Turning Point - Douglas House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We rated Turning Point - Douglas House as outstanding because:

- There were strong, person centred clinical leadership and governance arrangements, led by a well-respected registered manager. The manager clearly articulated the changes they had made to the hospital through listening to staff, patients and other stakeholders. This was complemented by a comprehensive range of audits which were fully completed to continuously drive improvement. The manager had clearly articulated positive changes following audit.
- Patients and staff worked in true partnership as equal partners with a focus on recovery principles and shared decision making. Managers were looking to consolidate this through adopting the 'implementing recovery through organisational change' programme. The service involved patients in a range of ways and at all levels from involvement in their own individual care goals through to involvement in the hospital through to commenting on Turning Point's national policy and campaigning work. This was exemplified by the manager who encouraged patient representatives to be fully involved in the presentation made to the CQC inspection team.

We also saw:

- Staff carried out thorough risk assessments on patients to ensure they could be cared for in a rehabilitation environment. The hospital manager took immediate and significant action to address the washing arrangements in one bedroom so that it fully complied with same sex guidance. The hospital had minimal incidents but when these occurred staff took appropriate action to address them and learn lessons.
- The hospital was recovery focused with care and support plans developed from the mental health recovery star tool. Patients received multidisciplinary input from a range of staff which included an occupational therapist, an arts therapist and assistant psychologist. Staff provided enthusiastic and individualised support to patients over daily tasks such as planning and shopping for meals, cooking and tidying. There were good systems in place to support adherence to the Mental Health Act (MHA).The MHA co-ordinator attended ward rounds on a weekly basis to promote adherence to the MHA.
- Staff engaged with the local city-wide review team to discuss and co-ordinate the admission of all patients into rehabilitation beds across Manchester. The hospital started planning for patient discharge from when patients were first admitted. There was a small outreach team to work with patients on discharge if they needed ongoing proactive support. There had been no complaints at Douglas House for the last 12 months.

However we also found that:

- The medical input to patients provided by the local mental health trust was not covered by a written service level agreement that clearly outlined the rights and responsibilities of each party and the appropriate local escalation and resolution if any matters of concern were raised by either party.

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 rehabilitation and recovery services.

Turning Point - Douglas House has been registered with the CQC since 8 February 2011. It is registered for the following regulated activities: assessment and treatment under the Mental Health Act and 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 four inspections carried out at Douglas House. The most recent inspection took place on 22 July 2013. Douglas House was compliant across all the standards we looked at on that inspection which included consent arrangements, meeting people's care and welfare needs, meeting nutritional needs, safeguarding, recruitment of staff, complaints and record keeping.

At the time of this inspection, there was a registered manager in place who was also the 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 July 2015. On that visit we found good overall adherence to the MHA and MHA Code of Practice and only identified minor shortfalls. Managers of Douglas House provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice in these areas.

Our inspection team

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

Why we carried out this inspection

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

How we carried out this inspection

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?

Summary of this inspection

• 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 asked the local commissioners of the service and the local Healthwatch about their involvement and views.

We carried out an announced visit to this location on 7, 8 and 18 March 2016. During the inspection visit, the inspection team:

- looked at the quality of the hospital environment
- observed how staff were caring for patients
- spoke with eight patients who were using the service and two relatives
- spoke with seven front line staff including nursing staff and support staff, the occupational therapist, the mental health act co-ordinator and the lead responsible clinician for the location
- interviewed two senior managers with responsibility for these services, including the registered manager and the nominated individual
- attended and observed a hand-over meeting and a healthy cooking and eating group
- looked at treatment records of eight patients
- looked at the Mental Health Act documents of three patients
- carried out a specific check of the medication management in the hospital and looked at all relevant prescription charts and
- looked at a range of policies, procedures, audits and other documents relating to the running of the service.

What people who use the service say

We spoke with eight patients who used the service and two relatives. Most patients were seen by the expert by experience. Patients told our expert by experience that staff were approachable and friendly. Patients told us that there was a good variety of activities available to them, including arts, trips out and cooking. Patients were universally complementary about the care they received.

Patients felt fully involved in the running of the hospital.

We spoke with two relatives of current patient at Douglas House. They were both complimentary about the respectful care their relatives received. One relative stated that their relative had made good progress since moving to Douglas House.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were appropriate admission assessments in place to ensure that patients could be cared for safely in a rehabilitation environment.
- Whilst there were ligature risks these were mitigated by appropriate assessment, individualised risk management and therapeutic engagement of patients.
- The hospital mostly complied with the Department of Health required guidance on same sex accommodation and took immediate and significant action to address the washing arrangements in one bedroom so that it fully complied with same sex guidance.
- There were enough staff to ensure the safety of patients at all times.
- Staff carried out thorough ongoing risk assessments on patients.
- There were a range of well-completed health and safety, medication and maintenance audits in place.
- Nursing staff worked within appropriate medicine management arrangements.
- Staff understood safeguarding procedures and took action to safeguard vulnerable patients.
- The hospital had minimal incidents but when these occurred they told us about them and took appropriate action to address them and learnt lessons.

Are services effective?

Good

We rated effective as good because:

- The hospital was recovery focused.
- Care and support plans were developed from a recognised recovery based assessment tool (the mental health recovery star tool).
- Patients received medical and clinical interventions to minimise symptoms of their mental health through both medication and psychological interventions.
- Patients received input from a multidisciplinary team which included an occupational therapist, an arts therapist and assistant psychologist.
- Staff providing enthusiastic and individualised support to patients over daily tasks such as planning and shopping for meals, cooking and tidying.

Summary of this inspection

- Patients received support to ensure they received appropriate physical and dental health care.
- Managers carried out a number of audits including medication, multidisciplinary team records, patient involvement, risk management and infection control.
- There were good systems in place to support adherence to the Mental Health Act (MHA).The MHA manager attended ward rounds on a weekly basis to promote adherence to the MHA.
- Where mental capacity assessments were carried out, these were decision specific and followed the principles and stages set out in the Mental Capacity Act.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients were universally positive about the staff in the hospital providing high quality care and support.
- We observed staff providing positive and enthusiastic support to patients including a very positive group meeting on healthy eating.
- Carers we spoke with were also very positive about the support their loved ones had received.
- Patients were seen as active partners and were encouraged to be involved in many decisions. For example, patients were actively involved in the presentation that the managers of the hospital gave to us.
- Patients were encouraged to be involved in their own recovery, the running of the hospital, regional meetings and commenting on national policy through the national organisation.
- Patients had access to advocacy input on a telephone referral basis; which promoted patients to access advocacy themselves.

Are services responsive?

Good

We rated responsive as good because:

- Douglas House staff engaged with the city-wide review team to discuss and co-ordinate the admission of all patients into rehabilitation beds across Manchester
- Patients who had recently been admitted to Douglas House had received a gradual process of visits, overnight stays and extended leave before being transferred fully.
- The hospital started planning for patient discharge from when patients were first admitted.
- There was a small outreach team to work with patients on discharge if they needed ongoing proactive support.
- The hospital had a homely feel.

Summary of this inspection

- The hospital provided vegetarian options and Halal food to meet the needs of current patients.
- There had been no complaints at Douglas House for the last 12 months.

Are services well-led?

Outstanding 

We rated caring as outstanding because:

- Patients were universally positive about the staff in the hospital providing high quality care and support.
- We observed staff providing positive and enthusiastic support to patients including a very positive group meeting on healthy eating.
- Carers we spoke with were also very positive about the support their loved ones had received.
- Patients were seen as active partners and were encouraged to be involved in many decisions. For example, patients were actively involved in the presentation that the managers of the hospital gave to us.
- Patients were encouraged to be involved in their own recovery, the running of the hospital, regional meetings and commenting on national policy through the national organisation.
- Patients had access to advocacy input on a telephone referral basis; which promoted patients to access advocacy themselves.

Are services responsive to people's needs?

We rated responsive as good because:

- Douglas House staff engaged with the city-wide review team to discuss and co-ordinate the admission of all patients into rehabilitation beds across Manchester
- Patients who had recently been admitted to Douglas House had received a gradual process of visits, overnight stays and extended leave before being transferred fully.
- The hospital started planning for patient discharge from when patients were first admitted.
- There was a small outreach team to work with patients on discharge if they needed ongoing proactive support.
- The hospital had a homely feel.
- The hospital provided vegetarian options and Halal food to meet the needs of current patients.
- There had been no complaints at Douglas House for the last 12 months.

Are services well-led?

We rated well-led as outstanding because:

- There was strong person-centred culture.

Summary of this inspection

- Governance arrangements and audits were comprehensive and were proactively reviewed reflecting best practice.
- Staff welcomed the views of people who use services, relatives and stakeholders and saw this as a vital way of improving the service.
- The registered manager clearly articulated how they had listened to patients, relatives and stakeholders and could clearly outline the changes that had been made to the service and its practice as a result.
- There was a strong commitment to working with other agencies to improve care pathways and challenge stigma.
- There were high levels of staff satisfaction. Staff were proud to work at Douglas House and spoke highly of the culture.
- Staff were actively encouraged to raise concerns and changes had been made to address staff concerns.
- There was strong collaboration and a common focus on improving quality of care and patient's experiences.
- The registered manager and the clinical team leader drove continuous improvement.
- There was a clear proactive approach, for example through developing a bespoke support service to help manage the transition of patients from the hospital to the community.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We carried out a routine Mental Health Act (MHA) monitoring visit in July 2015. On that visit, we found good overall adherence to the MHA and MHA Code of Practice. We identified minor shortfalls on that visit. Managers of Douglas House provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice. On this inspection, we found that the issues raised had been addressed. For example staff collected better evidence to show that they had given patients forms that recorded leave approved under section 17, there was improved recording on the legal certificates (T2 forms) when higher dose medication was given and improved systems to try and ensure approved mental health professional reports were on file.

The hospital had a MHA manager who ensured that the responsibilities of the MHA were met. There were good systems in place to support adherence to the MHA. The records we saw relating to three out of four detained patients were generally well kept with good evidence of patients being informed of their rights as detained patients, good records relating to the approval of section 17 leave and good arrangements to ensure all patients having appropriate legal authority to treat on a T2.

The MHA manager attended wards rounds on a routine basis. This helped to ensure that any key deadlines or tasks required by the MHA were met.

There were regular and robust audits of the hospital's MHA duties. Staff had received relevant training including training on the changes in the revised MHA Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff spoken with demonstrated a good awareness of the Mental Capacity Act (MCA). Staff understood in what situations the MCA would be used. For example, for treatment decisions for physical health issues.

Staff provided information to patients to enable them to make informed choices. Patients' capacity to understand their responsibilities to keep medicines safe was assessed prior to agreeing a staged process for self-medication.

Where capacity assessments were carried out, these were decision specific and followed the principles and stages set out in the MCA. Staff understood the process to follow when decisions needed to be made if a patient lacks capacity over any given decision. Where significant decisions were made, staff ensured that safeguards were in place to support incapacitated patients.

Turning Point had a policy and a checklist for the consideration of Deprivation of Liberty Safeguards (DoLS). The checklist supported staff to consider whether a patient was being deprived of their liberty due to significant restrictions on patients. There were no patients subject to DoLS at the time of our inspection. Informal patients were consenting to stay on the unit, were free to leave and were not subject to restrictions.

Long stay/rehabilitation mental health wards for working age adults

Outstanding ☆

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

Douglas House provided rehabilitation to patients with enduring mental health needs. The hospital was a converted detached house over four floors. There had been adaptions to the building to remove major risks including screening on the stairwell and an external fire stair case from all floors. The hospital had a number of safety and ligature risks throughout the unit. Ligature risks were places to which patients intent on self-harm might tie something to strangle themselves. The ligature risks included domestic taps, curtain and blind rails which were not fully collapsible and domestic restrictors on windows. However these risks were mitigated by robust individualised admission assessment processes to ensure that only those patients who could safely be managed with these risks were accepted for admission utilising positive risk taking approaches.

Care records confirmed that none of the current patients had a history of self harm, suicide or ligaturing. There were ligature knives available in staff areas and staff knew where they were kept so staff could respond if an incident occurred. There had been no incident of ligaturing in the last four years or more. Patients told us that they felt safe.

Most of the bedrooms were on gender segregated corridors off a central staircase; with the first floor designated as female with a separate women only lounge and the second floor designated as male. On each of these corridors there was one en suite bedroom and at least one bathroom with a separate toilet. Toilet and bathing facilities were grouped to achieve as much gender separation as possible.

On the ground floor there were two bedrooms currently designated as beds for female patients; one of which had en suite facilities. The bedroom that did not have an en suite was situated in the reception foyer area with no bathing facilities nearby. This meant that any women patient had to pass a general foyer area and go upstairs to access bathroom facilities. The arrangements for this room did not always comply with the Department of Health gender separation requirements. We raised this with the manager on the first day of the inspection and they immediately arranged for finances to be approved and a workman drew up plans to convert the room to have an en suite room so that it would comply with the gender separation requirements. When we returned, the en suite bathroom was nearly completed and we have since received assurances that it was completed at the end of March.

The hospital was clean and well maintained. The manager immediately addressed a poorly maintained window restrictor we found in a dormer window on one of the rooms on the top floor. Patients and staff commented favourably on the cleanliness of the hospital. The only exception was the inside of the microwave in the rehabilitation kitchen which was stained with food. Patients were encouraged to take responsibility of the cleanliness of the equipment in the rehabilitation kitchen as part of their recovery. The cleanliness of the microwave

was addressed immediately. Cleaning equipment was colour coded and mops and buckets were stored appropriately to maintain hygiene and prevent cross contamination.

The clinic room was clean and tidy. The clinic rooms and refrigerators were checked daily by nursing staff to ensure that medicines were stored at the correct temperature and were safe to use. The clinic room had resuscitation equipment, including a defibrillator which was checked daily to ensure it was working correctly.

The hospital was homely and comfortable. Regular checks on the environment included health, safety and fire arrangements and cleanliness of the communal areas. There were daily cleaning schedule records and checks on the operating and storage of food temperatures of fridges and freezers in the kitchen.

Patients at Douglas House were stable in their mental health and did not present with ongoing management problems. Managers had therefore deemed that Douglas House would not have a seclusion facility. If patients could not be de-escalated, staff at Douglas House would look to transfer the patient to the nearby local psychiatric intensive care unit run by the local NHS mental health trust. The consultant psychiatrist who provided care and treatment for all patients at Douglas House worked at this trust which would help facilitate speedy transfer. Care plans showed that there were no patients with a current risk of violence and aggression at Douglas House.

All bedrooms had fire alarms and nurse call systems. We tested the call system on the top floor and staff responded to the alarm within 90 seconds. This meant that staff responded well to the alarms when they were pressed.

Safe staffing

There were eight qualified nurses employed at Douglas House and eight and a half whole time equivalent (wte) nursing assistants, including a part time project worker. Douglas House had minimal staff vacancies with one full time nurse vacancy and no nursing assistant vacancies. Managers had taken action to fill these vacancies.

There was a minimal number of shifts that had to be filled by bank or agency staff to cover sickness, absence or vacancies. For example in the three month period from 1 August 2015 to 31 October 2015 was there were only eight shifts each month that required bank or agency staff. There were no shifts in this period that did not have the expected staff numbers on shift. In the last 12 months, Douglas House had three staff leaving over the last year which led to a staff turnover of 16%. It had a sickness rate of 4% which meant that people received care and treatment from staff who rarely went off sick.

Many staff had worked at Douglas House for many years. Staff could tell us detailed information about the needs of the patients including their strengths, interests and support needs. Patients therefore received care from regular staff who knew their needs and helped promote their recovery.

On each shift, there were four staff on duty during the day including at least one clinical team leader, one qualified nurse and two support workers. This reduced to two staff at night including one qualified nurse. Staff and patients felt that there were enough staff to meet the needs of patients at Douglas House. Turning Point had another rehabilitation hospital in the locality so staff could be deployed from there to cover short term absence.

There were a variety of other staff to provide care and treatment including an arts therapist, a project worker and an occupational therapist. There was a clinical lead nurse and an experienced registered manager.

There were eleven patients at Douglas House during our inspection visit. One patient had been discharged when we returned. Patients told us and records confirmed that that there were sufficient staff and activities, escorted leave and one to one named nurse sessions occurred without being cancelled.

Patients were registered with local GPs who provided medical input for physical health conditions. A consultant psychiatrist based from the local mental health NHS trust provided consultant psychiatrist input to Douglas House which had been arranged through the clinical commissioning group contract. The psychiatrist attended weekly and ensured that each patient was reviewed at these meetings. During out of hours and when the psychiatrist was on leave or away, psychiatric input came from the doctor on call from the trust. This arrangement was reported to work well but was not formalised through any written service level or partnership agreement. Staff at Douglas House had recognised the need for a partnership or service level agreement and had made attempts to progress the drawing up of such an agreement. The consultant psychiatrist confirmed that staff at Douglas

House liaised appropriately with the medical team. This ensured the monitoring and management of patients' mental health and medication, which optimised recovery and managed any anticipated risks.

Staff records showed which mandatory training they had attended. The hospital used a training matrix which showed when training was due and whether a member of staff had attended training. This showed that most staff were up-to-date across the mandatory training subjects. All care staff had received up-to-date emergency first aid training, information governance training, health and safety training and safeguarding training The training matrix showed that there were a few gaps; where there were gaps, this was identified as requiring attention by those relevant staff through e-learning or booking on face to face training with dates for upcoming sessions.

The hospital had systems in place to ensure that staff were recruited appropriately with the correct checks to ensure that the right staff worked with vulnerable patients. This included taking up references, disclosure and barring checks, photographic ID checks and checking nurses' registration. The only shortfall was that on a two staff files, there were gaps in staff employment histories without a corresponding satisfactory explanation of the reason for such gaps. The regulations state that care employers should receive explanations of gaps to ensure people employed are of a suitable character. When we returned, managers had ensured that any gaps in staff employment history were covered by a satisfactory explanation.

Assessing and managing risk to patients and staff

Douglas House provided hospital care for the rehabilitation of patients with enduring mental health needs. There was a robust pre admission assessment in place to ensure patients were well enough to be cared for in a rehabilitative environment. The hospital did not have a seclusion room and did not use restraint. Staff used de-escalation methods to support patients who presented with occasional disturbed behaviour. Staff worked with patients to learn how to cope when they became agitated and what triggers may cause this. We saw evidence of this planning in patient files and patients were actively involved in developing these plans.

Staff risk assessed patients using a recognised comprehensive tool to assess all patients on admission to Douglas House. The team reviewed these assessments on a regular and ongoing basis. Where there were particular concerns, assessments would be reviewed if required. We reviewed eight care records and all of these had up-to-date risk assessments with detailed individualised risk management plans.

Patient risk assessments then led to risk management plans which detailed the action staff needed to take to minimise the risk to and from individual patients. Information about patients' risk included indicators of patients' relapse symptoms, patients' behaviours and coping strategies to support patients to lessen their distress.

We spoke to the consultant psychiatrist who worked at the local mental health trust and was currently the responsible clinician for all the patients at Douglas House. They said that staff at Douglas House worked well with patients and had successfully rehabilitated some challenging patients. They also told us that staff provided appropriate support to monitor and manage risk using positive risk taking approaches.

Douglas House was an open unit and there were appropriate signs by the door advising informal patients of their rights to leave. There were no blanket restrictions in place; patients had access to fresh air, mobile phones and their possessions.

Patient records were held electronically with some paper records. Records were held securely in the staff office. Staff were aware of their responsibilities to keep patients information confidential.

Staff could describe the safeguarding reporting process in the hospital. Staff described that they reported any incidents to the nurse in charge or manager. This would then be referred to the local authority and NHS trust which had placed the patient at Douglas House. Turning Point had its own safeguarding policy and procedure. The policy guided staff to follow the local authority/NHS safeguarding procedures. Douglas House had copies of the relevant local authority and NHS trust safeguarding policy for staff to refer to. There were posters in the reception area for patients to inform them of their right to raise a safeguarding alert directly to the local authority. Managers of the hospital had notified us of any safeguarding alerts they had made. For example, staff had raised an alert as they suspected

financial abuse. There was one ongoing safeguarding investigation at the time of the inspection; the hospital was conducting its' own investigation following advice from the local adult safeguarding team in the local authority.

Medicines were stored securely, in a locked cupboard in a locked room. Audits of the management of medicines took place on a weekly and monthly basis. The hospital had appropriate arrangements for managing controlled drugs which were drugs which required special storage and additional record keeping rules. The registered manager was the controlled drugs accountable officer. They had received information from the local controlled drugs local intelligence network to ensure they were up-to-date on current best practice on the storage and recording of controlled drugs. Medicine charts showed that patients received the medication they were prescribed.

When children visited patients at Douglas House, there were a number of rooms, including the activity room and lounge, which could be used to accommodate the visit.

There was a range of comprehensive health and safety checks which were completed regularly to ensure that all appropriate health and safety regulations were met. There was a monthly infection control audit which showed staff were adhering to prescribed infection control measures including hand hygiene, waste and clinical waste disposal and immunisation checks. The hospital had a business continuity plan which guided staff on what to do in the event of particular emergencies including the arrangements in place if there was a major event which meant that all patients had to transfer out of Douglas House. This included all up-to-date contact details which were in a separate folder which could be taken in an emergency to help manage the situation.

There was a corporate risk register and risk assurance framework which identified the risks that the company had identified nationally. Douglas House had their own local register. The risks identified were risks that could happen in the future such as pandemic outbreak, unprovoked assault on staff by patient and confidential data breach. The hospital had controls on all the risks identified in the risk register and therefore did not have any significant risks that required ongoing monitoring or action to address them.

Track record on safety

We looked at the incidents that had occurred recently at this hospital. All independent hospitals were required to submit notifications of incidents to us. The hospital had notified us of appropriate relevant events including safeguarding incidents and incidents which involved the police. There had only been three notifiable incidents in the past year. Managers had taken appropriate action to manage these incidents. There had been no serious incidents at Douglas House.

A range of performance indicators were monitored every month and reported centrally. Governance arrangements were in place to ensure there were appropriate reviews of incidents and complaints, and action on audits.

Reporting incidents and learning when things go wrong

Staff were aware of the systems to report and record incidents. Incidents were reported on an electronic incident recording system. We saw as part of the audit process the manager collated reported incidents onto a monthly spreadsheet and this included any actions taken and the outcome of incident analysis. We saw that no serious incidents had occurred at the hospital. Other incidents recorded included minor verbal altercations between patients and occasional incidents of patients returning late from leave.

Staff felt that incidents were reduced by the therapeutic relationship they had with patients such as knowing patients well, reducing triggers and identifying early warning signs.

When incidents occurred there was a debriefing session, which looked at what led up to the incident and helped staff consider issues that had arisen, how staff reacted and how things could be done differently next time.

We saw that there was a system to ensure lessons had been learnt, for example, Turning Point had a newsletter which provided alerts and informed staff of safety lessons which had occurred in other services nationally. This included alerts on so called ‘legal highs’ and advice from the local authority following a safeguarding incident with a local taxi firm. Following an alert about self closing devices on fire doors being faulty in another service, staff at Douglas House had checked their devices were working.

We observed a handover and saw incidents were discussed. Staff reported that debriefs took place after incidents. Staff were aware of their responsibilities around

Long stay/rehabilitation mental health wards for working age adults

Outstanding ☆

duty of candour which required staff to be open and offer an apology when an incident occurred resulting in patient harm. There had been no incidents which met this threshold at the hospital.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff used a recovery model to support patients' recovery. Care and support plans were developed from a recognised recovery based assessment tool (the mental health recovery star). This tool assessed and provided guidance on recovery based support to people with mental health needs. The mental health recovery star was a collaborative tool and allowed patients to set goals and map their own progress against these goals. We saw evidence that this assessment tool was being used by staff to plan care with patients. This was developed into a collaborative care plan that enabled recovery and social inclusion. The care plan clearly identified service user goals and, where there was further needs or goals identified by staff, these would be separately recorded. This helped to ensure that patients that lacked insight still developed and worked towards their own recovery goals but this was augmented by staff identifying goals to work with individual patients, for example, staff supporting patients to gain improved insight.

Care plans provided good information for patients and staff (including new staff) to fully understand what patient's strengths and needs were and how their needs were being met. The support plans that staff produced from the recovery star assessment were of a good standard to meaningfully maximise recovery from mental health problems, independence, functional ability, achievement of self-care and patient goals. This meant that patients received a holistic multidisciplinary assessment and formulation of their individualised needs.

Patients received medical and clinical interventions to minimise symptoms of their mental health through both medication and psychological interventions. Patients were able to discuss their medication at their weekly ward round. Patients commented that they were able to discuss and agree changes to their medication with their consultant psychiatrists who listened to them and acted on their concerns. This meant that patient's medication was at an optimum level which suited them; at levels which helped to relieve the symptoms of mental ill health whilst ensuring that side effects were minimised.

Patients also received individualised practical support to aid their recovery. For example, access to appropriate welfare benefits support, help with budgeting, assistance with activities of daily living, such as shopping, cooking and cleaning. Throughout our time at Douglas House, we saw staff providing enthusiastic and individualised support to patients over daily tasks such as planning and shopping for meals, cooking and tidying. Patients were supported to access social, cultural and leisure activities, education and vocational resources to help aid their recovery. Two patients were undertaking regular voluntary work.

Patients received support to ensure they received appropriate physical and dental health care including attending primary and secondary medical care appointments. All patients had weekly physical health checks. Patients were encouraged to attend their GP for annual physical health checks. Patients had a comprehensive 'my physical health check' plan which was a recognised tool formulated by the charity Rethink Mental Illness to improve physical health outcomes for people affected by mental illness in line with national CQUIN (Commissioning for Quality and Innovation) targets.

When people were ready for discharge, staff from the hospital and the care co-ordinator supported patients to access personal budgets as appropriate to support their individualised recovery goals on discharge.

Best practice in treatment and care

The hospital evidenced that they were providing care and treatment to ensure effective rehabilitation to patients. This was underpinned by principles of further recovery, optimising medication regimes, engagement in psychosocial interventions and gaining skills for more independent living. This clearly evidenced the characteristics of an effective rehabilitation unit as detailed in recent best practice guidance for commissioners of rehabilitation services for people with complex mental health needs. This report was produced by the Joint Commissioning Panel for Mental Health which was

collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. The focus of this guidance is around the individual gaining support in recovery with patient involvement and social inclusion in order to successfully transfer back into the wider community.

Staff at Douglas House followed the National Institute for Health and Care Excellence (NICE) guidelines in the care and treatment of schizophrenia and prescribing of anti-psychotic medication [CG178]. At the time of our inspection, two patients were on a high dose of anti-psychotic medication (which was where antipsychotics were given above recommended levels either in a single or combined dose). High dose anti-psychotics were covered by the appropriate MHA legal certificates. The reasons for prescribing high dose anti-psychotics treatment were recorded to understand why the patient required medication at higher doses. Patients were monitored for appropriate side effects whilst on high-dose antipsychotics.

Patients had access to psychology and art therapists. This meant that patients had access to talking therapy and other treatments to aid their recovery in line with best practice. This included cognitive behavioural therapy, family therapy and art therapy.

There was evidence that the progress of patients was regularly monitored and updated, including through looking the recovery star scores to show patients' progress. Managers measured the overall progress that had been made to progress patients' recovery across the hospital every six months. The latest results showed the hospital was effective in supporting patient recovery with patients making progress against their stated goals.

Managers carried out a number of audits including medication, multidisciplinary team (MDT) records, patient involvement, risk management and infection control. Turning Point had a quality assurance process which was underpinned by best practice. Managers assessed the services against the regulations we inspect against. The audits confirmed that the hospital was meeting the best practice identified in audit with occasional minor shortfalls identified.

The hospital did not formally participate in external quality initiatives in the rehabilitation of patients used in the service such as the Royal College of Psychiatrists' peer review network which provided accreditation of rehabilitation services.

Skilled staff to deliver care

We spoke with a number of staff including the registered manager, clinical lead and unregistered nursing staff and other professionals including the social worker and occupational therapist. Staff were positive about their work and motivated to provide quality care and treatment. Staff were able to show they had expertise to support patient's recovery and address patients' complex and diverse needs including supervising patient medication regimes (including assessing and overseeing patient self-management), physical health promotion, psychological interventions, arts therapies, self-care, everyday living skills and support with meaningful occupation.

Staff confirmed that they had received additional training and this was confirmed by training records seen. This included training on suicide and self-harm, personality disorder awareness, support planning and positive behaviour support. We found that staff had access to regular supervision and had received annual appraisals with all staff having had an appraisal in the last year.

Multidisciplinary and inter-agency team work

Patients received MDT input from medical staff, registered nursing and unregistered nursing staff and other professionals including an occupational therapist, an arts therapist and assistant psychologist. MDT meetings occurred every week. Patients were registered with their local GP for physical health assessment and ongoing checks. Staff could access other professionals for patients via referral through the GP, for example dietician or speech and language therapy. There was full time domestic support and a chef was employed via a centralised catering service within Turning Point.

We observed a handover. There was comprehensive information on each patient to ensure that all members of the MDT who attended were kept up to date on current issues with patients and to inform decisions about future holistic care needs.

All patients were allocated the same care coordinator from the local mental health trust's city wide review team. This

helped to ensure that professionals were informed of key events and reviews of patients' care. The care coordinator attended MDT meetings and care programme approach reviews. Staff from Douglas House attended the city wide review meetings to discuss patients awaiting assessment and near to discharge across all rehabilitation services available to patients in Manchester.

All the beds at Douglas House were reserved for patients registered with a GP within the boundaries of Manchester local authority area through a block purchase contract with the local clinical commissioning group (CCG). Managers met regularly with local commissioners funding patients' care. Staff from the CCG told us that they were very happy with the quality of the services patients received. They also confirmed that Douglas House provided effective and quality services and that it was a valued part of the local rehabilitation pathway.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

We carried out a routine Mental Health Act (MHA) monitoring visit in July 2015. On that visit we found good overall adherence to the MHA and MHA Code of Practice. We identified the following minor shortfalls on that visit:

- Section 17 leave forms were not always given to patients to fully inform them of any conditions of leave,
- The legal certificates for agreeing treatment for detained patients did not detail the maximum combined dose when more than one anti-psychotic medication was prescribed and
- Corresponding approved mental health professional (AMHP) reports were not always available alongside the detention papers to fully understand and check the decisions made to compulsorily detain patients.

Managers of Douglas House provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice. On this inspection we saw that the issues raised had been addressed, for example improved evidence to show the section 17 leave forms had been given to patients, improved recording on the T2 form when higher dose medication was given and improved systems to try and ensure AMHP reports were on file.

The hospital had a MHA manager who ensured that the responsibilities of the MHA were met. There were good systems in place to support adherence to the MHA. The records we saw relating to three out of four detained patients were generally well kept:

- There was a full set of detention papers on each file.
- Good evidence of patients being informed of their rights as detained patients including the right to access independent mental health advocacy services.
- Good records relating to the approval of section 17 leave.
- Good arrangements to seek informed consent for treatment for mental disorder for detained patients with all patients having appropriate legal authority to treat on a T2.
- Evidence of hospital managers hearings and mental health tribunals occurring.
- There were regular and robust audits of the hospitals MHA duties.
- There was evidence of medical scrutiny of detention papers through arrangements with clinicians in the mental health NHS trust.

Staff were aware of their duties under the MHA. Staff had received relevant training including training on the changes in the MHA Code of Practice. Nursing staff had attended or were booked on a bespoke training session on the MHA for nurses in independent hospitals. Staff also benefitted from the MHA coordinator attending the hospital regularly. The MHA coordinator attended wards rounds on a routine basis which helped to ensure that any key deadlines or tasks required by the MHA were met.

Good practice in applying the MCA

Staff spoken with demonstrated a good awareness of the Mental Capacity Act (MCA). Four patients at Douglas House were detained under the Mental Health Act (MHA) and treatment decisions for mental disorder for these patients were therefore made under the legal framework of the MHA. We saw that patients' mental capacity to consent to their care and treatment had been assessed as required. Staff understood the limitations of the MHA, for example staff knew that the MHA could not be used for treatment decisions for physical health issues.

Staff provided information to patients to enable them to make informed choices. For example there was a library of easy read leaflets about medication available on the unit so patients could fully understand the benefits and risks

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Outstanding ☆

before deciding if they agreed to proposed medication. Patients' capacity to understand their responsibilities to keep medicines safe was assessed prior to agreeing a staged process for self-medication.

Where capacity assessments were carried out, these were decision specific and followed the principles and stages set out in the MCA. Staff understood the process to follow when decisions need to be made if a patient lacks capacity over any given decision; for example, looking fully into the patients' best interests before any major decision was made. Where significant decisions were made, staff ensured that safeguards were in place, for example, the manager ensured that one former patient was supported by an independent mental capacity advocate when serious medical treatment was considered because they did not have family or friends.

Informal patients were consenting to stay on the unit, were free to leave and were not subject to restrictions. Patients had a high degree of autonomy, including being able to leave the hospital without any significant restrictions.

Turning Point had a policy and a checklist for the consideration of Deprivation of Liberty Safeguards (DoLS). The checklist supported staff to consider whether a person was being deprived of their liberty. There was no-one subject to DoLS at the time of our inspection.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Outstanding ☆

Kindness, dignity, respect and support

We spoke with eight patients who used the service and two relatives. Patients were universally complementary about the care they received from compassionate staff. Patients told us that staff were kind, compassionate, approachable and friendly. Patients told us that staff were always available to talk to and were always professional. This was summed up by one patient who stated that staff were respectful and treated them as an adult. Patients were also complementary about the medical input they received, stating that the doctor listened to them fully and acted on their concerns.

Patients told us that there was a good variety of activities available to them, including arts, music sessions, quizzes, trips out and cooking. Patients commented that the activities met their needs and interests and kept them busy. Patients also received ongoing support and encouragement to help them reach their rehabilitation potential, for example with support to cook independently and staged support to self-manage medication.

One recently admitted patient told us that staff had supported them to settle in.

We observed very positive interactions between patients and staff. This was particularly evident in the 'healthy eating' group which was attended by eight patients. The session was led by the hospital's project worker who encouraged participation from all patients, provided enjoyable educational input using appropriate humour and encouraged patients to take ownership of better eating to promote their mental and physical health.

Patient's carers were complimentary about the respectful care their relatives or friend received. One relative of a patient stated that their relative had made good progress since moving to Douglas House.

The involvement of people in the care they receive

Patients told us that they were meaningfully involved in their care and treatment. Two patients were involved in the initial presentation that the hospital managers and staff gave to us about the hospital. Their full involvement was actively encouraged by the registered manager. This included one patient who had very recently been discharged following a successful rehabilitation stay for eight months. Patients were seen as equal partners and gave examples of how the hospital had been proactive in promoting their own rehabilitation whilst also supporting patients to speak up about the hospital.

Patients felt involved in their own care and were encouraged to identify their own recovery goals through staff working with them on the recovery star. The recovery star clearly evidenced patient involvement and patients identifying their own needs and goals. The recovery star work then was incorporated into a care plan which was individualised and written in the first person. Where staff had identified further needs that the patient had not considered or the patient did not always agree with, staff wrote supplementary details in the care plan to identify professionally identified needs or goals.

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Patients were involved in the running of Douglas House. Patients had regular community meeting where they could comment on the day to day running of the hospital including activities, the environment including any repairs required, patient suggestions and changes in the running of the hospital. The minutes showed that staff acted promptly to address matters brought up at the community meetings.

Patients were involved in the recruitment of staff working in the hospital.

As a national social enterprise, Turning Point had various levels of service user involvement locally, regionally and nationally. Turning Point had a ladder of participation model for service user involvement. This allowed services to benchmark against progress from providing information through to full partnership with a practice toolkit to achieve partnership. Staff at Douglas House had audited the hospital in February against these standards and showed that there were significant partnership working. The service user representative talked passionately about how the staff engaged and worked in partnership with patients. Patients at Douglas House had the opportunity to comment on social policy nationally through the organisation and its' positions as a large national mental health provider. For example, the chief executive of Turning Point was a member of the House of Lords and encouraged debates in services to evidence patients' real experiences when commenting in parliament. Patients at Douglas House recently had a discussion on their experiences of housing and homelessness which was fed up the organisation to inform the debate.

Patients had access to advocacy input via a telephone call or by completing a referral form. This included independent mental health advocacy support which was specialist advocacy input when patients are detained under the Mental Health Act to help patients understand their rights.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Staff carried out assessments of patients who were usually already in another hospital to consider the appropriateness of admission for rehabilitation to this hospital. Staff liaised with NHS staff to coordinate the transfer of patients from acute mental health wards and secure care, including transferring patients who were already detained under the Mental Health Act. The beds at Douglas House were block purchased by the local clinical commissioning group for patients who were resident in Manchester. There was a city-wide review team who discussed and coordinated the admission of all patients into rehabilitation beds across Manchester. Minutes of the city-wide review referrals process confirmed that Douglas House staff engaged as an active partner in the discussion process and meetings with the city wide review team. There was no-one waiting to be admitted to Douglas House and there were two available beds when we inspected.

We saw that patients who had recently been admitted to Douglas House had received a gradual admission process. This included visits, overnight stays and extended leave before being transferred fully to the care of the hospital. One of the patients who had come from secure care had received a slower process of orientation and admission to help assist in the transition from many years in locked care. This meant that patients were admitted into Douglas House taking into account their individual needs.

All the patients were under the same care co-ordinator from the city-wide review team. The care coordinator attended ward rounds and care programme approach meetings. The care coordinator liaised with the community mental health teams to prepare for moving patients back to community services when patients were discharged. This meant that when decisions had to be made the right people were involved in the decision and the hospital was cooperating with other services where care and treatment was shared.

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We saw records of regular contact and communication with mental health professionals from relevant the local mental health NHS Trusts. Staff at the hospital worked with other professionals to co-ordinate information and reports when people had hospital managers or a mental health tribunal.

The hospital started planning for patient discharge from when patients were first admitted. Patients' recovery care plans identified what assessments and treatment would promote recovery, including mental health promotion and equipping patients with daily living skills. There were three patients who had been discharged over the last six months. Patients on the care programme approach process were reviewed every three months and the local care coordinator was invited and attended these meetings. The length of patient stay varied based on their individual needs. The average length of stay was approximately 18 months. Patients whose in-patient stay lasted beyond 12 months had a clinical review meeting which outlined the barriers to discharge and to agree how these barriers could be overcome. There were no patients subject to a delayed discharge at the time of our inspection.

There was a small outreach team to work with patients on discharge if they needed ongoing proactive practical support. Prior to discharge patients were supported to access individualised budgets to fund any extra support they might need to help remain in the community and avoid readmission to hospital. At the time of our inspection, staff from the outreach team were providing support to three patients who had been discharged from Douglas House. On occasions, patients were also discharged onto a community treatment order (CTO) under the Mental Health Act. The CTO order would immediately be transferred to a responsible clinician from the local mental health trust to provide ongoing community supervision.

The facilities promote recovery, comfort, dignity and confidentiality

Douglas House provided a range of facilities, including a general lounge, a conservatory, a female only lounge, an activity room, a pool table and a rehabilitation kitchen. The hospital had a homely feel.

Patients told us the food was good and that they enjoyed it. We spoke to the chef who told us of the rolling menu and other options available. The catering service at Turning Point had recently been centralised which helped to ensure consistent and healthy options; however, we did hear that this change had resulted in slightly less flexibility around patients' choice.

Patients were able to personalise their rooms and we saw evidence of this. There were also lockable storage facilities in bedrooms.

Douglas House employed an occupational therapist (OT) and art therapist. The art therapist was involved in collaboration between a local university and art gallery to produce an exhibition of art to help challenge the stigma around mental ill health. All patients were engaged in meaningful activities. Activities occurred during the day supported by the OT, art therapist and project worker; during evenings and at weekends, this was led by nursing staff and nursing assistants.

Patients had access to a telephone with a privacy hood. Patients had access to their own mobile phones. There were signs around the hospital to remind patients that they should not use their camera or recording device on their phones. These arrangements were working well with patients working within these rules. Patients had access to the internet via a computer in the activity room. The computer had appropriate controls to ensure patients did not access inappropriate material. There were well maintained notice boards with a range of information on Turning Point, mental ill health and local community services including advocacy services.

Patients could access hot and cold drinks during the day or night. Patients had direct and unlimited access to a garden area. These were well maintained and provided seating as well as a smoking shelter for patients to use.

Meeting the needs of all people who use the service

Patients had a weekly activity timetable which was developed with them. This included activities that matched their interests and to help them reach their rehabilitation goals. Activities were provided by the multidisciplinary team. Patients were supported to access local amenities such as public transport, local libraries, shops or the gym.

Attempts were made to meet patients' individual needs including cultural, language and religious needs. The hospital provided vegetarian options and Halal food to meet the needs of current patients. Food was prepared on site and patients could choose from a menu. The provider

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had systems to assess and monitor the quality of food and gain feedback. A choice of meals was available. Staff had a good understanding of the implications of Ramadan for Muslim patients who were fasting and how the hospital needed to adapt their approach to meet patients' needs. This meant that patients' diversity and human rights were respected.

Listening to and learning from concerns and complaints

Information about how to make a complaint was clearly displayed on the noticeboards for patients to read. Patients had weekly community meetings where they could raise issues and concerns informally. Patients told us and minutes confirmed that they felt well supported by staff in raising issues and staff looked to address and resolve issues. Patients were reminded of the complaints procedure at community meetings.

There had been no complaints at Douglas House for the last 12 months. Patient told us they could talk to staff if they had any concerns and were confident that their complaint would be taken seriously. Staff were open and encouraged patients to speak at community meetings and talk through any concerns they had, which meant they could often deal with a problem quickly and reduce the need to formally complain. Staff were aware of their responsibilities to offer an apology where appropriate.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Outstanding ☆

Vision and values

Turning Point's vision was 'doing whatever it takes to make more things possible for more people'.

Turning Point had the following values

- We believe that everyone has the potential to grow, learn and make choices.
- We are here to embrace change even when it is complex and uncomfortable.
- 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 treat each other and those we support as individuals however difficult and challenging.
- We deliver better outcomes by encouraging ideas and new thinking.

The registered manager had identified five areas for Douglas House to improve further. These were

- Ongoing and continuous improvement through audit and action planning.
- Monitor and adhere to the pillars of clinical governance.
- Continuous development of staff through training, reflective practice, research and education.
- Engaging effectively in the Implementing Recovery through Organisational Change (ImROC). IMROC was a programme for changing how the hospital runs to optimise meaningful recovery of people with mental health problem.
- Striving to be recovery focused and a service of involvement and participation with all stakeholders.

There was strong person-centred culture. The views of people who use services, relatives and stakeholders was welcomed and seen as a vital way of improving the service.

There was a strong commitment to providing a recovery focused rehabilitation service. The hospital used the recovery star tool to monitor its' progress with patients to achieve meaningful recovery for them. This showed that patients achieved very good recovery outcomes and progressed on from Douglas House.

There was a strong commitment to working with other agencies to improve care outcomes. Staff proactively liaised with NHS staff to coordinate the transfer of patients from acute mental health wards. Staff were active partners in the city wide review meetings who discussed and coordinated the admission of all patients into rehabilitation beds across Manchester. Staff at Douglas House were also involved in working with the commissioners of the service and were looking at developing shared assessment tools and pathways across all of the providers of rehabilitation services in Manchester.

There was a strong commitment to challenge the stigma of mental ill health. Staff and patients were working together on a project (in collaboration with a local university and art gallery) to produce an exhibition of art to help challenge the community's attitudes to mental ill health.

The hospital had also begun a small outreach service to continue to provide targeted support to patients on discharge to prevent further admissions. This was subject to local authority funding, individualised budget arrangements or other funding in place to fund community support work services. The registered manager hoped to provide and extend this as a bespoke service for patients discharged from Douglas House by working in conjunction with community mental health teams to fully support patients' transition from hospital to the community, especially after significant hospital stays.

Good governance

The hospital had appropriate and effective systems in place to ensure regular monitoring of the quality of care and treatment. There was a comprehensive audit plan in place. These included medication audits, multidisciplinary input, recording keeping, Mental Health Act, health and safety. Actions were identified following the audits and where improvements were identified, these were completed. Improvements following audits had been identified. Audits looked at how successful the hospital had been in assisting people to recover from their mental health distress using patients' progress on the mental health recovery star. This showed that most people had been assisted positively to manage their mental health better and recover, through improved coping skills, improved self-esteem and improved mental health.

The range of audits were comprehensive and appropriately challenging. The manager had articulated to staff the changes implemented as a result of these audits. Changes included environmental improvements, the introduction of improved rights recording tools to evidence that detained patients had been given their rights, changes to personal protective equipment to reduce the risks of allergies, improved practices around patients self medicating and improved notifications to external parties to invite them to care programme approach meetings. This helped to ensure that staff saw the benefits of audit to recognise what they did well, improve their practice and ensure better outcomes for patients. The audits were very well organised and the registered manager was able to quickly access all of the information we asked for prior to, during and after the inspection.

The audits showed a clear commitment to providing continuous improvement within the high quality, rehabilitation model offered by Douglas House. Action from the audits led to high quality, improved clinical practice occurring at Douglas House such as clear, comprehensive, recovery focused care plans which showed meaningful patient engagement.

The manager took action quickly on issues that we raised during the inspection. For example, we highlighted that one bedroom on the ground floor did not fully comply with the Department of Health guidance on same sex accommodation. The manager took immediate action to address this by getting approval of funds and a workman to draw up plans on the day we raised the issue. The manager then ensured that a new en suite toilet and shower was fitted to address the washing arrangements so that it fully complied with same sex guidance.

We saw records which showed that meetings were held with people who use the service to gather additional feedback from them. Actions were identified from meetings and there was evidence that these were completed.

The service pro-actively gathered the opinions of staff, people who use services and visiting professionals. They were encouraged to complete comment cards about the hospital. Feedback was very positive from a range of stakeholders. For example, there were local staff surveys carried out at Douglas House. The manager had taken account of the views of staff in the service and as a result staff break times were changed, there was a new staff room created, there were more computers in the service and there had been changes in how the staff rota was done.

The service provided a regular comprehensive report to the people who commission the service - the local clinical commissioning group. This report showed that the staff within the service had regard to the views of the people that used the service, and were reviewing compliments and complaints, incidents, activities and evidence to promote recovery and reduce inequalities in accessing the service. This showed a clear commitment to monitoring the service and continual improvement.

There were a range of governance meetings held to consider the performance of the hospital including clinical governance meetings, clinical services development, health and safety, medicines management, Mental Health Act group and local qualified staff and whole staff team meetings. The regional nurse manager visited the hospital regularly to review the performance of the hospital and the registered manager. The regional nurse manager was very

complementary about the clinical and managerial skills of the registered manager. Staff at Douglas House were also equally complementary. The registered manager provided strong leadership and, on interview, showed their commitment and passion to providing high quality person-centred care and treatment.

We saw that risks were managed through regular health and safety audits. There was clear evidence that action had been taken very quickly to address any issues which were found during any of the health and safety audits. We discussed the window restrictor in one part of the hospital which was in place but the provider had identified it needed to be more robust. When we returned on the second day of the inspection, the manager had addressed this through arranging new restrictors to be fitted.

Leadership, morale and staff engagement

Staff reported receiving good support from the clinical leader and registered manager.

Staff undertook training, received supervision and appraisal, and attended team meetings to ensure they were competent and confident in their role. We saw that changes had occurred following staff meetings.

Staff were exceptionally complementary about the registered manager in terms of their patient focus, management approach and commitment to staff development. The registered manager was an experienced clinical leader who had very good clinical and managerial oversight of the hospital. The registered manager had an excellent understanding of the legal frameworks in which the hospital operated including the regulations we inspect against, the Mental Health Act and the Mental Capacity Act as well as services locally. The registered manager was supported by an experienced and committed clinical nurse manager. The representative from the clinical commissioning group and the consultant psychiatrist were very complimentary about the skills of the registered manager.

Staff were clearly committed to working as a team to ensure that patients received good recovery outcomes and patient centred care. There were high levels of staff satisfaction. Staff were proud to work at Douglas House and spoke highly of the culture. Staff were actively encouraged to raise concerns and changes had been made to address staff concerns. Morale was reported to be very good with a real commitment to teamwork to ensure patients' needs were met. Staff reported that they had been able to raise issues with managers. Staff reported that the registered manager went the extra mile to support them in their work. Staff were aware of the whistleblowing policy and told us that they knew how to raise any issues through this process or anonymously. Information on reporting concerns about patient care was displayed in staff and public areas.

Commitment to quality improvement and innovation

The regional nurse manager (who was also the nominated individual) received regular reports on the quality of the services provided through clinical governance meetings. Key events were reported and used to monitor and improve the hospital for example reporting on staffing issues, safeguarding, incidents, and bed occupancy. Information was analysed and action taken to maintain and sustain quality services where necessary.

Turning Point had a quality improvement tool which monitored their services' performance against the measures we check using the safe, effective, caring, responsive and well led domains. Any shortfall was formulated into an action plan which was then monitored. At the time of our inspection, there was no outstanding action to be taken at Douglas House. The completed improvement tool for Douglas House was clear and comprehensive evidencing the work that staff, managers and patients had done to ensure the hospital met or exceeded the measures within the tool. This meant that the performance of the hospital was monitored in order to be a good service and drive improvement. The internal quality tool did not fully consider what measures the hospital could take to strive to be outstanding across each key question.

The registered manager benchmarked the service against the pillars of clinical governance, which are seven themed areas which were used to make sure the hospital deliver the highest quality health care patients. These seven areas were:

- Service user, carer and public involvement
- Risk management
- Clinical audit
- Staffing and staff management
- Education and training
- Clinical effectiveness
- Clinical information

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Outstanding ☆

The hospital was committed becoming a member of the Implementing Recovery through Organisational Change (ImROC) programme is a new approach to helping people with mental health problems. ImROC aimed to change how the NHS and its partners operated so that they could focus more on helping those people with their recovery. There were no immediate plans for the hospital to be accredited with the Royal College of Psychiatry quality network. However the manager was interested in progressing this.

Outstanding practice and areas for improvement

Outstanding practice

There was strong person centred, clinical leadership and governance arrangements, led by a well-respected registered manager who clearly articulated the changes they had made to the hospital through listening to staff, patients and other stakeholders. This was complimented by a comprehensive range of audits which were fully completed to continuously drive improvement and managers articulating positive changes made from audit results.

Patients and staff worked in true partnership as equal partners with a focus on recovery principles and shared decision making. Care plans clearly evidenced true and meaningful engagement and service users had a proper say in the running of the service as partners. Managers were looking to consolidate this through adopting the 'implementing recovery through organisational change' (ImROC) programme.

The art therapist and patients were working together on a project (in collaboration with a local university and art gallery) to produce an exhibition of art to help challenge the stigma around mental ill health.

Areas for improvement

Action the provider SHOULD take to improve

The provider should continue to work with the local mental health trust to ensure that the medical input provided is covered by a written service level agreement that clearly outlines the rights and responsibilities of each party and the appropriate local escalation and resolution if any matters of concern were raised by either party.