Elysium Healthcare (Healthlinc) Limited

Healthlinc House

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Healthlinc House is an independent healthcare service providing care and treatment to people with a learning disability and/or autism. Healthlinc House is owned and operated by Elysium Healthcare Limited.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support

The service did not always support people to have the maximum possible choice, control and independence be independent and they had control over their own lives.

Staff did not always focus on people's strengths and promoted what they could do, so people had a fulfilling and meaningful everyday life.

People were not always supported by staff to pursue their interests.

Staff did not always support people to achieve their aspirations and goals.

The service did not always effectively work with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative.

Staff did not always do everything they could to avoid restraining people. The service did not always record when staff restrained people, and staff did not always learn from those incidents and how they might be avoided or reduced.

The service did not always give people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs.

People were able to personalise their rooms.

People did not always benefit from the interactive and stimulating environment.

The service did not always make reasonable adjustments for people so they could be fully in discussions about how they received support, including support to travel wherever they needed to go.

Staff did not always support people to take part in activities and pursue their interests in their local area and to interact online with people who had shared interests.

Staff enabled people to access specialist health and social care support in the community.

Staff did not always support people to make decisions following best practice in decision-making. Staff communicated with people in ways that met their needs.

Summary of findings

Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome.

Staff did not always support people to play an active role in maintaining their own health and wellbeing.

Right care

Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care.

People did not always receive kind and compassionate care. Staff did not always protect and respect people's privacy and dignity. They did not always understand and respond to their individual needs.

Staff did not always understand how to protect people from poor care and abuse. The service worked well with other agencies to do so. However, management were not always informed of every incident that may have happened. Staff had training on how to recognise and report abuse. However, they did not always know how to apply it.

The service had enough appropriately skilled staff to meet people's needs and keep them safe.

People could not always communicate with staff and understand information given to them because staff did not always support them consistently and understand their individual communication needs.

People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language), pictures and symbols (add to or delete as appropriate) could interact comfortably with staff and others involved in their treatment/care and support because staff had the necessary skills to understand them.

People's care, treatment and support plans reflected their range of needs and this promoted their wellbeing and enjoyment of life.

People did not always receive care that supported their needs and aspirations, or was focused on their quality of life, and followed best practice.

People could take part in activities and pursue interests that were tailored to them. The service gave people opportunities to try new activities that enhanced and enriched their lives. However, this could be restricted due to access to transport.

Right culture

People did not always lead inclusive and empowered lives because of the ethos, values, attitudes and behaviours of the management and staff.

People did not always receive good quality care, support and treatment because although there was trained staff and specialists, they did not always meet people's needs and wishes.

People were not always supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people did not always receive compassionate and empowering care that was tailored to their needs.

Summary of findings

Staff did not always know and understand people well and some staff were responsive, supporting peoples' aspirations to live a quality life of their choosing.

Staff did not always place people's wishes, needs and rights at the heart of everything they did.

People and those important to them, including advocates, were not always involved in planning their care.

Staff did not always evaluate the quality of support provided to people, did not always involve the person, their families and other professionals as appropriate.

The service enabled people and those important to them to worked with staff to develop the service. Staff valued and acted upon people's views.

People's quality of life was not always enhanced by the service's culture of improvement and inclusivity.

Staff did not always ensure risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity.

SUMMARY

Our rating of this service stayed the same. We rated it as inadequate because:

- People's care and support was not always provided in a safe, clean, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs.
- People were not always protected from abuse and poor care. The service did not always have sufficient, appropriately skilled staff to meet people's needs and keep them safe.
- People were not always supported to be independent and did not always have control over their own lives. Their human rights were not always upheld.
- People did not always receive kind and compassionate care from staff who protected and did not always respect their privacy and dignity and understood each person's individual needs. People did not always have their communication needs met and information was shared in a way that could be understood.
- People's risks were assessed regularly but not managed safely. People were not involved in managing their own risks whenever possible and we saw staff intervene to restrain before the use of any de-escalation.
- When restrictive practices were used, there was a reporting system in place. However staff failed to use this system to report all incidents of restraint and this limited management attempts to reviews and try to reduce the use of these practices.
- People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- People's care, treatment and support plans, reflected their sensory, cognitive and functioning needs.
- Staff had not understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- People were in hospital to receive active, goal oriented treatment. People had clear plans in place to support them to return home or move to a community setting. Staff worked well with services that provide aftercare to ensure people received the right care and support they went home.
- Staff supported people through recognised models of care and treatment for people with a learning disability or autistic people. Leadership was good, and governance processes helped the service to keep people safe, protect their human rights and provide good care, support and treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	

Summary of findings

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Summary of this inspection

Background to Healthlinc House

Healthlinc House is an independent healthcare service providing care and treatment to people with a learning disability and/or autism. Healthlinc House is owned and operated by Elysium Healthcare Limited.

This was a planned comprehensive inspection timed to review the services progress against the enforcement action we had taken and placed the service in special measures. The inspection was unannounced to the provider.

This previous inspection was a focused inspection in November 2021 and triggered by receipt of concerns from staff about the safety of the service and that people who use the service were subject to unreasonable restrictions. The CQC issued enforcement action, a requirement notice for Regulation 10 Dignity and Respect and warning notices for Regulation 13, Safeguarding service users from abuse and improper treatment and Regulation 15, Premises and equipment.

Our previous comprehensive inspection of this service in April 2021 rated the service inadequate overall. The key questions were rated as good for effective, requires improvement in caring and responsive whilst safe and well led were rated as inadequate. The service was placed in special measures when the report was published in July 2021. Conditions on the registration of the service were applied. These included presenting regular weekly reports on staffing levels and incidents to the CQC and that the registered provider must not admit any service user to Healthlinc House without the prior written agreement of the Care Quality Commission.

Healthlinc House can accommodate a maximum of 25 male and female people in self-contained apartments or ensuite bedrooms.

We expect Health and Social Care providers to guarantee people with autism and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people. Throughout the report and in respect of this statement we refer to “people” or “people using the service” rather than the term patients.

This was a comprehensive, unannounced re-inspection of the service in line with the CQCs special measures guidance. We looked at all of the five key lines of enquiry.

Due to the seriousness of the concerns CQC found during this inspection, we sent a letter to the provider detailing our concerns and giving them opportunity to provide documentary evidence that risks were managed, and patients were safe. The provider responded to the challenges around the safety of the site by providing some immediate mitigation of risk as requested by the CQC. They also decided that the site should close and, in the months following the visit in January 2022 the provider worked closely with commissioners, NHS England, the local authority and CQC to ensure the safe discharge of all patients. The hospital closed on 31 March 2022.

What people who use the service say

One person told us they understood what medication they were on and why they were on it.

Another person told us they could only go out in the community when the minibus was free.

Summary of this inspection

One person told us things haven't improved since we most recently inspected in November and that they feel their physical health care isn't being looked after.

One person told us they felt things were alright.

A relatives told us that communication between the hospital and them was not great. Care plans were not always being shared with family members.

A relatives told us there was a lack of clarity about staff changes and the change of management.

One relative told us they were concerned about how the hospital were caring for their loved ones physical health.

Our inspection team included an inspection manager, three inspectors, an assistant inspector and a Mental Health Act Reviewer.

Before the inspection visit, we reviewed information that we held about the location, reviewed the feedback from staff and received feedback about the service from other organisations.

During the inspection visit, the inspection team:

- visited the communal and accommodation areas of the hospital, looked at the quality of the environment, and saw how staff were caring for people;
- spoke with three people who were using the service;
- spoke with one relative who had family members using the service;
- spoke with the manager of the service, and members of the senior management team from the providers regional team;
- spoke with the consultant psychiatrist and six healthcare support workers;
- reviewed four independent care, education and treatment review records of people using the service and two sets of care plans and risk assessments in more detail;
- reviewed incidents in the previous six months recorded on IRIS (the providers incident reporting system);
- reviewed closed circuit television (closed circuit television) of reported incidents of restraint;
- reviewed prescribing records for two people using the service;
- looked at a range of policies, procedures, records and other documents relating to the running of the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Requires Improvement
Caring	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Is the service safe?

Inadequate

Safe and clean care environments

Following our previous inspection, we told the provider that they 'must ensure that people's care and support is always provided in a safe, well equipped and well-maintained environment which meets peoples sensory and physical needs'. At the time of this inspection, we found that people were cared for in wards that were clean well equipped, well furnished, and fit for purpose.

Maintenance of the wards had improved, and some parts of the hospital had been redecorated since our follow up inspection in December 2021.

A new maintenance request system log had been designed and implemented from 18 November 2021. Environmental and maintenance issues were reviewed daily in the hospitals Central Morning Meeting. A member of the maintenance team attended that meeting to review with the clinical team any new or existing action progress, barriers, and challenges. The new system allowed easy identification of new actions, outstanding and priority items. The Hospital Director or any member of the senior management team could review on this as and when required.

People were cared for in wards where staff had completed risk assessments of the environment and removed or reduced any identified risks.

People had easy access to nurse call systems and staff had easy access to alarms.

The service had improved it's mitigation against the risk of visitors from catching and spreading infections, such as COVID-19. The site as a whole had adopted the national guidance directed at nursing homes as it included both a residential care service as well as the hospital. This meant visitors and staff had to demonstrate they had been vaccinated against COVID-19 or had a recognised exemption.

The service tested for COVID-19 infection in people using the service and staff. Testing was available routinely for staff in line with the provider's national policy and offered to patients as required.

The service made sure that infection outbreaks were effectively managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing in the event of an outbreak.

The service followed shielding and social distancing rules. Managers had provided clear information for all staff and visitors to the unit in regard to keeping socially distanced within the hospital.

However, we found staff did not always use personal protective equipment (PPE) effectively and safely. We reviewed closed circuit television we saw members of staff not wearing their masks appropriately. Staff had masks sitting below their noses or placed down past their chins.

The service's infection prevention and control policy were up to date and subject to regular review in line with governmental guidance. The service supported visits for people in line with current guidance. When face to face visiting had not been possible the managers had provided technological support and communication options to allow relatives to keep in touch with people using the service.

All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food.

Safe staffing

The service had enough nursing and medical staff, who knew the people and received mandatory training to keep people safe from avoidable harm. This was up to date and met the needs of people and staff. Any agency staff who had outstanding training had been booked to attend the hospitals training which took place in January 2022.

The service provided additional specialist training, when we reviewed the training figures, we found evidence that 94% staff had Learning Disability training and 84.5% staff had completed a training module on the care of people with Autism.

The overall compliance rate for mandatory training for permanent staff was 93%. Mandatory training courses included autism and learning disability awareness and Therapeutic Management of Violence and Aggression (TMVA). Managers ensured that agency staff had completed these training courses before working with people. We found the content of the learning disability and autism awareness courses was basic and did not cover the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, trauma-informed care, human rights and all restrictive interventions.

Staff recruitment and induction training processes promoted safety including bank and agency staff.

The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted. However, a person told us they could only go out into the community if the minibus was available as another person might be using the bus.

The numbers and skills of staff matched the needs of people using the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and health care assistants for each shift. However, when there was staff sickness members of the multi-disciplinary team would cover the short fall.

The service had enough staff on each shift to carry out any physical interventions safely. However, when reviewing closed circuit television, we saw that some physical interventions were not carried out safely and people were put at risk of harm.

The service had enough daytime and night-time medical cover, and a doctor was available to go to the hospital event of an emergency.

Staff shared key information to keep people safe when handing over their care to others. Handovers were at the start and the finish of each shift.

Assessing and managing risk to patients and staff

People did not live safely and free from unwarranted restrictions because the service failed to assess, monitor and manage their safety consistently.

People were not involved in managing risks to themselves and in taking decisions about how to keep safe. We observed staff failing to positively engage with people to explore alternatives and de-escalate risk behaviours resorting to restraint as a first level intervention. We observed through closed circuit television footage examples of missed opportunities where de-escalation may have prevented the restraint of people.

Staff failed to recognise signs when people experienced emotional distress and failed to support them to minimise the need to restrict their freedom to keep them safe. We saw in people's faces and body language on closed circuit television footage that they were distressed whilst being in restraint and no action was taken to support them.

Whilst care records were stored securely in an electronic patient record staff had not kept accurate or complete care records particularly when recording the use of force. We were concerned that people weren't supported when they were distressed or displaying behaviours that could place them at risk.

At the time of this inspection, we found the provider was not routinely auditing closed circuit television footage when restraints took place to ensure the incidents were being managed properly. If they had, they would have seen the improper use of force and recognised the inaccuracies in incident reporting. We observed some closed circuit television with management and this was the first time they had seen some incidents as they were not fully documented. Staff involved directly in the inappropriate use of force were subject to suspension pending an investigation and safeguarding referrals were made.

All incidents of excessive force were in one multiuser apartment, interactions seen in other apartments have not raised similar concerns. Of the ten incidents reviewed for apartment 7 three triggered significant concerns about patient safety as well as staff failure to act appropriately. That was 50 % of incidents of aggression reviewed at random for that apartment. However, staff from other units attended Apartment 7 to support staff and witnessed staff abuse of patients. There had been a complete failure of staff to report the abuse of people by their peers and we believe this exposed patient to a significant risk of future harm.

We found there had been a lack of oversight of staff actions on some units and management were not always aware of incidents that put people using the service at risk. There had been a lack of direct supervision from qualified staff in the apartments that contributed to this shortfall.

Staff had not always considered less restrictive options before limiting people's freedom.

Staff failed to restrict people's freedom based only on their individual needs. We found that staff were not correctly following these plans and people's freedoms were restricted disproportionately to the risk of themselves or others. Sometimes not as a last resort and not for the shortest time possible. This was despite each person's care and support plan including ways to avoid or minimise the need for restricting their freedom.

Inadequate

Wards for people with learning disabilities or autism

Staff had not made every attempt to avoid restraining people and did not always do so only when de-escalation techniques had failed and when necessary to keep the person or others safe.

If a person's freedom was restricted by staff, they failed to offer emotional support when needed.

People were not only restrained where evidence demonstrated it was necessary, lawfully justified, used for the minimum period of time, had a justifiable aim, and was in the person's best interest, and that it was used in a safe and proportionate way.

In a review of closed circuit television recordings of incidents reported by staff we found that staff had used additional force to that described in the incident report and some staff used unauthorised techniques to restrain a patient and bring them to the floor.

During the review of closed circuit television, we were concerned that there was a was a lack of Registered Nurse or other clinically qualified staff to ensure oversight of restraints and ensure care and treatment was being delivered in a safe and effective manner. We found there was no regular medical review of people using the service to establish if there were any injuries or emotional support offered to service users.

Peoples' freedom was restricted when they were placed under restraint. We told the service to activate their closed circuit television which was installed around the hospital in a warning notice dated 25 November 2021. This action had come from a complaint that there was no review of incidents. The closed circuit television was made operational on 7 December 2021.

Staff were trained in the use of restrictive interventions; the training was certified as complying with the Restraint Reduction Network Training standards. However, we observed on closed circuit television that there was a failure of some staff to putting their training into practice which placed people at risk of harm.

People were not always protected from verbal abuse by other patients. Closed circuit television footage showed that on two occasions incidents reported to CQC as patient-on-patient verbal abuse were taking place while the patient being abused was in fact in restraint. On neither occasion did staff take proactive measures to remove the patient from the room even though they had opportunity to do so.

If staff restricted a person's freedom, they did not routinely take part in post incident reviews and considered what could be done to avoid the need for its use in similar circumstances. A weekly incident review meeting led by the clinical psychologist did produce some learning around specific incidents and trends. However, the feedback from these meetings was not addressed at broader staff meetings or in one-to-one supervision with care staff who were directly involved in the use of force.

Staff had training on how to recognise and report abuse but did not apply it consistently. We identified multiple occasions were staff observed behaviours but failed to report these to management. The management team worked well with other agencies but were not always aware of all incidents to be able to discuss them.

People and those who matter to them had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern. However, a family member told us that they were not consistently informed of updates in regard to a concern raised by them.

Inadequate

Wards for people with learning disabilities or autism

Medicines management

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.

We saw that staff did not always record physical health observations for people after the use of rapid tranquilisation if they declined to have observations taken. This was not in line with the rapid tranquilisation policy.

People received support from staff to make their own decisions about medicines wherever possible.

People could take their medicines in private when appropriate and safe.

Staff made sure people received information about medicines in a way they could understand.

Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating, when medicines were given covertly, and when assessing risks of people taking medicines themselves.

Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines.

Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.

We saw that medical equipment in the clinic room was checked daily and the contents of the emergency bag was checked weekly.

Staff reviewed the effects of each people's medication on their physical health according to NICE guidance.

People received their medicines from staff who prescribed, administered, recorded and stored their medicines safely.

Track record on safety

People did not receive safe care because staff did not always report incidents or learn from safety alerts and incidents.

The service had not managed incidents affecting people's safety well. Staff did not recognise incidents and report them appropriately and managers had failed to investigate incidents and share lessons learned. We found incomplete incident reports and notifications sent into CQC were often not fully completed with all the information required.

Staff failed to raise concerns and record incidents and near misses and this contributed to a failure to keep people safe.

There was clear evidence of inadequate and inaccurate recording and logging of incidents which failed to safeguard patients. CQC reviewed 20 closed circuit television recordings of incidents which had been recorded or logged. The closed circuit television footage was not always consistent with the provider's records. In some incidents there were significant and concerning omissions regarding patient safety. These included incidents of patients being tackled to the floor by members of staff. The written accounts of the incidents omitted or minimized the use of force and restraint by staff.

Inadequate

Wards for people with learning disabilities or autism

We saw a very poor level of incident reporting and the closed circuit television we reviewed contained footage of inappropriate, overly aggressive and disproportionate use of restraint. There were six incidents where patients were exposed to harm with potentially very distressing effect. All incidents of potential physical abuse were witnessed by other staff members, but none had been reported. The management team had not previously identified these incidents until CQC requested the information. We were not assured the provider would have been aware of the incidents had it not been for our review of the footage. However, once the provider was aware of the incidents they were reported to the police, who took no further action.

Although the provider conducted a 'reducing restrictive practice' audit in December 2021, the service did not always record any use of restrictions on people's freedom. Managers were not always able to review the use of restrictions to look for ways to reduce them.

Managers and staff were aware of the Learning from Deaths Mortality Review (LeDeR) Programme.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Overall, staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after.

We reviewed the care records for seven people and we found these were detailed, up to date and person-centred. We saw that staff used recognised scales to measure people's outcomes. There was a physical health champion who made sure that people's physical health needs were met and reviewed.

Best practice in treatment and care

Staff did not always understand people's positive behavioural support plans if they had them or provide the identified care and support. Overall, staff made sure people had access to physical health care as required.

Not all staff had access to specialist positive behavioural support training, although they did have access to advice and support from the psychology team who wrote the PBS plans.

We saw that people's physical health was discussed by staff during the daily morning meeting. Staff used a recognised rating scale called National Early Warning Score (NEWS2) to record and monitor people's physical health. The GP visited the service monthly and more often if needed. Each person had an annual review of their physical health in line with current national recommendations.

There were not always clear pathways to future goals and aspirations, including skills teaching in people's support plans.

We reviewed the weekly activity timetables of five people and found that activities for three people had not taken place as planned. Staff did not always record why they had not taken place. Many of the activities that people had access to

focused on passing the time rather than being goal-oriented activities. People did not have links to meaningful activity in the community, such as voluntary work or education. This meant people had limited access to meaningful activities to promote their independence and aid their recovery. Group activities had stopped due to COVID-19 restrictions. The Occupational Therapist told us they had plans to re-start group activities as restrictions eased.

Skilled staff to deliver care

Not all staff were knowledgeable about and committed to using techniques which reduced the restriction of people's freedom. People were supported by staff who had received relevant training. Managers supported staff through regular clinical supervision of their work.

We reviewed the closed circuit television footage of 20 incidents and found that staff used inappropriate techniques to restrain six people, which amounted to physical abuse. We saw no evidence of staff using less restrictive options such as verbal re-direction instead of using restraint. In each example other staff members were present but did not report the inappropriate use of restraint to their line managers, suggesting that this was normal and accepted practice. This meant that people's human rights were not protected.

Staff had limited access to specialist training courses, the manager told us that only one specialist training course could be offered at a time.

Staff told us they received regular supervision. We reviewed supervision rates for the 6 months prior to the inspection and found supervision compliance was above 80% for six months. However, staff told us they did not receive enough emotional support when they experienced racial abuse from the people they supported. The psychologist told us they had not been able to offer reflective sessions to staff since December 2021 due to a member of the team leaving, but they planned to restart this support.

Multi-disciplinary and interagency team work

Staff shared clear information about people and any changes in their care, including during handover meetings. Staff from different disciplines worked together as a team to benefit people.

Staff supported each other to make sure people had no gaps in their care. The service worked closely alongside other healthcare professionals including GP, psychiatry, district nurses and diabetic nurses to provide holistic care to people. We saw that community teams and commissioners were invited to attend care review meetings.

Staff told us that handovers provided them with relevant information about the people they supported. Staff from a variety of disciplines attended a daily morning meeting to receive important updates about people's care. A variety of professionals attended the morning meeting including; a doctor, speech and language therapist, the ward manager, clinical nurse lead and the maintenance team. Information about recent incidents, changes in people's physical health needs, observation levels and section 17 leave were discussed at the meeting.

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

Staff did not always make sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

We reviewed the Mental Health Act records for five people and saw that the Responsible Clinician had agreed for each person to have daily leave in the hospital grounds or the community. However, staff did not support three people to take their daily leave and staff had not clearly recorded the reasons why people had able to take their leave. Two staff members told us people's leave was affected when the service was short staffed or staff were supporting other patients.

Inadequate

Wards for people with learning disabilities or autism

Staff explained to each person their rights under the Mental Health Act, repeated it as necessary and recorded it clearly in the people's notes each time. In the records we reviewed, we found evidence of staff reminding people of their rights every three months.

People had easy access to information about independent mental health advocacy. Advocacy posters were displayed at Healthlinc House in areas where people could see them. Mental Health Act Advocates were invited to and attending care reviews for people.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. There was a Mental Health Administrator at Health Linc House, who followed up on SOAD requests if there was a delay in allocation.

Good practice in applying the Mental Capacity Act

Staff followed best practice on assessing mental capacity, supporting decision-making and best interest decision-making.

95.7% of permanent staff had completed Mental Capacity Act training. Overall, staff completed mental capacity assessments with people when they were needed. However, we found staff had not completed a mental capacity assessment around consent to treatment for one person in a timely manner and had only done this after the person's condition got worse. Staff found the person lacked capacity to make this decision and held a best interest meeting to agree a treatment plan. The delay in assessing capacity meant staff did not support the person to be involved in the decision-making process at the time the decision needed to be made and had exposed the person to a decline in their health that could have been avoided.

Staff followed best practice for people lacking capacity to make decisions about their medicines. We reviewed medication care records for six people and found each person had a mental capacity assessment in place about their medication needs. People had access to easy-read information about specific medicines and pictures. This supported people's decision-making and involvement in their own treatment.

Staff ensured that an Independent Mental Capacity Advocate was available to help people if they lacked capacity to make decisions for themselves and they had nobody else to represent their interests. Independent Mental Capacity Advocates were invited to best interest and care review meetings.

People were consulted and included in the decisions about the use of surveillance. We reviewed community meeting minutes for November and December 2021 and saw that the installation of closed circuit television was discussed with people.

Is the service caring?

Inadequate

People did not always receive kind and compassionate care from staff who used positive, respectful language at a level people understood and responded well to. During our onsite inspection, we observed staff talking to people with respect and using communication methods that supported their needs. However, with reviewing closed circuit television footage of incidents we saw actions made by staff during restraint that were not always kind and compassionate.

Inadequate

Wards for people with learning disabilities or autism

Staff were not always patient and did not always use appropriate styles of interaction with people. During our onsite inspection, we observed calm, focused staff who were attentive to people's emotional and other support needs including sensory sensitivities. However, on reviewing closed circuit television footage we saw staff use body language that would appear confrontational. We saw staff push people out of their personal space.

People did not always have the opportunity to try new experiences, develop new skills and gain independence. Activity plans were implemented for each person using the service however these were not being reviewed by the management team to see if they had been achieved. During our onsite inspection, we observed some people, but not all, doing activities. We also saw no group activities were taking place. People we spoke to told us they go out into the community but only when the vehicle the staff use is available.

Staff did not always know when people needed their space and privacy and respected this. When reviewing incidents on closed circuit television we saw staff enter a person's room without knocking, this resulted in the person getting upset which then resulted in the person being held in restraint.

Staff did not always follow the policy to keep people's information confidential. We saw in our review of closed circuit television that staff had left people's observation records out on the side of communal areas where other people could read them. However, care plans and personal details were password protected on computers and in locked files.

People were supported to access independent, good quality advocacy. People told us they had a named advocate. We saw posters about advocacy services on the walls of the hospital. The advocacy service visited the hospital twice a week.

Involvement in care

Staff told us people were asked to make daily decisions on what they might want to do. We were told that people were invited to their own care planning meetings and reviews.

People and those important to them took part in making decisions and planning their care and in risk assessments. However, family members told us they did not always get copies of these.

Staff supported people to maintain links with those important to them. We found the service provided a quiet space for people to make phone calls and video calls.

Staff made sure people understood their care and treatment and found ways to communicate with people who had communication needs. The provider made easy read documentation to explain this to people. People told us they understood what medication they were on and why they needed it.

Not all staff informed and involved families and carers appropriately. However, family members we spoke with told us communication between the provider and them can be difficult.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as inadequate.

Inadequate

Wards for people with learning disabilities or autism

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Further to our inspection undertaken in April 2021, conditions were placed on the registration of the service. One of the conditions was that the provider must not admit any service user to Healthlinc House without the prior written agreement of the Care Quality Commission. The service had 25 beds, however at the time of our inspection, 15 people were accessing the service of Healthlinc House, including two people who were on home leave.

Discharge and transfers of care

We found limited evidence that staff had carefully planned discharge for people. However, we were informed of one recent discharge which had been planned. People had discharge plans in place, however these were not always rehabilitation focused. This had led to a culture of containment rather than rehabilitation. Staff supported people when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported peoples' privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality, however people could not make hot drinks and snacks at any time. People were isolated from one another and there was limited focus on rehabilitation.

Each person had their own bedroom, which they could personalise. However, several bedrooms were sparse and contained limited personal possessions. People had a secure place to store personal possessions. People were accommodated in apartments which were isolated from one another. There was no communal lounge to enable people to mix with one another, and there was no main dining area to enable people to eat together. We found this had led to people being isolated from one another.

Staff used a full range of rooms and equipment to support treatment and care. However, we were informed by two staff members that the occupational therapy room could not be used when the occupational therapist was off duty. This meant ward staff had limited access to resources.

People had access to quiet areas and a quiet room. People could not always make phone calls in private.

The service had an outside space that people could access easily. However, most peoples were unable to access unescorted ground leave. At the time of our inspection, people could only meet with visitors in the grounds or in a room outside the main building.

People were not freely able to make their own hot drinks and snacks and were dependent on staff. Staff had not ensured that hot drinks and snacks were freely accessible, as people's access to kitchens was risk assessed. The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff had not supported people with activities outside the service, such as work, education and family relationships.

Inadequate

Wards for people with learning disabilities or autism

There was no evidence that people's activities had increased during easing of restrictions in relation to COVID-19. Three staff members told us staffing levels had limited people's access to the community. One staff member described feeling "more like a prison officer".

Staff helped people to stay in contact with families and carers. Staff had encouraged people to develop and maintain relationships both in the service and the wider community. Staff had purchased iPads which people could use to speak to relatives and friends. However, one person told us she hadn't been always able to speak to her husband when she wanted to.

Meeting the needs of all people who use the service

The service had not always met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

The service's strategy, vision and model did not always meet the needs of people. There was limited evidence that people were being actively engaged in rehabilitation. The provider had a record of peoples' activities, which evidenced that each person had received 25 hours of activity per week. However, not all activities recorded had been therapeutic or rehabilitative. Staff had included activities such as listening to music or watching television as a meaningful activity. We reviewed five activity plans, out of which, three people (60%) had not completed the activities laid out in their activity plan.

During our inspection, we found limited evidence that people could access information on treatment and local services. However, staff had ensured that peoples understood their rights and how to complain.

Staff were able to access information leaflets available in languages spoken by the people and local community. Staff and people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual peoples.

People had access to spiritual, religious and cultural support. The provider had a multi-faith room on site, which we observed to be used by people.

Listening to and learning from concerns and complaints

The service had not always treated concerns and complaints seriously, investigated them and learned lessons from the results, or shared these with the whole team and wider service.

People, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in people areas. These were presented in an easy to read format.

Managers had not always shared feedback from complaints with staff and learning was not always used to improve the service. Managers had not always listened to complaints from peoples, carers and regulators, and had not always made changes in response to the complaints and suggestions. The provider had not always responded and made changes in response to complaints raised by staff.

Inadequate

Wards for people with learning disabilities or autism

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. The service had seen a change in leadership in mid-December 2021. The provider's regional lead nurse for learning disability service took up the role of hospital manger as the previous registered manager moved to another role.

While the new management team had begun to make improvements to the overarching management and governance of the hospital, there was still a significant amount of work to be done around establishing good leadership, communication with Clinical Commissioning Groups (CCGs) and other external stakeholders. This included ensuring that robust governance around monitoring restraint technique using closed circuit television and ensuring incidents reported to CQC were accurate and that patients were not placed at risk.

The broader leadership team (hospital manager, consultant psychiatrist and psychologist) had recently changed and the manager and psychologist were temporary until substantive people could be appointed. Carers and patients said they found the constant change of staff was unsettling.

Vision and strategy

Staff knew and understood the provider's vision and values but had failed to apply them in the work of their team.

Whilst the provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible, they were far from achieving this vision.

Managers were clear that they had set a culture that valued reflection, learning and improvement and were receptive to challenge and welcomed fresh perspectives. However, we failed to see this in action during the inspection process. Managers did not appear to have oversight of what was taking place in the service due to the poor application of their vision and values and robust governance procedures.

Senior managers from Elysium's national and regional leadership teams also responded quickly to concerns raised during the inspection and visited the site. We were concerned that they have not had the oversight of the service and was reactive in their approach rather than proactive. They reached a decision that the service would close and ensured there was immediate effective mitigation of risk to people using the service whilst that discharge and closure process was put in place.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. Whilst staff said they could raise any concerns without fear, we found evidence during the inspection that they did not. Staff had witness inappropriate restraints, poor communication skills and had not reported this to management.

Inadequate

Wards for people with learning disabilities or autism

Leaders told us that they had worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. We were able to find evidence of this during the inspection. In addition, the management team did not have a full understanding of the concern about aspects of a closed culture operating in parts of the hospital. The failure of staff to fully report incidents when people using the service had been physically assaulted during restraint was not apparent to the systematic review of closed circuit television coverage.

The provider invested in staff by providing them with training to meet the needs of all people using the service. However, the impact of training was not effectively monitored. Staff had received some specialist training and support in the best ways to help support people living with a learning disability but this learning was not evidenced in our observations of staff behaviours.

Governance

Governance processes were ineffective and did not help to hold staff to account, keep people safe, protect their rights and provide good quality care and support.

Governance had not been part of the routines of the individual apartment teams and there had been a disconnect between local practice and the information and actions decided at a hospital level. Staff meetings to address these issues had been infrequent and the lack of qualified staff having the opportunity to spend time with and develop teams of care staff further reduced the opportunities for management to effectively communicate with staff. In partial mitigation of this lack of regular communication, important messages about clinical safety were highlighted in the extensive use of posters and written communication to staff.

The provider kept up to date with national policy to inform improvements to the service.

Staff used recognised audit and improvement tools.

Whilst staff did clinical audit, benchmarking and quality improvement work they failed to understand and improve the quality and effectiveness of care for patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but had not used that information to good effect.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed.

Senior staff demonstrated compliance with regulatory and legislative requirements after we had taken enforcement action. Following the imposition of conditions on the registration of the service managers had provided the CQC with an action plan and provided a weekly update on progress, staffing levels, incidents and other monitoring data required. However, this was not effective in making progress in a timely way to protect patients. In addition, we were not assured that managers had systems in place to identify risk issues and poor performance without the having conditions on their registration that they were required to meet.

Staff were able to explain their role in respect of individual people without having to refer to documentation.

Inadequate

Wards for people with learning disabilities or autism

Staff had not always acted in line with best practice, policies and procedures. They had not understood the importance of quality assurance in maintaining good standards.

Information management

Staff collected and analysed data about outcomes and performance and engaged in local and national quality improvement activities.

Engagement

The provider sought feedback from people and those important to them and used the feedback to develop the service.

The service worked well in partnership with advocacy organisations and social care organisations, which helped to give people using the service a voice.

Managers engaged with other local health and social care providers and participated in regular reviews with the local host CCG.