Mr & Mrs G Rawat

Davigdor Lodge Rest Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We inspected Davigdor Lodge Rest Home on the 29 December 2014. Davigdor Lodge Rest Home is a family run mental health care home that provides support for up to 25 people. On the day of the inspection 24 people were living at the home. The age range varied from 32 to 70 years old. The home provided care and support for people living with past and present mental health needs, such as depression, schizophrenia and substance misuse related mental health needs.

The home is centrally located in Hove with good public transport links to the city centre. The central location enabled people to regularly access local bars and shops nearby and the seafront was a short walk away. Many people living at the home have lived there for many years.

The provider also has good retention of staff and management. Throughout the inspection, people spoke highly of the home. One person told us, “I don’t want to ever leave.”

A registered manager was 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 and associated Regulations about how the service is run.

At the last inspection in July 2014, we asked the provider to take action to make improvements in management of infection control, care and treatment, quality assurance

Summary of findings

of the home and the premises. An action plan was received from the provider which stated they would meet the legal requirements by 1 December 2014. At this inspection we found improvements had been made, but further areas for improvement were still identified.

People's needs had been assessed and care plans developed. However, care plans and risk assessments did not always contain sufficient guidance to enable staff to provide safe and responsive care. Despite concerns with documentation, we saw that people consistently received the care they required. Staff members were clear on people's individual healthcare and mental health needs, but we have made a recommendation for improvement in this area.

People's medicines were stored safely and in line with legal regulations. People told us they received their medication on time, however, omissions in the recording of administration of medicines were identified. We have identified this as an area of practice that requires improvement.

Davigdor Lodge Rest Home was undergoing a rolling programme of maintenance work. This work was still on-going on the day of our inspection, and further work was required to ensure people lived in a safe environment.

A dedicated activities coordinator was in post and provided opportunities for social stimulation and interaction. However, they only worked one day a week. People commented this was not sufficient and they often found themselves with little to do. We have identified this as an area that requires improvement.

Incident and accidents were not consistently recorded or monitored for any emerging trends or patterns. The provider has been asked to make improvement in this area.

Staff received training that was relevant in supporting the needs of people living at Davigdor Lodge Rest Home. Staff received on-going support through handovers, staff meetings and supervisions. One staff member told us, "The training is great."

Staff understood the needs of people and care was provided with kindness and compassion. People told us they felt confident in the skills of staff members. One person told us, "I rate them 10 out of 10." People looked comfortable in the company of staff and management. It was clear staff and management had spent time getting to know people, their history, likes and dislikes.

People were treated with respect and dignity by staff. They were spoken with and supported in a sensitive, respectful and professional manner. Staff members respected people's privacy and always knocked on their door before entering. Staff understood the importance of monitoring people's mental health and well-being on a daily basis. Staff worked closely with healthcare professionals and was responsive to people's changing needs.

People told us they felt safe living at Davigdor Lodge Rest Home. Staff had received safeguarding adults at risk training and staff were able to tell us what they would do if they had any concerns. Staff had received training on the Mental Capacity Act (MCA) 2005, alongside Deprivation of Liberty Safeguards training (DoLS).

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?

Davigdor Lodge Rest Home was not consistently safe. Risk assessments were not consistent and did not always record the measures required to keep people safe. The home required on-going maintenance work to make it a safe environment for people.

Medicines were stored safely; however, omissions with recording were identified.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work with adults at risk. Staff had a good understanding of how to recognise and report any concerns, and the home responded appropriately to allegations of abuse.

Requires Improvement

Is the service effective?

Davigdor Lodge Rest Home was effective. Staff received training which was appropriate to their job role. This was continually updated so staff had the knowledge to effectively meet people's needs.

Staff had a good understanding of peoples care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements.

People had a choice of food and were provided with a well-balanced diet. They also had access to a range of healthcare professionals as and when needed.

Good

Is the service caring?

Davigdor Lodge Rest Home was caring. People told us they were happy with the care they received at the home. They said staff knew them well and that they trusted them.

Staff were kind, patient and friendly and had developed good relationships with the people they supported. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Good

Is the service responsive?

Davigdor Lodge Rest Home was not consistently responsive. Care plans lacked guidance and information for staff to provide safe and responsive care.

Opportunities for social activities or engagement were limited. People also felt there was not enough to do at the home.

Requires Improvement

Summary of findings

There was a complaints procedure in place and people felt comfortable raising any concerns or making a complaint.

Is the service well-led?

Requires Improvement

Davigdor Lodge Rest Home was not consistently well-led. The home's statement of purpose required updating, and the culture of the home was not always embedded into everyday care practice.

Incident and accidents were recorded, but were not analysed for any emerging trends, themes or patterns.

People spoke highly of management and the provider. Feedback was regularly obtained from people and staff to help make improvements to the running of the home. The home was clear on the improvements required and remained focus on delivering care that was personalised to each person living at the home.

Davigdor Lodge Rest Home

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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

We inspected the home on the 29 December 2014. This was an unannounced inspection. The inspection team consisted of an inspector, specialist mental health advisor and an Expert by Experience who had experience of mental health care homes. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, members of the public, relatives and healthcare professionals such as GPs and care coordinators. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection, we spoke with nine people who lived at the home, two staff members, the chef, cleaning assistant, the assistant manager and the registered manager.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, the lounge and the dining area. We spent time observing staff interactions with people and how comfortable people appeared in the company of staff members. We also spent time sitting and talking with people.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at six care plans and subsequent risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Davigdor Lodge Rest Home. This is when we looked at their care documentation in depth and obtained their views on how they found living at Davigdor Lodge Rest Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Davigdor Lodge Rest Home. One person told us, "Staff make me feel safe." Another person told us, "I am safe because there is lots of staff around." Although people told us they felt safe, we have found areas of practice which were not consistently safe.

At our last inspection in July 2014, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008. This was because the environment was not clean and tidy and did not protect people against the risk of infection. Improvements have been made.

Infection prevention measures were effective and in place. Davigdor Lodge Rest Home now had a dedicated cleaning company who worked seven days a week and were responsible for the cleaning. During the inspection, we walked around the building and noted new flooring such as laminate and carpets had been fitted. Fixtures such as lamp shades were free from dust and curtains were also free from stains. Wash basins and taps had been deep cleaned, and bathrooms were clean and tidy with hand sanitizer and paper towels.

A quality assurance framework was now in place to govern the effectiveness of infection control. The infection control audit looked at areas such as the environment, equipment and personal protective equipment. Where shortfalls were identified, a plan of action was implemented along with action points. Weekly checks were also conducted which inspected the standards of infection control throughout the home. However, on the day of the inspection, a strong smell of urine was smelt in one of the communal lounges. This was brought to the attention of the registered manager, as the odour had not been identified in the weekly check.

On-going work was still required to make Davigdor Lodge Rest Home a safe place to live. The home had been subject to severe water damage which had consequently affected people's bedrooms and personal belongings. At the last inspection in July 2014, the provider was in breach of Regulation 15 of the Health and Social Care Act 2008. This was because areas of home remained stained with water damage and patches of the ceiling sagged. We found improvements had been made but areas of the building still required addressing. The assistant manager told us, "We have a team of builders coming in on a regular basis and we have an on-going programme of maintenance and building work that needs completing." The on-going work included electrical re-wiring and new furniture. A number of sofa's were torn or split. We were informed that the on-going work should be finished by January 2015.

People were informed and kept updated about the on-going programme of maintenance works. Due to the mental health needs of people, the registered and assistant manager met with people to discuss the impact of builders. People commented they might feel uneasy and anxious about having the work men around. Therefore, it was arranged for people to meet the work men and ensure they felt comfortable around them. People commented they found this useful and haven't found it so disturbing having the building work done.

Medicines were administered through monitored dosage systems (MDS). MDS is a medication storage device designed to simplify the administration of medicines. Medicines were placed in separate compartments allowing the person to be given the correct medicine and dose at the correct time. We looked at a sample of Medication Administration Records (MAR charts). MAR charts are a document to record when people receive their medicines. Most MAR charts were clear and accurate; however, we identified several omissions. One MAR chart reflected the person had not been administered two of their medicines for over two weeks. There was no recording to show if the person had refused, or why they had not been administered. We brought this to the attention of the registered manager, who was also unaware why the omission occurred. We have identified this as an area of practice that required improvements.

Medicines were stored safely. There was one dedicated locked clinical room which was appropriately equipped so that medicines could be kept safely. Some prescription medicines known as controlled drugs (CDs) have legal requirements for their storage, administration, records and disposal. CDs are prescribed medicines used to treat severe pain, induce anaesthesia or treat drug dependence. However some people abuse them by taking them when there is no clinical reason to do so or divert them for other purposes. For these reasons, there are legislative controls for CDs. CDs were stored, recorded and ordered appropriately. The stock levels of CDs were checked on a regular basis and CDs were administered in the presence of

Requires Improvement

Is the service safe?

two care staff as per good practice guidelines. Medicines were administered directly from the clinical room and people were seen attending the clinical room when they required medicines.

People commented they had a good understanding of their medication and received their medicines on time. If required, staff members supported people on a regular basis to receive their depot injection (medication that is used for some types of mental distress or illness). One person told us, "Staff tell me what medicines I have. If my medicine's changed I would see my psychiatrist as-well."

People were supported to live autonomous independent lives. Staff understood the importance of positive risk taking and supporting people's freedom. People told us they felt able to take every day risks. One person told us, "I go to the supermarket, to the cinema and to the park by myself." Some people commented they felt too anxious to take risks, but staff were supporting them to take more risks. For example, staff were in the process of supporting one person to apply to live in their own flat.

Risks to people were assessed and risk assessment developed. They included aggression, suicide, deliberate self-harm and violence. They considered the nature and level of risk. However, risk assessments did not always record the measures or actions required to reduce the risk or minimise the risk of harm. One person had been identified at medium risk of crossing the road safely. Guidance was not readily available on the measures required to reduce the risk. Risk assessments also failed to match information provided in the person's care programme approach (CPA). CPA is a particular way of assessing, planning and reviewing someone's mental health care needs. One person's risk assessment identified them as low risk of financial abuse; however, their CPA reflected they were vulnerable to financial exploitation. Risk assessments were not constant with the identified risks in people's CPA's and therefore did not provide staff with guidance on how to manage risks in a consistent manner. We have identified this as an area of practice that requires improvement.

People had mixed comments about staffing levels. Some people felt the home was sufficiently staffed while other people told us they felt there were not enough staff. Staff felt the home could benefit from more staff. A recurring problem was staff going off sick at short notice. Management confirmed if staff did go off sick, one or both of them would cover the shift as a care assistant. However, when staff went off sick, this had a knock on effect for people who required support that day to access activities or have one to one with staff. One person told us, "There are not enough staff to take me out. I am in a wheel chair and need help to go to the shops." Staff rotas confirmed the home always operated with the minimum number of assessed staff required (one team leader and two care staff) however, this impacted on staff's ability to take people out. We have identified this as an area that requires improvement.

Staff had received training in safeguarding adults at risk and had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. The management of the home recognised when to report any suspected abuse. Safeguarding policies and procedures were up to date and appropriate for this type of home, in that they corresponded with the Local Authority and national guidance.

People were protected as far as possible by a safe recruitment system. Staff files confirmed that a robust recruitment procedure was in place. Files contained evidence of disclosure and barring service (DBS) checks, references included two from previous employers and application forms

Good

Is the service effective?

Our findings

People told us they felt confident in the skills and abilities of staff. One person told us, "They are very helpful." Another person told us, "I can talk about things with staff."

People were able to make choices about what they wanted to eat. We saw there was regular communication between staff and the chef. On a daily basis, people were given choices and a menu was displayed in the communal dining room providing a daily reminder. We were invited to join people at lunch time to share their experience. The meal time was unrushed; staff interacted in a friendly manner and was aware of people's needs. The atmosphere in the dining room during the meal was relaxed, quiet but friendly and people chatted together if they wanted.

People spoke highly of the food, confirming they could make daily choices. Refreshments were available for people to help themselves and we saw people eating at varying times of the day which suited their preference. A kitchenette was available for people to have access to a microwave and oven to make their own meals. On the day of the inspection, the kitchenette was out of action due to on-going maintenance work throughout the home. We asked if the kitchenette was used by people, or if they held workshops to promote people's independent living skills, such as cooking. Management commented that most people preferred to eat and dine in the communal area, but if someone expressed a wish to cook independently they would facilitate and support this. People commented they found having the kitchenette available useful. It enabled them to make snacks and hot drinks throughout the day.

Some people had specific dietary requirements either related to their health needs, such as diabetes, or their own preferences. Following a hospital admission, one person had experienced a choking event which had consequently left them anxious about choking in the future. Staff members ensured a soft diet was available for them and provided reassurance around mealtimes when their anxiety levels were raised.

Staff told us how they monitored people's food and fluid intake and monitored for any signs of weight loss and malnourishment. One staff member told us, "If someone was continually refusing to eat or only eating small amounts, we would record this on a daily basis in their evaluation notes and report our concerns to their GP." We were informed people who consented were weighed on a monthly basis. Where people had been weighted monthly, there was no evidence which indicated people had experienced significant weight loss, and most people had remained at the same weight or put weight on.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people living with mental health needs. Staff regularly attended training provided by the local council and the provider had an on-going schedule of training. Staff told us they felt training opportunities were 'great'. During the staff induction at Davigdor Lodge Rest Home, a day's training was provided on mental health awareness. This provided staff with an understanding of people's individual mental health conditions and what those meant. Staff also received further mental health awareness training provided by the local council. A number of staff had attained a National Vocational Qualification (NVQ) in care and other staff members commented on how they had started their NVQ.

The provider and management supported staff professional development through the use of regular supervisions and appraisals. Supervision is a formal meeting where training needs, objectives and progress for the year were discussed. Staff commented they found the forum of supervision useful to air any concerns or queries. One staff member told us, "Supervision is where we can express concerns. We can also request supervision if were not happy."

People we spoke with confirmed they had regular contact with their GP, care coordinator and psychiatrists. One person told us, "I go to the Doctors by myself, but staff make the appointment for me." Another person told us, "Staff remind me to go to the Doctors."

Staff monitored people's health and well-being on a daily basis. The home had a daily diary which recorded any input, advice or guidance from a visiting healthcare professional such as a district nurse or care coordinator. Many people living at Davigdor Lodge Rest Home had lived there for over 10 years. Some people's physical needs were beginning to outweigh their mental health needs. Staff responded to changes in people's physical health in a timely manner. A recent example included one person's health which had deteriorated. It was decided more effective care could be given elsewhere to meet their primary need, which had become a physical health need.

Good

Is the service effective?

People told us, they would be upset about leaving the home, but recognised the home did not provide nursing care. The registered manager commented that people were supported by staff to source a nursing home and were involved throughout the process of moving.

People confirmed staff effectively managed their mental health needs. One person told us, "If I feel unwell or low, I know I can talk to staff." Documentation confirmed staff supported people to attend CPA (care programme approach) reviews and consultations with psychiatrists. Staff commented they had a good understanding and knowledge of monitoring people for any signs or symptoms which may indicate a person's mental health needs were deteriorating. One staff member told us, "We get to really know everyone and their routine. If we identified any changes in behaviour or routine, we would talk with the person and also contact their care coordinator and psychiatrist."

Staff had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 sets out how to support people who do not have capacity to make decisions at specific time. Staff understood the need to protect people's rights when they had difficulty in making decisions for themselves. People were able to move freely inside and outside the home. Policies and procedures were readily available to staff on DoLS if it was needed. These provided staff with guidance regarding their roles and responsibilities under the legislation.

Management and staff understood how people may make unwise decisions (decision that may place them at risk) and recognised when additional support may be required to manage those risks. Some people used other means of self-medicating pain relief, such as alcohol. The registered manager and staff work in partnership with people and the multi-disciplinary mental health teams to help people reduce their alcohol consumption and manage their pain more effectively. Documentation confirmed it was agreed that staff should not purchase alcohol and limit the amount of alcohol intake per week. Therefore reducing the risk, but also respecting people's rights to make unwise decisions.

Good

Is the service caring?

Our findings

People told us they received care from kind and compassionate staff. People commented their privacy and dignity was respected and that staff working at Davigdor Lodge Rest Home were very caring.

The inspection team spent time walking round Davigdor Lodge Rest Home, sitting with people, observing care and talking. The home presented as calm and relaxing for people. People could come and go as they pleased and enjoyed spending time in their rooms and the communal areas.

With people's permission, we viewed people's bedrooms. They could bring their own furniture and decorate their rooms as they wished. One person showed us round their bedroom with obvious pride. Pointing out things they had brought, found from local charity shops and their favourite items. One person had their pet bird with them, which provided them with comfort and also helped them to feel valued.

Staff had the skills and understanding of how best to support people in a caring manner. People were called by their preferred name and staff clearly had built rapports with them. We saw one staff member approach a person who was a little upset, quietly offering sympathetic support and assistance. We saw people felt comfortable approaching staff, and there was a feel of genuine respect and understanding between staff and people.

People's privacy and dignity was respected. People told us their privacy and dignity was also maintained and upheld. One person told us, "I give them 10 out of 10 for respecting my privacy." Before staff entered someone's room, they knocked and gained permission to enter. Staff recognised that people's rooms were their own private space and they needed to gain permission before entering. This enabled people to have the privacy they needed. People held their own keys and could lock their rooms. People told us they appreciated being able to do so, but understood staff could gain access in an emergency.

Staff understood the importance of knowing and respecting people as individuals. One staff member told us, "We get to know people and understand what they like and don't like." From our observations throughout the day, staff had a good understanding about each individual, their likes, dislikes, personality and life history. Management also had a clear understanding of each person, their background and how they preferred to receive their care and treatment.

Where possible, staff supported people to promote their independence. A few people were being supported by staff to regain or promote independence with their finances. Staff told us how they assisted people with budgeting or would hold people's money until they gained confidence to manage their finances independently. During the inspection, we spent time with one person who told us how they went to the manager's office to collect their money. The registered manager would help them count their money and through this process they were re-gaining skills in managing their finances.

People were encouraged and supported to make their own decisions. We saw people could freely make hot drinks and had access to the internet through the shared computer. Each person living at Davigdor Lodge Rest Home had their own care plan. Most people confirmed they were aware of their care plan and were actively involved in designing it. Care plans were signed by the individual to indicate their consent and documentation confirmed care plans were reviewed on an on-going basis. Some people were adamant they did not have a care plan and did not need one, nor did they have any mental health needs. Management and staff confirmed that not everyone recognised or understood their mental health needs, and they continually liaised with their care coordinators to ensure they received the care and treatment required. Where required, the registered manager would request advocates for people to ensure their voice and opinion was heard.

People were regularly consulted about the care and treatment they received and what they wanted to do. People told us they felt involved in their care and could always approach the registered manager, assistant manager or staff with any questions. 'Resident meetings' were held on a regular basis. These provided people with the forum to discuss any concerns, raise any questions and contribute to the running of the home. People commented they found the opportunity of 'resident meetings' helpful as it also meant they were kept informed and updated on any changes and what was going on in Davigdor Lodge Rest Home.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff were responsive to their needs, however, people felt opportunities for social engagement and stimulation could be improved.

At the last inspection in July 2014, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008. This was because care plans lacked sufficient guidance and detail on people's individual care needs. Improvements had been made, but there were still areas that required addressing.

Since the last inspection, the provider had designed and implemented a new format of care plans. These considered the person's specific need, outcome goals, recovery goals and actions required to meet those goals. Goal setting in mental health is an effective way to increase motivation and enable people to create the changes they desire. One person had identified they liked to do shopping online but they found this difficult. Their agreed goal was for staff to teach them how to use the internet to enable them to do this. Some people had clear goals in place, however, we found this was not consistent in all the care plans we viewed. Where care plans were reviewed, it was not clear if the person had met their goal or if further work was needed in order for them to achieve the goal. It was not clear the progress the person was making. We have identified this as an area of practice that requires improvement.

A care plan is something that describes in an accessible way the services and support being provided to an individual. Within the back of each person's care plan, there was information from their mental health team or care coordinator. However, this information was not clearly explained within the person's overall care plan. Some people living at Davigdor Lodge Rest Home had been subject to a community treatment order (CTO) following on from detention under the Mental Health Act in the past. A CTO means that the person has to keep to certain conditions to stay in the community. However, their care plan was not informative as to whether they were still subject to the CTO and the impact of that. Some people had been detained under Section 37 and restricted by Section 41 of the Mental Health Act 1983. This meant they could be recalled to hospital if they breached their restriction. Their care plan did not clearly explain the restriction, if the person understood the restriction and whether the restriction was reviewed on a regular basis.

Management and staff had a firm understanding of each person, whether they were subject to a CTO and what restrictions were in place and the impact of those restrictions. However, this was not evident in people's care plans. Therefore for new members of staff or agency staff, this information would not be readily available. We have identified this as an area that requires improvement.

Personalised information on individual need was recorded; however, care plans lacked information on people's preferences. For example, whether they preferred support from female or male staff. Personal information on people's daily routine and what a normal day looked like for that person was not available. Information was not readily available on how the individual perceived their mental health and what was important to them. For example, if their mental health deteriorated, or if there was any medication they would not want to be given. Although staff members had a firm understanding of people's personal preferences, for new members of staff or agency staff, this information was not available. Information such as personal preferences it vital in recognising how people can remain in control of their life and regain a meaningful life despite living with a mental health need. We have identified this as an area that requires improvement.

We recommend that the service considers the National Institute for Health and Care Excellence quality standard for service user experience in adult mental health.

People told us they enjoyed going out. One person told us they enjoyed going to the local parks or to the cinema. Other people commented they enjoyed spending time in their room watching television. However, most people felt there was not enough to do at Davigdor Lodge Rest Home.

A dedicated activities coordinator was new in post, but only worked one day a week. People spoke positively of the activities coordinator and enjoyed the activities provided such as film nights, bingo or trips out; however, people confirmed activities were only available on a Wednesday. During the inspection, we found most people spent time sitting around or watching television. The opportunity for meaningful activities or stimulation was limited for people. People were also not regularly encouraged to participate in task based activities such as laundry; which could help with their recovery and enhance their daily living skills. The registered manager and assistant manager were aware of the limited opportunity for social engagement and meaningful activities. They were working in partnership

Requires Improvement

Is the service responsive?

with the activities coordinator to ascertain what activities people would enjoy and what would be specific to people's individual needs. However, further improvement is required. We have identified this as an area of practice that requires improvement.

People's religious and cultural needs were documented within their care plan, however, it was not clear whether they required support to meet their needs, or if they were practicing their religious or cultural needs. Documentation in the home's daily diary reflected one person had requested support to attend the local church. Information in their care plan did not record whether they required weekly support from staff to attend church or if the local Vicar visited the home. The registered manager informed us how the person had built links with the local church and receives support from other members of the congregation to attend. It was clear their religious needs were being met, but this information was not readily available in their care plan. We have identified this as an area of practice that requires improvement.

People told us they felt listened to and staff responded to their individual needs. People confirmed if they were not happy about something, they could approach their key-worker or the registered manager. One person told us, "She is very good, if there's anything wrong, she attends to it straight away." People were assigned a named key worker who was responsible for coordinating their day to day needs. People commented they got on with their key worker and enjoyed the weekly key worker sessions. One person told us, "I really like my key worker; I give them 10 out of 10."

Systems were in place to record and take action following on from written and verbal complaints. There were no complaints recorded on the day of our inspection. People told us they felt able to complain and expressed confidence their complaint would be taken seriously.

Requires Improvement

Is the service well-led?

Our findings

People spoke highly of the provider, registered manager and assistant manager. One person told us, "The registered manager is excellent." People knew the manager by name and said she was, "Approachable and caring." Although people felt the home was well-led, we have identified areas that require improvement.

There was a clear management structure at Davigdor Lodge Rest Home which provided lines of responsibility and accountability. Staff were aware of the line of accountability and who to contact in the event of any emergency or any concerns. A registered manager was in day to day charge of the home, supported by an assistant manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home.

There was a statement of purpose which detailed the philosophy of the home. This included promoting and respecting people's individuality and diversity. The vision of the home was documented as "At Davigdor Lodge Rest Home we collaborate with clients to help them achieve personal goals. The care staff at Davigdor Lodge Rest Home will help the client to identify personal goals and demonstrate a belief in existing strengths and abilities." Although a vision and philosophy was in place, we found this was not embedded into every day practice. Care plans did not consistently record people's goals or individual strengths. People we spoke with were not clear on what goal or aim they were working towards or wished to achieve. The statement of purpose also referenced the Care Standards Act 2000. Care standards Act 2000, was superseded by the Health and Social Care Act 2008 which now regulates health and social care service. We discussed with the assistant manager the need to update this information. We have therefore identified this as an area of practice that requires improvement.

Quality assurance systems were in place to monitor the running of the home and the effectiveness of systems in place. These included health and safety checks, medication audits, infection control audits, care plan audits and daily reporting checks. However, despite having systems, the provider did not have processes to monitor incidents and accidents for any emerging trends or themes. The managers confirmed there were no mechanisms to monitor incidents and accidents and this would be implemented. We also identified two incidents from the home's communication book which should have been recorded as an incident and accident. One example included where a person fell and required medical attention. Another example included where a person raised their fist to a staff member. Management confirmed these should have been recorded as incidents and an accident, ensuring a clear audit trial was recorded and the subsequent actions. We have identified this as an area of practice that requires improvement.

There were systems and processes in place to consult with people and staff. The provider sent out regular satisfaction surveys. This enabled management to monitor people's satisfaction with the service provided. Results from the 2014 survey found that 72% of people were happy with the support they received. 68% of people felt confident to say something negative about management and 77% of respondents confirmed they felt unique and special. Respondents who were not happy with the service provided, were asked for feedback and action was taken. However, documentation did not confirm what action was taken or whether the provider implemented an action plan. We have identified this as an area of practice that requires improvement.

Regular staff meetings were held which provided staff with the forum to air any concerns or raise any discussions. Minutes from the last meeting confirmed the last CQC inspection was discussed, and staff were provided with the opportunity to give any feedback on the findings and the report.

The home operated within a culture of honesty and transparency. Staff s and people were made aware of the last inspection and how the home failed to meet four regulations of the Health and Social Care Act 2008. People and staff were involved in the decisions on how improvements could be made.

The owner (provider) visited the home on a daily basis and people spoke highly of them. One person told us, "He takes me shopping when I need things, which is great." The registered manager confirmed she felt supported by the owner and received regular one to ones to ensure her on-going professional development.

Davigdor Lodge Rest Home is a family run mental health care home that has been within the family for over 15 years. The owner is a qualified mental health nurse having over 20

Requires Improvement

Is the service well-led?

years' experience in the mental health field. The assistant manager told us, "This is a small family run care home. We have a wealth of mental health experience and our strength is that we can provide personalised individual care to people. We recognise where we need to improve and we are striving to do so." The home had a clear understanding of recognising individual needs and valuing people's individuality, however, the experience of the owner was not consistently utilised into practice. For example, the home did not explore innovative models of mental health recovery or follow best practice evidence based research in mental health.

We recommend that the service considers the Social Care Institute for Excellence, protecting dignity in mental health.

Many people living at Davigdor Lodge Rest Home had done so for many years. Most people commented they did not wish to leave. One person told us, "The staff are wonderful. I like it here and I want to stay here for as long as I can." Throughout the inspection, it was clear management had spent time getting to know people, their mental health needs, triggers and personality traits. People appeared comfortable in the company of management and staff.