

Turning Point

Turning Point – Douglas House

Inspection report

54 Barlow Moor Road
Didsbury
Manchester
M20 2TR
Tel: 01614340539
www.turning-point.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary


- The service provided safe care. The hospital environment was safe and clean. There were enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward team included a full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service worked to a recognised model of mental health rehabilitation. It was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- The back garden was in need of some maintenance including weeding.
- The clinic room temperature was over 25 degrees on the day of our inspection. This had been documented but no action taken to mitigate.
- There was one weekly check of the emergency bag missing.
- There was an out of date mask in the defibrillator bag.
- Safeguarding level two training was at 53%.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good 	

Summary of findings

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Summary of this inspection

Background to Turning Point - Douglas House

Turning Point is a national health and social care charity, providing services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

Turning Point operates Douglas House which is an independent mental health hospital in Didsbury, Manchester, which can admit both informal and detained patients. Douglas House provides a total of 12 beds to both men and women and provides Community Rehabilitation and recovery services. Turning Point - Douglas House has been registered with the CQC (Care Quality Commission) since 8 February 2011. At the time of our inspection there were 11 patients at the hospital.

It is registered for the following regulated activities:

- Assessment and treatment under the Mental Health Act
- Treatment of disease disorder or injury. These regulated activities permit the hospital to provide care and treatment to informal and detained patients.

There have been five inspections carried out at Douglas House. The most recent inspection took place on 7, 8 and 18 March 2016. Douglas House was rated outstanding at the last inspection, gaining outstanding in both the caring and well led key question and good in safe, effective and responsive.

At the time of this inspection, there was a registered manager in post. There was also a named controlled drugs accountable officer. This meant that there was a senior person in charge who checked that the hospital met the appropriate regulations and oversaw the arrangements for managing controlled drugs (drugs that require special storage with additional record keeping rules).

We carried out a routine Mental Health Act (MHA) monitoring visit in January 2023. On that visit we found good adherence to the MHA and MHA Code of Practice, and we did not raise any issues relating to the service.

What people who use the service say

Patients told us that staff were kind, caring and supported them with their mental health and other needs. They told us that they felt the hospital had improved their lives and they were able to give us examples of how they felt this had happened, for example in relation to improving fitness and physical health.

Patients told us that staff were approachable and that they often spent time talking with them. They told us the hospital offered tasty food and they were able to cook for themselves on a weekly basis with support if needed.

Patients told us there were lots of activities on offer at the hospital and that they enjoyed taking part in these.

We reviewed carer feedback and found this to be positive. Patients told us they were encouraged to involve their family and carers in their care if this was something they wanted to do. For example, inviting them to ward rounds and important meetings about their care.

Summary of this inspection

How we carried out this inspection

The team that inspected the service comprised of 1 CQC inspector, 1 specialist advisor who was a rehabilitation nurse manager and 1 expert by experience. An expert by experience is someone who has experience of using mental health services.

We inspected this service as part of our ongoing mental health inspection programme.

To get to the heart of patients' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting this location, we reviewed information which was sent to us by the provider and considered information we held about the service. We carried out an unannounced visit to this location on 5 September 2023.

During the inspection, the inspection team:

- looked at the quality of the hospital environment
- observed how staff were caring for patients
- spoke with 8 patients who were using the service
- spoke with 7 front line staff including nursing staff and support staff, the assistant psychologist, the mental health act and quality lead and the lead responsible clinician for the location
- interviewed the registered manager and the clinical lead
- attended and observed a multi-disciplinary meeting, and a best interest meeting
- looked at treatment records of 6 patients
- carried out a specific check of the medication management in the hospital
- looked at a range of policies, procedures, audits and other documents relating to the running of the service
- observed an art group

Summary of this inspection

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Outstanding practice

We found the following outstanding practice:

- The provider had recently focused specifically on physical health to improve the physical health of the patients. There were two physical health tools used at the hospital, the Lester tool to assess cardiometabolic health and a tool called “my physical health improvement plan.” The Registered Manager had focused their dissertation around closing the gap between mental health and physical health and had implemented a health improvement plan which merged the other tools and RAG (Red Amber Green) rated improvements patients wanted to make in their physical health and any actions needed to achieve this.
- In addition to the work above, the hospital had successfully made a bid for some national lottery funding from Sport England to progress their programme called “one step at a time”. The programme was co-produced with the patients in keeping with the ethos of the provider “doing things with, not for people” and the patients were involved in taking part in a focus group where a list of ideas for improving physical health were discussed. Patients were encouraged to tick which initiatives they felt would most benefit them. This was then developed into the one step at a time programme, to enable exercise, tailored fitness plans, 1-1 personal trainers and wearable technology to track progress. It was recognised by the hospital that access to normal pathways to improving physical health were not always accessible to people with an enduring mental illness. This often was due to inequalities in social and financial circumstances as well as body image issues and low self-esteem or motivation due to illness and effects of medication. Therefore, the provider had developed the programme to try and close this gap between mental health and physical health by offering the services within the hospital.

Areas for improvement



Action the service SHOULD take to improve:

- The service should ensure that the temperature in the clinic room continues to be monitored and appropriate advice sought, and action taken if it rises above 25c.
- The service should ensure the maintenance of the back garden is kept up.
- The service should continue to ensure that no checks of the emergency bag are missed in line with the providers policy of weekly checks.
- The provider should ensure that all staff attend level 2 safeguarding training as planned in October 2023 to ensure that compliance figures continue to increase.

Our findings






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Good	 Outstanding	Good	Good	Good	Good
Overall	Good	 Outstanding	Good	Good	Good	Good

Long stay or rehabilitation mental health wards for working age adults

Good 

Safe	Good 
Effective	Outstanding 
Caring	Good 
Responsive	Good 
Well-led	Good 

Is the service safe?

Good 

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The hospital was in a detached house set over four floors. Basement, ground level and floors one and two.

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified.

Staff could not observe patients in all parts of the wards. However, this was mitigated using observations. Patients were on a minimum of hourly checks and staff knew patients extremely well, including their risks.

The ward was mixed sex but complied with guidance around mixed sex accommodation. The male bedrooms were on a separate floor to the female bedrooms. There was a female only lounge on the female floor and several bathrooms on each floor.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. There were several potential ligature anchor points. However, these risks were mitigated by robust pre admission assessment to ensure anybody who was at high risk of ligaturing was not admitted to the hospital.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. The front and side gardens were large and well maintained, however, the back garden needed some maintenance including weeding.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, the clinic room was over 25 degrees on the day of our inspection, and this had been documented and no action had been taken to mitigate. An incident form was completed at our request and guidance sought from the providers medicines team and the pharmacy provider. We could see the temperature had risen above 25 degrees a few days earlier and appropriate action was taken, an incident form was completed, and advice sought on how to decrease the room temperature. Advice given was to keep the blinds closed and set fans and an air conditioning unit up in the room. This had been done and the temperature reduced, however on the day of our inspection it was extremely hot outside and the fans and air conditioning had not managed to reduce the temperature as they had on previous days. We received an update from the provider following our inspection, they had contacted their pharmacy department and the external pharmacy who managed their medications. They had advised that although small infrequent temperature excursions are unlikely to have an adverse effect on medications, they advised a review of the air conditioning unit in the clinic room to check it was sufficient for the size of the room, as well as closure of blinds.

Staff checked, maintained, and cleaned equipment for most days. However, we noted that the last weekly checks of the emergency bag were missing from the clinic room. As the emergency bag was closed using secure tags, it was clear the bag had not been opened and equipment from the previous checks would have remained in the bag. We also noted the masks in the defibrillator bag were out of date, we requested new masks were sought and the provider confirmed this had been completed in the days following the inspection.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. There were minimal vacancies within the service with only one qualified nurse vacancy and no support worker vacancies. The occupational therapist had recently left the service and the role was being advertised for a new one.

The service used very little bank and agency staff. However, they did have a reliable and familiar group of bank staff who worked at the service when required. Agency use was rare.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates, in the last 12 months four staff had left. This had been for career progression or staff who had chosen to go back into education.

Managers supported staff who needed time off for ill health.

Levels of sickness were low.

Long stay or rehabilitation mental health wards for working age adults

Good 

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. On each shift there was one qualified nurse and one support worker. There was also an additional support worker on duty 10am until 6pm to support with leave for patients. However, there was also a wider multi-disciplinary team that complimented the staffing levels. This included a therapy team Monday to Friday (Occupational therapy assistant and assistant psychologist), the Clinical Lead and the Registered Manager.

The ward manager could adjust staffing levels according to the needs of the patients. As patients were at the hospital on a commissioned basis, if observations needed to be increased this could be accommodated by the commissioner increasing the patients funding to accommodate this. The Registered Manager told us this was never an issue to accommodate and happened immediately as the risk was identified.

Patients had regular one- to-one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The medical cover for the hospital consisted of a full time permanent consultant psychiatrist, one trainee doctor and one speciality doctor in training. The trainee doctors worked five days per week and covered two services. The on-call rota included the consultant psychiatrist and the speciality doctor. This was a citywide rota and included consultant psychiatrists from other services. A doctor could attend the hospital very quickly in an emergency. If there was a physical health emergency, then 999 would be used.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All training was above 85% apart from Safeguarding level 2 at 53% (level 3 was at 85%) and Equality, Diversity and Inclusion Awareness that was at 73%.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 4 patient records and found risk assessments to be of a high standard. They were detailed, thorough and reviewed regularly.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff knew the patients extremely well. They were able to tell us about specific patient risks and how they were managed. These were also detailed in risk assessments for any new or unfamiliar staff.

Staff identified and responded to any changes in risks to, or posed by, patients. We found that risk assessments were reviewed when incidents occurred and monthly.

Staff followed procedures to minimise risks where they could not easily observe patients. Due to the layout of the building, it was not possible to observe patients in all areas. However, staff used observations to check on patients at regular intervals (minimum hourly).

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

The service did not use restrictive interventions and staff were not trained in this. If a patient's mental health was deteriorating to the point where restraint may be required, they would be moved to a more appropriate setting. However, the provider did train staff in the use of de-escalation and breakaway techniques should these be required.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff did not use rapid tranquilisation and it was not prescribed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. Safeguarding level one was at 100% and level three was at 85%. Although safeguarding level two was only at 53%, we were able to see staff were booked onto this course in October 2023. The provider had organised specific training for this for Douglas House staff to ensure staff who were non compliant could attend.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. For example, staff could tell us about recent safeguarding concerns they had raised including financial abuse and physical abuse.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff followed clear procedures to keep children visiting the ward safe. This would be arranged prior to a visit but most patients used their section 17 leave to visit children in a more appropriate setting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They went to the local authority; the local NHS mental health trust investigated on their behalf.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Patient notes were comprehensive and all staff could access them easily. Some records were electronic and could only be accessed using a secure log in. Paper records were stored in the staff office which was locked.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. They had recently employed a pharmacy service who visited the hospital monthly and checked the medicines, carried out audits and ensured stock was ordered when required.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were discussed in two weekly ward rounds; side effects were monitored, and changes discussed with the patient.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely for the most part. Medicines were stored in the locked clinic room, the nurse in charge had the key. There was also a spare set, in case of emergencies.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The pharmacy team would request a transfer of care from the GP and carry out medicine reconciliation to ensure correct medicines were prescribed.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients were monitored when starting new medicines and any side effects reported to the doctor. If necessary, changes were made outside of ward round so that patients did not suffer unnecessary side effects for longer than necessary.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE (National Institute for Clinical Excellence) guidance.

Long stay or rehabilitation mental health wards for working age adults

Good 

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They were able to tell us examples of incidents they had reported and how they did this.

Staff reported serious incidents clearly and in line with policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. There had been no recent serious incidents to review.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. This was done in team meetings and in one-to-one supervision. Staff also had access to email where information could be shared amongst the team.

Staff met to discuss the feedback and look at improvements to patient care. There were monthly team meetings and staff were invited to share learning and suggest improvements.

Is the service effective?

Outstanding



Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 6 patient records and found that thorough preadmission assessments had taken place, to decide if Douglas House was the correct place for the patient to reside and to reduce the risk of the patient having to move again. Staff

Long stay or rehabilitation mental health wards for working age adults

Good 

attended the citywide rehabilitation meetings where referrals were discussed and were able to put forward the advantages and disadvantages of the patient being admitted to Douglas House. Once the decision was made that Douglas House was the correct place, thorough assessments of the patients historical and current mental health needs were made.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The provider had recently focused specifically on physical health to improve the physical health of the patients. There were 2 physical health tools used at the hospital, the Lester tool to assess cardiometabolic health and a tool called “my physical health improvement plan.” The Registered Manager had focused their dissertation around closing the gap between mental health and physical health and had implemented a health improvement plan which merged the other tools and RAG (Red Amber Green) rated improvements patients wanted to make in their physical health and any actions needed to achieve this.

Staff carried out audits around physical health such as for patients who were prescribed clozapine ensuring that blood tests and ECGs were carried out when required. Some staff had completed extra training to assist in physical health checks, this included venepuncture training to take blood samples when required. However, as the model of care encouraged rehabilitation back into independent or semi-independent living, visits to the GP were encouraged for most physical health issues and patients were all registered with the local GP. This meant that patients were building up skills needed post discharge to enable them to live independently.

In addition to the work above, the hospital had successfully made a bid for some national lottery funding from Sport England to progress their programme called “one step at a time”. The programme was co-produced with the patients in keeping with the ethos of the provider “doing things with, not for people” and the patients were involved in taking part in a focus group where a list of ideas for improving physical health were discussed. Then patients were encouraged to tick which initiatives they felt would most benefit them. This was then developed into the one step at a time programme, to enable exercise, tailored fitness plans, 1-1 personal trainers and wearable technology to track progress. It was recognised by the hospital that access to normal pathways to improving physical health were not always accessible to people with an enduring mental illness, this often was due to inequalities in social and financial circumstances as well as body image issues and low self-esteem or motivation due to illness and effects of medication. Therefore, the provider had developed the programme to try and close this gap between mental health and physical health by offering the services within the hospital.

Patients were also encouraged to join in local community groups around physical health and some patients were attending local weight loss groups and had some fantastic results.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery orientated. Care plans were coproduced with patients, and this meant that they were meaningful to patients. We saw very person-centred care plans, this meant that from reading them, you felt a sense of the patient and what they wanted to achieve during their admission. Where delicate subjects were discussed (for example weight loss) the care plans focused on the positives and were respectful of patients' insecurities and fears.

Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. There was a wide range of psychological therapies on offer for patients. This included 1-1 and group therapies, cognitive behavioural therapy, anxiety management and substance misuse work. There was an assistant psychologist at the hospital 4 days per week. The occupational therapist had recently left the service and recruitment was ongoing. However, the occupational therapy assistant worked full time at the hospital and was running many groups. This included, relaxation, art, family involvement and carer groups, celebrations of specific days such as pride and religious celebrations. There had recently been a carers event which was well received.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g., NICE)

Staff identified patients' physical health needs and recorded them in their care plans. We saw evidence of management of weight loss, diabetes, and mobility issues.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw evidence of patients being taught recipes for healthy meals, these were displayed on the wall in the patient kitchen and patients often cooked as a group to support each other.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. We saw patients accessing weight loss classes either online or in person to support with weight management.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. They used the recovery star and health of the nation outcome scales.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. There was a range of audits that were carried out at the hospital. These included, medication and clinic room audits, care records audits and mental health act audits. We were able to see examples of these and where shortfalls were found, action was taken to remedy this.

Managers used results from audits to make improvements. The clinical lead used information from audits of records to identify training needs for staff and was able to deliver some of these sessions one to one with staff.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Long stay or rehabilitation mental health wards for working age adults

Good 

The service had a full range of specialists to meet the needs of the patients on the ward. There was a range of staff that worked at the service. This included, doctors, junior doctors, speciality doctors, qualified nurses, support workers, a peer support worker, an assistant psychologist and an occupational therapy assistant. There was also a registered manager a clinical lead and a mental health act coordinator/quality advisor, administration staff, a chef and cleaning staff. At the time of our inspection the art therapist had left the service but a new one had been successfully appointed and was due to start in post soon after the inspection.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The service rarely used agency staff. However, when they did there was always another experienced nurse on the ward at the start of the shift to show them what to do. There was also an induction checklist for staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Appraisals took place annually for all staff and were at 100% completion.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed the minutes of the last three team meetings, we were able to see a set agenda which included safeguarding, staffing, policies and audits. Staff who attended had shared thoughts and ideas and the minutes were emailed out to staff that could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All but two of the qualified staff at the service had completed family intervention training.

Managers made sure staff received any specialist training for their role. The Registered Manager had completed a master's degree and other staff had completed training in physical health related subjects such as venepuncture.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers and senior staff felt comfortable addressing poor performance and commented that human resources were supportive if this became a formal performance management issue.

The hospital had a peer support pathway in place that worked extremely well. There were two current members of staff who had come into their roles via the peer support pathway and the pathway had proved to be very successful. This was testament to the hard work that staff carried out in supporting the patients through their rehabilitation journey and back into paid or unpaid work roles. One of the staff took on the lead for service user involvement and worked closely alongside service users promoting events for the patients and their families.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended a multidisciplinary meeting on the day of our inspection. This was attended by, the registered manager, the named nurse for the patient, the consultant psychiatrist, junior doctor, psychology assistant, a student nurse, the patient's care coordinator, and the patient's advocate. The patient was also invited into the meeting to give their views. We observed a thorough discussion around the patients care, risks and discharge plans.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. We saw good examples of team working within the organisation, for example, Douglas House worked closely with another mental health rehabilitation hospital run by Turning Point; they shared ideas and worked together.

Ward teams had effective working relationships with external teams and organisations. The staff described good working relationships with the local NHS Trust and its community mental health teams. However, there was sometimes delays in care coordinators being allocated to patients and this could cause delays in discharge planning.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a Mental Health Act lead within the organisation who often based themselves at Douglas House.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We observed a multidisciplinary review where the advocate for that patient attended and fully contributed to discussions.. The advocate reported good relations with the hospital.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. We saw that all patients at the hospital had access to section 17 leave, most of which was unescorted. We were able to see patients utilising this throughout the day and evidence in records of this happening.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The last Mental Health Act monitoring visit for Douglas House was in January 2023. On that visit we found good adherence to the MHA and MHA Code of Practice, and we did not raise any issues relating to the service.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months, all patients were detained under the Mental Health Act.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We observed a best interest meeting for a patient following a mental capacity assessment around housing. This was done on a decision specific basis and all options were considered by the team prior to a decision being made, including what the patient wanted and trying to keep their wishes at the centre of the meeting.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Long stay or rehabilitation mental health wards for working age adults

Good 

Is the service caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed kind and caring interactions between patients and staff during our inspection. It was clear staff knew patients well and that patients felt at ease with the staff in the hospital.

Staff gave patients help, emotional support and advice when they needed it. Patients told us during interviews how staff had helped them during their admissions. Examples of this included support at weight loss groups, help with arranging housing, benefits and supporting them during leave and meetings regarding their care.

Two nurses who worked at the service, were voted for, in part, by patients, to receive nominations and later awards for mental health nurse of the year and runner up as nurse leader of the year.

Staff supported patients to understand and manage their own care treatment or condition. Patients care plans were very patient centred and were coproduced with patients. We were able to see the patient voice throughout the care plans and during decisions about treatment and care, such as medication reviews and discharge planning.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Patients gave unanimously positive comments about the staff at Douglas House. They told us they felt safe, cared for and commented that staff made them feel that they mattered.

Staff understood and respected the individual needs of each patient. We were able to observe during ward rounds and staff discussions that they knew patients well and understood their needs on an individual basis.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

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Good 

Staff introduced patients to the ward and the services as part of their admission. There was a welcome pack for patients to read and staff would show them around on admission. The staff would also go to meet the patients prior to admission so they already knew some staff before arriving.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate. For example, patients were consulted on questions they would like to ask new staff being interviewed to work at the hospital. If they felt comfortable doing so, they were able to join the interview panel to take part in the interview process.

Patients could give feedback on the service and their treatment and staff supported them to do this. We reviewed patient meeting minutes for the patient community meeting for the last three months. We saw evidence of patients being involved in decisions about the service, for example, discussing a carers event, new staff starting and involvement in local community events such as the local pride festival.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services. They attended the hospital on a weekly basis.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. There had been a recent carers event organised by the hospital. The carer's event had a raffle, cake and drinks, and involved selling bookmarks, cards, and keyrings made in the hospital art group. Patients' families attended and a new information pack about the hospital was given to those that attended along with the hospital newsletter. Money raised was donated to a charity of the patients' choice.

Staff helped families to give feedback on the service. We reviewed carers feedback forms. They told us that carers felt the hospital was a friendly welcoming environment. Carers felt involved in the service and listened to. Carers also requested another carers event as they had enjoyed the last.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good 

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Long stay or rehabilitation mental health wards for working age adults

Good 

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. However, sometimes this was out of the hospital's control, for example awaiting housing placements or a care coordinator. The hospital did as much as they could to chase up these things and ensure that the patient was successfully discharged. The average length of stay was 18 months but some patients had been there for longer than this.

The service had no out-of-area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. For example, if they needed readmission to a local NHS hospital due to deteriorating mental health.

Staff did not move or discharge patients at night or very early in the morning.

If a patient needed more intensive care and this was not far away from the patient's family and friends. There was a psychiatric intensive care unit at the local NHS Trust.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and four of these had an en-suite bathroom. For patients without an en suite, there were enough shared bathrooms. Each patient had a space to keep their belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. We had a tour of the hospital during our inspection and were able to view patients' bedrooms with their consent. We saw patients had personalised their rooms with their own belongings such as photographs of family and friends, ornaments and their own bedding.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. There was a large lounge, a conservatory, outdoor area, dining room, kitchen and gym. There was also a female lounge on the floor where female bedrooms were located.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff.

Long stay or rehabilitation mental health wards for working age adults

Good 

The service offered a variety of good quality food. The chef was based at the hospital and was able to take requests from patients daily. Patients were very complimentary of the food. Patients also did group cooking sessions where they made food for each other. In the patient kitchen there were healthy recipes on the wall that patients could use to aid healthy eating and support with weight loss.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. This included taking part in local community groups such as local colleges, exercise groups and weight loss classes.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were two bedrooms on the ground floor for anyone with mobility issues.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. During our tour of the hospital, we saw lots of information displayed around the building for patients to read. For example, local community groups, groups to support people with substance misuse issues, information about the mental health act and advocacy.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed. The staff told us this was easy to access using an online tool.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The onsite chef was able to cater for any specific dietary needs, for example vegetarian and vegan diet, kosher and halal meals.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. This was discussed in feedback forms completed by carers that we reviewed as part of our inspection.

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Good 

The service clearly displayed information about how to raise a concern in patient areas. There was information available on how to raise a concern or complaint in the hospital. There was also signposting to services that could support patients complaining.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There were few complaints about the service and no themes had been identified.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. This was done via team meetings and if needed individual one to ones.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Local leadership was provided by an experienced registered manager who was supported by a clinical lead nurse and administration team. At ward level there were senior nurses and other experienced staff to ensure the services provide safe, effective care that met the needs of patients.

Senior staff had a good understanding of the services they managed and adhered to a recognised model of care, staff we spoke to shared this understanding. Senior staff had the skills, knowledge and experience to perform their role and made sure they were accessible and visible to staff and patients at the hospital.

Patients at the hospital told us they trusted the registered manager and senior staff and felt they were treated fairly and listened to. Staff told us they also felt well supported by leaders within the hospital and that they had a truly open-door approach. More senior members of the management team within the organisation also visited the hospital.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The providers values underpinned all work with patients. They were:

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Good 

- We all communicate in an authentic and confident way that blends support and challenge
- We commit to building a strong and financially viable Turning Point together
- We deliver better outcomes by encouraging ideas and new thinking
- We treat each other and those we support as individuals, however difficult and challenging
- We are here to embrace change, even when it is complex and uncomfortable
- We believe that everyone has the potential to grow, learn, and make choices

Staff had the opportunity to contribute to discussions about the strategy of the services and any changes to them.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

We spoke to 7 staff during our inspection. They told us they felt very well supported by the managers and senior leaders in the organisation and at the hospital. They told us they were supported to progress within their roles and offered suitable specialist training and educational opportunities. They were also able to seek out their own courses relevant to their role and ask for the time to undertake these. Staff appraisals included conversations about career development, and they had access to opportunities and training to do so.

Staff told us they felt able to raise concerns when they had them and felt empowered to speak up. Staff were extremely positive about their work and showed genuine care and compassion for the patients they were looking after. Many staff had worked at the hospital for some years.

Candour, openness, honesty, and transparency were a clear part of the hospital culture and staff and patients could challenge poor practice. Staff knew the whistle-blowing process and about the role of the Speak-Up Guardians. All staff we spoke to said they felt able to raise concerns without fear of retribution.

The service's staff sickness and absence rates were low and there were clear policies and procedures in place to address poor staff performance and keep people safe.

Two staff at Douglas House had been successful in the Turning Point Nurse Awards. One nurse had won mental health nurse of the year, and another came runner up in the mental health nurse leader award. These awards were voted for, in part by the patients at the service.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

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Good 

The governance framework ensured that information about the hospital fed up to the senior leaders in the organisation and back down to the hospital. Managers were able to attend regional meetings with other registered managers and senior leaders in the organisation to feedback and discuss performance of their service. This ensured good oversight of the hospital and a focus on improving the quality of care provided.

The rights of patients who were detained under the Mental Health Act were protected. The service operated systems to monitor and record adherence to both the Mental Health Act and Mental Capacity Act and ensure staff discharged their duties under each act appropriately.

An effective multi-disciplinary team was in place and functioned well to ensure all patients at the hospital received the psychological and occupational therapies appropriate to their needs, in line with national guidance.

Governance systems and processes were in place to ensure the hospital environment was clean and safe and that staff could provide effective, good quality care to patients. Staff undertook local clinical audits on a regular basis covering all aspects of care quality.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service had a local risk register which fed into the provider risk register. The registered manager was able to add to the local risk register and feed this up to more senior staff who reviewed the provider risk register. The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Any incidents were reported, investigated, reviewed and escalated through the hospital's governance structure.

Information Management.

The care records we reviewed were completed in a timely way, accurate and protected patient confidentiality. Staff made notifications to external bodies as needed. Patients were informed if their personal information was shared with external bodies and their consent was sought appropriately.

Managers had access to dashboards so they could monitor performance of staff, for example an overview of training.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

The staff at the hospital worked hard to ensure that patients were engaged in the local community. For example, they had recently attended the local pride event.

Patients had opportunity to give feedback on the service they received. The advocacy service provided patients with support to do this if required and would attend meetings with patients if they requested this level of support.

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Good 

There was a bimonthly newsletter for the hospital produced by staff. This detailed events that had taken place, upcoming events and news about staff. We reviewed the last 2 and found discussions around a barbeque, celebrations of the Kings coronation, Eid and feedback from patients about a new gardening group that had commenced.

There were patient, staff and carer feedback forms and the themes from these were analysed to look for themes and trends. Recent staff feedback forms had shown increasing figures for questions around leadership, the provider and how proud they are to work for them, feeling valued at work, learning development opportunities and psychological support and wellbeing.

Care coordinators were invited to the ward rounds and reviews for patients, discussions took place from early in the admission regarding future placements for patients and the service engaged with future placements with the aim of a smooth transition for patients.

Learning, continuous improvement and innovation

The service offered student nurses, placements at the service.