Eco Wings & Nights Limited

Eco Nights

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

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.

About the service
Eco Nights is a respite service providing accommodation and personal care for up six younger people who have a learning disability and/or living with autism. On our first 'out of hours' visit the service was supporting two people and at the time of our second 'out of hours' visit the service was supporting seven people. One person was undertaking a teatime visit and not staying the night.

People's experience of using this service and what we found
Right Support
• The service recorded when staff restrained people. However, improvements were required to demonstrate staff's interventions prior to restraint being used and lessons learned to show how staff learned from those incidents and how they might be avoided and reduced.
• The service is a large bungalow which enables people who use the respite service to access the community. The premises is situated within the local community and did not feel unfriendly, intimidating or institutionalised.
• People were able to use communal areas as they wished and to have privacy for themselves if they chose to be alone.
• Each bedroom at Eco Nights was decorated to a specific theme. The provider's representative stated people had been involved in choosing the theme.
• Staff enabled people to access healthcare provision and services as needed in consultation with their relatives.
• Staff supported people with their medicines.

Right Care
• Staff understood how to protect people from harm and abuse. Where internal investigations were completed, improvements were required to ensure these were robust.
• People received appropriate care that was kind, and which met their needs. However, we were concerned that an agency member of staff used at Eco Nights, did not know the names of two people they supported or the gender of one person. Profiles for people using the service were evident but not for all people being supported on our second 'out of hours' visit to Eco Nights. The agency member of staff confirmed they had not read the profiles.
• People's care and support plans reflected their range of needs. Risks to people were assessed and recorded. Where appropriate, people were supported to take positive risks.
• People who had individual ways of communicating, using body language, sounds, objects of reference and

Makaton, could interact with staff.
• The service had enough staff to meet people's needs. Steps were being taken to recruit permanent members of staff so as to reduce reliance on staff from the provider's 'sister' services and staff from external agencies.

Right culture
• The service's quality assurance, monitoring and oversight arrangements required improvement.
• Staff were not aware of the ethos and values of the provider or the principles of 'Right support, Right Care and Right Culture'.
• Despite not all staff having up to date training, people received appropriate care. The provider and their representative told us staff had not received updated training due to the COVID-19 pandemic.

We have made recommendations about safeguarding investigations and the security of COSHH items.

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 [published October 2019].

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support, right care, right culture.

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.

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.

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**

Care Quality Commission

Eco Nights

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 completed by one inspector.

Service and service type
Eco Nights is a residential respite care service providing accommodation and personal care. 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 announced. We gave the service 48 hours' notice of the inspection because most people using the service attended the provider's day care service and we needed to be sure that the provider [who is also the registered manager] or their representative would be in the office to support the inspection.

Inspection activity started on 6 July 2022 and ended on 27 July 2022. We visited the respite service on 6 July 2022 and completed additional 'out of hours' visits on 11 July 2022 and 20 July 2022, so that we could speak with people using the service and staff. We spoke with people's relatives on 27 July 2022.

What we did before inspection
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.

During the inspection
We spoke with two people who used the service and six people's relatives about their experience of the care provided. Not all people who used the service were able to verbally communicate with us as they used different ways of communicating, including using Makaton, objects of reference and their body language. We spoke with three members of staff including the provider's representative who managed the service on a day to day basis.

We reviewed a range of records. This included six people's care records and three people's medication records. We looked at three staff files in relation to recruitment, induction and staff supervision. A variety of records relating to the management of the service, including staff training data and quality assurance records were viewed.

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 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Safeguarding concerns were reported to the local authority and Care Quality Commission to protect people from abuse and harm. Although a record of the issues was maintained, internal investigations were not routinely undertaken or robust to demonstrate improvements and lessons learned. This was discussed with the provider's representative at the time of inspection. They told us they would discuss this with the registered manager to ensure required improvements were made going forward.
• When people became anxious and distressed, the service recorded when staff restrained people. However, improvements were required to demonstrate staff's interventions prior to restraint being used as it was unclear if restraint was used as a last resort. There was little evidence of lessons learned to show how staff learned from these incidents and how they might be avoided and reduced.

We could not be assured that appropriate arrangements were in place to protect people from unlawful restraint. This was a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• There was no impact for people using the service but not all staff who worked at Eco Nights had completed or updated their training relating to protecting people from harm and abuse.
• Relatives told us they had no concerns relating to their family member's safety. Comments included, "Yes, I do feel [Name of person using the service] is safe, I have peace of mind when I drop them off to Eco Nights", "Definitely, they are safe" and, "They [relative] are as safe as can be."
• Staff were able to tell us about the different types of abuse and describe what actions they would take to protect people from harm. Staff stated they would escalate concerns about a person's safety to the management team and external agencies, such as the Local Authority and Care Quality Commission.

Assessing risk, safety monitoring and management
• Risks to people using the service were not being managed to reduce the risk of exposure to or harm from substances categorised as 'hazardous to health' under the Control of Substances Hazardous to Health [COSHH] regulations. On the first day of inspection, potentially harmful substances used within the service were not stored appropriately. We brought this to the provider's representative's attention and immediate action was taken to remove the items.
• On the second out of hours visit to Eco Nights, the keys to the laundry room were left in the lock. COSHH items were stored within this area and easily accessible. This placed people at risk of potential harm.

We recommend the provider refers to current guidance or seeks advice from a reputable source to ensure the security of COSHH items is always maintained.

• Evidence to demonstrate current and emerging risks presented by the pandemic had not been identified for individual staff members. This meant staff who may be at increased risk of contracting COVID-19, for example, those with underlying health conditions or from ethnic minority groups had not been assessed. Where staff were working between different settings, a risk assessment to mitigate the spread of COVID-19 had not been considered or completed.
• Risks to people's safety and wellbeing were assessed and recorded for people using the service.
• Risks relating to the service's fire arrangements were monitored and included individual Personal Emergency Evacuation Plans [PEEP] for people using the service. However, staff employed at the service had not participated in regular fire drills. Fire drills allow staff to practice evacuation procedures to ensure they are fully aware of how to safely exit the building and to test the PEEP's.

Preventing and controlling infection
• The provider was not following up-to-date government guidance on how to operate safely during the COVID-19 pandemic. Not all staff were using Personal Protective Equipment [PPE] effectively and safely. Although there was no outbreak of COVID-19 when we completed a second out of hours visit to the service, neither member of staff wore a face mask.
• On the second out of hours visit to the service, staff failed to request evidence of the inspector's proof of their rapid lateral flow test prior to allowing them to enter the service.
• Communal toiletries and topical creams were seen in the main bathroom. We could not be assured people had their own products to reduce the risk of cross infection from one person to another. This was discussed with the provider's representative at the time of inspection and all items were removed.
• Not all staff who worked at Eco Nights had completed or updated their training relating to infection, prevention and control. Not all staff had completed COVID-19 training or received training relating to the 'donning and doffing' of Personal Protective Equipment [PPE]. This refers to how to safely put on and take off PPE.
• Staff confirmed there were sufficient supplies of PPE at the service. The respite service was clean and odour free.
• We were assured the provider was accessing testing for people using the service and staff.

Staffing and recruitment
• Staffing levels told to us were being maintained for the numbers of people using the service. Relatives raised no concerns about staffing levels or their family member's needs not being met. However, comments were raised about the high usage of agency staff and a wish for more permanent staff to be employed at Eco Nights. The provider's representative confirmed a recruitment drive was in place to employ permanent staff.

• Staff rosters confirmed there was a lack of permanent staff employed at Eco Nights. At the time of inspection five members of staff from the provider's day care service were intermittently deployed at the respite service.
• The staff rosters showed agency staff were routinely deployed to Eco Nights to plug staffing shortfalls. The provider's representative confirmed a regular core group of agency staff were used at the service. This was to ensure they knew the needs of the people they cared for and supported. On the second out of hours visit, the agency member of staff on duty did not know the names of two people using the service and referred to one person by their wrong name and gender.
• Minor improvements were required to the provider's recruitment practice and procedures. There was one written reference and no Disclosure and Barring Certificate [DBS] for one applicant. The DBS provides information including details about convictions and cautions held on the Police National Computer. The

information helps employers make safer recruitment decisions. The applicant's health screening form was completed after they commenced in post.

Using medicines safely

• Medicines were stored safely and securely. Medication Administration Records [MAR] were viewed for three people. These were in good order, provided an account of medicines used and demonstrated people were given their medicines as specified by the prescriber.
• Relatives spoken with raised no concerns relating to medicines management. One relative told us the provider had gone above and beyond what might normally be expected where difficulties had arisen with the manufacturer to obtain certain medicines for their family member.
• Where people were prescribed PRN [when required] medication, people using the service did not have a PRN protocol in place. This provides information about what the medicine is for, symptoms to look out for and when to offer the medicine.
• Suitable arrangements were in place to ensure staff who administered medication were trained. However, not all staff who administered medication had had their competency to administer medication assessed.

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. Any conditions related to DoLS authorisations were being met.
• Where people had a lap belt in place to keep them safe and where one person's electronic equipment was held in the office, reasons for the restriction were not recorded to evidence these had been agreed as part of 'best interest' procedures. A 'best interest' assessment determines the person's wishes and whether any restrictions in place are in the person's best interest. Following the inspection the provider's representative confirmed action had been taken to address this.

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.

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 provider's representative confirmed information was collected in a variety of ways to regularly assess and monitor the quality of the service provided. This included the completion of audits at regular intervals to help identify and manage risks to the quality of the service and to help drive improvement.
• Although there was no impact for people using the service, the arrangements to assess and monitor the service required improvement. There were missed opportunities to mitigate risks and to monitor trends and lessons learned. The provider had failed to identify the areas for improvement found as part of this inspection.
• We found one person was exposed to restrictive practices. Documented reasons for the restricted practices were not recorded detailing the impact of the restriction or to evidence the restrictions had been agreed as part of 'best interest' procedures. Following the inspection the provider's representative confirmed action had been taken to address this.
• A core group of agency staff were deployed to Eco Nights to ensure appropriate staffing levels were maintained. Although there was an agency profile available confirming all required recruitment checks had been completed by the external agency, not all training remained in date and this had not been picked up by the provider so as to enable them to contact the external agency. For example, one agency member of staff's training relating to infection, prevention and control, first aid and safeguarding had expired in May 2022.
• There was no evidence of a formal induction or training completed for the newest member of staff employed at Eco Nights. The provider's representative told us the member of staff had been invited to attend their induction and to complete online training. Following supervision, a target date was set for them to complete their training but this and completion of their induction remained outstanding, despite them being employed since March 2022. No evidence of induction was available for 10 out of 12 agency staff used at the service.

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

• Staff were not aware of the 'Right support, right care and right culture' principles that should underpin their

day to day working practices. Not all staff working at Eco Nights had evidence of training attained relating to the people they support. For example, specialist training in autism or the care of people who have a learning disability.
• The registered manager was aware of their regulatory responsibility to submit statutory notifications to the Care Quality Commission. However, the provider and their representative had not reported an incident in March 2022, involving the police. No information was recorded to confirm if this incident had been reported to the local authority.
• Staff were clear about their day to day roles and responsibilities, with the person in charge on each shift taking the lead.
• Staff felt supported and valued by the registered manager and the provider's representative. One member of staff told us, "[Name of registered manager and the provider's representative] are really great and supportive. I get the support I need; you can always contact them."
• Relatives were complimentary regarding the management of the service, particularly the provider's representative who was in day to day charge of the respite service. Comments included, "[Name of provider's representative] is absolutely superb" and, "[Name of provider's representative] is very supportive and understanding and if you need advice, they are there for you. They bend over backwards and are interested in the young people they support."
• Relatives confirmed communication with the registered manager and the provider's representative was very good. Relatives stated they were responsive when answering and replying to telephone and email messages. Comments included, "[Name of provider's representative] is very good and she communicates well with me" and, "Communication is great, no concerns."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Relatives told us after their family member received respite care at Eco Nights, they received a detailed report outlining their experience. Relatives stated the information received was informative and if they had any queries, they could either contact the registered manager or the provider's representative.
• All relatives spoken with confirmed they were periodically asked to complete a satisfaction survey. This enabled the provider to gain feedback about the service provided, to build and maintain positive relationships, establish effective communication and to monitor trends.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service.

Working in partnership with others
• Information available showed the service worked in partnership with people's relatives, key healthcare and adult social care organisations and professionals.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We could not be assured that appropriate arrangements were in place to protect people from unlawful restraint.