East London NHS Foundation Trust

Forensic Services Directorate John Howard Centre

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWK60	Forensic Services Directorate, John Howard Centre	Bow ward Morrison ward Westferry ward (psychiatric intensive care unit)	E9 5TD

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

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

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

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

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

Summary of findings

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

Summary of findings

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Summary of findings

Overall summary

We last inspected forensic wards provided by East London Mental Health Foundation Trust at the John Howard Centre in December 2012. We carried out that inspection under our previous inspection regime. Consequently, we did not rate the service. The service complied with all the regulations we checked at that time.

We will rate forensic wards at our next comprehensive inspection of East London Mental Health Foundation Trust.

We carried out this focused inspection on 11 November 2015 in response to information we had received about the safety of the service. Some patients had gone absent from the service without leave. Additionally, in July 2015, there was a serious disturbance on Westferry ward.

This inspection was focused on checking whether the service was meeting the required standards in relation to:

- How staff managed risks to ensure the service was safe.
- Patient involvement in planning their care and treatment.
- Patient access to activities.

This inspection found:

- The service robustly assessed and managed risks. The service obtained information about each patient prior to their admission. This included detailed information on risk. Ward staff developed plans to manage risks to the patient and others which were put into practice as soon as the patient was admitted. The multi-disciplinary team (MDT) on each ward regularly reviewed risks and amended management plans to ensure they were effective.
- The MDT kept patient leave arrangements under constant review. Patients were only granted leave when staff had followed trust procedures and made the appropriate safety checks.
- The trust had undertaken detailed investigations when patients had gone absent from the service and after the disturbance on Westferry. The trust had ensured the learning from these investigations had been shared with staff to improve the security of the service.
- Staff safely administered patients' medicines.
- The MDT assessed each patient's needs and developed a comprehensive care plan. Patients' mental and physical health needs were effectively met.
- Staff had the appropriate skills and knowledge in relation to working with patients in a forensic service.
- Staff supported patients to plan and review their care.
- Staff treated patients with dignity and respect.
- Patients reported that they were able to participate in a range of activities.

Summary of findings

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

Are services safe?

We have not rated this service yet. We will fully report on this question and provide a rating after the next comprehensive rating of the service. This focused inspection found:

- The service robustly assessed and managed risks. The service obtained information about each patient prior to their admission. This included detailed information on risk. Ward staff developed plans to manage risks to the patient and others which were put into practice as soon as the patient was admitted. The multi-disciplinary team (MDT) on each ward regularly reviewed risks and amended management plans to ensure they were effective.
- The MDT kept patient leave arrangements under constant review. Patients were only granted leave when staff had followed trust procedures and made the appropriate safety checks.
- The trust had undertaken detailed investigations when patients had gone absent from the service and after the disturbance on Westferry. The trust had ensured the learning from these investigations had been shared with staff to improve the security of the service.
- Staff safely administered patients' medicines.

Are services effective?

We have not rated this service yet. We will fully report on this question and provide a rating after the next comprehensive inspection of the service. This focused inspection found:

- The MDT assessed each patient's needs and developed a comprehensive care plan. Patients' mental and physical health needs were effectively met.
- Staff had the appropriate skills and knowledge in relation to working with patients in a forensic service.

Are services caring?

We have not rated this service yet. We will fully report on this question and provide a rating after the next comprehensive inspection of the service. This focused inspection found:

- Staff supported patients to plan and review their care.
- Staff treated patients with dignity and respect.
- Patients reported that they were able to participate in a range of activities.

Summary of findings

Are services responsive to people's needs? We have not rated this service yet. We will report on this question and provide a rating after the next comprehensive inspection of the service.	
Are services well-led? We have not rated this service yet. We will report on this question and provide a rating after the next comprehensive inspection of the service.	

Summary of findings

Information about the service

At this inspection, we inspected three medium secure forensic wards at the John Howard Centre. The wards we inspected were: Bow, a ward for 15 female patients; Morrison, a 16-bed long-stay rehabilitation ward for male patients and Westferry, a psychiatric intensive care unit (PICU) for 11 male patients.

The multi-disciplinary staff on all three wards included a medical team, consultant psychiatrist, qualified nurses, healthcare assistants, psychologists and occupational therapists.

Our inspection team

The team that inspected this core service consisted of nine people: an inspection manager, two inspectors, three nurses, a pharmacist, a Mental Health Act reviewer and an expert by experience. The expert by experience is a person who has developed expertise in relation to health services by using them.

Why we carried out this inspection

We carried out this focused inspection in response to information we had received about the safety of forensic inpatient/secure wards provided by East London Mental Health Foundation Trust at the John Howard Centre.

Some patients had gone absent from the service without leave. Additionally, in July 2015, there was a serious disturbance on Westferry ward at the John Howard Centre.

How we carried out this inspection

Before the inspection visit, we reviewed the information that we held about forensic inpatient/secure wards. This inspection was focused on checking whether the service was meeting the required standards in relation to:

- How staff managed risks and ensured the service was safe.
- Patient involvement in planning their care and treatment.
- Patient access to activities.

During the inspection visit, the inspection team:

- Visited Bow, Morrison and Westferry wards.
- Read five patient records on Bow, eight on Morrison and five on Westferry.
- Spoke with two patients on Bow, two patients on Morrison and four patients on Westferry.
- Checked how staff managed medicines on each ward and reviewed medicines administration in detail on Westferry.
- Spoke with the manager for each ward.
- Spoke with 15 other staff members across all three wards, including doctors, an occupational therapist, qualified nurses, healthcare assistants and a pharmacist.
- Carried out a Mental Health Act review visit on Morrison and spoke to six patients on the ward.

East London NHS Foundation Trust

Forensic Services Directorate John Howard Centre

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bow ward Morrison ward Westferry ward (psychiatric intensive care unit)	Forensic Services Directorate, John Howard Centre.

Are services safe?

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

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

Our findings

Safe and clean environment

- We checked the clinic rooms on Bow, Morrison and Westferry. All these rooms were clean and well furnished. Staff knew how to access resuscitation equipment, ligature cutters and medicines to use in an emergency.
- Secluded patients were as safe as possible. Each ward had a seclusion room with a clock, toilet and washing facilities. When in use, staff on duty outside the seclusion room could easily observe the patient. In addition, on Westferry ward, the seclusion room had equipment which enabled staff to remotely monitor the patient's breathing.
- We found all three wards to be clean and well-maintained. Staff carried out daily checks to ensure patients were cared for in a suitable environment. On Bow ward, a wall-mounted television had been recently installed. It had not yet been boxed-in and there were lose wires which may have posed a risk to patients. The ward manager told us she had alerted the estates department and was waiting for it to be fixed. We told senior managers about this during the inspection and they told us it would be immediately rectified.
- On each ward all staff carried personal alarms and had radios which linked to a nurse call system. Alarms were regularly tested to ensure they were functioning correctly.

Safe staffing

- For each ward, the trust had specified the safe staffing level for each shift, in terms of the number of qualified nurses and healthcare assistants. During the inspection, we confirmed that all the wards were staffed in line with the trust's agreed staffing level.
- 'Bank' staff, who were experienced trust employees, covered vacancies. For example, on Bow there were three vacancies for qualified nurses. These vacancies were covered by 'bank' staff who were familiar with the needs of the patients on the ward. The Bow ward manager told us the trust had already recruited to these posts and new staff were due to start in the next few weeks.
- Ward managers were able to obtain additional staffing resources to meet the needs of patients. For example, they told us that if patients required one to one observation they arranged additional bank staff for the shift.
- We spoke to two patients on Bow, two on Morrison and four on Westferry. They said they were able to have one to one time with nursing staff. Staff told us their managers expected them to spend regular one to one time with patients and they had sufficient time to do this.
- In general, staff arranged for patients to have their leave from the wards as planned. However, on some occasions, due to unforeseen events, planned leave was cancelled at short notice. Staff then made alternative arrangements to ensure that patients were able to go on leave at another time. For example, a patient on Bow ward told us she did not receive her leave as planned on the weekend previous to our inspection. The ward manager told us that although the ward was fully staffed on that day, it was very busy, and the planned period of escorted leave was for three hours. Leave records showed staff had escorted the patient for a shorter 30 minute period of leave on the day in question and had then escorted her for the longer period of leave later in the week.
- Staff on all the wards carried personal alarms. They told us there were enough staff on the wards to intervene and ensure their personal safety when incidents occurred. Records showed staff had completed trust mandatory training on physical interventions with patients.

Assessing and managing risk to patients and staff

- The MDT had obtained appropriate information about the risks in relation to each patient which enabled them to safely manage the patient as soon as they were admitted. For example on Wesferry, the MDT asked for a report on risks from the referring agency. Prior to a new

admission, the ward manager sent all of the staff who would be in contact with the patient an email with detailed information about the patient which fully informed them about potential risks. This included details of the patient's background, legal status and offending behaviour.

- A nurse carried out a comprehensive risk assessment as soon as the patient was admitted. They used standardised documents to assess individual risks in relation to health and safety. The nurse evaluated risks in relation to issues such as self-harm or self-neglect, substance misuse and sexually disinhibited behaviour. Additionally, they completed a recognised tool about each patient to assess the risk of violence and develop an appropriate risk management plan.
- Risk assessments and management plans were reviewed by the multi-disciplinary team (MDT) if there was an incident or a change in the patient's health or circumstances. For example, we attended a MDT meeting on Morrison where staff analysed the current risks in relation to a patient and revised management plans to ensure the safety of the patient and others. On Westferry, staff had recently reviewed the management of risks to a patient because the patient was observed to be distressed. Staff were carrying out 15 minute observations of the patient to check on their wellbeing.
- Additionally, the MDT reviewed each patient's risk assessment and risk management plan at a care programme approach (CPA) meeting which took place every six months.
- The trust robustly managed risks in relation to granting patients leave from the service. The MDT was responsible for making decisions about patient leave. In the case of most patients, the service had to ask for permission from the Ministry of Justice (MoJ) before patients went out of the service on leave. After MoJ permission was obtained, the MDT constantly reviewed leave arrangements. The MDT cancelled patient leave when staff had assessed that there was a risk the patient would abscond. Additionally, staff carried out a pre-leave risk assessment with the patient just before every period of planned leave and made a decision about whether it should go ahead. Staff kept notes on how the patient had responded to the period of leave and the MDT used this information, together with their knowledge of the patient's current mental state, to make decisions about granting future leave. Staff carried out 'pat down' searches of patients before and after leave.
- The service had plans in place to cover situations where a patient had not been granted leave but may need to go out of the service in an emergency, if they required urgent hospital treatment, for instance. These plans specified how the patient should be transported and what additional security arrangements were required to ensure the safety of the patient and others.
- Patients told us they felt safe on the wards. A patient told us "staff are on the ball" and intervened promptly to ensure patients were safe.
- The trust had effective procedures to improve the safety of the service. For example, security arrangements included monthly searches of patient rooms and the use of a sniffer dog to detect illegal drugs.
- We checked medicines management practice on Westferry. There were effective procedures to ensure patients received their medicines safely. A pharmacist regularly checked medicines administration charts and supplies of medicines. Staff were carrying out the appropriate monitoring of a patient who had recently received rapid tranquilisation. Several patients were prescribed high dose anti-psychotic medicines. Staff were monitoring their physical health in accordance with the trust's policy.

Track record on safety

- The trust had detailed information about incidents on the wards and the use of seclusion and restraint. Most of these incidents had occurred on Westferry . Staff on this ward had a plan to achieve a 30% reduction in the use of restraint by May 2016. They aimed to achieve this by improving the way staff responded to distressed patients and by providing more options for patients to relax. The staff team had attended further training on techniques to defuse potentially dangerous situations and had introduced more activities for patients on the ward.

Are services safe?

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

Reporting incidents and learning from when things go wrong

- Staff knew how to use the trust's incident reporting system. Patient records showed staff had consistently followed the trust's procedures when incidents occurred.
- The trust compiled monthly information on the incidents that had been reported from each ward to assist staff to monitor trends and take action when required. For example, on Westferry, information on the number of incidents of restraint each month was on display for staff and patients. This showed there had been progress towards the ward target of achieving a 30% reduction in the number of these incidents.
- The trust had completed an investigation report on the serious disturbance on Westferry which took place in July 2015. The trust had made an in-depth analysis of the unique factors involved in the occurrence of this event and how staff had responded to it. The trust had subsequently carried out a number of actions to improve the safety of the service. We were satisfied that the trust had taken all appropriate steps to reduce the risk of a similar incident.
- There were effective arrangements for staff to learn from incidents. For example, when patients had gone absent without leave, the trust had thoroughly investigated the circumstances. We read reports on these incidents which included recommendations and learning points. The trust had promoted staff awareness of these learning points through meetings, training events and newsletters.
- The trust supported staff to develop their skills in working with patients on forensic wards. For example, the trust had trained staff on the situational factors, such as the relationships between patients and between patients and staff, which could affect safety and security.
- The trust had also developed revised procedures to ensure staff thoroughly checked the details of the people patients were in contact with during periods of leave.
- The trust had used the data on incidents to identify trends and develop initiatives to improve the safety of patients and staff. On Westferry ward there were recurring incidents of patient on patient violence and patient on staff violence. To improve, the ward had taken a zero tolerance approach and all assaults were reported to police. Another concern was the number of racially abusive verbal assaults by patients against staff. Staff have acted to address this. For example, staff have met with individual patients to challenge this behaviour and explain that racial abuse is illegal and unacceptable. These measures have been effective and have resulted in a downward trend in verbal and physical assaults.
- Staff told us their managers provided them with appropriate support when incidents occurred.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- The service effectively met patient needs. All admissions were pre-planned and staff obtained information from the referring agency about the patient before admission. Prior to a new patient's transfer to the ward, the multidisciplinary team met to discuss the patient's background and plans for their care and treatment. The ward manager allocated a named nurse to take responsibility for assessing the patient's needs and developing a care plan. The nurse developed an initial care plan which included information on how staff should observe the patient on admission to the ward. The nurse then met with the patient over the next few days to develop a comprehensive care plan.
- Assessments included full details of the patient's current presentation and behaviour, a check on their physical health, details of their sleep pattern, their dietary requirements and what support they required in relation to smoking cessation.
- Care plans were comprehensive and up to date. The named nurse had ensured there was appropriate information on how the patient's mental and physical health needs were met, how they maintained contact with family and friends, their treatment and activity programme and their goals and interests. Care plans were reviewed at weekly MDT team meetings.
- Patient records were accurate and up to date. Senior nursing staff on each ward undertook regular checks on the quality of record keeping. The 18 patient records we reviewed included all the appropriate current information about the patient's health and behaviour and the implementation of their care plan.

Skilled staff to deliver care

- On each ward, patients received input from the full range of mental health professionals. For example, on Bow ward, an occupational therapist worked with patients to develop an individual programme to meet their needs and develop their skills. They had worked intensively with some patients who were hard to engage in order to promote the participation and wellbeing of these patients.
- Staff received the necessary specialist training and support in relation to working in forensic services. All new staff (including non-clinical staff) had attended a security briefing before they worked on the wards. This covered their individual responsibilities and how security was managed by the service. Subsequently, staff received training according to their role in the MDT. For example, a qualified nurse told us she was required to attend mandatory basic life support training and complete on-line training on subjects such as safe manual handling, safeguarding and the Mental Health Act. The nurse told us she had taken on-line tests on medicines administration and was currently being observed and supervised by a more senior nurse whilst she provided patients with their medicines. She said she would only administer medicines herself once her competency to do so had been confirmed by a more senior colleague.
- The nurse had also attended a five day course on how to manage behaviour from patients which challenged the service. Shesaid the course included practical sessions on defusing potentially difficult situations and how to safely restrain patients.
- Each ward manager had detailed information on the completion of mandatory training by their staff team, which enabled them to ensure staff completed their training in line with the trust's standards.
- The trust supported staff to deliver appropriate care. Newly qualified nurses said they had mentors who were enthusiastic and motivated them to develop their skills. Staff told us about reflective practice sessions which were taking place on the wards each week which they found helpful in terms of developing good teamwork and improving their knowledge.

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

- We reviewed adherence to the Mental Health Act (MHA) and the MHA code of practice on Morrison. Patients told us their rights were explained to them and they were able to access support from an advocate. Patients had requested tribunals to review their detention.
- The trust had ensured that the documentation in relation to the detention of patients was accurately completed and up to date.

Are services effective?

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

- All six patients we spoke with had escorted leave in accordance with the most recent letters sent by the Ministry of Justice.
- The correct consent to treatment forms were attached to medicines charts.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with eight patients who told us staff were kind and helpful. Patients said staff knocked before they entered their rooms and spoke with them politely.
- During the inspection, we observed staff talking and interacting with patients in a friendly and supportive way. For example, they responded with appropriate information and explanations when patients asked them questions.
- The ward manager allocated a named nurse to each patient on every shift. The named nurse was responsible for engaging with the patient during the shift and monitoring their well-being. Patients told us this was helpful to them and they felt they could talk to staff and express how they were feeling.
- All the staff we spoke with had a good understanding of the individual needs of patients. For example, they were able to explain the patients' backgrounds and how their care and treatment was being delivered.

The involvement of people in the care that they receive

- Patients were actively involved in planning their care. Patients told us how their named nurse involved them in developing and reviewing their care plan. The 18 care plans we read showed that most patients had participated in the care planning process and had given their views on their care and treatment. Some patients had declined to be involved, and this was clearly recorded.
- Patients told us they were activities available which met their interests. Patients told us they engaged in sports and physical activities and there were a range of educational and art groups. For example, a patient told us they were improving their maths and literacy skills by attending classes. Patients said there were activities available at weekends and during the evenings.
- Patients told us they attended MDT meetings and had the opportunity to discuss their care and treatment with staff. Pharmacists visited the wards each fortnight and held drop-in sessions for patients when they could ask questions about their medicines. Additionally, on each ward there were weekly community meetings where patients were able to raise any issues of concern.
- The trust arranged for each patient to see an advocate. Patients told us they could use the advocate to support them to ask questions about their care and treatment at MDT meetings.

Are services responsive to people's needs?

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

Our findings

We did not inspect the service in relation to this question during this focused inspection. We will report on this question and provide a rating after the next comprehensive inspection of the service.

Are services well-led?

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

Our findings

We did not inspect the service in relation to this question during this focused inspection. We will report on this question and provide a rating after the next comprehensive inspection of the service.