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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

• The service failed to provide safe care. Some ward environments were unsafe and dirty. Potential infection risks had been left unaddressed and we found food hygiene issues in two kitchens.
• Maintenance of the hospital environment remained a concern. Work needed to ensure persons safety, wellbeing and privacy had not been addressed. The maintenance log was not fit for purpose and urgent work had not been prioritised.
• The level of restriction imposed on some people using the service had not been fully recognised. The scope of the restrictive practice review was too limited and omitted consideration of some of the physical and psychological restraints placed upon people.
• Staff had not understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. An internal review of a person's care regime minimised the degree of restraint used in managing behaviours that challenge. Risks to others, assessed by the clinical team, were not considered when considering if the person was segregated.

However:
• Staffing levels overall met the providers planned levels of safety staffing. However, there were three occasions we could identify were staff allocations went against the care plans to maintain the safety of two people using the service.
• Managers were able to demonstrate that they had responded to learning around closed cultures of care. Training around closed cultures had been delivered to staff and additional visits to the service and oversight from the regional management team had been put in place. However, there had been delays in providing CCTV coverage to social areas of the hospital.

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	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Healthlinc House

This focused inspection was completed on receipt of concerns from two members of staff about the safety of the service and that people who use the service were subject to unreasonable restrictions.
Healthlinc House is an independent healthcare service providing care and treatment to people with a learning disability and/or autism. Healthlinc House is owned by Elysium Healthcare Limited.
Our previous inspection of this service in April 2021 rated the service as good for effective, requires improvement in caring and responsive. The service was rated inadequate for safe and well led and overall. The service was placed in special measures when the report was published in July 2021. Conditions on the registration of the service were also applied and remain in place. 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 focussed, unannounced inspection. We looked at two of the five key lines of enquiry specifically safe and well led.
We did not rerate the service as we did not review all of the two Key Lines of Enquiry (Safe and Well Led) inspected.

How we carried out this inspection

Our team included an inspection manager, 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 two staff and received of 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 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.
You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.
Action the service MUST take to improve:

• The service must ensure that the privacy and dignity of all people using the service is always maintained (Regulation 10 (2) a)

• The provider must engage a suitably qualified independent clinical expert to;
conduct a review of people using the service in single person accommodation at Healthlinc House (Apartments 1,2,3, 8b, 10, 11 and the bungalow) which includes reference to;
a. the planning and oversight of all restrictive interventions
b. a process of assurance that these people using the service are subject to the least restrictive interventions
The provider must obtain a written assessment from the suitably qualified independent clinical expert with findings and recommendations in response to the review referred to in 1 (a) and (b) above
The review and written assessment must be shared with the CQC, Lincolnshire County Council, Lincolnshire CCG and the relevant home CCG's for people using the service by 4.00 pm on Friday 7 January 2022.
The provider must consider the restrictions posed by the deployment of staff and placement of furniture in the care environment that present a physical or psychological barrier to a person using the service's free movement in the hospital. The current locked door audit must be expanded to cover consideration of these additional restrictions for all apartments and be completed and returned to the CQC by 17 December 2021 with a clear plan to reduce these restrictions where identified.(Regulation 13 (1) (4) b (5)

• The provider must ensure that there is an effective system in place to monitor and manage the maintenance of the hospital.
The provider must ensure that the hospital is kept clean and any actions from infection prevention audits completed as priority. (Regulation 15(1)(a,b,c,e) and (2))

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	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Wards for people with learning disabilities or autism

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Wards for people with learning disabilities or autism safe?

Inspected but not rated

Safe and clean care environments

Not all areas were safe, clean well equipped, well furnished, well maintained or fit for purpose. We found that one apartment was dirty and had not been cleaned in line with the local care plan. We also found that issues identified as potential infection risks had not been addressed.

Maintenance, cleanliness and infection control

We found one apartment to be very dirty and poorly maintained. We reviewed the cleaning records for the last six months (30 June 2021 to 10 November 2021) and found it had only been cleaned on 75% of days overall. Staff recognised the apartment needed daily cleaning as the person using the service had behaviours which left the apartment soiled at times by urine, faeces and vomit.

We observed a member of staff cleaning up vomit without wearing the required Personal Protective Equipment. This presented a possible risk of spreading infection. Within the apartment we found other evidence of dried food and faeces that had not been effectively cleaned in areas the person using the service had direct access to.

We also found that there was significant damage to the walls, flooring and decoration of the apartment. For example, there was an area of flooring had been ripped up and the floor underneath was exposed.

The site maintenance log for dates between 11 May 2021 to 21 November 2021 recorded seven jobs raised as maintenance concerns within the apartment. Cross referencing with the observations we made of the apartment we found none of these jobs had been addressed before the person using the service left the apartment on 12 November 2021.

The person using the service had been put at potential risk of harm from exposed edges, damage to the flooring presenting a trip hazard and infection as there was exposure to old food, traces of faeces, vomit and urine.

In response to the CQC raising its concerns about the cleanliness and state of repair of the apartment the provider brought forward plans to move the person to a new suite of rooms that were prepared to meet the persons long term needs.

There were also some gaps in the cleaning records for the kitchen supporting this apartment. The kitchen had been cleaned on 86% of days in the same period. Fridge temperatures had been checked on 78/133 days. The fridge had a damaged door seal which had been reported but not replaced.

We found that these checks had been completed more reliably in the other apartments.

The privacy of one vulnerable person being cared for had been compromised by a lack of screening when using the garden. The manager told us that the person's' privacy should be protected using parasols to obscure the view from above. This protection was not in place during our visit as set out in their care plan. The manager told us that the shading canopy was damaged in the summer of 2021 and had not been replaced before the person moved on the 13 November 2021. This meant that they had been denied privacy for at least six weeks.

Nursing staff

The service had enough nursing and support staff to keep people safe.

Staff had told CQC there had been staff shortages in the previous few months. CQC were in receipt of weekly staffing information as part of ongoing enforcement action. Staffing levels overall met the providers planned levels of safe staffing. There were some short-term shortages of staff at the start of shifts due to unplanned absence or sickness. However, the provider had addressed these gaps by allocating other staff or recruiting additional staff to join the shift later. This meant managers and staff from non-nursing professionals were used to fill gaps impacting on their normal working.

Use of restrictive interventions

A staff member told us that people using the service were subject to regular restraint to control their movements and alleged that people using the service were locked in their rooms on occasion. CCTV covering communal areas was not operational, and we could not confirm this allegation made by staff. We did not witness that staff locked doors during our unannounced inspection visits.

We found that the providers' reducing restrictive practice audit was very narrowly focused on the provision of door locks and the ability of people using the service to open their doors independently. Therefore, they judged that people could be considered free to move in and out of their rooms independently. However, other potential restrictions on peoples' movements had not been considered. We observed four or more staff gathered outside bedroom doors that presented a psychological and physical barrier to free movement. The arrangement of chairs for these staff, left in place in their absence, also presented a potential restriction.

For one person, the presence of four or more staff was recognised as a potential trigger to distress and violence as they associated that amount of staff with being restrained. This was identified in the weekly incident review meeting of 3 November 2021 as an action recorded as completed the following week. However, our observation was this potential trigger and restriction remained in place.

The area between the apartments 2 and 3 was cluttered with chairs left in place for the four staff on observation duties. This could be perceived as a further barrier preventing people using the service leaving their rooms. This problem had not been addressed by the provider. We were not assured that staff always made every attempt to avoid using restraint by using de-escalation techniques and only restrained people when de-escalation failed and when necessary to keep the person using the service or others safe. However, the summary record of incidents reviewed did demonstrate that de-escalation had been used in 50% of all incidents reported (742 out of 1467 incidents of aggression).

We reviewed all incidents for a person receiving care in October 2021. Fourteen incidents were identified in that time and all related to physical or verbal aggression. Our analysis found that on ten occasions staff resolved the incident by physically restraining the person and returning to their apartment. Seven of these episodes resulted in the person being returned to their room under restraint (50%), and three episodes resulted in significant restrictive practice with the use of supine restraint and on two occasions rapid tranquilisation. Records also showed that within the same month there

were ten occasions when the person had left without any incident. The combined evidence was that on most occasions the person came out of their room, there was an incident and in most these occasions' restraint was used to remove the person from social areas of the unit. Incident report reports did not evidence that any attempt was made at de-escalation before the use of force.

We also reviewed the number of incidents over a longer period to ensure that our findings for October were not an anomaly. The hospitals IRIS incident record showed a total of 88 incidents of physical/verbal aggression by this person between 14 May and 8 November 2021, 64 of which were outside the person's apartment. This continuing level of aggression to staff and other people using the service was a consistent part of the person's behaviours that challenged, and regularly returning the person to their own room under restraint and isolating them from other patients to manage this challenge met the definition for Long Term Segregation (LTS).

The Mental Health Act (MHA) Code of Practice defines LTS as "a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis".

We discussed this with the Responsible Clinician who gave the view that the person was being managed in her own 'self-contained apartment' and therefore could not be construed as LTS. This was contrary to the CQC's national guidance and we requested that the provider conduct a further review of their decision based on the analysis we provided.

Are Wards for people with learning disabilities or autism well-led?

Inspected but not rated

Culture

The hospital was at risk of developing a closed culture of care and the provider had not fully addressed these risks. The provider had trained staff in recognising the warning signs of a closed culture of care. However, we found the use of restraint was minimised in an internal review and managers assurance around incidents was limited by the absence of CCTV.

Following concerns about the culture of care and a reliance on restrictive practices the management team provided assurance about how they had addressed the potential risks of a closed culture of care at the hospital.

CQC has described a closed culture of care as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. The risks of developing a closed culture of care are heightened in services that provide care to people with a learning disability or autism who may not be able to directly communicate their experience of care and where people in a service are highly dependent on staff for their basic needs. CQC has also identified that where restrictive practices are regularly used and people remain in a service, such as a mental health unit, for months or years are potential indicators of a closed culture.

Managers told us they had introduced awareness training sessions for staff to raise their awareness about what a closed culture was. Their hope was to provoke thought and discussion amongst staff to enhance their knowledge and understanding.

Managers also described several monitoring tools and practices in place to mitigate the risk of closed culture. This included unexpected visits by the regional team members, and the installation of CCTV in communal areas. However, although the CCTV system was installed at the hospital there had been delays bringing it into operation. The registered manager told us they had regular communication with the provider's IT department to ensure this was addressed as an urgent need. No agreed date for the system becoming live was available at the time of our inspection. This left managers without a method to review staff responses to incidents.

However in response to our request to review the situation of the person receiving care set out above, on the 24 November 2021 we received a review response from a senior clinician within the provider's regional management team, concluding the person receiving care was not subject to long term segregation.

The first part of that review cited the fourteen incidents detailed above and concluded that on most occasions, the person had returned to their apartment of their own accord. In their summary they conclude that there was only one occasion when the person returned to their apartment in restraint holds. This contradicted our findings, where we found in the same period seven occasions where the person had been returned to the apartment under restraint, and three further occasions where they had returned to their apartment after being released from supine restraint in the corridor area. The providers review also failed to mention the two occasions where rapid tranquilisation was used as well as supine restraint.

The review failed to accurately report the level of restriction involved in the care this person and the ongoing risk of harm they present to others. The review did not adequately address the criteria set out in the providers own policy on segregation and seclusion.

The current risk management plan for the person mentioned above stated that in order to manage the risks' identified the person will reside in a single apartment with 24 hour support and would not have independent access to the shared kitchen area for the apartments within the unit. These restrictions were not acknowledged within the review.

The providers review did not address the planned restrictions for the person to remain in their apartment with the frequent use of force to do so, and limiting access to communal areas, opportunities for group activities or section 17 leave except with a staff escort.

The impact of failing to make an accurate assessment of the care regime of this person using the service was to potentially leave them without the appropriate safeguards required by the MHA Code of Practice. These concerns would also extend to the potential impairment of the rights of other people using the service restricted to the same degree and segregated from other people receiving care.

CQC was not assured that people using the service in single person apartments within the hospital have had their needs competently assessed. This was a failing of the provider to effectively identify a pattern of restrictive intervention, use of force or to recognise a potential indicator for a closed culture of care.

Governance

Our findings from the Safe key question demonstrated that governance processes had not operated effectively to maintain a safe environment.

The hospital's maintenance log was not kept up to date with progress, outstanding work had not been risk assessed or prioritised.

Inspected but not rated

Wards for people with learning disabilities or autism

We reviewed the electronic maintenance log from 11 May 2021 to 21 November 2021. There were 162 tasks recorded as opened in that time. The log allowed no priority or weighting to be given to urgent tasks and no progress was noted. Some repairs covered areas of infection control risk in kitchen areas as well as problems highlighted in apartment 8a.

We found other concerns around infection control risks in kitchen areas reported in May 2021 and August 2021.

We discussed these concerns with the Registered Manager, who agreed the system to ensure there was oversight of maintenance was not adequate and they were actively looking for an alternative.

The providers track record shows that previous concerns around maintaining the environment and cleanliness have not been addressed. The service was already subject to an requirement notice (published 23 July 2021) that they 'MUST ensure that people's care and support is always provided in a safe, well equipped and well-maintained environment … Staff report maintenance issues and that all maintenance schedules are completed within the timeframes set. Regulation 15(1)(a)(e)'

The providers oversight of repairs and maintenance was impaired by the lack of a system fit for purpose that would allow jobs to be prioritised and progress tracked to completion. Items identified in infection prevention and control (IPC) audits had not been prioritised and acted on prolonging the potential risks.

These failures put people using the service at potential risk of harm from the environment and of infection.

This section is primarily information for the provider

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	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The service failed to provide the protection of privacy for a vulnerable person using the service for at least six weeks.

This section is primarily information for the provider

Enforcement actions

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to provide an accurate and competent review of the care regime of a patient as requested by the CQC. The CQC was not assured that the patient and others in single person apartments within the hospital had their needs competently assessed against the protective safeguards set out in the MHA Code of Practice. Without that assurance we believed that people using the service may have been exposed to the risk of harm, as internal oversight had failed to identify a pattern of restrictive intervention and use of force.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The providers oversight of repairs and maintenance was impaired by the lack of a system fit for purpose that would allow jobs to prioritised and progress tracked to completion. Items that had been identified in infection prevention and control (IPC) audits had not been prioritised and acted on prolonging the potential risks. These failures were risks to patients. The failures put patients at potential risk of harm from the environment and of infection