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?	Inspected but not rated
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

The Health and Social Care Act 2008 allows CQC to add, vary or remove existing conditions of registration for a registered provider or registered manager. Using these powers to address the issues we found at our inspection of Healthlinc House in April 2021, we issued a Notice of Proposal to add conditions on 11 May 2021. The provider made representations against the conditions to be imposed, and having independently reviewed the representations CQC decided to uphold some of the conditions and withdraw others. A Notice of Decision to add the upheld conditions to the providers registration was issued on 25 August 2021. The provider did not challenge the revised conditions which became active on 23 September 2021. The provider started to comply with the additional conditions as soon as they came into effect.

The additional conditions placed on the providers registration included:

- The provider cannot accept any new admissions without written approval from CQC.
- The provider must send to CQC a weekly review of all incidents of restraint.
- The provider must carry out a review of staff qualifications and submit a plan of action showing how they will ensure all staff have the right skills to work with patients safely.
- Demonstrate how they will ensure that all staff including agency staff have received specialist training to enable them to work effectively with people who have learning disability and autism.
- The provider must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experienced registered nurses and healthcare support workers to meet the needs of all patients on every shift.
- The provider must submit weekly reviews of its staffing levels.
- The provider must submit a weekly report or copies of any analysis or audits they have undertaken to monitor completion and / or implementation of the systems set out in the above conditions.

In addition to the enforcement we have taken, the Chief Inspector of Hospitals, Ted Baker, has placed Healthlinc House into special measures. Services placed in special measures will be inspected again within six months of publication of the original report dated 23 July 2021. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question, we will take further enforcement procedures. The service will be kept under review and, if needed, could be escalated to urgent enforcement action.

We found:

- Staff did not manage peoples distress effectively and further incidents, soon after the initial incident occurred, resulted in harm and injury to staff and other people. We could not be assured that the provider always checked the qualifications, skills and experience of all agency staff before they worked with people. Although specialist training was available, the provider considered this as optional for staff. The provider did not have robust systems in place to show what specialist training staff had completed. The acuity and presentation of some new admissions was such that staff felt they did not always have the skills, qualifications and knowledge to work effectively with people's distress in a rehabilitation setting.
- People were not always protected from poor care because the service did not have enough permanent staff. The service relied heavily on agency staff, who didn't always know the people they were caring for. The impact was delay in staff response times to safely manage restraint procedures. Staff were often not able to take their full break entitlement or breaks from observation duties during a shift because there was no cover for them. People using the service said they often had to wait for the required number of staff to become available to escort them on leave or into the grounds.

Summary of findings

- The service did not have a full multidisciplinary team to deliver the range of care and treatment necessary to meet the needs of people with learning disability and autism in a rehabilitation setting. There had not been any meaningful occupational therapy input since September 2020 as there had not been an occupational therapist in post. This meant some people had not had a full occupational therapy assessment and evaluation to support their rehabilitation programs.
- Registered nurses did not have any ongoing mandatory training or competency assessments for administering medications.
- Only 30% of registered nurses had received regular supervision. Supervision rates for healthcare support workers was 72%. Only very recently, and after close scrutiny visits and a requirement of the clinical commissioning group, had registered nurses started to be visible on the apartments to give support to the healthcare support workers who delivered the majority of the patients care.
- There were eight delayed discharges. The longest length of stay for one person was nine and half years. The other seven delayed discharges ranged from six to three years.
- 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. This had been reported following our previous inspection. The decoration in the accommodation was tired, some integral window blinds were broken, the communal lounge areas of the apartments and some bedrooms were not clean. Paintwork was chipped and not clean the environment in the apartments was not homely or conducive to good mental wellbeing for people living there. Furniture was dated, sparse and not comfortable. The provider did not have adequate oversight for maintaining the quality and control of cleanliness in the apartments.
- Leaders did not articulate a clear vision for the service and so were unable to ensure a cohesive, good quality service was provided. Although the service described itself as an enhanced rehabilitation service, many staff believed they were working with people towards containment of distress and behaviour modification. While other staff believed they were offering activity programs to promote wellbeing and daily routine. Staff told us they used to understand the providers vision and values but thought they had moved away from this. Senior managers did not have effective oversight of the gap in service provision vacancies in the multidisciplinary team had created.

However

- Staff understood how to protect people from abuse and the service worked well with other agencies to do so. The provider reported and investigated all incidents of alleged abuse to the local authority and CQC.
- People were involved in managing their own risks whenever possible. There was clear evidence in personal behaviour support plans of people identifying what helped them to feel safe.
- Restrictive practices were only used as a last resort, for the shortest time and in situations where people were a risk to themselves or others. Staff did not use seclusion, although the provider had a policy which outlined how seclusion would be used if required. The service monitored and reported the use of restrictive practices. They reviewed all incidences of restraint and used the examples as learning within their restrictive intervention's reduction programme.
- Risk assessments, positive behaviour support plans and care plans were of high quality. They were comprehensive, personalised, holistic and updated as required. They showed evidence of co-production with people using the service and reflected people's needs and aspirations. They were easily accessible to staff.
- Staff used the principles of stopping over-medication of people with a learning disability, autism or both (STOMP) to only administer medicines that benefitted people's recovery or as part of ongoing 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

Contents

Summary of this inspection

Background to Healthlinc House

This focused inspection was completed because we had information from a clinical commissioning group and four serious incident reviews giving us concerns about the safety and quality of the care. For example, lack of staff who knew the needs of the people using the services, delays with people going out into the community and cancellation of some activities provided within Healthlinc House. Healthlinc House is an independent healthcare service providing care and treatment to people with a learning disability and autism. Healthlinc House is owned by Elysium Healthcare Limited. Our previous inspection of this service in July 2019 rated it as RI for Safe; Good in all other domains and good overall.

Healthlinc House can accommodate a maximum of 25 male and female people in self-contained apartments. Each apartment can accommodate between one and six people. Each apartment provides single sex accommodation. At the time of inspection there were 22 people receiving care and treatment, 19 of whom were detained under the Mental Health Act 1983. One was on a trial section 17 leave at their new placemen. Two people were subject to Deprivation of Liberty Safeguards (part of the Mental Capacity Act 2005), where people receive care in a way that does not inappropriately restrict their freedom.

We expect Health and Social Care providers to guarantee autistic people 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 all the key lines of enquiry for the Safe, Caring and Well led key questions and specific key lines of enquiry for the Effective and Responsive key questions.

We decided to re rate the service based on our findings. The rating for this service went down. We rated the service inadequate overall.

How we carried out this inspection

How we carried out the inspection

This was a focussed, unannounced inspection. We looked at all the key lines of enquiry for the safe, caring and well led key questions and specific key lines of enquiry for the effective and responsive key questions. We re-rated the safe, caring, responsive and well led key questions on these findings.

Our team included four CQC inspectors and a specialist advisor pharmacist on site. An expert by experience and an inspection manager working remotely.

Before the inspection visit, we reviewed information that we held about the location, reviewed the feedback from three staff and peoples focus groups, and received a range of feedback about the service from other organisations.

During the inspection visit, the inspection team:

Summary of this inspection

- 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 nine people who were using the service
- spoke with four relatives, who had family members using the service
- spoke with the manager of the service, and members of the senior management team
- spoke with 21 other staff members including doctors, nurses, therapists, and healthcare support workers
- attended and saw four multi-disciplinary care and treatment planning meetings and two staff handovers
- reviewed the minutes of team meetings
- reviewed training records
- reviewed and tracked six care and treatment records of people using the service
- reviewed eight serious incident reports
- reviewed eight prescription charts of people using the service
- carried out a specific check of the clinic rooms and medication management, and
- looked at a range of policies, procedures, records and other documents relating to the running of the service.

You can find further 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.

What people who use the service say

We spoke with nine people using the service and four relatives who had family members using the service. People using the service were mostly complimentary about the care they received. People told us staff they knew were kind and friendly, helped them to make decisions when they didn't know what to do and work out how to do things they had not done before or had forgotten how to do.

Three people told us staff were willing to speak to the doctor and nurses for them when they felt they couldn't do this themselves. Though two people told us this was different now because the nurses were more visible around the hospital and in the apartments and the doctor went on walks around the grounds with them so he could get to know them better. One person told us they used this walkabout time with the doctor to ask questions about her care and he answered all her questions honestly. Another person told us they preferred to talk to the doctor during these walks rather than going into the care planning meeting where there were a lot of people.

Three people said that the apartments were often too noisy for them. Two people told us they got frightened when peers were distressed and violent. They said it felt like staff did not know what to do to stop them and staff seemed reluctant to keep the distressed person away from them in another room.

Most people said there were enough activities if they wanted to do them. Though two people said they would like to learn how to cook and wash their clothes for themselves before leaving Healthlinc House for supported accommodation. They said they could not do this because they had not had an Occupational Therapy assessment.

All the carers we spoke with told us they felt their loved one was happy at Healthlinc House. Two carers told us they thought the staff were good, and staff had been very accommodating to fit in with their other carer responsibilities when planning treatment meetings. However, one carer said their relative did not like it when they had lots of different staff working with them and this seemed to happen quite often.

Summary of this inspection

One carer said that whenever she visits staff give her a briefing about her relative including anything they felt they were struggling with, and gave her a rundown of their daily routines. Staff always offered her a drink and were very polite. Another carer confirmed she had visited the hospital quite a lot and had not heard any staff being nasty or disrespectful to people living there. However, the same carer said she had found it difficult to get key staff to ring her back when she had a query.

Areas for improvement

Wards for people with learning disability and autism.

The provider MUST ensure that:

- All permanent and agency staff have the required training and skills to manage people's escalation of distress effectively. They have robust and monitorable systems in place to track staff's specialist and non-mandatory training. They have robust systems in place to check, monitor and assure themselves that all agency staff are trained to the same standard as their own permanent staff. Regulation 12(2)(c)
- People's care and support is always provided in a safe, well equipped, well-furnished and well-maintained environment which meets people's sensory and physical needs. The apartments are clean, comfortable, and well maintained and there are clearly identifiable systems and lines of responsibility in place to ensure the quality and frequency of cleanliness in the apartments. Staff report all maintenance issues and that all maintenance schedules are completed within the timeframes set. Regulation 15(1)(a)(e)
- The provider must ensure that there is robust leadership in place that sets out how the service will ensure it will provide safe, good quality care. Regulation 17(1)
- There is always an adequate number of suitably qualified, skilled staff to cover peoples observations and escort requirements, staff absences, all staff break entitlements, staff rotations from observation duties and to have an adequate response team that can respond in a timely manner without detriment to another of the hospital. Regulation 18(1)

Wards for people with learning disability and autism

The provider should ensure that:

- The multidisciplinary team communicates effectively with each other and the healthcare support workers to deliver cohesive packages of care for people.
- They have a clearly identifiable model of practice that is suitable for the people who use their service.
- They address all their delayed discharges and identify discharge dates and clear discharge plans for all people.
- There is a full multidisciplinary team to deliver the range of assessments, care and treatment necessary to meet all the rehabilitation needs of people to facilitate safe discharge.
- There are systems in place to carry out competency assessments of registered nurse's medication management. All eligible staff have and are receiving regular good quality supervision and appraisal in line with the providers policy.

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	Inspected but not rated	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inspected but not rated	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Inspected but not rated
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

Are Wards for people with learning disabilities or autism safe?

Inadequate

The rating for this service has gone down. 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. This had been reported on at our previous inspection. While the ground floor had benefitted from redecoration and signage, high ceilings above stair wells had not been completed because we were told the maintenance engineers could not work safely at the height required. Redecoration of the conservatory had not been completed in full and there was still some painting and window blinds to be replaced. The conservatory was one of the few indoor, ground floor communal areas for people to relax and occasionally receive visitors, it was not comfortable or inviting. The decoration in the gym was tired and walls and doors were scuffed. Being the largest ground floor space, it was used for other purposes including limited storage and staff meetings. People told us it was often not available to them because it was used for staff restraint training, there were training posters and flip chart sheets around walls. The sensory room was not comfortable and had no off the floor seating so anyone who could not sit at floor level could not use the room as intended. The beanbags that could have been available had not been maintained and refilled. The visitor's room was also the multi faith room, this meant if it was being for one purpose it could not be used for the other. There was very little in the room to show that it was a place for contemplation, meditation and prayer, carers and people told us it was also quite noisy in the daytime.
- The decoration in the apartments was tired, door frames and paintwork were chipped and not clean. Some integral window blinds were broken and could not be closed or opened, making the environment appear dark. Not all en suite bedrooms were clean. Bedroom one in apartment nine had been vacated that day, the bed frame was dirty, the paintwork in the room was scuffed and not clean. The bathroom had dirty cloths around the sink area, the toilet was had not been cleaned and properly flushed for a few days and the toilet brush was caked in dried excrement with a strong odour. The toilet seat was missing. The overall environment was sparsely furnished, furniture was dated and not comfortable. The communal areas of the apartments were not personalised or homely and not conducive to good mental wellbeing for people living there.
- Managers did not have adequate oversight for maintaining the quality and control of cleanliness in the apartments. Apart from some kitchen cleaning records and refrigerator temperature check charts, we did not see any cleaning records for the apartments or en suite bedrooms. Staff told us they worked alongside and encouraged people living in the apartments to keep these areas clean and tidy themselves. Staff did not know whose responsibility it was to ensure the quality of that cleaning. This meant there was a risk that infection could breed in these areas and could spread

causing illness to staff and the people using the areas. This was particularly important during the covid pandemic. We saw evidence of a maintenance painting schedule with many of these areas scheduled for 2021, but even areas that had been completed in 2019 were now in need of redecoration and were not on this schedule. Neither did we see evidence of any scheduled works for repair of the blinds and windows in the apartments.

- People were not always protected from poor care because the service did not have enough permanent staff. Although the provider allocated staff to apartments according to patients required observation levels, these levels of staffing were insufficient if those staff were not available because they were attending to other duties or incidents. This meant that there was not enough staff to cover all staff breaks, patients ad hoc escorts to go out, or other incidents that may occur. Staffing establishment was 13 registered nurses, nine nurses in post and four vacancies. The service had 143 healthcare support workers, with 130 in post and 13 vacancies. Of those in post eight were either pregnant and on light duties or on maternity leave, and a further three were due to leave the service by mid May 2021.
- Data we saw on site showed sickness absence levels at 13 April 2021 was 7% overall, with short term absence at 3% and long-term absence at 4% and absentees as a proportion of the workforce was 21%. However, as part of the factual accuracy process the provider told us they had miscalculated the total proportion of workforce figure and inadvertently included staff in the Healthlinc residential service. They submitted a revised figure, for the proportion of the workforce, of 15% which is still higher than we would expect.
- The service relied heavily on agency staff to cover staff vacancies and absences. Data for agency use between 01 February 2021 and 11 April 2021 showed: there were 5408 shifts to be covered; 3903 were covered by permanent staff; 546 were covered with agency staff; 639 were covered by locum agency; 159 were covered by bank staff and 161 shifts were uncovered.
- We could not be assured that peoples observations levels were always being covered adequately because of the short staffing. Staff feedback, feedback from people using the service and our observations inspection observations during our visit suggested that in practice in the apartments, staff were covering more than one person's observation levels. Staffing for each shift was based on people's observation levels and included a mix of agency, bank and permanent staff. However, we saw daily working rosters showing many shifts were between two and four staff absent. This meant that any supernumerary support staff and nurses had to fill the gaps, which meant there was no longer capacity to cover staff breaks and other unscheduled events. Such as staff needing to go off sick or additional escort cover to allow people to go out. During the evening inspection we saw that in at least two apartments staffing levels were two staff short. We saw a staff member was struggling to allocate staff to all the observations for the shift, and when questioned about what would happen if they could not allocate to all observations they told us they needed to be creative, and work together to make sure everyone was being checked.
- Permanent staff told us they were often taken away from their care duties to induct and guide agency staff which was time consuming and they could not rely on them in the same way they could their permanent colleagues. People using the service told us they did not always feel comfortable with new staff and agency staff were often not as friendly or confident as permanent staff.
- The service managers were aware of the pressures of staffing all shifts and had recently introduced some measures to address this, including the addition of three floating staff between 11.00 and 19.00 and registered nurses when available. However, this was still not enough staff to cover all staff absences, rest breaks and cover for staff rotation from enhanced observations. People using the service said they often had to wait for the required number of staff to become available to escort them on leave or into the grounds. There were often delays in staff response times to manage restraint and procedures and other urgent duties.
- Staff did not manage peoples distress effectively and further incidents were occurring soon after the initial incident, which resulted in harm and injury to staff and other people. The acuity and presentation of some new admissions was such that staff felt they did not have always have the skills, knowledge and resources to work effectively with their distress in a rehabilitation setting. We reviewed four reported serious incidents and looked at a further four incidents on site, spoke with 14 healthcare support workers and nine people using the services. While staff used a variety of de-escalation and distraction strategies, if the distressed person was determined they wanted to leave the area of possible containment before they fully settled, they were allowed to. Staff were aware that to do otherwise would

amount to seclusion. This sometimes led to further incidents of aggression often in the presence of, or targeted at other people and staff. Five of the nine people using the service we spoke with said that the apartments were often too noisy for them because of their peers' distress. Eight of the fourteen healthcare support workers we spoke with told us they did not feel they had the skills, knowledge or resources to work effectively with all new referrals in the rehabilitation setting. Three people using the service told us they sometimes felt afraid and frustrated that staff did not seem to be able to stop some peers from becoming aggressive towards them and others. They said it felt like staff did not know what to do to stop them and staff seemed reluctant to keep the distressed person away from them in another room.

- We could not be assured that senior managers always checked the qualifications, skills and experience of all agency staff before they worked with people. Staff told us they asked the agencies they used for copies of any agency staff restraint training certificates but could not be sure that all agency staff were trained in the same techniques and strategies as Healthlinc House permanent staff. Three weeks after our inspection, and as part of ongoing routine serious incident reviews, the manager sent us copies of four agency staff profiles. While this document was on Elysium headed paper and showed a photograph of the agency staff member with details of their training, the forms themselves had been filled in by the employing agency. On one form the confirmation of training column had not been completed. Three of the four profiles showed that agency staff had completed prevention and management of violence and aggression (PMVA) training and not therapeutic management of violence and aggression (TMVA) training, which was the providers preferred training for their permanent staff. While these two training methods have the same certification rating they use different techniques and philosophy. Three staff told us this mix of technique and strategy can cause confusion and mixed messages when used at the same time.
- Registered nurses were not required to do ongoing training or competency assessments for their medication management. Registered nurse's compliance rates with supervision was low at 30% with 3 out of possible 10 for registered nurses and 72% with 85 out of a possible 118 for healthcare support workers. Supervision data that was available showed staff supervision had been sporadic since January 2020. Appraisal was low at 60% with 66 staff out of possible 110 completed and in date. Managers had recognised this and were working on improving the figures. A dashboard showed that by end of April 2021 all eligible staff would have received an appraisal.

However

- We reviewed and tracked eight peoples care records. All people had a personalised risk assessment, a risk matrix and a positive behaviour support plan, which was updated regularly. All risk assessments and management plans were of high quality and demonstrated co-production with people using the service. We saw evidence of how people were involved in managing their own risks whenever possible. There was clear evidence in positive behaviour support plans of people showing what helped them to feel safe and calm. The risk management plans, and positive behaviour support plans were easily accessible to staff working in the apartments.
- Restrictive practices were only used as a last resort, for the shortest time and in situations where people were a risk to themselves or others. The service monitored and reported the use of restrictive practices. They reviewed all incidences of restraint and used the examples as learning within their restrictive intervention's reduction programme.
- Staff followed National Institute for Health and Care Excellence guidance when administering rapid tranquilisation including physical health monitoring. Staff recorded safeguarding concerns in patients risk assessments and care plans.
- Most permanent staff had received basic mandatory training to keep people safe. At the time of our inspection we saw data showing mandatory training compliance was 74%. However as part of our data request after the inspection the data showed mandatory training compliance was actually 87%. Though National early warning score (NEWS) at 61% and Safe administration of medicines level 1 (intended for registered nurses only) at 50% were below the desired 75%.

Inadequate

Wards for people with learning disabilities or autism

- While registered nurses had not always been visible on the apartments or around the hospital to give direction, support and guidance to the healthcare support workers. Since the local clinical commissioning groups scrutiny visits to the hospital in late March and early April 2021 we was advised by two patients and two support workers that registered nurses were now more visible.
- Staff knew how to report incidents and safeguarding concerns. The provider reported and investigated all serious incidents and allegations of abuse and reported to the local authority and CQC where appropriate. Where required the manager was able and willing to take any disciplinary action needed. Lessons learned were shared with the wider care team through team meetings, apartment handovers and group email.
- We reviewed eight people's medicines charts. People received the correct medicines at the right time. People's medicines were regularly reviewed to monitor the effects of medicines on their health and wellbeing. Only registered nurses managed and administered medicines and they followed systems and processes to safely prescribe, administer, record and store medicines. However, it was noted that registered nurses were not required to do any specialist training or competency assessments for their medication responsibilities. This is contrary to medicines management guidance.
- Staff used the principles of stopping over-medication of people with a learning disability, autism or both (STOMP) to only administer medicine that benefitted people's recovery or as part of ongoing treatment.

Are Wards for people with learning disabilities or autism effective?

Inspected but not rated

This was a focussed inspection and we did not look at all key lines of enquiry for this domain.

We did not rate this domain:

- The provider could not tell us how many staff had completed the specialist non-mandatory training or what courses people had completed. While specialist training for permanent staff to meet the needs of people was available, this was optional and not well recorded. Learning disability and autism awareness, and an introduction to epilepsy and diabetes were part of the induction training but not repeated as refresher courses. This meant that without staff having adequate skills, knowledge and resources people using the service and staff could be put at risk of physical or psychological harm. People could be subject to undue restraint if their needs were not being net adequately and staff did not know what else to do.
- The provider did not have a full multidisciplinary team to deliver the range of care and treatment necessary to meet the needs of people with learning disability and autism in a rehabilitation setting. There had been no meaningful occupational therapy input since the occupational therapist went on maternity leave in September 2020 and was not replaced. Care records showed that several people did not have any occupational therapy skills assessments to inform their rehabilitation plans. Two people told us they would like to be able to cook and do their washing before moving on to supported accommodation, but they had not been assessed to see how they could be taught to do this.
- While people were supported by a team of staff from a range of disciplines, multidisciplinary working was not as good as it could be. Communication between the multidisciplinary team and the healthcare support workers delivering care was not always effective. This meant that on occasions not everyone was clear about the desired care outcomes. The introduction of the psychologically informed environments (PIE) model, which started in late 2019, and designed to underpin and provide a stronger psychological care and treatment basis for the service had stalled in its progress. There was confusion within the staff groups about what model they were delivering as a service. Some staff thought they were providing a containment and behaviour modification service while other staff told us they were providing activities to promote wellbeing and daily routine. No staff spoke with made any reference to rehabilitation. This meant the service was not working to clear guidelines for the treatment of people with learning disability and autism that

enabled all people with this diagnosis to reach their optimum level of independence. The service did not work to national guidance in rehabilitation, working towards recognised models of rehabilitation care and treatment. A lack of occupational therapy specific assessment and treatment plans contributed to a lack of effective rehabilitation programmes for people with a learning disability and autism.

However

- People's human rights were upheld by staff who supported them to be independent and have control over their own lives.
- Assessment of people's needs started at admission. Care and support plans were personalised, holistic and reflected people's needs and aspirations. Care plans were updated following treatment reviews and any significant events. The psychologists had completed positive behaviour support plans and the speech and language therapists had completed necessary dysphagia and communication assessments.
- People had good access to physical healthcare and were supported to live healthier lives. There was a designated physical healthcare co-ordinator and the service had a good relationship with the local GP's one of whom visited the hospital twice weekly.
- Managers provided an induction and orientation programme for new and temporary staff. There was also a dedicated new starters mentor and buddy whose role it was to support and mentor new starters through their induction and orientation process.

Are Wards for people with learning disabilities or autism caring?

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- Patients told us that while most permanent staff were kind, agency staff were not so kind or considerate because they did not understand their needs.
- Patients complained about the noise levels in the apartments when peers were in distress, and anxiety about the risk of violence from peers when staff did not effectively manage their distress.
- We could not be assured that all patients would speak up about poor care, or realise they were experiencing poor care.

However

- Some patients told us staff encouraged them to make choices for themselves and we saw this happening during our inspection. People, and those important to them, took part in making decisions and planning of their care. Staff supported people to understand and manage their care, treatment or condition.
- People had easy access to independent, good quality advocacy. Staff supported people to keep links with those that were important to them. Staff protected people's privacy and dignity whenever possible
- Staff kept contact with and shared information with those involved in supporting people, as appropriate. However, two of the seventeen clinical commissioning groups involved with this service said communication between themselves and the service was not always right or prompt.

Inadequate

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism responsive?

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because :

- There were eight delayed discharges. The longest length of stay for one person was nine and half years. The provider told us there had not been any suitable placement available when this person had been ready to step down. The other seven delayed discharges ranged from six to three years. In all cases reasons were either because new placements had fallen through or suitable placements had not, or could not, be found in the areas people and their families wanted to move to. In one case where the person had been admitted in October 2014, the provider told us that it had been agreed with the persons commissioners and family that they should reside at Healthlinc House on a long term placement. This is not usual practice for a hospital such as this and there were no plans in place to demonstrate how institutionalisation of the person would be prevented. The provider also told us that as they had people from seventeen different clinical commissioning groups (CCGs) around England and not all CCGs were as willing to work as closely with the hospital as some others when looking for move on placements.
- We saw 15 discharge plans. Although these plans had discharge dates and some had identified discharge locations, or plans for discharge location. None of the plans we saw had clear social, functional, and psychological or behavioural rehabilitation goals the patient needed to obtain to facilitate a successful discharge. None of the plans we saw identified the risk of institutionalisation or how this would be avoided.
- Privacy and quiet space was not always available, the only private spaces that people could personalise were their en suite bedrooms. The communal apartment living was not homely, and comfortable and often very noisy. The gym which was the largest communal space was often used for staff training or meetings which meant people could not always access this area when they needed to.
- The hospitals design and layout did not always support peoples good care and support. With the therapy areas and outside space downstairs and most accommodation upstairs based around eleven apartments. People could only move around the building and grounds freely if they had the required number of staff to escort them at the times, they wanted them. Whilst not restrictive practice, it was assumed that people would occupy their apartments in the evenings, rather than wander around the hospital and grounds.

However

- The service provided people with a choice of good quality food. People could access drinks and snacks at any time.
- The service met the equality needs of all people. Staff helped people with advocacy, cultural and spiritual support, though staff and people using the service told us the hospital would benefit from a separate multi faith room. People's communication needs were always met. People had access to information about their rights in appropriate formats.
- People, and those important to them, could raise concerns and complaints easily and staff supported them to do so. The service treated all concerns and complaints seriously, investigated them and learned lessons from the results. Lessons learned were shared through apartment handovers and team meetings and staff email accounts. The provider always sent letters of apology to people using the service and their carers where necessary.

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

Inadequate

Our rating of this service went down. We rated it as inadequate because:

Inadequate

Wards for people with learning disabilities or autism

- Our findings from the other key questions showed that the following governance processes were not sufficiently robust to ensure the quality of care provided or the quality of the environment. Senior managers did not have a robust system to monitor the ongoing competence of registered nurses to administer medications. Supervision for registered nurses was very low at 30%. Specialist training for staff was not mandatory and the provider did not have robust systems or processes in place to record and monitor those staff who had completed specialist training. We were not assured that the provider had adequate systems in place to ensure all agency staff were trained to the same levels as their own staff.
- Maintenance schedules were not completed in a timely manner, and some repairs, such as the blinds in the apartments did not work and had not been reported. There was no oversight for ensuring that cleaning of the apartments was completed to a high standard.
- Leaders did not articulate a clear vision for the service and so were unable to ensure a cohesive, good quality service was provided. Although the service described itself as an enhanced rehabilitation service, many staff believed they were working with people towards containment of distress and behaviour modification. While other staff believed they were offering activity programs to promote wellbeing and daily routine. Staff told us they used to understand the providers vision and values but thought they had moved away from this. Senior managers did not have effective oversight of the gap in service provision vacancies in the multidisciplinary team had created.
- Senior managers did not have effective oversight or assurance that people's distress was managed effectively to prevent harm or injury. We reviewed four serious incidents that resulted in harm to people using the service and staff. In each incident, there were inconsistencies in how staff managed the incident and de-escalated the situation. Senior managers did not have assurances that staff had the correct knowledge of how and when to prevent escalation of incidents. The high use of agency staff to cover regular staff shortages affected the management of incidents, because agency and permanent staff received different training.
- Senior managers did not ensure all staff who worked in the service received the same training in the management of violence and aggression. Systems and processes to check agency staff training were not effective. Agency staff were trained in different restraint techniques used by permanent staff. This meant, that confusion and mixed messages could occur during a restraint procedure and people using the service and staff could be exposed to the risk of injury. We reviewed four serious incidents which highlighted this issue.
- The length of stay of people using the service was not managed proactively to ensure people did not remain at Healthlinc House for longer than necessary. Reviews of care pathways with all necessary stakeholders to identify appropriate placements in a timely way when rehabilitation needs had been met were not effective.

However:

- Staff had respect for the new manager who had been in post since December 2020. The manager was willing to address issues of staff poor performance and absence. The overall absence rate since December 2020 had dropped from 9% to 7% in April 2021 and absentees as a proportion of the workforce had dropped from 37% in December 2020 to 15% in April 2021.
- Despite the challenges they were facing staff were committed to providing high quality care to people who use their services. Leaders and staff, we spoke with genuinely wanted to keep patients safe and believed they were providing the best possible care they could for people using the service. Staff and leaders were acutely aware of protecting people's rights.
- The provider promoted equality and diversity in its work. There were opportunities for career progression. Staff felt able to raise concerns without fear of retribution and were aware of the speak up guardian.
- The leadership at the service was working towards creating a learning culture, however some of the learning, particularly from serious incident investigations, had not always been followed through or monitored and therefore had not become embedded in practice. Staff, carers and people using the service knew how to raise complaints. We saw complaints trackers showing how those complaints had been investigated and responded to. Staff knew about the whistleblowing policy and procedures.

Inadequate

Wards for people with learning disabilities or autism

- People, and those important to them, worked with managers and staff to develop and improve the service. The provider was willing to work with external agencies to improve their service and sought feedback from people and those important to them and used the feedback to develop the service. Staff engaged in local and national quality improvement activities.
- The provider was committed to working with external agencies including the host clinical commissioning group, local authority and CQC to drive forward improvement in their service.

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 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People's care and support was not always provided in a safe, well equipped, well-furnished and well-maintained environment which meets people's sensory and physical needs. The apartments were not clean, comfortable, or well maintained. There were no clearly identifiable systems and lines of responsibility in place to ensure the quality and frequency of cleanliness in the apartments. Maintenance schedules were not being completed in timely manner. Staff were not reporting all maintenance issues.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Not all permanent and agency staff had the required training and skills to manage people's escalation of distress effectively. While staff had basic mandatory training, specialist skills training was not mandatory or monitored. • The provider did not have robust and monitorable systems in place to track agency staff's specialist and non-mandatory training. The provider could not assure themselves that all agency staff were trained to the same standard as their own permanent staff. This meant the provider could not be sure that all staff could provide safe care and treatment. Under the Health and Social Care Act 2008 we issued a Notice of Decision to add conditions to the providers registration to address these issues.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider was not pro actively addressing all their delayed discharges and not all people had clear discharge plans with dates. The provider had failed to secure a full multidisciplinary team to deliver the range of assessments, care and treatment necessary to meet all the rehabilitation needs of people to help facilitate independence and timely discharge. • The provider had not ensured that there was robust leadership in place to manage the service effectively. Managers and staff could not articulate a clear vision explaining how the service will ensure it will provide safe, good quality care.

This section is primarily information for the provider

Enforcement actions

Under the Health and Social Care Act 2008 we issued a Notice of Decision to add conditions to the providers registration to address these issues.

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 • There was not always an adequate number of suitably qualified, skilled staff to meet peoples needs. Although the provider allocated staff to apartments according to patients required observation levels, these levels were insufficient if those staff were not available because they were attending to other duties or incidents. This meant that there was not enough staff to cover all observations, peoples planned and ad hoc escort requirements, staff breaks, staff rotations from observation duties, or other incidents that may occur. • There were no robust systems in place to carry out competency assessments of registered nurse's medication management. There was no requirement for registered nurses to undertake on going training for their role and registered nurses supervision was inadequate at 30%. Under the Health and Social Care Act 2008 we issued a Notice of Decision to add conditions to the providers registration to address these issues.