Eothen Homes Limited

Eothen Residential Homes - Gosforth

Inspection report

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Gosforth
Newcastle Upon Tyne,
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Ratings

Overall rating for this service	Good
Is the service responsive?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 and 18 March 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of regulation regarding record keeping.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met the revised legal requirements. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eothen Residential Homes – Gosforth on our website at www.cqc.org.uk.

Eothen Residential Homes – Gosforth is a care home for up to 37 older people. At the time of the inspection there were 30 people living there. All rooms were en-suite and had direct dial land lines. Wi-Fi and computers were available throughout the home for people to use.

A registered manager was in post at the time of the inspection. 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.

We found the provider had met the assurances they had given in their action plan and were no longer in breach of the relevant regulation.

Summary of findings

The standard of care planning and record keeping had improved. Care plans were person centred and updated since our last inspection.

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 responsive?

We found that action had been taken to improve the responsiveness of the service.

Improvements had been made to record keeping arrangements. Care plans and risk assessments were accurate and up to date.

We could not improve the rating for: 'Is the service responsive?' from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Eothen Residential Homes - Gosforth

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Eothen Residential Homes – Gosforth on 13 October 2015. The registered manager sent us some additional information on 16 October 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider had been made after our comprehensive inspection on 17 and 18 March 2015. We inspected the service against one of the five questions we ask about services: 'Is the service responsive?' This is because the service was not meeting a legal requirement at the time of our initial 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 was undertaken by one adult social care inspector. During the inspection we reviewed a sample of care records. These included three people's care plans, their progress notes, risk assessments and review records. We discussed our findings with the registered manager.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in March 2015 a breach of legal requirements was found. We found care staff were aware of changes to people care needs and were supporting people to meet their current needs. However, we found that people had not been protected against the risk of unsafe or inappropriate care due to out of date records such as care plans and risk assessments. We reviewed the action plan the provider sent to us following our comprehensive inspection in March 2015. This gave assurances that action was being taken to improve record keeping arrangements.

The provider told us a plan was being put in place to ensure that all records were brought up to date and all those responsible had been made aware of the expectation that care records would always reflect current care needs and the need for accurate and appropriate records to be maintained.

During this inspection we found improvements had been made in record keeping arrangements relating to the care provided to people using the service.

Care records assisted in providing staff with important information about people using the service. They included a two page summary about each person's needs. The summaries outlined the key things that were important to people and how best to support them. Examples included how people could be supported with their mobility (getting around) and information about key risks, such as those relating to falls. We saw these were written in a positive and factual way.

Each person's needs were assessed when they first moved to the home and periodically thereafter. Areas such as overall dependency, nutritional needs and a social profile were all completed. From these assessments, plans of care and more detailed risk assessments were drawn up. Care plans were signed by the person they related to and the staff member who had drafted them. This meant people had confirmed they were aware of and agreed with the content.

Some care plans were highly detailed. For example, one care plan we looked at relating to a medical condition provided detailed information about how the condition affected the person, clear steps about how the person would need to be supported, along with information about external care professionals involved in the person's care. These included support around speech and language, physiotherapy and eye care. Another care plan relating to oedema (fluid retention) ensured staff had been provided with clear and appropriate information to meet this need. One care plan, although recently completed, was generic in nature, rather than person centred. We highlighted this to the registered manager, who reviewed the document and provided an updated care plan a few days after our initial visit.

Staff completed periodic evaluations of care plans, which noted significant events and changes relating to each area of need. For example, in relation to mobility plans, when a person had fallen, the circumstances around the fall were described and, if appropriate, the care plan was then updated. All the care plans examined had been reviewed and updated by staff when there had been changes in people's needs. Staff also evaluated, reviewed and updated risk management plans.

We found the assurances the provider had given in the action plan with regard to record keeping had been met.