

# HMP Moorland

## 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.

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# 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 desk based focussed inspection. We inspected only those aspects mentioned in the Requirement Notice issued as a result of the inspection in February 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.

# HMP Moorland

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

This inspection was carried out by a CQC health and justice inspector who had access to remote specialist advice.

### Background to HMP Moorland

HMP Moorland is a category C training prison that holds approximately 1000 men. Nottinghamshire Healthcare NHS Foundation Trust provides a range of healthcare services to prisoners, comparable to those found in the wider community. This includes GP, dental, pharmacy, substance misuse and primary mental health services. The location is registered to provide the following regulated activities: treatment of disease, disorder, or injury, diagnostic and screening and surgical 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 inspected this service with HMIP between the 8 and 11 February 2016. 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. This report can be found by accessing the following website: <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmpyoi-moorland-2/>

We carried out this desk based focussed inspection and found that the trust had taken appropriate action.

### Why we carried out this inspection

We undertook a desk based focussed inspection under Section 60 of the Health and Social Care Act 2008, to check that the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, specifically whether they had satisfied the requirement notice issued as a result of the inspection in February 2016.

### How we carried out this inspection

We carried out a desk based review of a range of information that we held about the service and reviewed and analysed the documentary evidence submitted by the trust in relation to the Requirement notice issued.

# Are services safe?

## Our findings

### Medicines management

During our inspection in February 2016 we found the trust could not be sure of the efficacy of the medication and vaccines stored. This was because fridge temperatures exceeded recommended guidelines with no necessary action being taken.

There was evidence that the trust had carried out a review about the concerns identified and taken action to address these.

Action included:

- Taking advice from pharmaceutical companies about the medication and vaccines stored in the fridges.
- Identifying patients that may have potentially been affected and taking appropriate action which included writing to them to inform them of the situation. Patients were offered further vaccinations to ensure they were fully protected.

- New fridges were ordered.
- The trust reviewed their Standard Operating Procedures and found them to be comprehensive. They identified that staff had not been following them and took relevant action. This included all staff being re-trained on fridges and how to reset them.
- There was evidence of further management oversight of fridge temperatures which included audits being carried out on the checks made on the temperatures. The audits had identified some shortfalls, but the provider had taken the appropriate action to help address these which included discussions with staff and staff performance improvement plans being put in place.
- The trust shared information about these concerns across all of its locations to ensure that lessons were learnt

# 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.