HMP Hewell

Quality Report

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Date of inspection visit: 16 August 2017
Date of publication: 28/11/2017

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 in January 2017 as a result of the joint inspection with HMIP in September 2016.

Prisoners who received medicines were consistently and safely supported.

Positive changes to practice had been implemented to mitigate the restrictions placed on healthcare staff with regards administration of medicines. This helped to comply with dosage intervals and adhere to prescribed times.

Medicines were stored in a structured and organised way. This reduced the risk of patients receiving the wrong medication.

Systems had been put in place to help prevent patients experiencing delays in receiving their repeat prescriptions. This reduced the likelihood of gaps in treatment occurring.

Emergency resuscitation bags contained the appropriate emergency equipment. All items were in place and where applicable in date.

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 Hewell

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was completed by one CQC Health and Justice Inspector who had access to remote specialist advice if required and one Her Majesty's Inspectorate of Prisons Inspector.

Background to HMP Hewell

HM Prison Hewell is a multiple security category men's prison in the village of Tardebigge in Worcestershire. It was officially opened in June 2008. Care UK Health & Rehabilitation Services Limited provides a range of healthcare services to prisoners, comparable to those found in the wider community. The location is registered to provide the regulated activities, diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury. 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 in September 2016, at this time Care UK Clinical Services Ltd were registered to provide regulated activities. We found evidence that essential standards were not being met and one 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/hmp-hewell-2/. As of the 9 August 2017 Care UK Health and Rehabilitation Services Limited were registered to provide regulated activities at HMP Hewell.

Why we carried out this inspection

On the 16 August 2017 we undertook an announced focused 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 and specifically whether the significant improvements needed as identified in the requirement notices issued to Care UK Clinical Services Ltd, in January 2017, had been made.

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. During the inspection we spoke with staff and patients who used the service, observed practice and reviewed a range of documents.

Are services safe?

Our findings

At our previous joint inspection with HMIP in September 2016, we had concerns that some medicines were not being administered at suitable times and recommended dosage intervals were not always being adhered to. This could put patients at risk. For example, we found that medicines used to assist sleep or which had a sedative effect and had been prescribed to be taken at night time, were regularly administered as early as 4pm on a weekday and 3pm at weekends. At our focused inspection on the 16 August 2017, whilst this was still an issue, staff had made positive changes to their practice in order to help mitigate some of the constraints placed on them by the prison regime. This included the introduction of a new in-possession (IP) policy (IP is where patients hold their own prescribed medicines). The policy helped ensure that patients' IP status was regularly reviewed. In addition to this sleep clinics had been introduced and the medicine management team had explored the possibility of including sleep related medicines as IP. It was also evidenced that cases are looked at on an individual basis, if a patient does require medicines outside of the set administration times, a designated member of staff will go out to the patient daily and administer their required dose at the correct prescribed times in order to keep them safe.

At our previous joint inspection with HMIP in September 2016 we had concerns that medicines were not always being administered accurately and in accordance with the prescriber's instructions. Added to this we found staff did not manage patients' medicines consistently and safely. As a result too many patients experienced delays in receiving their repeat prescriptions, causing unacceptable gaps in treatment. At our focused inspection on the 16 August 2017 a number of measures had been put in place to improve administration procedures and mitigate the identified risks. Staffing levels had increased with the appointment of a pharmacy lead and a team of pharmacy technicians. This had resulted in a more consistent and well managed medicines administration process. SystmOne was being well utilised to assist the identification of patients whose prescription was due to expire within seven days. This helped ensure medicines were re-prescribed in a timely manner. Medicine error incidents had been significantly reduced. Patients who failed to attend for their medicines for three separate doses were visited by a pharmacy technician. This helped ensure the patient remained safe. A local medicines management group had been put in place and local operating procedures had been implemented to support staff. Where patients failed to engage in taking prescribed medicines, an appointment with the pharmacist was arranged.

At our previous joint inspection with HMIP in September 2016 we had concerns that medicines storage was disorganised. This could potentially lead to a risk of patients receiving the wrong medicines. At our focused inspection on the 16 August 2017 we saw that medicines were now stored in a structured and organised way, which was monitored and constantly reviewed to ensure these standards were maintained and evidenced stock control continued to improve.

At our previous joint inspection with HMIP in September 2016 we had concerns that fridge temperatures were not routinely recorded. We also noted that where some had been recorded that fell outside the required limits, remedial action had not been taken to help ensure quality of the medicines were maintained and therefore safe to take. At our focused inspection on the 16 August 2017 we found that fridge temperatures were still not being routinely recorded. However, we did find evidence that where temperatures had fallen outside of the safe range action had been taken by staff to address this to help ensure medicines remained safe. Where we found records which evidenced temperatures were not routinely being recorded, we did not find any medicines in any of the fridges that actually required cold storage. Therefore, the quality of the medicines was still maintained. When this was raised with the Registered Manager, they took immediate action; they updated the daily planner to include daily checks of fridge temperatures and removed all fridges that were currently not in use.

At our previous joint inspection with HMIP in September 2016 we had concerns that not all emergency resuscitation bags contained appropriate emergency medicine, and that some items were missing or out of date. This could result in a patient being put at risk in an emergency. At our focused inspection on the 16 August 2017 we found that all emergency bags contained appropriate emergency equipment and were therefor safe to use when attending an emergency.

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.