# HMP Ranby

## Quality 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.

## Summary of this inspection



## Detailed findings from this inspection

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**
We did not inspect the safe domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued as a result of the inspection in December 2016.

We found that the trust had taken action to improve their systems to help ensure the proper and safe management of medicines.

**Are services effective?**
We did not inspect the effective domain at this inspection.

**Are services caring?**
We did not inspect the caring domain at this inspection.

**Are services responsive to people's needs?**
We did not inspect the responsive domain at this inspection.

**Are services well-led?**
We did not inspect the well-led domain at this inspection.

# Summary of findings

## Areas for improvement

**Action the service SHOULD take to improve**

Action should be taken to remind staff of the importance of completing medicines administration records.

# HMP Ranby

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

This focused inspection was completed by two CQC Health and Justice Inspectors.

## Background to HMP Ranby

HMP Ranby is a Category C male prison, located in Retford, Nottinghamshire which can accommodate 1098 prisoners. Nottinghamshire Healthcare NHS Foundation Trust had been providing all healthcare services at the location since it was registered with CQC on 14 June 2012. Nottinghamshire Healthcare NHS Foundation Trust provides a range of primary, mental healthcare and substance misuse services to prisoners, comparable to those found in the wider community. This includes GP, nurse led and pharmacy services. The location is registered to provide the regulated activities treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures.

CQC and Her Majesty's Inspectorate of Prisons (HMIP) undertake joint inspections under a memorandum of understanding. Further information on this and the joint methodology can be found by accessing the following website: http://www.cqc.org.uk/content/health-and-care-criminal-justice-system

CQC inspect under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

CQC inspected this service with HMIP between the 7 and 11 September 2015. This report can be found by accessing the following website: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-ranby-2/

We found evidence that fundamental standards were not being met and a Requirement Notice was issued in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we subsequently asked the provider to make improvements regarding these breaches. We then carried out a focused inspection in December 2016 and found that sufficient improvements had not been made and issued another Requirement Notice. We checked these areas as part of this focused inspection and found the provider had addressed the issues identified.

## Why we carried out this inspection

We carried out an announced focussed inspection on 24 October 2017. This inspection was carried out to follow up on concerns raised during a previous focussed inspection in December 2016. We inspected only those aspects detailed in the Requirement Notice dated 5 July 2017[TM1][CR2]. We do not currently rate services provided in prisons.

## How we carried out this inspection

Prior to the inspection we reviewed the provider's action plan and other information received. We also contacted the commissioners of the service for their feedback. During the inspection we observed the administration of medicines in the morning and evening as well as speaking to six staff who were responsible for the management and administration of medicines. In addition, we looked at the systems in place for the storage, transportation and administration of medicines. We viewed a sample of medicines administration records and controlled drug

# Detailed findings

registers to ensure that staff were keeping accurate records. We spoke with the Head of Healthcare services at HMP Ranby and the provider's Area Manager and looked at the quality assurance processes used by the provider.

# Are services safe?

## Our findings

**Medicines management**

During our inspection in December 2016 we found that medicines management arrangements did not ensure the safe storage, administration and transport of medicines. Incidents relating to medicines were not always reported.

During this inspection we found that there was evidence that the trust had taken action to address issues relating to the safe storage of medicines.

Actions included:

- Medicines were organised in alphabetical order by patient surname. This meant staff could easily and quickly find the correct medicines to administer to each patient.
- Medicines that required storage in a fridge were stored safely because the fridge temperatures were checked on a daily basis. We saw that fridge temperatures were within an appropriate range to ensure the efficacy of the medicines.
- Controlled drugs were safely stored in accordance with the relevant legislation.
- Regular stock checks and audits of medicines were carried out which ensured that stocks of medicines tallied with the records kept by staff. However, during our visit we saw that staff had not always completed records to confirm whether or not prisoners had received their medicines.

There was evidence that the trust had taken action to address issues relating to the administration of medicines.

Actions included:

- Administration times had been reconciled across all areas of the prison. This meant that administration was not interrupted by other healthcare staff because most staff were administering medicines at the same time.
- There were two members of staff administering medicines together from each administration point. This meant one staff member could concentrate on speaking with prisoners and administering their medicines. The other staff member completed the medicines administration record on the electronic patient record system as well as double checking the prisoner's identity. In addition, both staff checked that the correct medicines were being given.
- The trust had worked with the prison to try and ensure that a prison officer was assigned to supervise the queue at the medicines administration hatch. This reduced any disorder and ensured that staff could concentrate on the task at hand. There was still one area of the prison where prison officer supervision was not available, the trust continued to raise this issue with the prison.
- Where possible, medicines were administered in line with the therapeutic dosage interval. Some medicines had been represcribed to be given twice a day instead of three times a day. There had been a focus on enabling as many prisoners as possible to receive their medicines 'in possession' which meant they could administer their own medicines.
- Night time sedation was given at a more appropriate time because medicine administration for those requiring supervised medication in cell, was operated later into the evening. As there was a focus on prisoners being able to keep their own medicines 'in possession' this also meant that, where appropriate, they could take their night time sedation at a time convenient to them.

There was evidence that the trust had taken action to address issues relating to the transport of medicines around the prison.

Actions included:

- The trust had purchased a supply of sturdy pharmacy bags which we observed being used for the transport of medicines around the prison.
- Staff told us that they would only transport medicines around the prison during 'patrol state'. This is when the majority of prisoners are locked in their cells.
- Should this not be possible, then staff would request an escort from a prison officer before transporting medicines around the prison.

There was evidence that the trust had taken action to address issues relating to the reporting of incidents relating to medicines. The staff we spoke with understood what to report as a serious incident and told us that they would receive feedback.

Actions included:

- Staff had been provided with training in incident reporting by the trust.
- Any lessons learned from medicines related incidents were shared with staff.

# Are services safe?

- The trust ran regular reports of incidents which identified any patterns and trends so that action could be taken.

# Are services effective?

(for example, treatment is effective)

## Our findings

We did not inspect the effective domain at this inspection.

# Are services caring?

## Our findings

We did not inspect the caring domain at this inspection.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

We did not inspect the responsive domain at this inspection.

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

## Our findings

We did not inspect the well-led domain at this inspection.