Care Quality Commission

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 effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection was completed on 8 July 2015, 17 July 2015 and 4 August 2015. Eco Nights provides pre-planned short term respite care for younger adults aged between 19 and 30 years of age. This may include younger adults who have a range of complex needs such as learning disability, autism and physical disability. Respite care can be arranged on a 'one off' or a regular basis. It can also be arranged for short periods of time (such as a few hours) or for longer stays such as a weekend or a week or longer. At the time of the inspection 36 people were using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's health and wellbeing were not appropriately assessed and required improvement.

There were insufficient numbers of staff available to meet people's needs.

Summary of findings

People were cared for by staff that were well trained and had the right knowledge and skills to carry out their roles. However, improvements were required to ensure that newly employed staff received a comprehensive induction.

Some aspects of care planning were not detailed and did not provide an accurate description of people's care and support needs. The management of medicines within the service was not safe and required improvement. Appropriate assessments had not been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected.

The provider's quality assurance arrangements were not appropriate to ensure that where improvements to the quality of the service were identified, these were addressed.

Staff had a good understanding and knowledge of safeguarding procedures and were clear about the actions they would take to protect people. Appropriate recruitment checks were in place which helped to protect people and ensure staff were suitable to work at the service. Staff felt well supported in their role and received regular supervision.

People's healthcare needs were supported and people had access to a range of healthcare services and professionals as required.

People were supported to be able to eat and drink sufficient amounts to meet their needs. The dining experience was positive.

People were treated with kindness and respect by staff. Staff understood people's needs and provided care and support accordingly. Staff had a good relationship with the people they supported.

There was an effective system in place to respond to comments and complaints.

You can see what actions we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe.

Medicines management required improvement so that people received their prescribed medication as they should and to ensure that it was kept in a way which maintained its quality.

Improvements were required to manage risks to people's safety.

We could not always be assured that there were sufficient staff to meet people's needs.

Staff knew how to recognise and report abuse to safeguard people and recruitment practices were safe.

Requires improvement

Is the service effective?
The service was not consistently effective.

Where people lacked capacity, records showed that decisions and restrictive practices had not been made in their best interests.

Improvements were required to ensure that staff received an induction.

Staff were trained and supported to carry out their roles and responsibilities.

The dining experience for people was positive.

Requires improvement

Is the service caring?
The service was caring.

People were treated with dignity and respect.

Staff interactions with people was positive and the atmosphere within the service was relaxed and calm.

Good

Is the service responsive?
The service was not consistently responsive.

Not all people's care plans were sufficiently detailed or accurate.

People had limited opportunities for community access that met their individual needs.

Complaints were managed well.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

The provider's systems to check the quality and safety of the service were poor and had not identified shortfalls in the quality of the service.

Requires improvement

Eco Nights

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 July 2015, 17 July 2015 and 4 August 2015 and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we reviewed the Provider's Information Report (PIR). This is information we have asked the provider to send us to evidence how they are meeting our regulatory requirements. We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

Not all people who received respite at the service were able to verbally communicate with us. We spoke with three people who used the service, four relatives, six members of staff, the current registered manager and a newly appointed manager who will be proposed as the registered manager for Eco Nights in due course.

We reviewed seven people's care plans and care records. We looked at the service's staff support records for four members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments, safeguarding and quality monitoring an audit information.

Requires improvement

Is the service safe?

Our findings

We found that the arrangements for the management of medicines were not consistently safe. We found that the temperature of the area where medicines were stored was not monitored and recorded each day whilst people received respite care. This meant that there was a risk that people's medication was not always kept in a way which maintained its quality.

There had been confusion and uncertainty about one person's medication at the time of their respite stay. The person's medication had not been received at the service in its original container. This meant there was no information to show that it had been supplied and labelled by the dispensing pharmacy or GP practice to show who it was prescribed for and the specific dose to be administered. Although the medication administration records [MAR] showed that the person was administered a lower dose until contact had been made with the person's relative, additional efforts to clarify the details with the prescriber, for example, GP, pharmacist or NHS Direct had not been considered. This meant that the person had not received all of their prescribed medication at the time they should and arrangements to clarify the person's regular medication from their family had not been sought in advance of their respite stay. The medication administration records [MAR] for two people showed that there were unexplained omissions giving no indication of whether people had received their medicines or not, and if not, the reason why was not recorded.

Staff involved in the administration of medication had received appropriate training and competency checks had been completed.

We found that appropriate arrangements were not in place to manage risks to people's safety. Although risks had been identified and staff were aware of these in relation to people's health and wellbeing, for example, the risk of choking, experiencing seizures as a result of a medical condition, at risk of poor nutrition or risks relating to people's nutritional regime through a tube, the risk assessments in place were not clear. Improvements were required as information relating to the specific nature of the risk to the person and the steps to be taken by staff to alleviate the risk were not robust or recorded.

People's care plans included information relating to their specific care needs and how they would like to receive their care and support. However, we found that improvements were required. Where some people could become anxious or distressed and their care plan referred to distraction or de-escalation techniques to be used by staff to ensure the person's and others safety and wellbeing, these were not recorded. The care plan for one person referred to them having a specific procedure in place relating to a life threatening medical condition and for staff to follow this procedure at all times. At the time of the inspection this could not be located and when discussed with the manager we were advised that the procedure had been requested from a healthcare professional approximately two to three months earlier but had yet to be received. The manager confirmed that no action had been taken to follow this up. In addition, we found that out of six manual handling assessments viewed, only one had been up-dated. Two assessments were written in 2009 and 2013 respectively and three people who required significant assistance with their manual handling needs did not have a manual handling assessment in place. We discussed the latter with the manager and they could not provide a rationale as to why these were not available within the individual's care plan. This showed that there was a risk that people may not have received personalised and responsive care in line with their needs.

We found that the registered provider had not ensured that people's assessments included all of their needs and that the information had been reviewed to assure themselves that it remained relevant.

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

The manager confirmed that staffing levels at the service were not calculated using a formal dependency tool to determine the number of staff required. They stated that the decision about staffing levels was made by the management team based on their knowledge of the person and what they felt would best meet the needs of the person to be supported and the safety of the staff. Not all staff felt there were sufficient staff on duty. Staff told us that up until recently there had been occasions whereby people had been left in the communal lounge whilst staff provided personal care for another person or were cooking in the kitchen. This meant that there were times when there were insufficient staff to meet people's needs safely. Our

Requires improvement

Is the service safe?

observations showed on the second day of inspection that there were sufficient staff available to meet people's needs. However, on review of the staff rosters, these suggested that there were insufficient staff on site as these did not identify which staff provided one-to-one support to enable people to access the local community and the daily management arrangements.

Relatives told us that their member of family was kept safe when they received respite care. One relative told us, "I have no concern about [Name of person who uses the service] safety." Staff told us that they felt people were kept safe at all times. Staff were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Staff were confident that the registered manager would act appropriately on people's behalf. Staff also confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if required.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for two members of staff showed that the provider had operated a thorough recruitment process in line with their policy and procedure. This showed that staff employed had the appropriate checks to ensure that they were suitable to work with the people they supported.

Requires improvement

Is the service effective?

Our findings

Staff confirmed that they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. However, not all staff were able to demonstrate that they were knowledgeable and had an understanding of MCA and how this should be applied. Records showed that each person who used the service had not had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had not been recorded. Where restrictive practices were in place to keep people safe, for example, the use of lap belts on wheelchairs to prevent people from falling out and a camera to monitor one person at night, these had not been recorded to demonstrate that these actions were in the person's best interests. We discussed this with the manager and they confirmed that they were not aware that the above actions should be applied in line with appropriate legislation.

The arrangements for the administration of covert medication for one person had not been assessed and agreed in their best interest by the appropriate people involved in their lives, for example, pharmacist and GP. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink. We discussed this with the manager and they confirmed that they were unaware that the above actions should be applied in line with appropriate legislation.

We found that the registered provider had not understood what they must do to comply with and act in accordance with the requirements of the Mental Capacity Act 2005.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with two members of staff and they confirmed that as part of their induction they had been given the opportunity to 'shadow' and work alongside more experienced members of staff. They stated that this had been helpful. However, we found that there was no record of induction available for two other members of staff, including the prospective new manager of the service. We discussed this with the registered manager and they assured us that a comprehensive induction had been completed and that these would be forwarded to the Care Quality Commission following our inspection. At the time of writing this report neither record of induction had been provided to us.

Staff told us that both face-to-face and e-learning training was provided. They had received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs to an appropriate standard.

Staff received supervision at regular intervals. They told us that supervision was used to help support them to improve their practice. Staff told us that this was a two-way process and records confirmed what staff had told us.

People told us and indicated by their non-verbal cues that they liked the meals provided. People were assisted and encouraged to choose what they wanted to eat and drink based on staff's knowledge of their likes and dislikes and by being offered suitable choices. Staff had a good understanding of each individual person's nutritional needs and how these were to be met. People's nutritional requirements had been assessed and documented. Where people required support and assistance to eat their meal or to have a drink, staff were observed to provide this with due care. However, staff told us that there were several occasions when the planned menu was not able to be adhered to as specific food items were not always available. Staff advised that they would often have to go out and buy bread and butter. Staff comments included that in these circumstances, "We have to make do."

People's healthcare needs were primarily managed by their relatives or those acting on their behalf. The manager advised that should people require medical assistance or interventions by a healthcare professional, this would be sought without delay and in conjunction with their member of family.

Good

Is the service caring?

Our findings

Relatives told us that they were happy with the care and support provided at the service. One relative told us, "[Name of person] appears really happy. They are happy to go to Eco Nights for respite and look as if they have had a good time when they return home. They always seem to have a smile on their face. We would know if they were not happy." Another relative told us, "[Name of person] loves going there [Eco Nights]."

Staff had a good rapport with the people they supported and we observed laughter and sociable banter which people enjoyed. We saw that staff communicated well with the people living at the service, for example, staff provided clear explanations to people about the care and support to be provided in a way that the person could easily understand. Relatives confirmed that the majority of staff worked at both Eco Nights and the provider's day care service, which their member of family also attended. They told us that this provided good continuity of care and meant that staff had a good knowledge and understanding of people's needs.

The manager advised and records showed that a variety of specialist communication aids and methods were being used to help aid people's communication with staff and others, for example, objects of reference, Makaton, symbols, pictures and gestures including eye pointing. In addition, specialist assistive technology was also being used to assist people who were unable to communicate using their own voice.

Staff demonstrated affection, warmth and care for the people they supported. Staff understood people's care needs and the things that were important to them in their lives, for example, members of their family, key events, hobbies and personal interests. People were also encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities.

Our observations showed that staff respected people's privacy and dignity. Staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to maintain their personal appearance so as to ensure their self-esteem and sense of self-worth by respecting people's choice and style of dress and hairstyle.

Requires improvement

Is the service responsive?

Our findings

We found that, where appropriate, those acting on people's behalf, provided and contributed information prior to the initial service being offered and agreed. The manager told us that the information was used to determine if the person's support needs could be met and to support the person's care plan. However, we found and the manager confirmed, that requests for up-dated information prior to a person's respite stay had not always been received from the relative or those acting on their behalf. Information forms in some cases had not been updated since 2013 and there was no information recorded to show what steps had been taken by the management team to follow this up. This meant there was a potential risk that some of the information recorded was out-of-date, not appropriate and people were at risk of receiving care and support that was not responsive to meet their needs.

Staff told us that information was shared through handover meetings and from discussions with senior members of staff. Staff also told us that they had access to people's care plans and associated records in paper format and via the service's computerised system.

Staff told us that the majority of people who received a respite service either attended school or attended day-care opportunities at the provider's own day-care service. Information about how a person liked to spend time engaging and participating in leisure activities was recorded within their individual care plan. These suggested that people liked both 'in-house' and 'community' based activities, for example, listening to music, watching the television, sensory stimulation and accessing the community. Staff comments about people accessing the community at weekends was variable. Staff told us that transport and suitable staffing arrangements did not always support and enable community based activities to take place, other than going for a walk to the local shops. This meant that people were not always supported to follow their hobbies and interests or take part in social activities at the weekend.

The provider had a complaints policy and procedures in place that ensured people's concerns were listened to. Relatives told us that if they had any concern they would discuss these with the management team or staff on duty. Relatives confirmed that they felt able to talk freely to staff about any concerns or complaints and were assured that if required these would be effectively dealt with.

Requires improvement

Is the service well-led?

Our findings

The provider used questionnaires for relatives and those acting on their behalf to seek their views about the quality of the service provided during the person's period of respite stay. The management team also monitored the quality of the service through the completion of a number of audits. Although these arrangements were in place, they were ineffective as they had not highlighted the areas of concern we had identified.

The provider did not have an effective system in place to manage medicines management safely or ensure that appropriate arrangements were in place to manage risks to people's safety. The manager confirmed that no medication audits were completed so as to ensure that medicines management was appropriate and people were kept safe. In addition, the management team demonstrated a lack of understanding of the key requirements of the Mental Capacity Act 2005 so as to ensure that people's human and legal rights were being respected. Some aspects of care planning and systems to ensure that information was accurate and up-to-date required reviewing and improvement. The provider did not have a system in place to check that records supported effective management of the service. The manager confirmed that no audits of the care records were completed so as to ensure that accurate information was available relating to the care people required to meet their needs. This meant that the systems in place for improving the service through governance and monitoring were not robust or effective to manage risk or ensure the health, welfare and safety of people who used the service.

The provider did not have an effective system in place to gain feedback from people or their relatives on the service provided for the purposes of continually evaluating and improving the service people received. The registered manager told us that following each period of respite, relatives were asked to complete a satisfaction questionnaire. The registered manager advised that these had not always been received from the relative or those acting on their behalf and at the time of our inspection only three completed questionnaires were available for us to view. There was no information recorded to show what steps had been taken by the management team to follow these up or to explore alternative ways of engaging with relatives. The registered manager confirmed that no action had been taken.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where the provider must notify us about certain events or incidents that affect the health, safety and welfare of people who use services, these had not been completed and forwarded to us. This was discussed with the registered manager and an assurance was provided that this would be addressed for the future.

Neither the registered manager or proposed manager had a knowledge, understanding or awareness of our new approach to inspecting adult social care services, which was introduced in October 2014. This meant that we could not be assured that they understood their responsibilities to deliver what is required and to keep themselves informed or up-to-date with key information.

Comments about the management and leadership of the service were positive. Relatives and staff told us that the registered manager was supportive. Relatives were confident that the service was well-led and managed to a good standard and told us that they would recommend the service to others. Staff told us that there was good teamwork and morale between staff was positive. However, comments were made that the proposed manager of the service was not 'hands on' and spent the majority of their time in the office.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered provider had not ensured that people's assessments included all of their needs and that the information had been reviewed and up-dated to assure themselves that it remained relevant. This was in breach of Regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered provider had not understood what they must do to comply with and act in accordance with the requirements of the Mental Capacity Act 2005. This is a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider had not protected people against the risks of inappropriate or unsafe care as the arrangements to assess and monitor the quality of the service provided was ineffective. This was in breach of Regulation 17(1)(2)(a), (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.