HC-One Limited

Oaklands (Essex)

Inspection report

Forest Glade
Dunton Hills
Laindon
Essex
SS16 6SX

Tel: 01268491491
Website: www.hc-one.co.uk/homes/oaklands-essex

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oaklands [Essex] is a residential care home providing personal and nursing care for people aged 65 and over. Some people were living with dementia. The service can support up to 55 people and at the time of our inspection there were 49 people living at the service.

People's experience of using this service and what we found
Information relating to people's individual risks was not always recorded or did not provide enough assurance that people were safe. Suitable arrangements were not in place to ensure the proper and safe use of medicines. The deployment of staff was not always suitable to meet people's care and support needs and concerns were raised about agency usage. Lessons were not learned, and improvements were not made when things went wrong. People were protected by the prevention and control of infection, but stale odours were observed on the first floor. Recruitment checks were generally satisfactory.

Not all staff employed at the service had completed their mandatory training. Though staff had completed an orientation induction, not all staff had completed a more robust induction. Some staff had not received regular formal supervision or an annual appraisal of their overall performance. Not all staff spoken with felt supported or valued by the management team. Best interest decisions were not always recorded where people had bedrails in place or a sensor alarm fitted to alert staff if they got out of bed and mobilised within their room. People at risk of poor nutrition and hydration were not properly and accurately assessed. Although the service worked with other organisations to ensure they delivered joined-up care and support, records suggested people did not always have access to healthcare services when needed. We have made a recommendation about this. People's comments about the food they received was positive.

People told us they were treated with care and kindness. Relative's comments about the level of care their loved one received was variable. This was attributed to agency staff usage and the impact on the quality of care people received. Concern was expressed regarding the amount of time staff spent completing paperwork and not interacting and talking with people. Many interactions by staff remained task and routine led. No-one spoken with had seen their own or their family member's care plan.

Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences. Where information was recorded this was not always accurate or up-to-date and evidence of staff interventions to demonstrate the support provided was not always recorded. End of life care plans were in place but provided limited information to guide staff on how to provide care to a person who was at the end stages of their life. People were not supported or enabled to take part in regular social activities that met their needs. Arrangements were in place to record, investigate and respond to any complaints raised with the service.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and

governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. There was a lack of understanding of the risks and issues and the potential impact on people using the service. We were not notified of all incidents as required by regulation. The Provider Information Return [PIR] which was submitted to us, portrayed an inaccurate picture of the service.

Rating at last inspection
The inspection was prompted by ongoing concerns raised by the Local Authority. A decision was made for us to inspect and examine those risks and concerns. We found significant improvements were required.

The rating at last inspection was good (published July 2018).

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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up
We will meet with the provider and request an action plan to understand what they will do to improve the standards of quality and safety. We will work alongside the provider, Local Authority and CCG to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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 effective.

Details are in our effective findings below.

Inadequate

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 responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Oaklands (Essex)

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.

Inspection team
The inspection team consisted of two inspectors on both days of inspection. Inspectors were accompanied on one day by an assistant inspector.

Service and service type
Oaklands [Essex] 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
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During 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 11 people who used the service, five relatives and one person who acted on a person's behalf about their experience of the care provided. We spoke with seven members of staff including; senior care staff and care staff. We also spoke with the service's chef, the registered manager, deputy manager and the area quality director. We also spoke with two visiting healthcare professionals. We reviewed 11 people's care files and four staff personnel files. We also looked at a sample of the service's quality assurance systems, the provider's arrangements for managing medication, staff training and supervision records, complaint and compliment records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further evidence from the area quality director of information relating to the service's staffing levels. We also received updated information relating to Legionella and heating equipment.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• Although staff had received moving and handling training, we observed six separate incidents where staff performed unsafe moving and handling practices. On three occasions staff placed people at potential risk of harm by placing their hands under people's armpits when assisting them to mobilise. This technique is unsafe, can hurt and cause injury because the person's armpits and shoulders have too much pressure on them.
• Not all staff were competent when using the stand aid hoist. Specifically, when supporting female persons to mobilise, staff were observed to place the sling across their breasts rather than under their breasts. This meant the person's breasts were flattened, causing the person discomfort and potential pain.
• Two staff assisted one person to transfer from their wheelchair to a sofa, but in doing so made the person lose their balance and fall onto the sofa. One member of staff assisted a person to mobilise on their own, but their care plan stated two staff were required. Following the inspection, the registered manager wrote to us advising all staff were booked to undertake additional manual handling training by 14 February 2020.
• 12 freestanding wardrobes were not secured to the wall. Retaining brackets to prevent the furniture falling or being pulled forward with a potential to cause injury and harm, were either loose or missing. We brought this this to the attention of the person responsible for maintenance. Immediate action was taken to make these safe.
• Environmental risks, for example, those relating to the service's fire arrangements were viewed. 10 people's bedroom doors were propped open by furniture or items of equipment, such as, walking frames. This compromised people's safety should a fire occur as it does not prevent the spread of fire and smoke. We told a senior member of staff about our concerns but they did not understand the potential seriousness and failed to take immediate action to minimise the risk.
• The Personal Emergency Evacuation Plan [PEEP] folder which was stored within the service's emergency 'grab bag' was not accurate or up-to-date. The folder contacted two PEEP's for people no longer living at Oaklands [Essex], There were no PEEP's for six people and 10 people did not have a completed 'Bedroom Fire Risk Assessment'.
• There were examples where risk assessments were not followed, did not exist or were not adhered to. For example, a person with known choking risks was not supported in line with their care plan for repositioning when eating or for consistency of food. Both were actions needed to reduce the risk.
• Another person had a pressure mat to alert staff if they moved independently [to avoid them falling]. However, this was under their bed and not plugged in. People using catheters did not have related risks identified such as blockages and urinary infections. This meant people had risks to their health and safety which were reasonably preventable but not being addressed.

Using medicines safely

• The Medication Administration Records [MAR] for ten out of 49 people were viewed. These were not in good order as they did not always provide an account of medicines used or demonstrated people were given their medicines as prescribed. This referred to unexplained gaps on the Medication Administration Record [MAR] forms, not everyone had received their prescribed medication and specific codes on the MAR form were not always used and recorded correctly.
• Where a variable dose of medication was to be administered, for example, one or two tablets to be administered, the specific dose given was not always recorded.
• Medication audits were completed each month. Where corrective steps were required, an action plan was completed but these were not signed off to confirm remedial actions had been addressed.

Effective arrangements were not in place to mitigate risks for people using the service or ensure medication practices were safe. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Staffing levels as stated by the registered manager were maintained during both days of inspection. However, the deployment of staff was not always appropriate. There were several occasions whereby communal lounge areas were left without staff support.
• People's and relative's comments about staffing levels were variable and concerns were raised about agency staff usage and the impact this had on people using the service. Where positive comments were recorded these included, "People do come quickly when I press my bell" and, "The staff come as quick as they can, I have a buzzer to push if I need it." Where less favourable comments were recorded, these included, "There's extremely high usage of agency staff now, it makes it unsafe on the floor, there just isn't enough staff. There's no one to answer the front door and when they [staff] answer it, it takes them away from the floor and this leaves residents vulnerable" and, "Having agency staff here is so hard on the residents, they just don't know people."
• One relative told us they had witnessed staff sometimes make promises to their relative which they were unable to keep because the service was short staffed. This referred to staff promising to give their family member a shower and then this did not happen.
• Staff told us they did not always have the time to sit and talk to people. One member of staff told us, "It would be nice to have more time to spend with the people we care for."
• People's dependency needs were assessed but not always accurate or up-to-date. Though the provider used a dependency tool to determine the service's staffing levels, this was last completed in September 2019.
• In general staff had been recruited safely to ensure they were suitable to work with vulnerable people; however minor improvements were required as not all gaps in employment had been fully explored.

Systems and processes to safeguard people from the risk of abuse
• People and relatives' comments about safety was variable. One person told us, "I wouldn't be here by choice, not because the place is bad, I would just rather be home, but I always feel completely safe here." A second person told us, "I don't really want to be here, it's not like home at all. I guess I feel safe." A relative told us, "I don't have confidence or trust [person] is safe."
• Staff had a good understanding of what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the management team, the organisation and external agencies, such as the Local Authority or Care Quality Commission.

Preventing and controlling infection
• The service was clean and odour free on the ground floor, however there was a strong odour of stale urine on the first floor throughout both days of inspection.

• Personal Protective Equipment [PPE] such as gloves, aprons and liquid soap were available to staff to prevent and control infection.
• Most staff had completed infection control training and understood their responsibilities.

Learning lessons when things go wrong
• Findings at this inspection demonstrated the provider was not continuously learning and improving from similar shortfalls and failings identified at their other service's in Essex. As a consequence, there has been no lessons learned to drive improvement and ensure the quality and safety of the service.
• Where concerns were raised through the service's complaints procedures, any improvements made were not sustained.
• Though audits and action plans were in place which had identified some of the shortfalls as evidenced within this report, actions to be taken and how these were to be monitored were not recorded.

Inadequate

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
• The meal time experience was varied and staff did not always pick up if people had the opportunities to eat at a table, if they were eating and/or if they had had enough. The registered manager provided assurances that more food was always on offer, however our observations did not see this in practice during our time in the service.
• There was also a reliance on relatives to support people to eat on the first floor. Three relatives told us they felt duty-bound to visit every day to ensure their family member received enough food and drink to meet their needs. One relative told us, "I worry when I go home, I shouldn't be worrying."
• Following the inspection, we were advised of an incident whereby one person's relative was given their lunchtime meal but this was placed by staff, 18 inches away from the table. This meant the person was unable to reach their food. The relative told us, "[Person] just sat there." The relative could not tell us anymore as they became tearful.
• People at risk of poor nutrition and hydration were not adequately assessed. The Malnutrition Universal Screening Tool [MUST] for some people was incorrect. MUST is a screening tool used to identify adults who are malnourished, at risk of malnutrition or obese. Following the inspection, the registered manager wrote to us and confirmed based on the Care Quality Commission's findings, people's MUST scores had been reviewed.
• Where people were at risk of poor nutrition, their weight was not always monitored at regular intervals and appropriate healthcare professionals, such as dietician were not consulted for support and advice.

This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• The staff training summary demonstrated there were gaps in some staff member's training. For example, one member of staff employed in December 2019, had 27 courses assigned but their target date for completion had expired, with some courses in progress and others assigned but not yet commenced as part of their online learning. In total only four training courses were recorded as having been completed. This was similar for two other people who's training summary was viewed as part of the inspection process.
• Where staff had attained a National Vocational Qualification [NVQ] or qualification under the Qualification and Credit Framework [QCF]; and had limited experience in a care setting, not all staff had completed the 'Care Certificate'. This was confirmed as accurate by the registered manager. The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life.

• The supervision planner for 2019 showed not all staff had received regular formal supervision. Records viewed confirmed this. Not all staff had received an appraisal in 2019. Not all staff felt valued and supported by the existing management team or organisation. Staff comments included, "I don't feel supported by the manager or deputy manager, they are not effective" and, "I would not feel confident to talk to the management team, I don't feel they would listen to me."

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Although there was some evidence to suggest the service worked with other organisations to ensure they delivered joined-up care and support, records demonstrated people did not always have access to healthcare services and interventions when needed.
• One person's relative told us they had had to ask staff and the management team to request a GP appointment, three times over a two-day period for their family member. Records available showed this was accurate.
• People's oral healthcare needs were not always assessed and recorded. Oral dental care was not a priority. For example, the care records for one person suggested staff had not assisted them to brush their teeth for the month of January 2020. This was discussed with staff, but they were unable to provide a rationale for the absence of records and could not tell us if the person had their own teeth or wore dentures.
• One person's care plan identified them as requiring a referral to a dentist. No evidence was available to show this had been followed up.

We recommend the provider seek advice and guidance to ensure clear arrangements are in place for seeking medical advice and support at the earliest opportunity and working collaboratively with other organisations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to their admission to the service. The quality of the assessments was inconsistent.
• People's protected characteristics under the Equalities Act 2010, such as age, disability, religion and ethnicity were identified as part of their need's assessment. Staff knew about people's individual characteristics.

Adapting service, design, decoration to meet people's needs
• Improvements to the service were required to make the first floor 'dementia friendly'. There was a lack of visual clues and prompts to promote people's orientation. For example, not all people's room displayed their name or any other visual clue to help the person to orientate themselves.
• On the first day of inspection the temperature within the main communal lounge felt cold. Three people confirmed they were cold, and five people had a blanket placed over them. The person responsible for maintenance told us the underfloor heating had not been working properly since 13 December 2019 but this had been reported to the provider. However, at the time of inspection these works remained outstanding. We discussed this with the Area Quality Director and further enquiries were made. Prior to us leaving the inspection we were advised works would be undertaken the following week. We asked to be notified once done. The Area Quality Director wrote to us on 6 February 2020, confirming a temporary heating solution was in place and the communal lounge was now warm.
• There was a lack of comfortable chairs for people in the communal lounge on the first floor. On both days of inspection, eight people only were able to sit in a comfortable chair, 10 people were noted to sit on dining

chairs from breakfast until they were assisted to bed.
• People living on the ground floor had personalised rooms which supported their individual needs and preferences. However, some people's bedroom on the first floor was noted to be sparse.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Staff demonstrated a basic understanding of MCA and DoLS and how this impacted on people using the service.
• People's capacity to make decisions had been assessed and these were individual to the person. However, best interest decisions were not recorded where people had bedrails in place, a crash mat to stop them from injuring themselves if they rolled out of bed or a sensor alarm fitted to alert staff if they got out of bed and mobilised within their room.
• Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Requires Improvement

Is the service caring?

Our findings

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

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 people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• People's comments about the quality of care and support they received was positive. Comments included, "The staff that care for us are faultless, they are so kind. I can talk to the staff, they always call me [name of person using the service], it makes me feel at home", "I suppose the staff are okay, you get used to them" and, "I've got no complaints, it's alright."

• Variable comments were made by relatives and those acting on people's behalf about the quality of care provided. Positive comments included, "Staff are friendly, and people are looked after well", "Can't fault the carers, they are amazing" and, "The staff are brilliant." However, not all relatives were complimentary regarding the level of care and support provided for their loved one or friend.

• Relatives and staff told us the high use of agency staff impacted on the quality of the care people received. Concern was expressed regarding the amount of time staff spent completing paperwork and not interacting and talking with people. One relative told us, "They [staff] are doing so much paperwork, they aren't able to do as much caring." Relatives did not feel their family member always received proper care or personal care, such as, regular baths or showers and proper oral healthcare. Observations and Information available as highlighted within this report, demonstrated people's comments were accurate.

• Care provided was primarily focussed on routines and tasks. Staff told us they did not always have time to sit and talk with people for any meaningful length of time. There was an over reliance on the television or listening to music, despite some people being asleep or disengaged with their surroundings and not watching the television.

• Staff including the deputy manager and some senior members of staff referred to people by their room number rather than by their name. This demonstrated a lack of respect and dignity for the people they supported.

• Where positive interactions took place, we observed support provided by staff as caring and kind. During these exchanges people were noted to have a good rapport with staff and there was much good humour and banter.

• People were supported to maintain and develop relationships with those close to them. Relatives confirmed there were no restrictions when they visited.

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

• Few people had seen their or their family member's care plan. One relative told us, "Although I have not asked to see X care plan, I have not been asked to contribute to this." Another person who acted on one person's behalf stated when the person had first moved to Oaklands [Essex] they were informed that a

formal review would take place, but this had not happened.
• People and those acting on their behalf had been given the opportunity to provide feedback about the service through the completion of questionnaires in 2019.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

• Findings at this inspection demonstrated people did not always receive care and support that was personalised and responsive to meet their needs. For example, one person remained in the communal lounge on the ground floor to have their lunch. Their plated meal was placed in front of them but over a 25-minute period we saw them repeatedly push their untouched plate of food away and pick up their empty glass. Despite staff walking past the communal lounge, no staff entered to help or enquire why the meal was untouched. We brought this to the registered manager's attention, whereby it was established the person was unlikely to eat their meal because of the vegetables placed on their plate. This was not recorded within their care plan and not known by staff. An alternative meal choice was later provided which the person enjoyed.

• One person's seven-day care plan stated they should be tested for a Urinary Tract Infection [UTI] if they became anxious and distressed. During the inspection the person was observed to be anxious and distressed, but no action was taken to establish if they had a UTI. When discussed with staff they confirmed they were unaware of the above actions to be taken.

• On the second day of inspection two people were observed to argue, with one person being unfriendly and unkind to another person. This was ignored by staff despite a member of staff sitting within the dining room completing paperwork.

• Care plans were not up-to-date or reflective of people's current care needs. The care plan for one person stated they did not have a catheter in place, but this was not accurate as the person had a catheter in place. Another person's care plan referred to them using a walking frame to mobilise, however the person was now immobile. The lack of up-to-date and accurate information placed people at potential risk of receiving care that did not meet their needs.

• Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences.

• Where people could be anxious and distressed and exhibit inappropriate behaviours towards others, information relating to known triggers and specific guidance for staff on how best to support individuals was not recorded. Where information was recorded relating to specific incidents, evidence of staff interventions to demonstrate the support provided and outcomes was not always recorded or appropriate.

• People's care plans had limited information about their wishes and preferred priorities, such as their spiritual and cultural needs at the end of their life. Without this information, staff would be unable to ensure people's wishes at the end of their life were respected. The provider had produced a seven-day plan to assess and monitor people's care, treatment and wellbeing at the end stages of their life, however these were not completed.

• Following the inspection, the registered manager wrote to us and confirmed based on the Care Quality Commission's findings, they were in the process of reviewing all care plans within the service.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People's comments about activities provided were not positive. People told us, "I stay in my room and don't do much" and, "I don't get involved in anything that goes on here, not that there is a lot going on. I went to the lounge once, but it was like god's waiting room and everyone had one foot in the grave." One person on the ground floor was overheard to say out loud, "There's nothing to do, why is there nothing to do, god it is miserable here."
• Relatives comments were equally not favourable. They told us there were minimal social activities offered and available for people to participate in, particularly for people living with dementia on the first floor. No activities were provided on the first day of inspection, and on the second day of inspection the person responsible for facilitating activities was observed to play music prior to lunch being served. Three relatives told us this was very unusual. One person asked the activities facilitator as to what was happening, they replied, "Nothing, just listening to music."
• Activities on the ground floor were sporadic and not always well planned and thought out. Two short quizzes took place on the first day of inspection, facilitated by a senior member of staff and the person responsible for activities. The quizzes were very similar, and few people participated.
• In the afternoon a DVD was put on, however no-one was consulted relating to the film choice. Shortly after the film commenced, the activities facilitator and three members of staff started to talk to people. The noise within the communal lounge was overwhelming which meant it was difficult for people to hear what was being discussed during conversations with staff and people trying to watch and listen to the film were distracted and could not hear the film properly. The registered manager entered the communal lounge and proceeded to offer people ice cream. We intervened and suggested the film should be paused to enable the latter to be undertaken and staff should hold their conversations elsewhere or after the film had finished. We discussed the above with the registered manager. Activities were planned better on the second day of inspection, but activities only took place in the morning.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• We did not see enough evidence of how AIS had been applied. The activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.

Improving care quality in response to complaints or concerns
• Arrangements were in place to record, investigate and respond to any complaints raised with the service. Since January 2019, the complaints log showed the service had received five complaints. These related to concerns about the level of care people received, lack of social activities for people using the service and agency staff usage. Each complaint had been investigated and responded to. Though this was positive, there was a lack of evidence to demonstrate lessons learned and learning outcomes to make the required improvements.
• A record of compliments was maintained to capture the service's achievements. One compliment

recorded, "[Name] had lived at Oaklands for three and a half years and the care they received was excellent, but especially so during their last few weeks."

• 10 compliments relating to the quality of care people received at Oaklands [Essex] were recorded on a well-known external website. However, two reviews recorded the level of care at the service was poor and they could not recommend the service to others. Concerns raised were similar to issues found at this inspection.

Inadequate

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

• The leadership and overall management of the service did not ensure it was consistently well-managed and led at both provider and service level.

• Findings at this inspection demonstrated the provider was not continuously learning and improving from similar shortfalls and failings identified at their other service's in Essex.

• Quality assurance and governance arrangements at Oaklands [Essex] were not reliable or effective in identifying shortfalls in the service. Specific information is cited within this report and demonstrated the provider's arrangements for identifying and managing these and areas for development were not robust and required significant improvement. There was a lack of understanding of the risks and issues and the potential impact this had on people using the service and those acting on their behalf.

• The Provider Information Return [PIR] which was completed and submitted to us on 5 December 2019, portrayed an inaccurate picture of the service. This failed to demonstrate the provider's and registered manager's duty of candour in respect of openness and honesty.

• Bi-monthly 'Home Visit Reports' by either the area director, area quality director or both, were reviewed for August, October and December 2019. The reports for August and October 2019, identified some of the issues highlighted as part of this inspection. Namely, improvements required to care planning, record keeping and lack of social activities. An action plan was not completed detailing how these were to be monitored and addressed. This demonstrated arrangements to assess and monitor the quality and safety of the service provided was not as effective as it should be, particularly as there was no reference to staffs care practice and the delivery of care provided.

• 'Out of Hours and Weekend Visit Reports for 16 November and 7 December 2019 and 3 January 2020, highlighted no areas for improvement. However, ongoing concerns about care provision had been identified by the Local Authority following their visits to the service in December 2019, January and February 2020 and from this inspection by the Care Quality Commission. .

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

• The registered manager was promoted to this role in March 2019. The registered manager told us they received support from the area director and area quality director but recognised a lot of ongoing support was being provided to other 'sister' services owned by the organisation. The registered manager had only

received one supervision since their appointment in November 2018, despite being new to this role.
• The Care Quality Commission was not notified of all incidents as required by regulation. Following the inspection, we were notified via an external source of an incident in August 2019, whereby one person required medical intervention. Neither the Local Authority or Care Quality Commission were notified of this incident. An internal investigation was not completed by the registered manager to look into the circumstances of the incident to ensure lessons learned.
• Suitable role models were not available to provide support and guidance to staff and to enable them to effectively carry out their roles.
• Not all staff spoken with were aware of the provider's vision and values or where this information was recorded.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's and relatives' views about the quality of service provided. A quality assurance questionnaire and subsequent report was completed in June 2019. The report detailed 67% of people stated the overall impression of Oaklands was either excellent or good and 33% of people rated the quality of the service as average. The report detailed 100% of relatives stated the overall impression of Oaklands was either excellent or good.
• Relatives told us they were aware of 'relatives' meetings but not all felt able to raise concerns. One relative told us, "I haven't raised any issues with them [registered manager] as I don't think it'll help." A second relative told us, "I don't have confidence to raise concerns." Relatives told us they had raised issues relating to the service's laundry arrangements, but these had not been addressed to a satisfactory outcome. Specifically, this referred to missing laundry and others wearing their loved one's clothes despite being labelled with their name.

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Working in partnership with others
• There was limited engagement with other organisations, agencies or networks to share best practice, expertise or resources to improve the service and deliver a good experience of care for people. Following the inspection, the registered manager wrote to us and confirmed the Local Authority had agreed to provide care planning training for staff on 11 February 2020.