

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

Ivy Lodge

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BH10 5NZ

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September 2013

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

Consent to care and treatment	✓	Met this standard
Care and welfare of people who use services	✓	Met this standard
Management of medicines	✓	Met this standard
Staffing	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	Acorn Lodge (Bournemouth) Limited
Registered Manager	Mr. Matthew Druce
Overview of the service	Ivy Lodge is a residential care home for up to seven adults with learning disabilities. Nursing care is not provided.
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'.

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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 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

At the time of our unannounced inspection six people lived at Ivy Lodge. We met them all and spoke with four and one relative. They were all positive about the home and its staff. For example, one told us, "I think it's excellent".

We also examined records, spoke with the manager and a support worker, and observed the support people received.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. We saw that staff respected people's choices.

People experienced care, treatment and support that met their needs and protected their rights. People talked about the various things they did and we observed that people were engaged with individual and group activities during our visit.

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

There were enough qualified, skilled and experienced staff to meet people's needs. We observed that people were relaxed with staff, who supported them in an unhurried manner.

The provider had an effective system to regularly assess and manage the quality of the service and risks to people's health, safety and welfare.

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

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

Consent to care and treatment

✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Staff respected people's wishes. For example, we observed a support worker ask an individual if they wanted to go for a walk with a group of other people and respect their decision to stay at home. Additionally, we witnessed the manager ask someone if they wished to meet us and check they were happy for us to read their notes prior to introducing us to them. We noted that staff knocked on people's doors before entering their rooms. We saw that support workers asked people if they wanted assistance before providing this.

People's essential lifestyle plans (care plans) promoted choice and decision making. For example, one person's communication plan stated, "Staff must make sure that I am involved in making decisions. I am very good at opting out if I don't want to do something and make my feelings very clear". Additionally, their plan for support with their diet noted that they were able to say what they would like to eat but indicated how staff might support them to choose varied meals.

We saw that each individual living at Ivy Lodge had signed a pictorial consent form, to show that staff had discussed medicines with them and to agree to support workers assisting them with their medicines. The medicines policy stated that if someone refused to take their medicines after staff supported them, for example explaining why they needed them, they should not be forced to take their medicines. Instead, the policy instructed staff to record this and seek advice from a health professional. The manager confirmed that no-one received medicines concealed in their food or drink.

Where people did not have the capacity to consent in particular situations, the provider acted in accordance with legal requirements. For example, one person's essential lifestyle plan recorded that they would be unable to give informed consent to any dental treatment that required sedation. The plan stated that the person's next of kin would need to be involved in the consent process, and possibly an independent mental capacity advocate.

People's essential lifestyle plans included information that assisted staff to respect people's wishes and best interests, in the event they were unable to make or communicate a decision themselves. For example, one person's plan had sections called "People in my life and their importance to me", "Things that make me feel happy", "I like to" and "Things I like to wear". We observed throughout the inspection that these preferences were respected.

The provider's training records showed that all staff had received training about the Mental Capacity Act 2005 and that this was updated every three years. We saw copies of course certificates for individual staff members that confirmed this. The manager and a member of staff we spoke with demonstrated a clear understanding of the principles of the Mental Capacity Act and when best interest decisions were required. We noted that staff had signed to confirm they had read the Mental Capacity Act code of practice.

We saw the home had a mental capacity policy that had been reviewed earlier in 2013. The beginning of the policy stated, "Every effort is made to encourage and support our residents in making decisions for themselves". It gave staff guidance about when and how to assess mental capacity, in line with the Mental Capacity Act 2005.

The manager confirmed there were no Deprivation of Liberty Safeguards in place, for example, to keep people in the house when they indicated they wanted to leave. We did not see any evidence that these were required at the time of our inspection.

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We met all the people who lived at Ivy Lodge, and spoke with the four who were able to talk with us and with one relative. They were all complimentary about the support they or their family member received. For example, one individual said, in a positive way, "It's okay here". Someone else commented that their relative was cared for well and was "always spotless". They also said, "I know he's happy there because he's always happy to go back there after the weekend". We observed that people were relaxed with the manager and staff and readily approached them.

Everyone we spoke with told us about their various activities. We also saw people talking with each other and with the staff about things they had done or were planning to do. One individual allowed staff to show us their photo album, which contained pictures from their various trips and holidays. A relative commented that their family member had plenty to do. We observed that people were often engaged in individual and shared activities such as cooking, art work and getting ready to go for a walk. This showed that the home supported people's involvement in activities they found meaningful.

We pathway-tracked one individual, who was not able to talk with us about their care. This meant we looked at records the provider kept about them, which included their essential lifestyle plan, and spoke with their relative and staff. Where appropriate we observed support workers as they assisted them. This was so we could evaluate how their care needs were assessed, planned and delivered.

People's care records contained an assessment of their needs. The person we were pathway-tracking had lived at Ivy Lodge for a few years. Their file contained their social services care and support plan. We saw that the home had undertaken further specific assessments, such as vulnerability to pressure sores and malnutrition screening. The home had also undertaken and reviewed risk assessments that considered the individual's risks associated with vulnerability, harm to themselves or others and self-neglect. These assessments had all been reviewed and updated twice in the past year. The person's essential lifestyle plan reflected this.

Essential lifestyle plans contained clear actions for staff to take so people received the

help and support they needed. We observed that support workers followed these instructions. For example, we saw a support worker assist an individual to eat some soft food at a time when others were having a snack that would not have been suitable for them. The staff member also supported them to drink fluid of the correct consistency from the person's special cup in the way specified in the plan. This showed they were familiar with the person's needs.

Where we were unable to observe care being provided we looked at relevant records that showed staff had taken the necessary actions to meet people's needs. For example, records of care given showed that the individual we pathway-tracked had received support with bathing and to attend activities as stated in their essential lifestyle plan. We also observed that people were clean and neatly dressed, which showed that they had been supported to maintain their personal hygiene.

We saw people's essential lifestyle plans were up to date, reflecting their current needs. We noted that staff signed annually to confirm they had read and understood the plan for the person we pathway-tracked. The manager and the support worker we spoke with were familiar with people and their essential lifestyle plans. This helped ensure individuals received the support they needed.

This all showed that people's needs were assessed and care and treatment was planned and delivered in line with their essential lifestyle plans.

Care and treatment was also planned and delivered in a way that was intended to ensure people's safety and welfare.

People received support to maintain their health. Essential lifestyle plans included plans to support individuals with their health. We saw that one individual's plan set out how they showed they were in pain and also the support they needed to have a healthy and nutritious diet. We noted that the plan reflected guidelines from the person's speech and language therapist.

Records showed that people were supported to attend annual health checks and had other contact with healthcare professionals such as general practitioners, dentists and community learning disability staff. This demonstrated that the provider ensured their health care needs were met.

There were arrangements to deal with foreseeable emergencies. For example, records showed that most staff had received basic emergency aid training within the past three years and that this was updated every three years. Records also showed that all staff had received training in coping with aggression. We noted that the essential lifestyle plan for the person we were pathway-tracking had a section titled "emergency situations", which set out the support they needed in event of the fire alarm sounding. Additionally, we saw the provider had a contingency policy that detailed procedures staff must follow in the event of an emergency such as power failure, a gas leak or flooding.

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

The manager told us all medicines were obtained from a local pharmacy. We saw that the pharmacy supplied most medicines in pre-labelled blister packs with separate compartments containing tablets and capsules to be taken at particular times. The manager explained that some people's tablets and capsules were supplied in labelled boxes on the pharmacist's advice.

We looked at the current medicines administration record (MAR) charts for each individual in the house. None showed gaps where people had missed their medicines because they were out of stock. We saw that the procedures for obtaining medicines were set out in the provider's medicines policy.

This all showed that appropriate arrangements were in place in relation to obtaining medicine.

There were appropriate arrangements in place to record medicines.

We saw the pharmacy supplied pre-printed MAR charts with people's medicines. These contained details of people's allergies and sensitivities to particular medicines. The manager explained that staff receiving the medicines into the home always checked that people's allergies had been recorded correctly and wrote these in the relevant space, if the pharmacist had omitted them.

We saw separate handwritten MAR charts in place for each individual for homely remedies such as paracetamol and cough linctus. We saw that GPs had authorised the homely remedies as safe for people to take. These MAR charts were initialled by staff to show they had checked the chart was written correctly.

MAR charts were filed in a medicines file with separate sections for the six individuals. We saw that each section was headed by a page with a photograph of the person and details of their allergies. The medicines file contained an index of staff initials, as they appeared on the MAR charts.

We saw that all current MAR charts had been completed fully on each occasion that medicines were administered, apart from a single set of missing initials the previous day. We asked the manager about this. They demonstrated how they audited medicines and, by counting the tablets in the box, showed us the medicine had been given but not signed for. They assured us they would address this with the support worker concerned when they were next on duty. We observed them discuss the matter with the senior support worker on duty during our visit.

We saw that staff had recorded and signed for medicines entering and leaving the home. We checked the amounts of tablets in stock for the individual we were pathway-tracking and saw that this corresponded with the MAR charts and the records of medicines entering and leaving the home.

This also showed that medicines were safely administered. In addition, staff training records and files showed that staff had received training in the safe administration of medicines and that this was updated periodically. Records showed the provider checked their competency before they supported people to take medicines and each year afterwards.

Medicines were prescribed and given to people appropriately. None of the MAR charts we saw showed that people received sedative medicines on an as-needed basis when they were agitated or distressed. The care records for the person we pathway-tracked showed that their general practitioner periodically reviewed the prescriptions for the individual's various medicines.

We saw that one individual had creams prescribed on an as-needed basis. The provider may find it useful to note that we did not see written instructions for staff as to when and how to apply these. The manager confirmed that staff who supported people with medicines knew them and were familiar with their care needs. They acknowledged that specific written instructions would assist support workers to meet people's needs, in the unusual event that temporary staff were assisting people with medicines. Shortly after the inspection the manager informed us they had put these in place.

Medicines were kept safely. We saw there were purpose-built lockable medicines cupboards secured to the wall. There was a separate medicines cupboard for controlled drugs, although this was empty on the day of our inspection. The manager told us there were no controlled drugs in use, and the controlled drugs register confirmed this.

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

We observed that people living at Ivy Lodge were engaged in activities with staff, and that the support they received was unhurried. This indicated that enough staff were on duty to meet their needs.

The manager explained that there were always at least two staff on duty at any one time during the day, and almost always three or four staff. At night there were two staff members who stayed awake. The rotas for the past three months confirmed this. We observed there were three staff on duty on the afternoon and evening of our inspection, alongside the manager. This was consistent with the staff rota for the day. The staff member we spoke with confirmed that staffing levels were sufficient for them to support people in the way they needed.

We observed that people living at Ivy Lodge were relaxed with the staff and, with the exception of a brand new member of staff, staff were familiar with people's preferences and needs. The manager confirmed that most staff had worked at Ivy Lodge for a number of years. Both the manager and a member of staff we spoke with independently confirmed the home never used agency staff but used overtime or a regular bank of staff to cover sickness and leave. The home's staffing policy indicated that agency staff were to be used only in an emergency, as a last resort. The rotas we saw showed a regular staff team who each tended to work a regular pattern of shifts. This meant that people could get to know their staff and helped ensure consistency of care.

Training records showed that new staff received comprehensive induction training, which was refreshed at specified intervals for all staff. This training included moving and handling, safeguarding vulnerable adults, food hygiene and infection control.

We looked at five staff files. These contained comprehensive information obtained before they started work at Ivy Lodge. This included photographic identification, criminal records checks, evidence of qualifications and references from previous employers.

Assessing and monitoring the quality of service provision

✓ Met this standard

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 meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

People using the service, their representatives and staff were asked for their views about their care and treatment and these were acted on.

We spoke with one individual's relative, who spoke positively about Ivy Lodge. They said they were in regular contact with the home and felt able to contact the manager if they needed to. They confirmed the home involved them in their family member's care, for example in reviews and GP appointments.

The manager told us they carried out an annual quality assurance survey to obtain the views of people living at Ivy Lodge, their relatives, professionals and staff about Ivy Lodge. We saw the results of the most recent survey carried out in autumn 2012. This had asked people to rate their satisfaction with various aspects of the accommodation, the staff and the care provided. People had rated all items highly and there were no adverse comments.

Meeting minutes showed that people were able to meet every few months to discuss life at Ivy Lodge. For example, they recorded that people had discussed matters such as recent trips and holiday plans, and their positive views about a newly installed bathroom.

Staff meeting minutes showed that staff had opportunities every few months to discuss issues concerning Ivy Lodge and the care of the people living there.

We asked to see details of complaints received since the last inspection. Records showed there had not been any and the manager confirmed this.

We also asked to see details of accidents and incidents since the last inspection. The manager explained there had been none, but if there had been they would be recorded in the accident book. We saw this comprised of sequentially numbered forms and that no

accidents or incidents had been recorded in the past year.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. For example, we saw current health and safety risk assessments for the premises and for specific activities such as food purchase and storage. These had been reviewed each year. We also saw an up to date gas safety certificate and a recent satisfactory electrical installation report. The manager maintained a fire log book, which showed they had undertaken a fire risk assessment and reviewed this within the past year. It also contained records of weekly fire safety checks and periodic fire drills.

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.

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