HMP Featherstone

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

Overall summary

We carried out an announced follow up inspection of healthcare services provided by Practice Plus Group Health and Rehabilitation Services Limited (PPG) at HMP Featherstone to follow up on requirement notices issued after our last inspection in May 2022.

At the last inspection, we found the quality of healthcare provided by PPG at this location required improvement. We issued Requirement Notices in relation to Regulation 12, Safe care and treatment and Regulation 18, Staffing.

The purpose of this inspection was to determine if the healthcare services provided by PPG were meeting the legal requirements of the requirement notices that we issued in August 2022, and to determine if the provider was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment.

At this inspection we found the required improvements had been made and the provider was meeting the regulations.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection we found:

- Staffing had improved and recruitment was ongoing to fill remaining vacancies.
- Regular bank and agency staff filled gaps in the rota to ensure safer staffing levels.
- Medicines administration was carried out professionally and competently.
- Short notice staff sickness and prison incidents meant that medicines administration was sometimes delayed.
- Staff took appropriate action when patients did not attend to collect their medicines.
- Governance arrangements relating to medicines management had improved although further improvements could still be made.
- Staff gave positive feedback about leaders and an improved working environment.

The provider should:

- Carry out regular balance checks of controlled drugs and record these in the controlled drug register.
- Implement an audit trail for items taken out of the emergency medicines stock cupboard.
- Remind staff of the importance of reporting all incidents and near misses.

Our inspection team

Our inspection team was comprised of two CQC health and justice inspectors.

How we carried out this inspection

We conducted a range of interviews with staff and observed the administration of medicines across four different areas in the morning and afternoon. We accessed patient clinical records on 28 February and 1 March 2023 to review processes relating to the safe management of medicines.

During the inspection we spoke with:

- Two nurses
- Two pharmacy technicians
- The regional lead pharmacist
- The head of healthcare and deputy head of healthcare
- Two prison officers.

We also spoke with NHS England commissioners and requested their feedback prior to the inspection.

We asked the provider to share a range of evidence with us. Documents we reviewed included:

- Audits relating to medicines
- Medicines missed dose reports
- Minutes of assurance meetings
- Complaints and incident reporting data
- Information relating to recruitment
- Staff rotas
- The provider's action plan submitted after the previous inspection.

Background to HMP Featherstone

HMP Featherstone is a Category C prison in the West Midlands which receives men from remand prisons. The prison is located near Wolverhampton and accommodates up to 687 prisoners. The prison is operated by His Majesty's Prison and Probation Service.

Health services at HMP Featherstone are commissioned by NHS England. The contract for the provision of healthcare services is held by PPG. PPG is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with His Majesty's Inspectorate of Prisons (HMIP) in May 2022 and published on the HMIP website on 31 August 2022. We found a breach of Regulation 12, Safe care and treatment and Regulation 18, Staffing.

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-featherstone-4/

Inspected but not rated

Are services safe?

Managing risks

At our last inspection, staffing levels meant that patient care was not always delivered in a timely way, particularly around the administration of medicines. At this inspection we saw that staffing levels had improved and on most days there were sufficient staff to administer medicines in a timely way.

The provider had a recruitment action plan in place along with regular recruitment monitoring calls and a tracker to effectively monitor progress with filling any remaining vacancies. Progress had been made with the recruitment of staff with several going through the recruitment and vetting process. Regular bank and agency staff worked at the prison to fill any gaps in the rota and staff we spoke with told us that the staffing situation was more stable than at our previous inspection.

We observed medicines administration in the afternoon of the first day of the inspection and again the following morning. There had been short notice sickness absence on the first day of the inspection which meant staffing levels were reduced. This was compounded by several incidents in the prison requiring an emergency response or assistance from healthcare staff. This meant that the start of medicines administration was delayed on two houseblocks, however it was still completed safely and with the support of prison officers. Senior healthcare staff also assisted to ensure patients received their medicines. On the second day of our inspection staffing was at the planned level and medicines administration ran smoothly and on time.

Medicines management

At our last inspection we found that patients did not always receive their medicines in a timely way due to the staffing levels which meant staff often had to administer medicines on more than one houseblock. There were also issues with medicines reconciliation not taking place in a timely way when patients first arrived at the prison as well as low numbers of patients able to have their medicines in-possession. Some patients left the prison without their prescribed medicines and changes were made to prescriptions without consultation with patients. In addition, the management of controlled drugs was not always safe.

We observed medicines administration twice during our inspection, once in the morning and once in the afternoon. Whilst there were some staffing pressures and prison related incidents which delayed the start of administration on the first day of our inspection, it was carried out safely, and as efficiently as possible. When a full complement of staff was available medicines administration started on time and was completed in a professional and timely way. Staff checked every patient's identification and the majority of medicines were in stock and available to give to patients. Staff worked well with prison officers to ensure that queues were safely managed and to chase up any patients who had not attended.

At the last inspection only around 40% of patients were able to keep their medicines in their possession, which greatly increased pressure on staff who were administering medicines. At this inspection this had increased to 87% of patients which meant that less patients had to attend the medicines hatches on a daily basis to be given individual doses of medicines. A weekly clinic had been introduced for the review of in-possession risk assessments which enabled staff to ensure that these were carried out in good time.

A reception nurse role had been created since the last inspection in order to bring about improvements to the medicines reconciliation process for patients arriving at the prison. The reception nurse verified patients' medicines within the

Inspected but not rated

Are services safe?

required timescale to ensure continuity of treatment. On occasion staff would stay late to see any patients who arrived at the prison in the evening. Patients leaving the prison were provided with medicines or a prescription to take with them and were also offered an appointment at the discharge clinic to assist with the transfer of any ongoing care and treatment.

Where a change to a patient's prescription was required, this was discussed at the 'Safer Prescribing' forum to ensure that decisions were made consistently and in line with guidance. Patients then received a letter informing them of the change and this gave them the opportunity to discuss the changed prescription in a face to face appointment.

The management of controlled drugs had improved with greater control and oversight of stock and record keeping. Controlled drugs registers had been implemented and we observed staff completing these during medicines administration. The head of healthcare completed regular checks of these and effectively dealt with any issues they found. Disposal of controlled drugs that were no longer required was better managed and there were only small quantities awaiting disposal. However, not all staff spoken with were clear about the process for arranging the collection and destruction of controlled drugs.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

At the last inspection the head of healthcare had very recently commenced in post and since then the provider had appointed a new deputy head of healthcare. Staff we spoke with provided positive feedback about leadership and an improved working environment. Ongoing staff recruitment had led to a more stable staffing situation and staff were kept updated with progress in recruiting to vacant posts. Daily 'Buzz' meetings were held in the middle of the day which allowed staff to update one another on key events and ensure that everyone was supported to complete any outstanding work.

There was a focus on the wellbeing of staff and the provider had held 'listening events' where staff could talk to the regional wellbeing lead to raise any matters of concern to them. The provider made funding available for staff to purchase items to support wellbeing. Friday afternoons were set aside for staff learning and development.

Culture of the organisation

Work was ongoing to develop the culture of HMP Featherstone and staff commented that there was now a more open and inclusive working environment. Changes had been made to some working practices, such as the management of medicines and staff have been supported to understand and implement these changes.

Governance and management

At our last inspection we saw that governance arrangements did not ensure the safe management of medicines, particularly controlled drugs. Regular audits of medicines were carried out on each of the houseblocks, which included checking that controlled drugs records were correctly completed. Where these audits had identified issues, actions were taken to rectify these and there was gradual improvement in the audit scores. However, staff were not always carrying out balance checks of controlled drugs and, even when carried out, were not always recording the checks in the controlled drugs register.

There was an emergency medicines cupboard located in the pharmacy room for staff to access out of hours, this was well organised, and a newly created list confirmed what items should be stocked. However, there was no audit trail of items put into or taken out of the emergency stock cupboard so it would be difficult to check that these items were being used appropriately.

Quarterly medicines management meetings were held to discuss issues such as medicines incidents, complaints, shared learning and training requirements for staff. In addition, safer prescribing forums were held on a regular basis to discuss individual patients and reach agreement on any changes required to prescriptions.

The provider had carried out training for some staff on the importance of reporting incidents and how to use the incident reporting system. At the last inspection there were very low numbers of incident reports and this inspection we saw that this had increased because staff had greater awareness and confidence in reporting incidents. Trends and themes were analysed and learning shared with staff. Whilst improvements had been made, we saw that staff were not always reporting incidents relating to missed doses of critical medicines.