Good

Sheffield Health and Social Care NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAHEC	Firshill Rise	Firshill Rise Assessment and Treatment Service	S4 7BW

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- The trust had responded to concerns we had raised at previous inspections, and we could see improvements in the service.
- The service had no delayed discharges at the time of inspection, and no patients had been readmitted to the ward within 90 days of discharge. However, the average length of stay for patients was 326 days which is above the national average.
- Staff were responsive to patients' needs and treated them with dignity and respect at all times.
- The use of positive behaviour support plans and techniques enabled staff to effectively understand, anticipate and meet patients' needs, which reduced incidents and promoted patients' wellbeing.
- There were different types of therapy available for patients including enhancing daily living skills through active support, practising mindfulness techniques and adapted cognitive behavioural therapy.
- A patient community group called 'Rainbow', met every two weeks looking at menus and what activities patients wanted to do. The trust told us that they also discussed patient experience and inclusion.
- Staff told us that local managers and the senior managers from the learning disability directorate were supportive and worked as part of the team.
- The trust provided counselling support for staff. They also offered group work to look at how to manage stress at work.
- Learning from complaints and incidents was good at ward level. The multidisciplinary team discussed incidents, including restraint and staff looked at how they could improve their practice following an incident. Patients were also included in debrief sessions following incidents.
- Staff had received training in positive behavioural support plans and had a good understanding of the patients' plans. The use of individual positive behaviour support plans are considered best practice when supporting patients who may have challenges communicating and understanding what is happening.

However:

- Staff did not consistently carry out two-stage assessments of patients' capacity to make specific best interest decisions, in line with the Mental Capacity Code of Practice. However, staff did use all tools available to them such as pictorial leaflets and sign language specialists to support patients to make decisions about their care and treatment.
- Medication was stored in and administered from the main office on the ward. This posed a risk to patients because staff could not monitor infection control. It also meant that they had to prepare medication for the patients in a busy environment and whilst we did not see any this could lead to errors.
- The completion levels for the mandatory training for autism awareness, dementia awareness and Deprivation of Liberty Safeguards were below 54%. The trust had a training target of 75%.
- Whilst the trust's policy on aggression and violence did not stipulate how many trained staff were deployed on the ward, staff told us that they did not always feel safe with fewer than three staff trained by the RESPECT trainers. We saw that this had only happened on three occasions in the three months prior to our inspection visit.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as good because:

- The trust had increased staffing levels. This was an issue that CQC raised as a concern at the last inspection.
- The ward did not use seclusion and they did not have a seclusion room. Staff used physical restraint only as a last resort. A debrief to staff and patients followed any incident to ensure that lessons were learnt and the frequency of incidents reduced.
- Emergency equipment was available if needed.
- Staff had received training and understood their responsibilities in relation to the safeguarding of vulnerable adults.
- The ward complied with the same sex accommodation guidelines written by the Department of Health.

However:

- Medication was stored in and administered from in the main office on the ward. This could compromise infection control. Also staff had to prepare medication for the patients in a busy environment and whilst we did not see any this could lead to errors.
- The trust's policy on aggression and violence did not stipulate how many trained staff were deployed on the ward.Staff told us that they did not always feel safe with fewer than three staff trained by the Respect trainers working on shift. However, 82% of staff had been trained to level three in the respect training and the trust provided evidenced that this was a rare occurrence on the wards and only happened on three occasions in the three months prior to our inspection.

Are services effective?

Good

We rated effective as good because:

- Staff had received training in positive behaviour support plans and had a good understanding of the patients' plans.
- Positive behaviour support plans were detailed and personal to the individual and their process was tracked
- There were different types of therapy available including mindfulness, adapted cognitive behavioural therapy and enhancing daily living skills.
- There were good working arrangements in place to facilitate transitions to and from the service.

Summary of findings

- The trust told us that five of six patients had an advocate at the time of inspection. The trust said that referral for advocates to work with patients is part of the standard admissions protocol and discussed in multi-disciplinary team meetings. However, evidence of their involvement in capacity assessments was not always recorded and evidence of their involvement was not consistently recorded by staff on the patient records.

However:

- The completion levels for the mandatory training for autism awareness, dementia awareness and deprivation of liberty safeguards were below 54%. This meant that staff did not have a good working knowledge of issues relating directly to the patient group.
- Staff did not consistently carry out two-stage assessments of patients' capacity to make specific best interest decisions, in line with the Mental Capacity Code of Practice. However, staff did use all tools available to them such as pictorial leaflets and sign language specialists to support patients to make decisions about their care and treatment.
- Staff did discuss best interest decision making when patients' lacked capacity to make decisions themselves, although we found limited evidence within the care plans to support this and a consistent process was not always followed.

Are services caring?

Good

We rated caring as good because:

- Staff were responsive to patients' needs and treated them with dignity and respect at all times.
- Staff prepared care plans in an easy read format, which was accessible to individual patients.
- Activities were organised on the ward as well as outings, the patients were offered a choice of activities they wished to take part in and took part in a participation group where they also discussed menu choices.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The team psychiatrist held a surgery in a private establishment on a quarterly basis to review known patients. The visit also gave staff at the establishment the opportunity to gain a better understanding of their patients. The result of these visits had led to a greater understanding of a patient's needs and fewer re-admissions to the ward.

Summary of findings

- Staff provided patients with their positive behaviour support plans in easy read format so that they were able to understood their care plan. Information was also available about patients' rights in relation to the Mental Health Act and about the ward in a format, they could understand.
- Ward staff worked with their colleagues in the community team to support patients who were from different ethnic and cultural backgrounds to ensure patients and their families were supported appropriately.

However:

- The average length of stay for patients was 326 days. We also saw good evidence of detailed transition planning for patients. Once a placement had been identified staff from the new service would come on to the ward to work with staff. This enabled staff to get an accurate picture of the patients' needs and preferences and to reduce the risk of a placement breakdown following discharge.

Are services well-led?

Good

We rated well-led as good because:

- Staff felt that the local managers and the senior managers from the learning disability directorate listened to them and worked with them.
- The trust provided counselling support for staff. They also offered group work to look at how to manage stress at work. The trust describes themselves as a 'mindful employer'.
- Learning for complaints and incidents was good at ward level. The multidisciplinary team discussed incidents, including restraint and looked at lessons learned.
- The ward had a risk register, the manager could add items to the register and these fed in to the overall risk register for the trust.
- Staff levels had been increased on the ward and the current manager had been in post for three months.
- However:
- Staff at ward level were unable to describe how lessons learned from other services within the trust were shared with them.

Summary of findings

Information about the service

Firshill Rise Assessment & Treatment Service is an eight-bedded in-patient service for men and women with a learning disability whose behaviour challenges.

Sheffield Health and Social Care NHS Foundation Trust wards for people with learning disabilities or autism were last inspected in 28 October 2014 under the name of the 'Intensive Support Service'. At this time, we found the service to be inadequate and made the following requirements of the trust:

- The provider must ensure that the service has a robust system in place to learn from incidents and ensure that the risk of harm is minimised.
- The provider must ensure that care plans and risk assessments are improved to ensure patients receive care which is appropriate, safe and effective
- The provider must ensure that managers and staff have knowledge in best practice areas, to ensure care is planned in accordance with this.
- The provider must assess and treat patients based on individual risk and identified needs, rather than placing emphasis on generic, restrictive risk management processes, which are not in line with current Department of Health guidance.
- The provider must improve care planning in relation to communication.
- The provider must ensure the service is following best practices by embedding positive behavioural support as a value and also ensuring where appropriate patients have relevant support plans in place.
- The provider must ensure that information about the complaints process is clearly displayed on the wards in formats patients can understand.
- The provider must improve how patient complaints are resolved and fed back to the patient.
- The provider must ensure patients and relatives/ advocates are aware of how to report incidents of abuse.
- The provider must ensure that the risks, benefits and alternative options of care and treatment are discussed and explained in a way that patients understand.
- The provider must promote better involvement of patients and their carers/family in writing and agreeing care plans and risk assessments and ensure patients have copies of these.
- The provider must consider ways of re-structuring set nursing teams and shifts, in order to enable a comprehensive handover.
- The provider must address the impact that staffing arrangements are having on patients accessing activities, outside space and leave arrangements.

Following that inspection, we allowed the trust time to put action plans into place and to make improvements to the service. We then re-inspected the service in June 2015 and found that the trust had made significant improvements to the service being provided. Following that inspection, wards for people with learning disabilities were rated as 'requires improvement'.

A Mental Health Act Reviewer visit took place on the 20 October 2016 and the following issues were identified:

- Patients did not have access to a ward pay phone.
- There were several restrictions affecting all patients, which were not based on individual risk assessment.
- Access to the outside secure garden required staff to unlock the door.
- Access to hot drinks/snacks required patients to ask staff for a hot drink.
- Three of the patients' records reviewed did not have an Approved Mental Health Professional (AMHP) outline report present where it was required. This was an issue raised at our last MHA monitoring visit.
- We found patients lacking capacity were not automatically referred to an IMHA. We found the ward was not monitoring the use of the IMHA service.

The trust has provided us with an action plan to address these issues.

Summary of findings

Our inspection team

Our Inspection team was led by :

Chair: Beatrice Fraenkel, Chair of Mersey Care NHS Trust

Head of Hospital Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Jennifer Jones, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised a Care Quality Commission inspector and three specialist advisers (a physiotherapist, a psychologist and a nurse) and an expert by experience who was a user of services.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, 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 the unannounced inspection visit, we reviewed information that we held about this service, asked a range of other organisations for information and sought feedback from patients at a focus group.

During the inspection visit, the inspection team:

- visited Firshill Rise and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service, we did not speak with any carers
- spoke with the manager for the ward
- spoke with 18 other staff members; including a consultant psychiatrist, consultant psychologist, nurses, physiotherapist and occupational therapists
- attended and observed one hand-over meeting and one multi-disciplinary meeting
- collected feedback from 11 patients using comment cards
- looked at six treatment records of patients
- carried out a specific check of the medication management on the ward
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with four patients who were admitted to the ward at the time of our visit.

They all spoke positively about the ward. They said there were plenty of staff about who really listened to them and were not overpowering. Three patients told us they felt safe. They told us that they were involved in their care and used language like 'brilliant 'and 'wonderful' to describe the support they received.

Summary of findings

One patient expressed their concern about the safety of patients and staff. This was fed back to the manager who immediately took actions to help that patient. We did not manage to speak with any carers.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff carry out assessments of patients' capacity to make decisions, thoroughly, and in line with the Mental Capacity Act Code of Practice.
- The trust should ensure that medication is administered in such a way that does not compromise safety.
- The trust should ensure that staff complete mandatory training for autism awareness, dementia awareness and Deprivation of Liberty Safeguards.
- The trust should ensure that the use of advocacy is consistently recorded in patient notes, and that advocates are routinely invited to take part in decision making processes to support the patient.
- The trust should ensure that all staff are competent and trained in the use of Respect interventions when dealing with aggression and violence.
- The trust should ensure that the manager reviews and signs off incident reports to ensure they have an overview of what is happening on the ward.

Sheffield Health and Social Care NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Firshill Rise Assessment and Treatment Service	Firshill Rise

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.

The Mental Health Act is part of the mandatory training for all staff. At Firshill Rise 100% of staff who required this training had received it.

We found patients who lacked capacity to make decisions about their care and treatment had not been offered the support of an advocate during Mental Health Act tribunals.

A tribunal is an independent panel that can discharge a person from the Mental Health Act. The tribunal hearings take place at the hospital. The tribunal has to decide if a person meets the criteria for being sectioned.

In one file, staff had noted that an initial capacity assessment of a patients' ability to make decisions about their care and treatment had been carried out. However, we could not locate further assessments, which should have been carried out after three months of admission.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was mandatory for staff and over 75% of staff had completed it.

However, only 57% of staff had completed Deprivation of Liberty Safeguards training. This placed patients at risk because staff may deprive patients of their liberty without recognising that this is what they would be doing.

Detailed findings

A lack of understanding was evident because staff we spoke with were unsure about how the Act applied to the patients on the ward.

Staff did not always follow a consistent two stage process of assessing capacity for specific decisions. For example, for one patient there was a record of their capacity on admission with regard to physical health medication. This patient was not detained under the Mental Health Act and it had been recorded that they lacked capacity to consent to their treatment plan. There was no best interest decision recorded around the administration of this patients' medication and treatment. We also found a second capacity assessment which stated that a patient lacked to consent to a care and treatment review. This patient was noted to lack capacity but a best interest decision had not been recorded.

However, we did see evidence that with three patients staff had used pictorial explanations to support decision making. Staff had also arranged a British sign language specialist to support another patient in decision making. For a third patient, staff had noted in the capacity assessment of how a meeting could be carried out to support a patient to feel more comfortable. We saw that Independent Mental Health Advocacy and Independent Mental Capacity Advocates were routinely applied for.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

The design of the ward did not meet the needs of the patient group in all areas of the ward. This was because the clinic room and the sensory room were off the ward this meant that staff had to leave the ward to access the sensory room and if they needed to use the clinic room. The sensory room was in the main reception area and even though the front door was accessible by keypad, patients could only access the sensory room if they were not considered at risk of absconding. Staff did not think the locked front door was sufficient security. The manager did tell us they had plans to alter the environment to ensure these rooms were included in the ward site but there were no plans or details of when this would happen. However, patients told us that their rooms were personalised, and that they could bring their own belongings onto the ward. Patients also said that they felt safe on the ward and that their belongings were also safe.

The medication was stored in the main office on the ward; this was so staff did not have to leave the ward. The area where medicines were stored was busy and had little space to allow for the safe preparation of the medicines. This presented an infection control risk. Information provided during the inspection showed there were several incidents related to infection control. The information was not clear if this was around medication. Following the inspection, we received confirmation that a note had been attached to the medication cabinet reminding staff to clean the area prior to dispensing medication. Staff used the space around the medication area to access the safe and workstations where they could access computers.

Resuscitation equipment was available and nurses checked the defibrillator daily. There was a grab bag and this contained immediate first aid equipment. This was checked daily. However, several minor items such as alcohol wipes were out of date by 12 months. These were replaced during the inspection.

The clinic room, although off the ward, did have a couch and other equipment that enabled staff to monitor a patient's general health. However, this room was not always available to staff as it was used as a consulting room by staff from the community team. This meant staff carried out health checks in the patient's bedroom. This may increase the risk of infection to the patient group, and meant that patients' dignity and respect was not upheld if examinations are carried out in patient bedrooms.

There were ligature points and blind spots on the ward (areas were staff could not see patients). A ligature point is something that patients can tie something to in order to be able to strangle themselves. Staff were aware of these and they had been assessed and included on the risk register. Staff reduced the risks to patients by individual risk assessments and observed patients who were mobile throughout the day and night.

The ward was mixed gender but complied with the same sex accommodation guidelines written by the Department of Health (2010) and within the Mental Health Act Code of Practice. All of the bedrooms were ensuite and there was a female only lounge. There were separate dining areas and patients could access several activity rooms.

Firshill Rise ward scored above the national average for cleanliness in a recent Patient Led Assessment of the Care Environment assessment. These are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment where care is provided, as well as supporting non-clinical services such as cleanliness. The 2016 Patient Led Assessment of the Care Environment assessment data looked at cleanliness, condition, appearance and maintenance, dementia friendly and disability. The assessment did not look at clinical care or how well staff did their job.

Staff told us that patients were risk assessed as to whether they could attend meetings with their care team, but if they were unwell then they would not be able to leave the ward and go upstairs to the meeting room. Patients were invited to multidisciplinary meetings, and we saw that staff supported them, prior to the inspection to complete a 'questions for my MDT' document. This allowed them to prepare for the meeting in advance, but also to have their opinions discussed should the patient choose not to attend the meeting.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Safe staffing

The ward at Firshill Rise had one vacancy for a full time nurse. The rate of staff leavers for this core service in the 12-month period was 24%, which was above the trust average of 16%. There were 630 shifts filled by bank staff to cover sickness, absence or vacancies and 119 shifts filled by agency staff. This was because staff were on long term sick. The agency shifts provided had been block booked so that the same staff came to the ward. At the inspection in September 2014, it was identified that the staffing levels were not adequate. As a result, the service now employed two nurses and three health care assistants during the day and one nurse and two health care assistants overnight. This was above the levels set out by the trust and they were putting forward a business case to maintain this level of cover. The use of the regular agency staff meant the impact on patients was lessened because they were able to get to know the staff.

The ward manager told us that, if necessary, due to the acuity of patients the clinical lead for the shift could arrange for extra staffing.

As at 13 October 2016, the training compliance for wards for people with learning disabilities or autism was 81% against the trust target of 75%. However, training in dementia awareness was only 22**%** (five out of 24 staff), for autism awareness only 52% (13 out of 24 staff) and for Deprivation of Liberty Safeguarding only 33% (two out of six staff) of staff who required this training had completed it. This put patients at risk because staff could not be sure if they were operating to best practice standards when providing support to patients.

Assessing and managing risk to patients and staff

Wards for people with learning disabilities or autism had used restraint with patients on 47 occasions between March and August 2016. The incidents were recorded and debriefs for the staff and patients happened after the restraint. The trust used RESPECT. This is a philosophy of support and empowerment and teaches prevention, de-escalation and physical interventions that do not cause pain or panic. Staff told us that there should be three staff trained in level three RESPECT on duty all the time and felt that this had not been happening, as a result they did not feel safe when dealing with incidents where behaviour was challenging. Information received following the inspection showed that all substantive staff were trained to level three. We reviewed staffing data and saw that instances of less than three RESPECT trained staff on duty was a rare occurrence and had only happened on three occasions in the three months prior to our inspection. In response to the concerns that had been raised by staff the trust had organised for four staff who worked flexibly on the ward to receive level three training. This was planned for 26 and 27 November 2016.

The service had not reported any safeguarding incidents to us between 1 August 2015 and 31 August 2016. We saw that this was because the staff used de-escalation techniques within individual behaviour support plans and this reduced the need for restraint or seclusion. The service had reported 35 safeguarding concerns internally. The trust confirmed that none of these required notification to the Care Quality Commission; in accordance with the criteria for reporting statutory notifications.

Staff used a detailed risk assessment tool, for all patients. Staff re-assessed risk after any incident and at the multi-disciplinary meeting. This ensured it remained up to date. Other assessment tools used included sexual risk violence protocols and historical clinical risk management – 20. These are in line with National Institute for Health and Care Excellence guidance.

We saw records that showed that a patient's behaviour had become unstable and extremely challenging and staff had used rapid tranquillisation three times over the course of a week. Each episode was reported as an incident and physical observations were carried out as required by the trust policy. Staff told us that patients were given time to settle when presenting behaviours which challenged, even if they were damaging the environment. To protect the other patients, they were asked to move to a quieter part of the ward. Staff said that this took place before they used any form of restraint or medication to resolve the behaviour.

Staff had training in safeguarding adults; all the staff had completed this training. All staff who we spoke with could describe what would constitute abuse and to whom they would report it.

We reviewed all the medication charts for the patients to assess how staff managed medication. All staff had completed their medicine management mandatory training and were managing medication appropriately. We noted that one drug card did not have a start date on the front; one out of six did not have details of the patient's

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

level of detention under the Mental Health Act on the front. This was resolved before we left the ward. None of the six patients had been prescribed high doses of anti-psychotic medication. However, medication cards seen showed that medication had been prescribed, but not used and no discussion had occurred to see if it was still suitable. Staff said it would be reviewed at the weekly multi-disciplinary meeting but this had not been recorded. We attended part of a multi-disciplinary meeting and observed that 'as and when required' medication was discussed, and were told that this is a standard process for all patients. An action plan received immediately after the inspection stated that 'as and when required' medication was to be reviewed on a weekly basis and paperwork would be supplied to allow for clear recording.

Patients were aware of items controlled by staff such as cutlery, lighters, scissors, knives and solvents, which staff did not routinely allow on the ward. As patients began to recover, they could have access to some of these items and this would be risk assessed. There were no blanket restrictions.

Staff were experienced in supporting patients with additional needs other than their mental health needs. Recording additional care plans was good and these included mobility, dietary needs and equipment.

Track record on safety

No serious incidents were reported on the trust's Serious Incidents, Requiring Investigation data or on Strategic Executive Information System regarding wards for people with learning disabilities or autism core service between 1 April 2015 and 31 March 2016.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents; they used an electronic reporting system. We reviewed incident records and found that staff reported all relevant incidents. However, the manager had a backlog of over 400 incidents that needed 'signing off'. This did not appear to affect the lessons learned for staff as incidents were discussed daily at the handovers. In addition, risk assessments for the patient involved in any incident were reviewed as part of the debrief. Staff told us that they regularly had debriefs within the team and looked at how they might improve their practice.

We did not see evidence that staff were involved in reviewing and learning from trust wide incidents. There was a concern that staff might miss an important learning point. Staff on the ward felt they were isolated as a service.

Managers and staff were aware of and could describe their responsibilities in regard to the duty of candour legislation. The duty of candour is to ensure that providers are open and transparent with people who use services and people acting lawfully on their behalf in general in relation to care and treatment. It sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We reviewed the care and treatment of nine patients on the learning disability and autism ward. This included six records of current patients and three records of patients who had recently been discharged. All of the patients on the ward were detained under Section 3 of the Mental Health Act. Each patient had a positive behaviour support plan. The British Institute for Learning Disabilities support the use of these plans as the techniques focus on de-escalation and the reduction of incidents of challenging behaviour. The trust told us that the institute had adopted the service's positive behavioural support plans as an example of best practice. Staff had written these plans in conjunction with the multidisciplinary team and involved the patient when possible. However, in one of the plans, for a patient who had been discharged there was a record of the person's capacity on admission with regard to physical health medication. This patient was not detained under the Mental Health Act and it had been recorded that they lacked capacity to consent to their treatment plan. There was no best interest decision recorded around the administration of the patients' medication and treatment.

We saw evidence that the care plans were good quality because they were recovery orientated and contained strengths and goals of the patient. Care plans were also holistic, taking into account the full range of patient needs. However three of the six care plans did not contain the patients voice and were not personalised, using significant amounts of medical terminology which the patients may struggle to understand.

Patient records were stored electronically and were secure.

Best practice in treatment and care

Patients care and treatment was planned and delivered in line with National Institute for Health and Care guidance. For example, medication was administered in line with National Institute for Health and Care Excellence guidance, we saw that staff checked the medication against the records and ensured they took them to the correct patient and patients were not receiving high doses of medications such as anti-psychotic medications.

Psychology therapies were available to patients as recommended by guidance. The psychologists provided individual mindfulness sessions. We were able to observe a session, and thought it showed good insight to the patients' needs, as the psychologist was able to use different images to help them have a successful session. Mindfulness is a type of meditation where you become more aware of your thoughts and feelings and in doing so you become able to examine your behaviours.

Patients' challenging behaviour was reduced because staff had received training in positive behaviour support plans and a member of the wider learning disability team had developed a workbook for staff who had not been trained, that explained what was meant by a positive behaviour support plan. Staff were able to describe the benefits of the plans to us for patients. This meant that staff learnt how they communicated and how they responded to different situations and by applying different skills staff could reduce the behaviour that is challenging.

Patients had access to healthcare professionals to monitor physical health needs alongside their mental health needs.

There ward used four clinical audits relating specifically to wards for people with learning disabilities or autism. This was to monitor practice and ensure good practice was in place on the ward. These were:

1. Use of antipsychotic medication in people with learning disabilities.
2. Care plans
3. An audit of 'Alternatives to Restraint referral outcomes within Sheffield Health & Social Care Provider Services'
4. Dysphagia

Skilled staff to deliver care

The ward at Firshill Rise had a full range of mental health professionals working on the ward and they had good links in to the community. The multidisciplinary team consisted of nurses, support workers, a psychiatrist, a psychologist, speech and language therapy workers a physiotherapist and an occupational therapist.

The trust's average appraisal compliance for non-medical permanent staff was 86%.On Firshill Rise as at 31 July 2016, the overall appraisal rates for non-medical staff was 64%, (this was below the trust average) and the overall appraisal rate for medical staff was 100%. This was above the trust average of 96%.

Information supplied by the trust showed that only 40% against a trust expectation of 80% of formal supervision

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

sessions had taken place. We saw a plan to show how the manager would ensure the rate was at 100% at the end of the financial year. However, staff told us that all of the managers were available for support and they felt they got good support through debriefs and clinical training.

Multi-disciplinary and inter-agency team work

Transition planning took place with partner agencies and staff from partner agencies would come to the ward to help make transition easier for the patient.

The ward held a weekly multi-disciplinary meeting where all professionals involved with a patient where invited to discuss the ongoing planning of care for that individual.

We observed a handover meeting during the inspection. These took place on a daily basis, where staff discussed each patient and referred to how they had been in the last 24 hours and what the patient wanted to do on that day. The handover was effective in sharing with staff what the needs of individual patients were and how these may have changed.

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

There were six patients detained under the Mental Health Act at the time of our inspection. We reviewed the files of these six patients and found that hospital managers meetings and tribunals were taking place. Staff automatically called for a tribunal for patients who lacked capacity but they did not always ensure an advocate was present to support them. One patient attended a hospital managers meeting without an advocate, this was for a renewal to a Section three detention under the Act. Staff had explained patients' rights to them under section 132 of the Mental Health Act and used an easy read version if needed. Patients also had access to an easy read version of the Mental Health Act Code of Practice. However, we saw that referrals to advocates were part of the admissions protocol and five of six patients had an advocate at the time of our inspection.

Paperwork relating to the Mental Health Act was up to date and stored correctly in all the files. Section 17 leave forms were correctly completed and those that were out of date were marked in a way that indicated they had lapsed. Patients told us they got their section 17 leave but sometimes staff had to change the time of the leave due to the needs of the ward. An example of this was a patient want to go to the hairdressers in the morning and staff changed this to the afternoon so that patients could use their Section 17 leave. Section 17 is a part of the Act that tells patients how they can leave the ward if they were being detained.

As at 13 October 2016, the compliance rate for Mental Health Act training for the core service was 100%, all relevant staff had received training to enable them to support patients.

Good practice in applying the Mental Capacity Act

The Care Quality Commission had not been notified that the ward had used any Deprivation of Liberty Safeguards between 1 March 2016 and 31 August 2016. A Deprivation of Liberty Safeguard application becomes necessary when a patient, who lacks capacity to consent to their care and treatment, has to be deprived of their liberty in order to care for them safely. It has to be demonstrated that this is in the patient's best interests and the least restrictive option.

The compliance for Mental Capacity Act training and Deprivation of Liberty Safeguarding level two for the service was 57% however these figures are for a team with less than ten eligible staff. This placed patients at risk because staff may deprive patients of their liberty without recognising that this is what they would be doing. However, no patients had Deprivation of Liberty safeguards in place at the time of the inspection.

Training in the Mental Capacity Act was mandatory for staff and over 75% of staff had completed it.

Staff did not always follow a consistent two- stage process of assessing capacity for specific decisions. For example, for one patient there was a record of their capacity on admission with regard to physical health medication. This patient was not detained under the Mental Health Act and it had been recorded that they lacked capacity to consent to their treatment plan. There was no best interest decision recorded around the administration of the patients' medication and treatment. We also found a second capacity assessment which stated that a patient lacked to consent to a care and treatment review. This patient was noted to lack capacity but a best interest decision had not been recorded. This was not consistent as in four patients' capacity assessments we found that the correct process

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

had been followed. We also saw that an informal patient without capacity to agree to care and treatment was being given medication without evidence of a best interests decision.

Staff understood the principles of the Act in line with their role and strongly believed patients should be involved in their day-to-day care and supported to make decisions about how their care and treatment was delivered.

However, we did see evidence that with three patients, staff had used pictorial explanations to support decision making. Staff had also arranged a British sign language specialist to support another patient in decision-making. For a third patient, staff had noted in the capacity assessment of how a meeting could be carried out to support a patient to take part and feel more comfortable.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

We undertook observations of staff interacting directly with the patients on the ward. Conversations with patients were appropriate to their level of understanding. Patients had a communication passport, which described how they communicated their needs, wishes and feelings and how they liked to be cared for.

Staff were responsive to patients and took time to understand their needs. One patient said they were happy and felt safe on the ward. Other patients were on one to one observations and the interactions observed were positive with staff trying to engage with the patient. We observed staff knocking on a patient's door before entering and if the patient had a sensory need they found other ways to notify the patient they were there, an example of this would be flashing a torch through the window on the door and if the patient wanted to open the door they would.

In relation to privacy, dignity and wellbeing, Firshill Rise assessment and treatment service was rated at 94% above the England and Trust average for privacy, dignity and wellbeing. Patient led assessments of the care environment assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care was provided, as well as supporting non-clinical services.

The involvement of people in the care that they receive

Patients were aware of their care plans and had been involved in their development. Patients told us that staff had listened to them about their needs, wishes and feelings and they knew people could only look at them with permission. Several patients told us they had copies of their care plans.

Staff provided information in an easy read format and activities were organised on the ward as well as outings. Patients told us the actual activities were usually different to those advertised. Nobody saw that as a problem as they were getting out each day and staff were engaging them in craft activities on the ward.

There was a patient community group called Rainbow, this met every two weeks and looked at menus, what activities patients wanted to do and they discussed how they were getting on. We saw minutes for several of these meetings. One patient told us that they didn't think they had any input in to services. However, a former patient was involved with the governance team and we were told they represented the learning disability community. We saw evidence that when patients were going to be discharged to the community they helped interview staff who would be supporting them.

We saw that the service was aware of the need to have positive engagement with service users and families and wanted to work on this. The service had commissioned a project in 2016, to understand the engagement with service users admitted to the ward. The project used a variety of methods to collate information from patients and their families regarding their time on the unit and their thoughts about areas such as daily life, activities, treatment, reviews and visitors. The report provides personal accounts relating to patient journeys and the experiences and perceptions of carers. The trust states that the recommendations form a valuable platform from which the service will continue to learn, develop via its action planning and quality improvement processes.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

The average bed occupancy for the core service was 76%. As at 31 July 2016, the average length of stay for the core service was 326 days for discharged patients and 325 days for current patients. Staff considered patients' discharge arrangements as part of the assessment process and reviewed these as part of the multi disciplinary meetings.

There was one patient on the ward who was from outside of the area and five from the local area. There were patients from Sheffield who, because of the level of support they required, were in specialist placements out of area. It is usually in the best interests of patients to be supported in placements which are close to their family and friends.

The ward supported patients with transition and discharge to other services to reduce readmissions to the ward. There were no readmissions within 90 days reported by the trust between 1 February 2016 and 31 July 2016 for the core service and there were no delayed discharges. The manager told us that once a placement or community service had been identified for a patient then staff from the new service would come on to the ward to work with staff. Providers of private social care services we spoke with confirmed that the patient received support from the ward before, during and after a discharge had taken place. The team psychiatrist held a surgery in one of the larger establishments on a quarterly basis. The result of these visits had led to a greater understanding of a patient's needs and fewer re-admissions to the ward.

The ward did not have any seclusion facilities. If a patient's behaviour had escalated to needing this level of intensive support, and could not be de-escalated, they were transferred to another ward within the trust that had these facilities. The trust told us that this had happened on one occasion, but the ward had made an immediate plan for the patient to return to the ward as soon as possible.

The facilities promote recovery, comfort, dignity and confidentiality

In relation to food in the 2016 patient led assessments of the care environment survey, the Firshill Rise assessment and treatment service scored higher than the England average of 87% with 91%.

The clinic room and the sensory room were located in the reception area of the ward. Access to the sensory room was limited and only patients who were not at risk of absconding were allowed to access it due to the close proximity to the main door. Staff and patients accessed the ward through a locked door. The ward was on the ground floor of the building and set out into two sides, Hillside View and Fernside View, with the main staff office in the middle.

There were six ensuite bedrooms and two flats which were used to help patients with supported living. There was a female only lounge available and several activity rooms. Patients had access to the kitchens and helped to prepare their meals.

There were also activity rooms on the upper floor but access to these was restricted to staff availability and the risk assessment of the patients.

Patients could access the garden from either side of the building and there was a swing ball activity set in one of the gardens. Patients told us this had only recently been set up and staff seemed to confirm this when they could not find the bats for patients who wanted to use it. Access was limited to the garden for patients who staff had assessed at risk of absconding, because they could climb over the fence.

Meeting the needs of all people who use the service

The ward was accessible to patients with reduced mobility. If specialist equipment were required then an assessment of need was carried out to ensure the right equipment was provided.

There was easy read information posted on the ward and pictures of staff so that patients could identify them.

The service provided positive behaviour support plans in easy read format and patients understood their care plan. Information was also available about their rights and about the ward in a format patients could understand. We saw evidence that interpreters were provided when necessary and staff ensured that they came to important meetings as well as to visit the patient to ensure their needs were being met and provide feedback to staff.

Activities were organised for patients based on risk and interests. Some of the activities provided included; arts and crafts, puzzles, sensory box, shopping, word searches and the patients helped plan the Halloween events and used the garden. One patient told us that the activities provided

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

were different from the activities organised. Staff told us that patients did not always want to do the organised activities so they did things on a one to one basis. Patients also had access to a laptop computer and depending on their risk assessment they could keep their mobile phone.

Patients had a community meeting every fortnight and those who wanted to could go. We saw minutes of the meetings and they had talked about food and menus, activities and any general issues patients wanted to discuss. This was the Rainbow Group.

Meals were provided on site and patients helped to develop the menus and cook the food. The menus contained low fat and healthy options and when necessary they were able to cater for patients with specific dietary needs. Snacks and drinks were available throughout the 24-hour period.

The trust was working together with the black and minority ethnic workforce group. They worked with local community groups and patients on the ward to improve the understanding of the mental health support available to them. They had been able to provide support and information for staff about a sensitive situation where a patient had been admitted to hospital for treatment against the wishes of their family. Staff worked with the patient to understand their situation and staff from the community were working with the family to improve relationships and understanding.

Listening to and learning from concerns and complaints

The service worked creatively to ensure patients could make their concerns known. There were complaints leaflets on the ward and patients told us they could tell the staff if they were unhappy. During our inspection we received information from a patient that had presented a complaint and the manager had dealt with this in a prompt manner.

The Firshill Rise assessment and treatment service received five complaints during the last 12 months (1 September 2015 – 25 August 2016). Complaints were investigated by someone from within the trust, but not associated with the ward, and the complainants received feedback from another manager. Where appropriate we saw that an apology had been given to patients for mistakes made, and the manager fed learning back to staff and had evidenced how they could make changes. Three of the five complaints were still under investigation by the trust. None of the complaints had been referred to the ombudsman. The service received six compliments during the last 12 months.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

The trust worked to a vision of 'providing high quality health and social care services'; this was underlined by their stated purpose 'to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community'.

The values of the trust were:

- Respect
- Compassion
- Partnership
- Accountability
- Fairness
- Ambition

Staff awareness of the vision and values of the organisation was limited when we spoke with them. All the staff told us that their priority was to provide personalised care to patients, and to support them in their recovery in order for them to live in the community.

Staff were respectful and treated patients with respect and compassion. Staff worked with external organisations and community organisations to ensure holistic assessments for the patients so that when they were discharged, the information provided did not just concentrate on their mental health needs but their whole life and the things which were important to them.

Staff were positive about local managers and the senior managers from the learning disability directorate. They told us that senior managers were on the ward on a daily basis and the Chief Executive and their deputy had worked some shifts with staff.

The trust provides counselling support for staff if they need to access this and covers a variety of different options from couples counselling to post traumatic stress counselling. They also offer group work to look at how to manage stress at work. The trust is a mindful employer, this means they provide support to their staff to help reduce stress and help them look after their own mental health.

Good governance

We saw that the ward had made improvements in governance arrangements since the last inspection and had responded to our concerns by completing their action plan.

Learning for complaints and incidents was good at ward level. The multidisciplinary team discussed incidents, including restraint and looked at lessons learned. The trust told us that they emailed safety alerts, serious incidents and information sharing to staff. The trust also used a learning disability governance framework to share learning from incidents and complaints and various monthly management meetings which were fed back to ward staff. However, this system was not fully embedded because we did not see any evidence of this during our visit to the ward, and staff told us that they were unsure of where they would see these updates, although did think they might find this information on the intranet.

Safeguarding procedures were in place and staff followed these.

Staff did follow the Mental Health Act policy and procedure.

The ward had a risk register, the manager could add items to the register and these fed in to the risk register for the trust. The site of the clinic room and the sensory room were on the risk register. The ward manager did tell us they were in the process of holding discussions on how they could improve the access to the sensory and clinic room but had nothing definite to share.

However, there were some outstanding issues found across the service which related to a lack of consistent governance arrangements. These were in areas such as the environment, supervision and mandatory training.

The trust provided us with information about mandatory training and whilst most of the training was at 81%, there were several areas pertinent to the learning disability service such as autism awareness, Deprivation of Liberty Safeguards and dementia awareness which were below 57%; this had an impact on patient care. For example, some staff had a limited awareness of the Mental Capacity Act and assessments were not consistently being carried out in line with the Code of Practice.

The trust provided data that showed figures for clinical and managerial supervision were low, although appraisal rates were at 100% for medical staff. Whilst the manager had only been in post for six months they were not taking responsibility for ensuring staff received supervision, which was at 40% against a trust target of 80%. We saw a plan to show how the manager would ensure the rate was at 100%

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at the end of the financial year. However, staff told us that all of the managers were available for support and they felt they got good support through debriefs and clinical training.

Leadership, morale and staff engagement

We did not see any evidence that the trust had completed a staff survey in the last 12 months. However, there have been several staff changes in the last 12 months; the assistant clinical director had been managing the ward until the appointment of the current manager. All of the staff spoken with told us they felt that managers were now listening to them and felt supported, for example staffing had been increased due to concerns raised by the staff team.

Staff reported they did not feel bullied or pressured in their role and they felt confident about taking any concerns, complaints or safeguarding to their line manager in order to keep patients safe.

Sickness levels for the ward were 9.7%, which was higher than the trust average. The manager informed us that there were staff on long term sick which affected their overall figures. Where someone was on long term sickness a block booking for bank or agency staff had been arranged so continuity for the service was maintained.

Commitment to quality improvement and innovation

The service was not part of any national quality improvement programmes.

However, the ward used a variety of methods to monitor internal quality improvement such as looking at service user engagement and using the governance framework and internal 'quality goals' to monitor progress and improvement.

The ward manager was working with the trust's 'microsystems coach' (an initiative to help frontline staff improve the quality and value of care delivered) to work on re-designing systems and processes with the aim of improving quality and freeing up 'time to care'.