Nottinghamshire Healthcare NHS Foundation Trust

RHA

HMP Ranby

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RHAY7	HMP Ranby	Healthcare Department	DN22 8EU

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare 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 Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of HMP Ranby Healthcare Department

Summary of findings

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Summary of findings

Overall summary

Medicines management issues had been identified at the last two inspections, where a breach in Regulation 12 had been identified in July 2016. This related to risks associated with the proper and safe management of medicines, which had not been identified or mitigated effectively. Findings included limited medicines administration times and medicines not being administered at the optimum therapeutic dose intervals. At this focused inspection, efforts to address issues raised by the joint HMIP and CQC inspection in September 2015, and the CQC focused follow-up inspection in July 2016 were evident; action plans were submitted with numerous targets achieved. However, at the time of this inspection, these breaches remained, but new areas were also highlighted which caused concern. Although medicines management had improved, there was still progress to be made.

There remained numerous amounts of tradable medicines which were issued in possession, however, work was underway to reduce this.

Despite some improvements, to the prison regime, some prescribed medicines were still not issued at therapeutic time intervals, and night medicines were been administered too early,. This was particularly evident over the weekend period when the clinical staff's working hours and the restrictions of the prison regime meant prisoners received night time medicines too early.

Medicines administration times were short and at times rushed which put the clinical staff under pressure and increased the risk of errors.

The transport of medicines was not safe as they were not held in a secured container whilst staff located them around the prison.

Documentation was not well maintained in recording the levels of stock drugs and completing the controlled drug register, where discrepancies were found.

On a local level, the service had experienced leadership with a commitment to improve. However, the limited provision of a pharmacist meant overarching operational clinical management was restricted in relation to medicines management. Meetings had been commenced with key stakeholders in the prison to discuss and review medicines management issues, but this was in it's development stage.

Our key findings were as follows:

- Although progress had been made, issues surrounding the safe storage, transport and administration of medicines were still concerning, which was on on-going breach of Regulation 12.
- Medicines administration remained constrained by the prison regime and the operational hours of the healthcare service, which limited its therapeutic effect.
- The medicines management policy was not prison specific and related to the wider trust. This meant there was no specific guidance on medicines management for prison healthcare staff.

Summary of findings

Background to the service

HMP Ranby is a Category C male prison, located in Retford, Nottingham, and can accommodate 1038 prisoners. Nottingham Healthcare NHS Foundation Trust had been providing all healthcare services at the location since it was registered with CQC on 14 June 2012.

Our inspection team

The inspection was undertaken by a CQC Health and Justice inspector, who had access to remote advice from two CQC pharmacist specialist inspectors.

Why we carried out this inspection

We carried out an unannounced focussed inspection on 7 and 8 December 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We inspected to check whether 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 notices issued in July 2016, Regulation 12– Safe care and treatment. (Regulated Activities) Regulations 2014. This was to confirm that the service had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection. This report covers our findings in relation to those requirements related to medicines management, and also additional improvements made since our last inspection. The follow up focused report following the inspection can be found by selecting the 'all reports' link for HMP Ranby on our website at www.cqc.org.uk.

During this inspection we inspected the provider against two of the five questions we ask about services:

- is the service safe?
- is the service effective?

These questions therefore formed the framework for the areas we looked at during the inspection.

At our previous inspection on 6 July 2016, we raised concerns regarding medicines management. The risks associated with the proper and safe management of medicines were not identified or mitigated effectively. Policies and procedures for medicines management required review without further delay to ensure the safety and effectiveness of medicines. We asked the provider to make improvements in this regard. In response to the Requirement Notice issued in July 2016, an action plan was submitted by Nottinghamshire Healthcare Foundation trust, and this was followed up at this unannounced focused inspection on 7 and 8 December 2016. Some reviewing of policies had been completed at the time of the inspection in December 2016, but work was still in progress.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Revise the safe transportation of medicines to ensure they are moved around the establishment safely and securely.
- Review how medicines are administered during evenings and weekends, in order to better meet the needs of the population and administer medicines within the correct time frames and at the correct dosage intervals.
- Regularly review the therapeutic use of medicines, including prescribing trends, dosage intervals, and sleeping medicines.
- Ensure staff are aware of the potential impact and detriment in under-reporting of incidents in relation to medicines management.

Action the provider COULD take to improve

- Ensure that medicines management policies address issues on a local level, and give clear guidance on processes to follow.
- Continue to work with the prison and NHS commissioners to review restrictions with the regime that do not allow medicines to be administered in a safe and timely way.
- Improve the storage and recording of stock and controlled drugs. Ensure regular audits are completed and documented accurately.
- Review pharmacist oversight of medicines management.
- Clinical staff administering medicines should have regular updates and assessments to ensure their knowledge is current and they are assessed for competency.

Nottinghamshire Healthcare NHS Foundation Trust

HMP Ranby

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

An action plan was submitted by the trust in response to our findings at the focused inspection in July 2016. Many actions documented on the action plan had been achieved. This included staff training in relation to therapeutic dose intervals and the reduction in lunch time medicines which impacted the therapeutic dosage intervals of medicines.

At our previous inspection on 6 July 2016, we raised concerns regarding medicines management. The risks associated with the proper and safe management of medicines were not identified or mitigated effectively. Policies and procedures for medicines management required review without further delay to ensure the safety and effectiveness of medicines. Although some reviewing of policies had been completed at the time of the inspection in December 2016, work was still in progress.

Overview of safety systems and process

- Medicines administration for house block 1, 2 and 3 were issued in house block 1 clinic room, where men from two wings (North and South) attended one clinic room that dispensed medicines at the same time. We were told discipline officers were allocated to supervise each queue to keep order and prevent prisoners from concealing or diverting medicines. However, due to lack of staff, it had been agreed that an officer would stand in the dispensing room to provide officer visibility. This could have resulted in a lack of privacy and confidentiality. At the time of inspection, there were no officers present in the clinic room, but they supervised the queues on each wing.
- The house block 1 clinic room had one computer terminal for both wings which meant medicines were issued to both wings at the same time. Although there were two separate dispensing hatches, these were not in use as they were considered to be unsafe;, therefore medicines were given through a gated door on each side. These arrangements were well established and there were no current plans in place to address or resolve this. The clinical staff alternated in issuing the prisoners their medicines from each wing, which meant it took some considerable time to complete this task. This meant prisoners were sometimes late attending workshops or education. Some prisoners told us they would sometimes miss their medicines because the queue was often too long and they could not wait. On some occasions, officers took prisoners back to their cells before they received their medicines.

Are services safe?

- Medicines administration from the main pharmacy room served the other house blocks, 4, 5, 6, and 7. This was the main pharmacy stock room with one dispensing hatch. There were two members of clinical staff dispensing medicines in a very tight time frame. The prison had altered the regime in September 2016 to allow medicines to start at 8am instead of 10am; however this still did not allow sufficient time for the medicines to be administered. Only 20 minutes were allocated for staff to administer a variety of medicines to an average of 35 prisoners, plus over the counter medicines (homely remedies). This meant the staff were under a considerable amount of pressure which risked drug errors occurring. Senior staff told us they felt the way controlled drugs were administered was unsafe. They confirmed the process was too rushed, especially in house blocks 4 to 7. This had been raised via the incident reporting system by clinical staff who highlighted that over 40 medicines were administered in a 20 minute time frame which put them under pressure and at risk of making errors. There was no record of the action management took to address this.
- Due to numerous controlled drugs (CD) being administered, staff said they were unable to sign the CD book as they administered the medicines. They recorded this on the computer system, and signed the book at the end of the medicines dispensing time. However, staff followed national guidance that required them to record in the CD book within 24 hours of administration. We found gaps in the records within the CD register, which meant CDs were left unaccounted for, and an inaccurate stock balance was recorded.
- CDs were not kept securely in the CD cupboard whilst the medicines were been administered as we were told this was too time consuming. They were left out on the work top but the pharmacy doors were locked during the medicines administration.
- At the time of inspection, we observed medicines administration in house block 1-3. The clinical staff discovered a dose of Tramadol was unaccounted for, and the CD book did not tally with the number of tablets in the box. It was later found that the administration of this medicine had been recorded on the computer system but it had not been documented in the CD book with the stock balance adjusted.
- Due to the prison regime and clinical staff's working hours, the time interval between administering doses of the same medicines as not always at optimum therapeutic intervals. Some medicines were given in short time frames, and not following national prescribing guidance. Records from the computer system showed examples such as Pregabalin (used to treat pain and anxiety), was prescribed 300 mg twice a day at 8am and 4pm, and was administered at 10.27am and 3.15pm, plus 10.18am and 3.05pm on two consecutive days. One prisoner prescribed Nefopam (used to treat pain) 30 mg twice a day at 8am and 4pm received them at 10.48am then 3.05pm, and the following day at 10.28am and 3.17pm, which was over the weekend period.
- Some medicines were prescribed three times a day which posed a problem with the prison regime, and meant there was too little time between dose intervals. Such medicines could be given up to 3.5 hours apart and included medicines such as Clonazepam and Gabapentin (both used to treat epilepsy or pain disorders). The staff had worked hard to significantly reduce lunchtime medicines being issued, and avoided prescribing these where possible.
- Night time medicines were often given earlier than indicated by national prescribing guidance. Due to their shift patterns nurses routinely dispensed medicines between 6pm and 7pm. A night time medicines appointment ledger had been created on the computer system to alert the staff which prisoners were prescribed night time medicines. At that time in the evening, there was only one nurse and one health care assistant (HCA) on duty and medicines were taken to prisoner's cells individually. During the inspection week, this number averaged between one to 10 prisoners on a nightly basis. However, some night time medicines were administered at 4pm during the general medicines administration time, including those intended to assist sleep. The computer system did not list a prescribed time of 6pm or 10pm to administer the medicines as none were issued at that time, so all were prescribed at 4pm. The clinical staff had to ascertain if it was appropriate for the medicine to be given at 4pm, and if it was not, they were able to record in the electronic patient record why the medicine was or was not given. Some prisoners collecting other medicines at 4pm

requested their sleeping drugs at that time, in case they were forgotten later on in the evening, or out of personal preference. At times the computer records noted this, but not always.

- The night time medicines were often given between 4pm and 7pm. This meant that prisoners were taking sleeping medication during late afternoon or early evening instead of at bedtime. This could result in them being drowsy or falling asleep too early, and potentially waking in the middle of the night when the effects had worn off. Three prisoners were given prescribed Zopiclone (a sleeping drug) at 3.55pm, 4.22pm and 5.21pm. Another prisoner received Zopiclone between 2.53pm and 3.30pm for seven consecutive days. According to the provider's policy, Zopiclone could be given in possession for 3 days following a brief risk assessment. At the time of the inspection, Zopiclone was given in possession to 12 prisoners and there were four that had to attend to have it administered. The computer records also confirmed a prisoner received Promethazine (used to treat allergies and prescribed as a sleeping drug) at 3.30pm and another prisoner received the same drug at 1.29pm on another day. Another prisoner prescribed Trazadone (an anti-depressant and sleeping drug) took them between 4.08pm and 4.37pm. Evidence was seen on the computer system that medicines administration times for night time were given no later than 4pm at weekends.
- The pharmacy main clinic room held stock registers for over the counter medicines, emergency and general medicines. However, the stock records did not tally with the medicines in the cupboard and numerous items were unaccounted for. This included sedative and opiate medicines such as Diazepam, Zopiclone, Tramadol and depot injections. Clinical staff took medicines from these cupboards, administered them to the prisoner and recorded them on the computer system. However, they failed to record them in the registers which meant the stock levels were inaccurate. Evidence was provided by the lead pharmacist that stock reconciliation was attempted onto the computer system, but as staff did not comply with this request, they reverted back to paper based records. However, this system still proved to be ineffective.
- Medicines and controlled drugs (CD) were not transported across the prison in a safe and secured way. General prescribed and over the counter medicines were placed in a white plastic bag, whilst CDs were held in the pharmacy technicians' pockets. The pharmacy technician told us if CDs were moved while the prisoners were out of their cells, they could be escorted by a prison officer. However, staff were placed at risk if walking around the prison during free flow, as prisoners could clearly see that medicines were contained in the bag.
- Medicines were issued in-possession (IP) and not in-possession (NIP). IP medicines were either given in daily, three days, 7 days, or a 28 day's supply. An IP policy had been written in October 2016, and was waiting to be reviewed and ratified before it could be implemented. This provided clear guidance for staff to prescribe and administer IP medicines, ensuring the process is effective. Nurses we spoke with said they felt there could be more IP medicine risk assessments if they were completed promptly. IP medicines were risk assessed by clinical staff and documented on the computer system. It was anticipated that this process would be better managed following the introduction on the reviewed IP policy. We observed completed risk assessments in patients' online records for IP medicines.
- NIP medicines were taken at the medicines hatch under supervision at set times. Medicinesprescribed generally, included tradable medicines and those used for the management of long term conditions. This included Pregabalin which was prescribed to 62 prisoners and all were NIP; and 70% of Dihydrocodeine (to treat pain) was prescribed IP. In October 2016, 70 prisoners were on Gabapentin but at the time of the inspection this figure had risen to 91; of which 36 were NIP and 55 were IP. This was a high number and justification needed to be sought for prescribing these medicines, whether in possession or not.
- The pharmacist routinely audited prescriptions and reviewed clinical records relating to medicines management. Although an average of 20 prescriptions per month were reviewed, this was not reflected in the records. There was no effective sytem to record or audit medicine reviews, which limited the level of assurance

available. Information reviewed by the pharmacict included administration times, IP risk assessments and repeat prescription templates. This evidence was seen at the time of the inspection.

- The pharmacist did not complete medicine reviews but was accessible to prisoners at specific times, and offered personalised one to one sessions on request to discuss their medicines. This included patient education on the usage and possible side-effects of their medicines.
- The GPs randomly reviewed prisoners' medicines, as and when the opportunity arose during or after a consultation. This included in possession and mental health medicines with liaison from the psychiatrist. GPs followed a prescribing ladder, which was a guidance document for the treatment of pain, accessible on the electronic patient record system. There was also a nurse who was a non-medical prescriber, and supported the doctors and pharmacist in reviewing medicines. This proved to be effective.

Safe track record and learning

- Between 1 November and 9 December 2016 there had been 36 incidents recorded relating to medicines management. We sampled reported incidents and other issues raised including medication given to the wrong patient, and prescribing errors, as well as time pressure and delays. These included a drug error for the administration of the wrong dose of Tramadol, and medicines being unaccounted for where the transfer of stock levels to the controlled drugs register was not recorded accurately. The recent introduction of the drugs and therapeutics meetings resulted in incidents reported being reviewed and discussed, enabling action to be taken to improve processes.
- The clinical and administrative healthcare management team were committed to improving the service and ensuring all HMIP recommendations and CQC requirements were met. Leadership was visible and experienced, and there were communication systems in place to escalate concerns. However, despite their commitment and some improvements, some aspects of of medicines management remained unsafe. The lack of full pharmacy cover meant the pharmacist attended the prison at set times on a part-time basis. However, the recent introduction of drugs and therapeutics meetings meant staff were able to review and discuss issues surrounding medicines management on a local level.

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.

Summary

We did not inspect this domain in full. However, we found pharmacy staff had not had recent updates or assessments in medicines management to assure us of their level of competency.

Effective staffing

- Clinical staff dispensing the medicines were either a nurse or pharmacy technician with the assistance of a healthcare support worker. A healthcare support worker we spoke with said they had received e-learning training on administering medicines, but there was no assessment or requirement to be signed off competent by a registered nurse or the pharmacist. They explained their role was only as a second checker of medicines including controlled drugs, but they did not administer the medicines alone. The pharmacy technician had completed a competency framework to administer medicines when they started in their role three years previously, but told us they had not received an update or refresher since that date. They administered all medicines including CDs but did not administer any type of injections. Although the system of un-registered nurses seemed effective in administering medicines, we could not be assured if the pharmacy staff's training was current, or if they were competent in performing this task.
- Clinical staff attended training in relation to therapeutic dose intervals, when to omit medicines and how to record it. This was delivered by the lead pharmacist, and we viewed an attendance record containing names and signatures of attendees.

Are services caring?

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

We did not inspect this domain.

Are services responsive to people's needs?

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

We did not inspect this domain.

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.

We did not inspect this domain.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines management arrangements did not ensure safe storage, administration, and transport of medicines. This is a breach of Regulation 12– Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines including controlled drugs were not transported across the prison securely. Incidents relating to the theft of prisoners' medicines were not reported. Medicines administration arrangements did not support patients to receive their prescribed medicines at optimum therapeutic dosage times, or intervals. Night time medicines were administered too early, including sedative drugs. This was particularly evident at evenings and weekends.