Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Date of inspection visit: 27 -30 October 2014 and 16 June 2015
Date of publication: 05/10/2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Intensive Support Service	TAHEC	Intensive Support 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 wards for people with learning disabilities or autism	Requires Improvement
Are wards for people with learning disabilities or autism safe?	**Requires Improvement**
Are wards for people with learning disabilities or autism effective?	**Requires Improvement**
Are wards for people with learning disabilities or autism caring?	**Good**
Are wards for people with learning disabilities or autism responsive?	**Requires Improvement**
Are wards for people with learning disabilities or autism well-led?	**Requires Improvement**

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

We undertook an inspection of the Intensive support service between 27 and 30 October 2014. At this inspection we identified serious concerns that we escalated immediately with the trust. We asked the trust to put in place immediate actions to address these concerns. The trust provided CQC with an action plan before the end of the site visit period of the inspection.

At the national quality assurance group it was identified that to be proportionate CQC would need to re inspect the service before issuing the report. The CQC waited until the action plans had been completed and re inspect the service on 16 June 2015. At this inspection we found that the trust, senior management and the staff on the ward had made significant changes to the service being provided. This report identifies our findings at the time of the initial inspection and in bold our findings at the time of the follow up inspection to demonstrate what was found and the remedial action the trust has taken to address these concerns.

We found overall the quality of care provided by the intensive support service (ISS) at our initial inspection was inadequate.

We found that overall the quality of care provided by ISS had improved at our follow up visit and now required improvement.

Arrangements in place to ensure patient's safety were unsatisfactory. Risk assessments had been completed to ensure the physical environment was safe and suitable. However where concerns had been identified these had not been actioned. We also found risks during our observations of the ward which had not been identified through the ward risk assessments or on the ward risk register.

Risk assessments had been completed. These were full and comprehensive including patient accessible areas, these also included assessments of ligature points. These were completed on 14 May 2015

One male patient was in a bedroom on the female side of the ward even though there was a vacant male room available. There was a female only lounge on the male side of the ward.

The accommodation has been designed to form two 'wings' with three individual, en-suite bedrooms (total six) and, two independent flats thereby supporting segregation. Each three bedded 'wing' has an allocated women-only lounge area.

Staff employed at the service did not have all the necessary skills and competencies to work with patients on the ward. For example staff had limited capability to communicate with patients who had little or no speech. We also observed staff had limited understanding of autism and this was demonstrated from their lack of awareness of the importance of visual prompts, engagement in meaningful activities and assessment of sensory impairments as well as implementation of coping strategies for patients who become anxious and distressed.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

Care plan evaluation and insight recording had also been completed Safeguarding information had been produced in an accessible format

Positive behaviour support (PBS) training had also been sourced and one staff was undertaking this in July 2015 accessed through the British institute of learning disabilities. Two further staff were undertaking the next steps in PBS and a further 19 were undertaking PBS next steps training.

Staff were unaware of this unannounced visit and we found that therapeutic activities for the patients were taking place

We found care planning and risk assessments were inadequate. Care plans were not holistic, personalised or recovery focused. The service did not embed best practices such as positive behaviour support, health action plans or Valuing People Now.

Summary of findings

Work has been undertaken on training staff to write care plans by putting in place a framework for them to work to. Care plans and risk assessments had been updated and we found input from the patients, we reviewed all of the patients on the wards case notes. Positive behaviour support training was planned which would be delivered to the whole staff group. Dates for this further training for all staff had not been set.

Patients were poorly engaged in relation to consent to care and treatment. Patients were not involved in multi-disciplinary meetings despite their care and treatment being discussed.

We found that patients and their advocates and family were engaged in consent to care and treatment. This was recorded at their involvement in Multi-disciplinary meetings.

Although we did observe some positive interactions between staff and patients such as patients being spoken to discretely by staff, the majority of interactions were poor. We observed for a period of hours patients were left wandering corridors without any activities to engage in. Patients were ignored by staff when they stood at office windows for long periods of time or knocked on the office door.

We saw therapeutic activities taking place on the ward. Patients were engaged and staff interactions we observed were positive.

Care plans were not in accessible formats or person centred. They did not include goals, aspirations and coping strategies. There was an absence of advocacy and the service was not actively promoted on the ward.

Care plans were in an accessible format and we also saw that health action plans, hospital passports and health action plan summaries were in place. Discharge planning occurred at point of admission.

We looked at how discharge was planned and how recovery focused the service was. What we found was inadequate. Discharge was not planned at the point of admission which meant it was unclear what patient's length of stay was likely to be. The ward environment did not optimise recovery because patients had limited access to facilities which promoted their independence and enabled them to learn new skills. Patients were unable to participate in basic tasks such as making a drink without staff supervision.

Summary of findings

Discharge was now being discussed from the start of the admission and we saw evidence of this in all of the care notes. We also found that delayed discharges had been escalated to managers of services, health and social care commissioners and recorded within safeguarding procedures.

Most areas on the ward were now open to patients including two flats that included kitchens.

The intensive support service was poorly led. Staff were unclear about the organisation values and behaviours. There were staff vacancies, gaps in training, the ward office was disorganised with filing trays full of patient confidential information and an overall lack of oversight to the poor care patients received.

We found that the ward manager and her line manager had made significant progress since our inspection. The ward office was now ordered and all staff had identified drawers and no confidential information was visible from outside the office. All out of date information had been removed from the walls and new noticeboards had been put on display and included up to date information. There were also new signs which clearly displayed the menu, activities and which staff were on duty.

Following our inspection we requested an immediate plan from the provider detailing how improvements would be made.

There had been significant improvements made against the submitted plan since the time of our last inspection.

Summary of findings

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

Are services safe?

Requires Improvement

We rated the services for patients with learning disability or autism as **'requires improvement'** because:

Risk assessments of the environment did not identify where patients could be placed at risk of harm and where concerns had been identified action was not always taken.

Risk assessments had been completed. These were full and comprehensive including patient accessible areas, these also included assessments of ligature points. These assessments had been completed on 14 May 2015.

One male patient was in a bedroom on the female side of the ward even though there was a vacant male room available. There was a female only lounge on the male side of the ward.

> **The accommodation has been designed to form two 'wings' with three individual, en-suite bedrooms (total six) and, two independent flats thereby supporting segregation. Each three bedded 'wing' has an allocated women-only lounge area.**

Ward staff had not received training in core areas where they were supporting patients who had complex communication needs and who also had autistic spectrum disorders.

Care plan evaluation and insight recording training had also occurred as well as training for all the staff in "safeguarding in an accessible format".

Individual patient risk assessments were not always completed or up to date which put patients and others at risk of harm.

All patients records now had a DRAM risk assessment

The service did not adhere to the Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) which could compromise the dignity and privacy of patients.

> **The accommodation has been designed to form two 'wings' with three individual, en-suite bedrooms (total six) and, two independent flats thereby supporting segregation. Each three bedded 'wing' has an allocated women-only lounge area.**

Summary of findings

Are services effective?

Requires Improvement

We rated the services for patients with learning disability or autism as '**requires improvement'** because:

We found care planning and risk assessment as requiring improvement. Care plans were not holistic, personalised or recovery focused. The service did not embed best practices such as positive behaviour support, health action plans and Valuing People Now.

Care plans now discussed in 1:1 sessions. We viewed all care plans and all were up to date.

Positive behaviour support (PBS) training had also been sourced and one staff was undertaking this in July 2015 accessed through the British institute of learning disabilities. Two further staff were undertaking the next steps in PBS and a further 19 were undertaking PBS next steps training.

Staff were not supported to develop knowledge, skills and experience to enable them to deliver good quality care.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

There was a failure to use alternative methods of communication to involve patients in decisions regarding their care.

Care plans were now in accessible formats and we also saw health action plans, health passports and health action plan summaries were in place

Are services caring?

Good

We rated the services for patients with learning disability or autism as '**good' because:**

We found that staff did not have the skills and abilities to engage patients in activities which often meant patient's needs were not being met.

We found staff had a poor understanding of patient's needs. For example, staff showed no understanding of patient's interests and how these could be used to inform effective care planning.

Summary of findings

We saw evidence of patients' needs being met and engaged with. We saw patients being supported to undertake cooking tasks make drinks and they were able to show us round the ward area. We saw in patients care records that patients had been off of the unit and into the community.

Where patients had communication plans, these were not used by staff which demonstrated a failure to engage patients effectively. This meant for these patients, engagement in the care plan process was limited.

We found patient involvement in care plans and their choice to have copies of their care plans. There was evidence of accessible formats to support patients in understanding their care but it was difficult to identify if patients had copies of their plans of care.

Are services responsive to people's needs?

Requires Improvement

We rated the services for patients with learning disability or autism as **'requires improvement** because:

The service did not have adequate discharge arrangements in place. Discharge was not planned at the point of admission which meant it was unclear how long patient's intended stay was likely to be or what the longer term plan was for individual patients.

Records showed that discharge arrangements are now routinely discussed on admission and contained in their assessment.

The physical environment was not conducive to patient's needs because promotion of Independence was not a focus of the service. This was demonstrated by the fact appropriate kitchen equipment was not available for patients to use and patients had no individual timetable of activities that promoted independence and daily living skills.

Staff ensured that patients had access to drinks and snacks during the day. We saw that the kitchen was open and patients were encouraged to enter and make drinks.

There were restrictions in place in the way people were cared for. People did not have access to telephones, access to outside space and bedroom doors were locked.

There was free access to an outdoor space on one side of the ward, however the other side of the ward had controlled access as there was a patient who was a high absconsion risk. We observed however patients spending time in both garden areas.

Summary of findings

There was no telephone available in the ward area. Patients were supported by staff to use the office phone to contact families and relatives where patients were unable to do this independently.

Are services well-led?

Requires Improvement

We rated the services for patients with learning disability or autism as '**requires improvement'** because:

The service was not well-led. There was insufficient staff with appropriate skills and competencies to meet patient's needs.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

Care plan evaluation and insight recording training had also occurred as well as training for all the staff in "safeguarding in an accessible format".

Positive behaviour support (PBS) training had also been sourced and one staff was undertaking this in July 2015 accessed through the British institute of learning disabilities. Two further staff were undertaking the next steps in PBS and a further 19 were undertaking PBS next steps training.

Staff were unclear about the organisations values or the ward philosophy on providing care to patients with learning disabilities.

There was a governance structure however the governance arrangements were not as effective as they could have been. Where audits and assessments had been completed concerns identified had not been actioned.

We found that some progress had been made when it came to vision and values, we spoke to three staff on duty and all knew about the trust visions and values

There was confidential and important patient information that was not being stored on the patients notes.

The ward office was now ordered and all staff had identified drawers and no confidential information was visible from outside the office. All out of date information had been

Summary of findings

removed from the walls and new noticeboards had been put on display and included up to date information. There were also new signs which clearly displayed the menu, activities and which staff were on duty.

When we raised our concerns with the senior management team of the trust they were not aware of the areas of our concern.

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Summary of findings

Background to the service

Sheffield Health and Social Care NHS Foundation Trust provides inpatient services for men and women aged 18 years and over to patients with a learning disability.

Services

Intensive support service (ISS)

The intensive support service (ISS) is based on the outskirts of Sheffield. They provide inpatient services for adults aged 18-65 years. The intensive support service is an eight bed purpose built unit that provides in-patient assessment and treatment for patients with learning disabilities who may have mental health problems and/or display challenging behaviour toward other people. The wards provide in-patient care and treatment for patients admitted informally and patients detained under the Mental Health Act.

At the time of the inspection there were seven patients using the service. Two patients were detained on sections of the mental health act, one person had a Deprivation of Liberty Safeguard (DoLS) in place and two other patients had been referred for DoLS applications.

The ISS is a location which has been inspected by the Care Quality Commission on one occasion since registration. In March 2014 we found the service to be compliant with all the areas we inspected. These were; the care and welfare of people who use services, cleanliness and infection control, supporting workers, assessing and monitoring the quality of service provision and complaints.

Our inspection team

Our inspection team was led by:

Chair: Dr Alison Rose-Quirie Chief Executive Officer, Swanton Care and Community Ltd

Team Leader: Graham Hinchcliffe, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included Care Quality Commission (CQC) inspectors. We also had a variety of specialist advisors which included consultant learning disability psychiatrist, expert by experience, family carer, senior learning disability nurse, social worker. The chair and head of inspection also visited the service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about learning disability services in Sheffield Health and Social Care NHS Foundation Trust and asked other organisations to share what they knew, including

speaking with local Healthwatch, independent mental health advocacy services and other stakeholders. We held public listening events, as well as listening events with carers.

We carried out an announced visit over two days between 28 October and 30 October 2014. During the visit we spoke with nurses, doctors and therapists. We talked with patients who use the service. We observed how patients were being cared for and we talked with carers and/or family members. We reviewed care and treatment records of patients who use services. We spoke with senior managers and looked at the environment of the wards.

There was a further unannounced inspection on 16 June 2015 by a CQC inspection manager and inspector. Our findings are reported within the main body of this report.

What people who use the provider's services say

We observed how patients were cared for, looked at records and spoke with staff and relatives

We spoke with five patients and two of their relatives. Most patients were positive about their experience of care at the ISS unit and told us they felt safe.

Most patients who were able to told us, they found staff to be "respectful" staff were alright and nice and patients relatives were mostly complementary about the staff. One relative told us "the lack of staff was a downfall".

Most patients we spoke with told us they went out with support into the community and attended some activities. Examples patients gave us about the activities they were involved in included cookery, arts and crafts, attended a disco outside of the unit and also a walking group. Some patients told us they 'helped out' on the reception area outside of the unit. One patient told us they had attended church and accessed the multi faith room within the building.

Patients also told us they had a takeaway meal at weekend but did not go out themselves to order or collect this.

Patients told us they did not know how to complain nor were they aware of advocacy services. One patient told us they were not always sure about their rights and most patients told us they did not have copies of their care plans as they were in the office.

Patients and relatives were not effectively engaged in care plans; staff had poor understanding of patient's communication needs and failed to effectively engage patients in care which optimised their recovery and independence.

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

- 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.

Summary of findings

- 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.

Care Quality Commission

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
Intensive Support Service (ISS)	Intensive Support Service (ISS)

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 CQC Mental Health Act reviewer and inspectors looked at five records during this inspection. We found that the records were kept accurately and in line with the Mental Health Act code of practice.

The T2 (certificate of consent to treatment) and T3 (certificate of second opinion) medication records, were completed accurately and in line with legal requirements.

Patients we spoke with were unaware of their rights and information had not been provided in accessible formats which patients understood.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were able to demonstrate a good knowledge and understanding of the Deprivation of Liberty Safeguards. However not all staff had received training which meant they were not always aware of their legal obligations.

Requires improvement

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

Summary of findings

We rated the services for patients with learning disability or autism as **'requires improvement'** because:

Risk assessments of the environment did not identify where patients could be placed at risk of harm and where concerns had been identified action was not always taken.

Risk assessments had been completed. These were full and comprehensive including patient accessible areas, these also included assessments of ligature points. These assessments had been completed on 14 May 2015.

One male patient was in a bedroom on the female side of the ward even though there was a vacant male room available. There was a female only lounge on the male side of the ward.

The accommodation has been designed to form two 'wings' with three individual, en-suite bedrooms (total six) and, two independent flats thereby supporting segregation. Each three bedded 'wing' has an allocated women-only lounge area.

Ward staff had not received training in core areas where they were supporting patients who had complex communication needs and who also had autistic spectrum disorders.

Care plan evaluation and insight recording training had also occurred as well as training for all the staff in "safeguarding in an accessible format".

Individual patient risk assessments were not always completed or up to date which put patients and others at risk of harm.

All patients records now had a DRAM risk assessment

The service did not adhere to the Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) which could compromise the dignity and privacy of patients.

The accommodation has been designed to form two 'wings' with three individual, en-suite bedrooms (total six) and, two independent flats thereby supporting segregation. Each three bedded 'wing' has an allocated women-only lounge area.

Our findings

Safe and clean ward environment

The care environment, equipment or facilities were unsafe.

The intensive support service was an eight bed ward which accommodated male and female patients in separated male and female bedroom corridors. However, one male patient was in a bedroom on the female side of the ward even though there was a vacant male room available. There was a female only lounge on the male side of the ward.

The accommodation has been designed to form two 'wings' with three individual, en-suite bedrooms (total six) and, two independent flats thereby supporting segregation. Each three bedded 'wing' has an allocated women-only lounge area.

The ward had a large nursing office in the centre of the ward accessible from each male and female corridor which did not enable staff to observe patients in all parts of the ward.

Staff were not always situated throughout the ward area to ensure patients were observed.

Some areas of the ward had mirrors placed to prevent blind spots. However not all parts of the ward could be observed which meant patients safety could not be ensured at all times.

Requires improvement

Are services safe?

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

We found that there was now a higher presence of staff in the main ward area to aid observation.

There were ineffective systems of risk identification and management in the short or long term which mean that opportunities to prevent or minimise harm were missed. A ligature risk assessment dated 26 August 2014 identified the risks in the unit for patient accessible areas. The ceiling mounted track hoist was identified as a risk. The actions identified to manage this risk was to risk assess patients who occupied these rooms. In the records of the patients using these rooms there were no risk assessments. Staff working on the ward were not able to locate any completed risk assessments for the patients in these rooms.

Patient en suite bathrooms and communal bathrooms and toilets had not been included in the ligature risk assessment. The taps in the bathrooms were not anti-ligature and could pose a risk to patients should they attempt to harm themselves.

Risk assessments had been completed. These were full and comprehensive including patient accessible areas, these also included assessments of ligature points. These assessments had been completed on 14 May 2015.

Taps in bathrooms are identified on the risk assessment and are to be replaced.

There were wires trailing from the TV and DVD player in the lounge area. These had not been identified on the risk assessment.

These wires had been made safe

Patients did not have free access to outside space without asking staff to unlock the door. Access to the ward was controlled and through locked doors. All of the internal doors including bedroom doors were locked.

We found bedroom doors unlocked and more staff working in the ward area.

Access to and from the unit was controlled through a locked door managed by ward staff. There was free access to an outdoor space on one side of the ward, however the other side of the ward had controlled access as there was a patient who was a high absconsion risk. We observed patients spending time in both garden areas.

Staff we spoke to were able to tell us where the resuscitation and defibrillator equipment was kept and weekly checks had been completed by the ward to ensure equipment, emergency drugs and defibrillator were safe to use and equipment was available. However; the resuscitation bag (grab bag) was not sealed. There was no signage on the ward to inform staff of where the defibrillator equipment was kept. This is required in order to reduce delay in locating the defibrillator in an emergency as referred to in the (Resuscitation Council (UK) minimum equipment and drugs list for cardiopulmonary resuscitation Mental health inpatient care May 2014).

This equipment was fully available, checked and safe to use. It was now sealed and had the correct signage in place to identify where it was kept.

We reviewed a record of an incident on the ward that identified a patient as having tried to ingest the alcohol gel used for hand cleaning on the ward. Although the qualified nurse had identified this and informed us they had requested that the hand gel was repositioned off of the ward, this had not been completed at the time of our visit.

This had now been removed.

The ward was clean throughout and two housekeepers were allocated to clean the ward area. However we saw that on the female side of the ward, curtains had been removed and left on the side. We found that signage and information throughout the ward had been removed. The qualified nurse told us an incident had happened on the ward in August 2014 and repairs or replacements had not been completed.

The signs had all been replaced. All of the curtains were in place.

Repair work was in progress to address one patient's bedroom area however, we did not see an environmental risk assessment in place to ensure the patient's bedroom remained safe for them to sleep or spend time in whilst repairs were undertaken. The interim head of learning disability services told us they had completed a list of issues identified with the building due to it being a new build. An example of this was there had been various leaks in the roof area over the ward. We saw work had commenced in one patients bedroom to repair this.

There was still on-going work with the roof.

Requires improvement

Are services safe?

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

There was a ligature risk assessment in place for the sensory room which was located outside the ward area. In this assessment the shelving and sensory equipment was identified as a ligature risk. This identified the risk was being mitigated by patients being supported on a 1 to 1 at all times. The qualified staff member on the ward told us that patients who used the service did not use this room without support from staff to reduce the risks to their safety.

The clinic room was clean and tidy and well equipped with examination equipment. The clinic room was accessible off the ward area. We were told by ward staff the clinic room was also used to see patients with a learning disability who accessed care and treatment in the community.

Safe staffing

We were provided with a staffing level document for the intensive support service dated 14 August 2014. This paper identified that the morning/afternoon shift would compromise of five staff per shift (inclusive of the shift manager) and the night shift would be three staff per shift (inclusive of the shift manager). This document also detailed in the event of staff shortage due to unforeseen circumstances (e.g. sickness, absence, bad weather) minimum staffing levels would reduce to three morning/afternoon shift and two per night shift again inclusive of the shift manager.

The service running up to seven beds has five staff on duty during the day and three staff on at night. There is always a qualified nurse on duty. When all of the beds (eight) are full the unit has six staff on duty during the day and three at night.

When these levels are not achieved staff would complete an incident report is to identify the deficit. These incident reports are highlighted to the senior management team who in turn will look at what actions need to be taken to address the issue.

We were told by the ward shift leader that where minimum staffing levels occurred staff had to complete an incident report on the incident reporting system. We were told the incident reports were then highlighted to the senior management team who looked at what actions need to be taken to address the issue. We asked what action had been taken since it was identified that the service frequently operated at minimum staffing levels.

We were told a target date of 31 December 2014 had been identified to ensure staffing levels were addressed appropriately.

The trust had taken action to train 27% of its bank staff in RESPECT level 3 training but recognised it had more to do to ensure all bank staff had the appropriate level of training and had plans in place to deliver this.

A Training plan was now in place for the in-patient area and 96% of the permanent staff (24 staff) and 92% of flexible staff (12 staff) had attended this training.

We were told that a lack of skilled staff to deliver care and treatment resulted in initial assessments of patients not being completed. There was no occupational therapy service model or pathway to assess all patients. This meant that assessment and treatment plans were not in place.

Care plans were now in accessible formats and we also saw health action plans, hospital passports and health action plan summaries were in place. Discharge planning occurred at point of admission.

There was a training matrix in place to monitor mandatory training completed by staff. We identified from looking at training records some staff had not completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Not completing relevant training meant that staff may not have had suitable competencies to ensure patient's rights were protected.

MCA training – 76% (16 staff) had undertaken it 24% are booked (5 staff)

DoLS training only 30% (8 staff) had attended, however the trust has now withdrawn this training due to the Cheshire West ruling. New course is planned for delivery in July 2015.

Assessing and managing risk to patients and staff

Five of the seven patient records were reviewed. These all contained DRAM (detailed risk assessment and management plan) risk assessments.

All patients records now had a DRAM risk assessment

Requires improvement

Are services safe?

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

One record we looked at had not been updated or reviewed since the patient's admission in March 2014. We saw that pre admission assessments were not always fully completed. We also found patients and/or family members had not been involved in these assessments.

Positive behavioural support plans (PBSP) had been developed for patients who were in the process of being discharged from the service or who had been discharged. We were told that patients who were currently in the unit did not have PBSP in place. There were no PBSP on the notes we reviewed.

This remained outstanding as staff are undertaking positive behaviour support training initial training in July 2015.Once this is completed the staff will complete PBS for all of the patients

There was a trust policy for the observations of in-patients which was dated March 2014.

Staff we spoke with told us all patients were on 15 minute observations. One record we reviewed had a care plan stating the clinical team had agreed to 15 minute observations throughout the night and this would be evaluated monthly. This had not been evaluated since it was started in May 2014.

Care plans are now discussed with staff or patients in 1:1 sessions. We reviewed all care plans reviewed and these were up to date

Guidelines for the use of physical restraint in the intensive support service identified that all staff should be RESPECT level 3 trained. Training records confirmed staff were RESPECT level 3 trained.

We found there was good medicines management and appropriate prescribing practices in place.

We saw medicines were kept in a fridge within the nursing office and checks were made to ensure the fridge was at the required temperature.

Staff were aware of how to make a safeguarding referral and had received training. However information was not available in an accessible format for patients with a learning disability and or autism, to inform them how to raise or report concerns about abuse.

Care plan evaluation and insight recording training had also occurred as well as training for all the staff in "safeguarding in an accessible format".

Reporting incidents and learning from when things go wrong

Staff were aware of how to record incidents and were able to give examples of when they had done this. However staff were unable to tell us what action had been taken following reporting incidents.

Lessons learnt issues are now routinely shared with staff at handovers and these are also included in staff meeting minutes. If staff do not attend meetings then these issues are also covered during handovers.

Are services effective?

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.

Summary of findings

We rated the services for patients with learning disability or autism as **'requires improvement'** because:

We found care planning and risk assessment as requiring improvement. Care plans were not holistic, personalised or recovery focused. The service did not embed best practices such as positive behaviour support, health action plans and Valuing People Now.

Care plans now discussed in 1:1 sessions. We viewed all care plans and all were up to date.

Positive behaviour support (PBS) training had also been sourced and one staff was undertaking this in July 2015 accessed through the British institute of learning disabilities. Two further staff were undertaking the next steps in PBS and a further 19 were undertaking PBS next steps training.

Staff were not supported to develop knowledge, skills and experience to enable them to deliver good quality care.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

There was a failure to use alternative methods of communication to involve patients in decisions regarding their care.

Care plans were now in accessible formats and we also saw health action plans, health passports and health action plan summaries were in place

Our findings

Assessment of needs and planning of care

The care and treatment delivered did not reflect current best practice guidelines. We reviewed five of seven care records. The completed assessments and care records were not personalised, holistic or recovery focused.

Care plans now discussed in 1:1 sessions. We viewed all care plans and all were up to date.

Care plans were now in accessible formats and we also saw health action plans, hospital passports and health action plan summaries were in place. Discharge planning occurred at point of admission.

Staff were not supported to develop knowledge, skills and experience to enable them to deliver good quality care. Staff told us they had not received training in ways to communicate with patients admitted to the ward. During the inspection we communicated with a patient using Makaton sign language. The staff were unaware the individual could communicate effectively in this way. This meant the patient was not able to make their needs known to staff as staff were not aware of how the patient could effectively communicate with them.

Not all of the patients were able to communicate effectively. None of the staff were able to explain any specific communication needs for individuals. There were no augmented forms of communication such as story boards, picture cards or visual timetables available.

Care plans were now in accessible format and we also saw health action plans, hospital passports and health action plan summaries were in place.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

Care plan evaluation and insight recording had also been completed Safeguarding information had been produced in an accessible format

Positive behaviour support (PBS) training had also been sourced and one staff was undertaking this in

Are services effective?

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.

July 2015 accessed through the British institute of learning disabilities. Two further staff were undertaking the next steps in PBS and a further 19 were undertaking PBS next steps training.

The content and language in patients' progress notes was sometimes inappropriate. An example of this was to explain an individual's behaviour as having a "tantrum" because their needs were not immediately met.

Action had been taken to review this and additional training had taken place.

An occupational therapist told us they had recently received training in sensory integration assessments for individuals who had an autistic spectrum disorder and severe challenging behaviours. However there were no assessments in place.

Off the main ward areas there was an equipped sensory room. This room was available to support both community and inpatients of the ISS service and was used at times by the community learning disability teams. We were told that as this room was off the ward it was only accessible if there was a full complement of staff.

Patients did not routinely have a health action plan in place. One patient without a health action plan had been an inpatient for over a year.

Care plans were now in accessible format and we also saw health action plans, hospital passports and health action plan summaries were in place.

A general practitioner (GP) visited the ward fortnightly, if required staff could request a GP to visit at any time.

Best practice in treatment and care

We found that the care and treatment delivered did not reflect current best practice guidelines as follows:

We looked at how the service had implemented the, 'Autism: recognition, referral, diagnosis and management of adults on the autism spectrum' National Institute of Health and Care Excellence (NICE) Guidance. We found there was an absence of any values that underpinned the philosophy of care expected when caring and treating patients who present with an autism diagnosis.

Training for this happened post inspection and more training was planned, although we were unable to test if this had been embedded fully.

Positive behaviour support plans were not in place for patients. The management in place for behaviours that some patients find challenging was to be offered calming and low stimulus on the unit. None of the plans included any proactive strategies or coping strategies. They only identified intervention was to escort them to their bedroom or quiet lounge.

This remained outstanding as staff are undertaking positive behaviour support training initial training in July 2015.Once this is completed the staff will complete PBS for all of the patients

There was minimal information produced for patients on the ward in accessible format.

There were new enclosed notice boards which had information in accessible formats, there were also new activity boards and menu boards which were in easy read format and included lots of pictures

There was no information in patient's records to demonstrate the principles of Valuing People Now 2010 were being embedded in the service. Patients were not engaged in meaningful activities that developed social inclusion or any of the principles of supporting patients with complex needs.

There was a ward timetable of activities displayed with some pictorial images on the male side of the unit. However; we did not see individual timetables relating to any therapeutic interventions in relation to the care and treatment of individual patients.

We found there were activity plans on display. These were being delivered at the time of the inspection. We observed a cooking sessions involving four patients and the staff interacted well and assisted when needed.

Skilled staff to deliver care

There was a multi-disciplinary team working on the ward. This team included a consultant psychiatrist, occupational therapist, psychologist, speech and language therapist, specialist nurse practitioner and a pharmacist.

We were told that a lack of skilled staff to deliver care and treatment resulted in initial assessments of patients not being completed. these assessments were not present on all of the patient files.

Are services effective?

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.

We found that initial assessments were completed and staff were endeavouring to ensure that this was ongoing and present in patient files.

We were told there was no occupational therapy service model or pathway to assess all patients. This meant that assessment and treatment plans were not in place.

We found that there was evidence of occupational therapy assessment and treatment plans in place.

There was a training matrix in place to monitor mandatory training completed by staff. We identified from looking at training records some staff had not completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Not completing relevant training meant that staff may not have had suitable competencies to ensure patient's rights were protected.

MCA training – 76% (16 staff) had undertaken it 24% are booked (5 staff)

DoLS training only 30% (8 staff) had attended, however the trust has now withdrawn this training due to the Cheshire West ruling. New course is planned for delivery in July 2015

The staff had not been provided with relevant training. They were not following best practice guidance and they were not able to communicate with patients who were sign language users.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

Multi-disciplinary and inter-agency team work

Daily handovers were completed as were weekly clinical meetings of patients. As part of the inspection we observed a clinical meeting. This meeting lacked structure and was not patient focused. The patient did not participate in the meeting, there was no discussion regarding the incomplete assessments or how the patient's care could be better co-ordinated to ensure treatment was safe and effective.

We found evidence within patient care records of patient involvement in their care and treatment.

Due to the needs of patients using the service we looked at how different communication systems were used in the service to effectively engage patients in decisions. We found no evidence of any augmented or alternative communication being used despite patients having little or no speech. This falls short of the requirements under the Mental Capacity Act 2005 to take all practicable steps to help patients make decisions, communicate in ways appropriate to patient's circumstances and permit and encourage patients to participate as fully as possible in acts or decisions affecting them.

Good

Are services caring?

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

Summary of findings

We rated the services for patients with learning disability or autism as **'good'** because:

We found that staff did not have the skills and abilities to engage patients in activities which often meant patient's needs were not being met.

We found staff had a poor understanding of patient's needs. For example, staff showed no understanding of patient's interests and how these could be used to inform effective care planning.

We saw evidence of patients' needs being met and engaged with. We saw patients being supported to undertake cooking tasks make drinks and they were able to show us round the ward area. We saw in patients care records that patients had been off of the unit and into the community.

Where patients had communication plans, these were not used by staff which demonstrated a failure to engage patients effectively. This meant for these patients, engagement in the care plan process was limited.

We found patient involvement in care plans and their choice to have copies of their care plans. There was evidence of accessible formats to support patients in understanding their care but it was difficult to identify if patients had copies of their plans of care.

Our findings

Kindness, dignity, respect and support

We found that patient's basic needs were ignored or not being met. For example, increasing independence, maintaining personal safety, well-being and managing challenging behaviour were not a focus of the service. During the time we were at the service, we saw no evidence of patients being supported to be independent and enjoy a range of meaningful activities.

We saw evidence of patients' needs being met and engaged with. We saw patients being supported to undertake cooking tasks make drinks and they were able to show us round the ward area. We saw in patients care records that patients had been off of the unit and into the community.

We saw two patients sitting in a living area whilst a staff member sat in the same room. The staff member did not communicate or interact with either of the patients. On another occasion, a patient stood in the hallway with their face pressed up against the office window for some time. During this time no staff intervened or provided the patient with an activity to do until it was brought to the attention of the nurse in charge by inspectors.

We spoke to staff and they lacked awareness of the principles of care set within Valuing People Now. They failed to appreciate the importance of ensuring patients had fulfilling and meaningful lives.

We asked staff how patients were offered choices in their care. We found activities were decided by staff and patient's views were not taken into account. Staff failed to use any forms of communication patients understood and did not develop any forms of communication to involve patients.

We observed staff interactions with patients and their immediate response to patients who approached staff for support. We spoke to patients who told us about their involvement in their care.

There was no use of equipment such as storyboards to aid communication and support patients to understand the care they received. This would also support patients to make choices. The use of appropriate methods of communication is important because it allows for greater understanding and reduces patient's anxieties and agitation which can lead to challenging behaviours due to their needs not being met or understood.

We found the service had begun using equipment such as notice boards to support patients to better understand their care and choices.

We saw limited patient engagement in meaningful age-appropriate activity during our inspections at the service. We saw patients wandering around the ward on numerous occasions throughout our two day visit. Patients were seen knocking and pressing their faces on the nursing office

Are services caring?

Good

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

windows and doors and were often ignored or dismissed by staff. However we did see some positive interactions with patients, where staff spoke kindly to patients and were discreet about the conversations being held in front of us.

Staff behaviour was entirely appropriate throughout our visit. All interactions we saw were positive and staff we interviewed displayed a caring attitude which translated into interactions with the patients.

However most patients who were able to told us, they found staff to be "respectful" staff were alright and nice and patients relatives were mostly complementary about the staff.

Most patients we spoke with told us they went out with support into the community and attended some activities. Examples patients gave us about the activities they were involved in included cookery, arts and crafts, attended a disco outside of the unit and also a walking group. Some patients told us they 'helped out' on the reception area outside of the unit. One patient told us they had attended church and accessed the multi faith room within the building.

On our arrival we were met with a patient who was working on the reception desk and he told us about his role.

We spoke with staff about equality and diversity and were told there was a well-equipped multi faith room available to patients. However, this was upstairs off of the main ward and only accessible if sufficient staff were available to accompany the patient.

This was still the same.

The daily progress notes we reviewed recorded that a patient had asked the ward to contact the Chaplin. We saw following this request that the patient had been accompanied to the local church.

The involvement of people in the care they receive

Patients were not involved in planning their care or decisions which were made on their behalf without their consent or support. The service did not listen to or consult patients about how they would like to receive their care. For example we observed a multi-disciplinary team meeting. The care needs of patients' and their future goals were discussed at the multi-disciplinary team meeting, however the patients' were not invited to and did not attend these meetings

We found in patient care records that there had been an improvement in patient involvement in their multi-disciplinary team meetings. The provider should continue to improve the patients involvement with their multi-disciplinary meetings.

None of the patients' in the service had copies of their care plans. The care plans in place were not written in an accessible format to assist understanding.

We found patient involvement in care plans and their choice to have copies of their care plans. There was evidence of accessible formats to support patients in understanding their care but it was difficult to identify if patients had copies of their plans of care.

The ward area was dull and stark with limited information (written or pictorial) to direct patients around the ward area.

Improvements to the ward area had been made and there were new noticeboards that had up to date information in them. There was also pictorial information on display.

We were told by ward staff and managers that admissions to this ward were usually planned. However we saw some pre admission assessment forms were incomplete and did not involve the patient.

We found completed pre-admission forms within care records reviewed. We observed staff discussions and involvement for a planned admission.

There was limited access to advocacy services on this ward. Information about the advocacy service was limited and was not available in an accessible format. We saw one patient had previous input from an advocate who had provided an in-depth email on the specific communication needs of the individual. However we found information had not been used to formulate an effective communication care plan.

Advocacy services are available for all patients this included both independent mental health advocates and independent advocates. This was provided by Cloverleaf and information was available on the ward.

Are services responsive to people's needs?

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

Summary of findings

We rated the services for patients with learning disability or autism as **'REQUIRES IMPROVEMENT'** because:

The service did not have adequate discharge arrangements in place. Discharge was not planned at the point of admission which meant it was unclear how long patient's intended stay was likely to be or what the longer term plan was for individual patients.

Records showed that discharge arrangements are now routinely discussed on admission and contained in their assessment.

The physical environment was not conducive to patient's needs because promotion of Independence was not a focus of the service. This was demonstrated by the fact appropriate kitchen equipment was not available for patients to use and patients had no individual timetable of activities that promoted independence and daily living skills.

Staff ensured that patients had access to drinks and snacks during the day. We saw that the kitchen was open and patients were encouraged to enter and make drinks.

There were restrictions in place in the way people were cared for. People did not have access to telephones, access to outside space and bedroom doors were locked.

There was free access to an outdoor space on one side of the ward, however the other side of the ward had controlled access as there was a patient who was a high absconsion risk. We observed however patients spending time in both garden areas.

There was no telephone available in the ward area. Patients were supported by staff to use the office phone to contact families and relatives where patients were unable to do this independently.

Our findings

Access, discharge and bed management

The service provides care and support to patients with a learning disability who live in the Sheffield area. ISS provides assessment and treatment for patients when they are in a period of crisis and require a period of hospital admission.

The service provides support for four weeks post discharge. This means that a bed is maintained for them even when they are on leave and while being reintroduced to their permanent residence.

The discharge arrangements were not always being planned at the point of admission. The care records we reviewed did not all contain a discharge plan.

Records showed that discharge arrangements are now routinely discussed on admission and contained in their assessment.

The ward environment optimises recovery, comfort and dignity

Patients had access to a lounge area with a television and a quiet lounge. There was a female only lounge on the male side of the unit. The quiet lounge was used for family or other visits.

All bedrooms provided en suite accommodation, showers and toilets. The ward also had a tracked accessible bathroom.

There was no telephone available in the ward area. Patients had to ask staff if they wanted to use the phone.

Patients did not have free access to outside space without asking staff to unlock the door. Access to the ward was controlled and through locked doors. All of the internal doors including bedroom doors were locked.

There was free access to an outdoor space on one side of the ward, however the other side of the ward had controlled access as there was a patient who was a high absconsion risk. We observed however patients spending time in both garden areas.

There was no information for informal patients which explained their right to leave the ward or how they could do so.

This had now been rectified

People find it hard to access services because the facilities and premises used are not appropriate for the services

Are services responsive to people's needs?

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

being provided There were areas off the main ward that were accessible to patients as part of a planned timetable of activities. These could be accessed at other times but only if accompanied by staff. These included:

- Keep fit room
- Activities of daily living (ADL) kitchen
- Arts and craft room
- Multi faith prayer room
- Multi-sensory room
- Clinic room.

The ward had designated areas (two sides) one each for male and female patients. However, one male patient was in a bedroom on the female side of the ward even though there was a vacant male room available. This meant that patients' privacy and dignity could be compromised.

The accommodation has been designed to form two 'wings' with three individual, en-suite bedrooms (total six) and, two independent flats thereby supporting segregation. Each three bedded 'wing' has an allocated women-only lounge area.

Patients were unable to access care they need as a result of physical and communication barriers.

Communication training had been completed immediately after the inspection. Further training is planned including Makaton.

Care plans were not reviewed or adapted to meet patients' changing needs and did not accurately reflect the changes in their condition, behaviours or circumstances. The care plans were not in accessible formats or person centred. They did not include goals, aspirations and coping strategies. None of the patients' in the service had copies of their care plans. Patients and relatives were not effectively engaged in care plans; staff had poor understanding of patients communication needs and failed to effectively engage patients in care aimed at which optimising their recovery and independence.

Care plans were now discussed in 1:1 sessions. All care plans were up to date that we reviewed. Care plans were now in accessible format and we also found health action plans, hospital passports and health action plan summaries were in place. There was evidence of patients and relative engagement in multi-disciplinary meetings and care plan reviews.

Ward policies and procedures minimise restrictions

There were some blanket restrictions in place for all patients which were not in line with the Code of Practice guidance. These included patients being unable to freely access food, drinks or snacks throughout the day.

Staff ensured that patients had access to drinks and snacks during the day. We saw that the kitchen was open and patients were encouraged to enter and make drinks.

There was no telephone available in the ward area. Patients had to ask staff if they wanted to use the phone.

There was no telephone available in the ward area. Patients were supported by staff to use the office phone to contact families and relatives where patients were unable to do this independently.

Patients did not have free access to outside space without asking staff to unlock the door. Access to the ward was controlled and through locked doors. All of the internal doors including bedroom doors were locked.

There was no information for informal patients which explained their right to leave the ward or how they could do so.

These issues have now been rectified

Listening to and learning from concerns and complaints

People do not find it easy to raise concerns or complaints. there was no evidence of how complaints are used as an opportunity to learn. The complaints process was not clear or easy to access for patients with a learning disability. There was no patient information about making complaints available on the ward although on access to the building, information was available in an accessible format.

We looked at two recent complaints. One from a member of the public and one from a family member. These complaints had been investigated by the trust and several recommendations had been made. The trust had provided information about the outcome of the complaint to the individual as well as providing information to them of where they should contact if this was not to their satisfaction.

Are services well-led?

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.

Summary of findings

We rated the services for patients with learning disability or autism as **'requires improvement'** because:

The service was not well-led. There was insufficient staff with appropriate skills and competencies to meet patient's needs.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

Care plan evaluation and insight recording training had also occurred as well as training for all the staff in "safeguarding in an accessible format".

Positive behaviour support (PBS) training had also been sourced and one staff was undertaking this in July 2015 accessed through the British institute of learning disabilities. Two further staff were undertaking the next steps in PBS and a further 19 were undertaking PBS next steps training.

Staff were unclear about the organisations values or the ward philosophy on providing care to patients with learning disabilities.

There was a governance structure however the governance arrangements were not as effective as they could have been. Where audits and assessments had been completed concerns identified had not been actioned.

We found that some progress had been made when it came to vision and values, we spoke to three staff on duty and all knew about the trust visions and values

There was confidential and important patient information that was not being stored on the patients notes.

The ward office was now ordered and all staff had identified drawers and no confidential information was visible from outside the office. All out of date information had been removed from the walls and new noticeboards had been put on display and included up to date information. There were also new signs which clearly displayed the menu, activities and which staff were on duty.

When we raised our concerns with the senior management team of the trust they were not aware of the areas of our concern.

Our findings

Vision and values

There was no credible statement of vision and guiding values. Staff are not aware of or do not understand the vision and values, objectives, plans or the governance framework for the in-patient learning disability service.

We found that some progress had been made when it came to vision and values, we spoke to three staff on duty and all knew about the trust visions and values. Significant work had been started with the ward team around, de briefs after incidents, Schwarz rounds topical discussions and reducing restrictions. Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work.

Staff posts which were interim at the time of our previous inspections were now substantive.

The ISS had a plan and supporting vision for the services it was providing. This was supported by a governance structure where the team could review progress and monitor the quality of care provided. The governance arrangements were not as effective as they could have been. Financial and quality governance are not integrated to support decision-making. The information that was being used to monitor performance or to make decisions was not reliable or not relevant.

There were low levels of staff satisfaction, high levels of stress, work overload and conflict within the organisation. Staff told us that they did not feel respected, valued, supported, appreciated and cared for. They told us when they expressed concerns regarding the lack of resources,

Are services well-led?

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.

including nursing leadership, psychology, speech and language therapy and occupational therapy, they felt these were not taken seriously and no action had been taken. Incident records had been completed in relation to staffing issues however it was unclear what action was being taken to make improvements. However staff told us they enjoyed working with the patients who used the service.

Staff who we spoke to on inspection told us they enjoyed working with the patients group and chose to work there.

Staff who we spoke to on inspection told us they enjoyed working with the patients group and chose to work there.

Staff did not express any concerns about high levels of stress and morale had improved.

Staff were unclear who the senior managers were. However the learning disability service had recently appointed new senior managers.

Staff were aware of their immediate line manager and service manager. These posts were now substantive.

Good governance

There was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level.

The lack of staff training and awareness were significant issues that threaten the delivery of safe and effective care are these had not been identified.

The service had recently identified and sourced autism and sensory needs training and were waiting for dates to be agreed. They had also identified two staff to undertake Makaton training to then cascade this training to other staff. The speech and language therapist had also undertaken some training immediately post inspection around communication with 15 staff.

Care plan evaluation and insight recording training had also occurred as well as training for all the staff in "safeguarding in an accessible format".

Positive behaviour support (PBS) training had also been sourced and one staff was undertaking this in July 2015 accessed through the British institute of learning disabilities. Two further staff were undertaking the next steps in PBS and a further 19 were undertaking PBS next steps training.

The ward office was disorganised. Filing trays were full of confidential information relating to patients which had not been appropriately filed away. Staff told us they had not had an opportunity to file papers away due to staff shortages and the demands and needs of patients.

We found that the ward manager and her line manager had made significant progress since our inspection. The ward office was now ordered and all staff had identified drawers and no confidential information was visible from outside the office. All out of date information had been removed from the walls and new noticeboards had been put on display and included up to date information. There were also new signs which clearly displayed the menu, activities and which staff were on duty.

Although staff raised concerns and completed incident forms in relation to staffing levels these were not actioned and a detailed plan to address the concerns was not in place. This meant the provider was aware patient's needs were not always adequately met but failed to make immediate improvements.

There was minimal evidence of learning and reflective practice. The impact of service changes on the quality of care is not understood. Not all staff had received mandatory training in areas such as Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We also found significant gaps in core training such as positive behaviour support, communication methods, sensory assessments and autism.

The ISS mandatory training spread sheet provided by the service indicated that only 20 of the 45 staff had completed Mental Capacity Act training and only 14 had completed Deprivation of Liberty Safeguards training. The record indicated that only 21 of the 45 staff had completed Autism Awareness training and only 3 members of staff had undertaken training in the Mental Health Act

MCA training – 76% (16 staff) had undertaken it 24% are booked (5 staff)

Are services well-led?

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.

DoLS training only 30% (8 staff) had attended, however the trust has now withdrawn this training due to the Cheshire West ruling. New course is planned for delivery in July 2015

Only 3 staff had completed their MHA training, however there are no further courses planned until 2016 due to the change in MHA CoP.

These numbers were also incorrect, the community figures had somehow been merged in with the ward numbers, there were only 21 staff allocated to the ward.

Staff we spoke with told us they received supervision every 2 to 3 months and a yearly appraisal.

Leadership, morale and staff engagement

Staff told us they enjoyed working with their immediate managers and if they had any concerns they were able to confidently raise that with them. Managers we spoke with told us that there were high levels of sickness on the ward which was causing difficulties covering the service with suitably skilled staff.

Commitment to quality improvement and innovation

There were no examples of commitment to quality improvement or innovation. The care provided did not meet acceptable standards.

Steps have been taken since the inspection to address many of the initial issues.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found the registered person had not ensured the care and treatment of service users met their needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met At the intensive support service care plans were not holistic, personalised or recovery focused. The service did not embed best practices such as positive behaviour support, health action plans or Valuing People Now. We were told that a lack of skilled staff to deliver care and treatment resulted in initial assessments of patients not being completed. One male patient was in a bedroom on the female side of the ward even though there was a vacant male room available A ligature risk assessment dated 26 August 2014 identified the risks in the unit for patient accessible areas. The actions identified to manage this risk had not been completed. Regulation 9 (1) (3)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found the registered person had not provided care and treatment in a safe way.

Requirement notices

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

At the intensive support service risk assessments of the environment did not identify where patients could be placed at risk of harm and where concerns had been identified action was not always taken.

We identified risks which had not been identified through the ward risk assessments or on the ward risk register.

Regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found the registered person had not protected people against the risks of having their privacy and dignity needs met. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At the intensive support service patients were not involved in decisions regarding their care and treatment. Where patients experienced difficulties in being understood, staff were unable to communicate with patients effectively to ensure their wishes and views had been appropriately considered. Patients were not always involved in multi-disciplinary meetings despite their care and treatment being discussed. Regulation 10 (1) (2)

Regulated activity	Regulation

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found the registered person had not provided sufficient qualified staff to meet the needs of people receiving the service. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At the intensive support service there were not sufficient numbers of qualified, skilled and experienced staff deployed to meet peoples needs at all times. Regulation 18 (1) (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found the registered person had not provided care and treatment with the consent from people using the service. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At the intensive support service patients were poorly engaged due to their communication needs in relation to consent to care and treatment . Regulation 11