Milewood Healthcare Ltd

Oxbridge House

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
Oxbridge House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Oxbridge House accommodates up to 13 people in one adapted building providing support for people with learning disabilities who may also experience mental health needs. At the time of our inspection visit there were nine people using the service.

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

Records did not demonstrate people received their medicines as prescribed. The medicine policy needed to be updated to make it relevant to the service.

Risks to people's health and welfare were not all in place. Records to evidence fire drills needed to be more robust. Care records were cumbersome and contained information not relevant to the person. Audits that had took place did not highlight the concerns found on the inspection day.

Accidents and incidents, although few, were monitored monthly for themes and lessons learnt.

Staff were recruited safely and felt supported by the registered manager.

People and their relative's views were sought, and they were very involved in the running of the service. However, relatives felt communication and the management of the service could be improved.

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.

The service was not always able to demonstrate how they were meeting some of the underpinning principles of right care, but were meeting the principles of right support and right culture. Oxbridge House did not always put people who used the service in the centre of the care provided. They did engage people to maximise their potential and staff demonstrated a clear understanding of the needs and challenges people with learning disabilities face within our society.

Right support:
• The model of care and setting did maximise choice, control and independence. People used the community and local attractions daily as well as going further afield. People chose and did what they wanted to do every day with support but without restrictions.

Right care:
• People did not always receive consistent person-centred care that promoted their dignity and human rights. Even though we found no harm to people we raised this with the provider who agreed to review peoples care. People were protected from the risk of abuse.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives. We saw meetings for people and staff were taking place. People were fully involved in how they wanted to live.

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

Rating at last inspection
The last rating for this service was good (published19 December 2017).

Why we inspected

This was a planned inspection based on the previous rating.

We carried out a focused inspection of this service on 25 June 2021. This report only covers our findings in relation to the key questions safe and well led as we were mindful of the impact and added pressures of Covid-19 pandemic on the service.

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.

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.

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 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 Oxbridge House on our website at 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 have identified breaches in relation to the management of risk, medicines management and records at this inspection.

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

Follow up

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 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Oxbridge House

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
One inspector and an Expert by Experience carried out this 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.

Service and service type
Oxbridge House 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.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from Healthwatch, the local authority commissioning and safeguarding teams. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 Oxbridge House and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and we spoke on the telephone to two family members about their experience of the care provided. We spoke with five members of staff including the registered manager, compliance manager, senior care workers, administrator and care workers. We walked around the building to carry out a visual check. We did this to ensure Oxbridge House was clean, hygienic and a safe place for people to live. We reviewed a range of records. This included two person's care records and multiple medication records. We looked at three staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

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.

Using medicines safely
• Records did not evidence medicines were administered safely.
• Handwritten records were not double signed and had no quantities recorded, therefore we could not check if the stock still in the home matched what had come in and what had been administered.
• Some prescribed medicines had no Medication Administration Record (MAR).
• One person was prescribed a topical cream. There was no MAR chart in place and the body map stated a different direction than what was on the pharmacy label. We were also told this person self-administers this cream but there was no evidence to support this.

Assessing risk, safety monitoring and management
• Not all risks to people's health and wellbeing had been identified.
• Where people had a particular risk there was no care plan or risk assessment in place to support staff to lessen the risk.
• Care plans were not fully updated when people's needs changed.
• Fire drills were taking place monthly. However, night-time fire drills took place with day staff which was not a true reflection of how the service would perform in the event of a real fire. Records of the time it took to evacuate and any actions following the fire drills were not in place. Some people who used the service struggled with fire drills, yet no further support had been sought and offered. We have shared our concerns with the Cleveland Fire Brigade.
• Records showed equipment such as electrical safety, fire equipment and gas boilers were well maintained and serviced regularly.

We found no evidence that people had been harmed however, records were either not in place or robust enough to demonstrate medicines were safely managed or people were kept free from harm due to the lack of risk assessments and fire practices in place. These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Staffing and recruitment
• The home had safe recruitment practices.
• There were enough staff to meet people's needs. One person said, "There is enough staff, if you want to go out and do something, you can go, if you want to."
• Relatives raised concerns about the consistency of staff. Comments included, "I am not sure the staff are

open and hones as they keep changing, I don't know them well enough" and "[Name] seems to like the staff but they just seem to be different all the time."

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. Staff demonstrated a good understanding of recognising the signs of abuse and how and where to report it. We observed people appeared comfortable around staff and there was a relaxed atmosphere.
• People told us they felt safe and secure living at the home. Comments included, "Here is safe" and "The staff make me feel safe." Relatives said, "[Name] is definitely safe, it is the best place they have ever lived" and "I have no worries about safety, everyone is fantastic."
• Staff were knowledgeable about safeguarding processes and how to raise any concerns. One staff member said, "I know all about whistle blowing and would have no worries about doing it if I needed."

Learning lessons when things go wrong
• Accidents and incidents were few, however, they were recorded to see if any trends could be identified.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• 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 using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• 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.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

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
• Audit systems and processes had not identified the shortfalls we found. They did not highlight the concerns around medicine records, risk management and fire drills.
• Although there were polices and procedures in place to support safe care delivery, they were not always customised to the needs of the location. For example, the medicine policy needed to be updated to reflect the system the service was using and to include up to date guidance. The provider confirmed after the inspection that this would be updated straight away.
• Care records were cumbersome and repetitive and included information not relevant to the person. The two care records we looked at had information on schizophrenia yet neither person had this condition.

We found no evidence that people had been harmed however, records were either not in place or robust enough to ensure people were provided person centred care.
These findings evidenced a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Continuous learning and improving care; Working in partnership with others
• The service worked closely with external health care professionals. However, recommendations from them were not always followed. We were told emails had been received to say the recommendations had changed. No evidence to support these statements were available for us to review on the inspection day.
• One person was prescribed a food replacement milkshake, however there was no care plan or risk assessment for this. There was no information for staff to follow on how to encourage food before offering the milkshake.
• Health/hospital passports needed to be reviewed so they were relevant to the person. For example, they included information relating to women when it was for a man.
• Relatives we spoke with felt the service could improve. Comments included, "The thing they could change is better organisation and they could inform people better, I feel like I don't know anything, for example when his appointments are, I am kept in the dark and whether he is still on the same medication" and "It is not that well managed."

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

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were supported to create person centred timetables of activities and attended activities they valued and enjoyed. One relative said, "Good things are they keep [Name] busy and he is happy, lots of improvements could be made though, constant staff would make a big difference."
• People living at the service and their relatives had opportunity to provide their feedback through meetings and questionnaires. However, relatives said, "I have been asked to give feedback, but I never got any feedback from that so the next time they sent me one I didn't bother as I thought there was no point" and "I have been asked for feedback but I haven't had any feedback on that yet."

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 understood their role in terms of regulatory requirements. For example, the provider notified CQC of events, such as safeguarding's and serious incidents as required by law.
• The management team were open and responsive to our inspection feedback.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks and ensure the proper and safe management of medicines. Regulation 12 (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had appropriate systems in place to check and maintain good care. Regulation 17 (2) (a) (b) (c)