Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Eco Nights

1A Limetree Avenue, Benfleet, SS7 5AA

Tel: 01268931491

Date of Inspection: 14 May 2013

Date of Publication: June 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✗ Action needed
Management of medicines	✓ Met this standard
Requirements relating to workers	✗ Action needed
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	Eco Wings and Nights Ltd
Registered Manager	Mrs. Victoria Holder
Overview of the service	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 more.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 May 2013, checked how people were cared for at each stage of their treatment and care and talked with carers and / or family members. We talked with staff and reviewed information given to us by the provider.

What people told us and what we found

At the time of our inspection to the service on 14 May 2013, we found no young people were receiving a period of respite at Eco Nights. Following our inspection we spoke with five relatives. All confirmed that they were very happy with the care and support provided for their member of family. They told us that staff rapport with the young people who used Eco Nights was positive. Comments included "The service is brilliant", "I have total confidence in the service's ability to look after and care for my relative" and "I feel that the staff team know the needs of [name of young person]."

It was apparent from our findings at this inspection that the absence of robust quality monitoring by the provider has been a contributory factor to the failure of the service to identify non-compliance, or any risk of non-compliance sooner. Improvements were required to ensure that support plans reflected the young people's care needs and any potential risks. Improvements were also required in relation to staff recruitment procedures and selection processes and ensuring that all staff received appropriate training, supervision and appraisal.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 25 June 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

Following our inspection we spoke with five young people's relatives. Relative's confirmed that they had been provided with appropriate information about the service and had visited Eco Nights prior to their member of family receiving a period of respite. This means that people were able to make an informed decision and choice on behalf of their relative as to the suitability of the respite service.

Relatives spoken with confirmed that their member of family was always treated with dignity and respect by staff. The Statement of Purpose advised relatives as to what was expected of staff in terms of respecting and ensuring young peoples privacy and dignity was maintained.

Not all relatives spoken with were able to confirm if they had seen a copy of their member of families support plan. However relatives told us that they had been asked to contribute information detailing the young person's personal preferences, likes and dislikes, routines and support needs. Records showed that people's equality and diversity needs were also taken into account and recorded, for example, their age, gender, race, cultural background and any disability.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights. However improvements were required to ensure that people were protected against the risks of receiving care and/or support that was inappropriate or unsafe.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Records showed that the provider had appropriate arrangements in place to assess the needs of the young person prior to admission. This included completion of a pre admission assessment and obtaining additional information from a person with responsibility for buying the service. Additional information was also seen to be provided by the young person's relative and/or representative. This ensures that the provider is able to meet the needs of the prospective young person being considered to receive respite care at the service.

The support plans for four out of 45 people were viewed. We found that none of the support plans viewed fully reflected people's care needs or provided instruction for staff on how support was to be delivered. It was concerning to note that the support file for one young person made reference to them having a range of complex medical support needs. The instruction within the support file directed staff to view a support plan from another external source. However this had not been received and records showed that the young person had already received a period of respite on a previous occasion and was scheduled to stay at Eco Nights in the near future despite the provider still not having received the information. This means that as a result of gaps, the delivery of care may not be reliable to meet the individual needs of the young person who receives a respite service.

Risk assessments were not completed for all areas of risk. Where these were in place information did not include the potential impact of each risk for the young person or provide specific guidance for staff as to the steps to be taken to minimise the risk. We also found that information recorded within the daily diary did not always provide sufficient evidence of staff interventions. For example, a diary entry for one person made reference to them experiencing pain. The diary provided no information detailing what interventions had been provided for the young person to find out what was the cause of their pain, the steps taken to relieve their discomfort and/or to seek advice from a healthcare professional.

At the time of our inspection to the service on 14 May 2013, we found no young people were receiving a period of respite at Eco Nights. Following our inspection we spoke with five relatives. All confirmed that they were very happy with the care and support provided for their member of family. They told us that staff rapport with the young people who used Eco Nights was positive. Comments included "The service is brilliant", "I have total confidence in the service's ability to look after and care for my relative" and "I feel that the staff team know the needs of [name of young person]." Relatives confirmed that communication between themselves, staff and the management team of the service was very good and was open and transparent.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. However improvements were required to maintain a record of all allegations and incidents of abuse, action taken, outcomes and to ensure all staff received safeguarding of vulnerable adults training.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Appropriate safeguarding policies and procedures were readily available. Staff spoken with were able to confirm that these were easily accessible.

The manager told us that over the preceding 12 months there had been no safeguarding alerts raised about the service, however they had initiated two safeguarding alerts themselves. Although the provider was able to advise us of each issue, a record of the safeguarding alert, action taken and outcome was not available for inspection. When discussed with the provider they confirmed to us that they had not maintained a record and were not aware that any abuse or allegation of abuse in relation to a young person who uses the service must be forwarded to the Care Quality Commission without delay.

The manager confirmed that all staff working at Eco Nights had received disengagement and physical intervention skills training. This was confirmed by six members of staff. On inspection of staff training records and the training matrix, records showed that only five out of 10 members of staff had received safeguarding training and this was completed in 2011.

Staff spoken with were able to demonstrate a good understanding and awareness of the procedures for responding to suspicion or evidence of abuse so as to ensure the safety and protection of the young people they supported.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

At the time of our inspection on 14 May 2013, no young people were receiving a respite service at Eco Nights. It was therefore not possible to look at the systems in place for ensuring the safe recording, handling and administration of medication within the service.

We found that appropriate storage systems for medication were in place for the protection of young people who use the service. A dedicated fridge used to keep medicines cold was readily available.

The staff training records showed that eight out of 10 members of staff who were employed at Eco Nights had received administration of medication training. In addition to the service's own medication policies and procedures a copy of 'The handling of Medicines in Social Care' guidance was evident.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

People were not cared for, or supported by, suitably qualified, skilled and experienced staff.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The staff recruitment files for two people employed within the preceding 12 months were requested as part of this inspection. The provider was unable to demonstrate that an effective recruitment and selection process was in place. The provider told us that documented evidence of recruitment checks carried out at the service were held within the organisation's head office.

Following our inspection the provider forwarded us the recruitment records for three members of staff. Records viewed showed that the provider did not have an effective recruitment and selection process in place. We found that not all records as required under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were readily available and arrangements in line with the provider's own recruitment and selection policies and procedures had not been followed. This means that people who use the service may not be safeguarded as staff may not have the qualifications, skills and experience to enable them to do their job in a way that protects the health, safety and welfare of the young people who receive a respite service at Eco Nights.

Records showed that there was no completed application form for one person and no evidence to show that a full employment history had been explored. There was no evidence to show that written references had been received for the three members of staff and no recent photograph had been sought. Criminal record data for only one employee was evident using the Disclosure and Barring Service (DBS). This helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The Disclosure and Barring Service replaces the Criminal Records Bureau and Independent Safeguarding Authority (ISA).

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

Significant improvements were required to ensure that people who use the service were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider confirmed to us that mandatory training for staff was completed at annual, bi-annual and three yearly intervals. This referred to manual handling, first aid, administration of medication, safeguarding of vulnerable adults, COSHH (Control of Substances Hazardous to Health), food hygiene, disengagement and physical intervention skills, epilepsy awareness, infection control, fire safety awareness and health and safety.

The individual training records for 10 members of staff were viewed and a copy of the staff training plan provided following our inspection. Records showed that not all mandatory training as stated by the provider had been completed by staff. For example, the training records for one member of staff employed in July 2012, showed that they had only received mandatory training for two out of a possible 11 subject areas. The provider confirmed that all staff working at Eco Nights had received additional training relating to the needs of the young people they supported. This referred specifically to autism awareness, stoma care, catheter care and Percutaneous Endoscopic Gastrostomy (PEG) feed.

The provider told us that all staff received an 'orientation induction' when they commenced employment at Eco Nights. The provider confirmed that the induction took place at the organisation's head office and lasted for between two and three hours. The staff recruitment records for three members of staff were viewed. There was no evidence to support that each staff member had completed the provider's internal induction. The provider confirmed that no staff had commenced Skills for Care Common Induction Standards and/or a comparable course. The latter is completed over a 12 week period and sets out the first things a new worker needs to know in relation to their job role and the young people they provide support to. Our findings showed that this did not concur with the provider's own induction policy and procedure. This stated that all new staff would complete an induction programme to the standard of the Skills for Care Common Induction Standards within 12 weeks of appointment. The provider told us that all staff received a copy of the staff handbook. The purpose of the handbook is to aid new staff to settle in

quickly by drawing together much of the information needed into one simple guide which can then be accessed as and when required.

The provider told us that all staff working at Eco Nights received formal supervision at three monthly intervals. Records for three members of staff were forwarded to us following our inspection however the records submitted did not include evidence of formal supervision having taken place. We discussed this with six members of staff and it was apparent from our discussions that staff did not receive formal supervision. Staff confirmed that informal supervision was undertaken as and when required, however no records were maintained to evidence the topics discussed. Records also showed that two out of three members of staff had received an appraisal. The purpose of an annual appraisal is to ensure that staff are competent and provide a high standard of care and support to people who use the service.

Five out of six members of staff spoken with stated that they felt valued as a member of staff by the provider and manager. Staff advised that morale at Eco Nights was generally very good and there was positive teamwork.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system in place to regularly assess and monitor the quality of service that people receive.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We asked the provider as to what arrangements were in place to effectively monitor and assess the quality of the service provided.

The provider confirmed to us that the views of those acting on behalf of the young people who received a respite service at Eco Nights were sought at the start of 2013. Records showed that the results about the quality of care and support provided were sought and recorded within satisfaction surveys. Comments viewed were noted to be very positive and included, "[name of young person] loves the Eco team and I feel very content in leaving my relative with them", "[name of young person] has settled really well into Eco Nights, it has a great home from home atmosphere", "I am completely happy with the service my family receives" and "What a great job you do for us all and the service you are giving to families who didn't have anything else before Eco Nights." The provider may find it useful to note that the results of the satisfaction surveys should be analysed so as to monitor potential trends and/or areas for improvement. The provider confirmed that as yet no survey to be completed by the young person had been devised.

Tick chart audits relating to catering, maintenance, infection control, medication, accidents and incidents and general record keeping were evident and these were noted to have been completed each month. The provider may find it useful to note that the records provided little evidence to show that where improvements were required these were recorded and/or an action plan completed.

It was apparent from our findings at this inspection relating to outcome four (care and welfare of people who use services), outcome seven (safeguarding people who use services from abuse), outcome 12 (requirements relating to workers), outcome 14 (supporting workers) and outcome 16 (assessing and monitoring the quality of service provision) that the absence of effective robust quality monitoring by the provider has been a contributory factor to the failure of the service to identify non-compliance, or any risk of non-compliance sooner. There was no evidence to show that the provider had effectively

monitored their own performance and level of compliance with meeting regulatory requirements. When asked to comment about our findings the provider stated "You are confirming what I know. I am a little gutted as to what you've found."

The records of the last three staff meetings were viewed. Records showed topics discussed but there was no evidence of monitoring or review of issues raised and there was no proof that staff working at Eco Nights were invited to raise issues.

We looked at the service's complaint procedures which informed people how and who to make a complaint to and included the stages and timescales for the process. The provider told us that there had been no complaints within the preceding 12 months. Our evidence from the completed satisfaction surveys suggested that those acting on behalf of the young people knew how to make a complaint if the need should arise and felt their views were listened to and acted on.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People experienced care, treatment and support that met their needs and protected their rights. However improvements were required to ensure that people were protected against the risks of receiving care and/or support that was inappropriate or unsafe. Regulation 9(1)(a)(b)(i)(ii)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. However improvements were required to maintain a record of all allegations and incidents of abuse, action taken, outcomes and to ensure all staff received safeguarding of vulnerable adults training. Regulation 11
Regulated activity	Regulation
Accommodation for	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

persons who require nursing or personal care	**Requirements relating to workers**
	How the regulation was not being met: People were not cared for, or supported by, suitably qualified, skilled and experienced staff. Regulation 21(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Significant improvements were required to ensure that people who use the service were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Regulation 23(1)(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have an effective system in place to regularly assess and monitor the quality of service that people receive. Regulation 10

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 25 June 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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