was run in line with the requirements of the duty of candour. Duty of candour is a requirement for providers to be open and honest with people when things may/could have gone wrong with the care they received.

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

- The culture within the service was centred on people's individual needs. Staff knew people well, care plans reflected people's preferences and wishes. Staff practice and care records showed people were supported to achieve good outcomes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People who used the service and their relatives could contribute and give their views about care and support they received. This included through conversations with the manager or through regular feedback on the electronic care planning records.
- Staff worked in partnerships with other professionals and people's families to ensure the care and support received was consistent. Health professionals told us how staff worked collaboratively with them to achieve good outcomes for a person who used the service.

Continuous learning and improving care

- There were clear tiers of accountability in the management structure within the service. The manager was supported by the trustees to make assess the service and plan for required improvements.