Foston Hall Prison (Health Care Centre)

Quality Report

Foston, Derby DE65 5DN
Tel: 01283 584300

Date of inspection visit: Desk based report
Date of publication: 18/07/2017

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.

Contents

Overall summary

In June 2016, during a scheduled joint inspection at HMP Foston Hall with Her Majesty's Inspectorate of Prisons (HMIP), we found issues related to the safe management of medicines. This was assessed as being in breach of Health and Social Care Regulations 2008.

Most health services at HMP & YOI Foston Hall are commissioned by NHS England, and provided by Care UK Clinical Services Limited. The full comprehensive inspection report of the June 2016 inspection, which was published on October 21, 2016, can be found on the HMIP website at: www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-yoi-foston-hall/

We carried out a desktop focussed review between March and May 2017 soley to ensure that changes had been implemented and that the service was meeting regulations. We found that the provider had made improvements in relation to medicine management since our last inspection in June 2016, and that it was meeting the regulation that had previously been breached.

Summary of findings

Specifically, the provider had addressed concerns regarding the administration of medicines in a timely way. These included carrying out medicine management reviews with individual patients and changing prescriptions when appropriate, amending the policy regarding patients having medicines in their cells, holding stocks of some medicines on site, and allowing patients to have access to pain relief at night.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Since the inspection in June 2016, the provider was found to have undertaken work to address concerns surrounding medicine management by:

- Reviewing the prison in-possession policy and medicines management provision to ensure that patients can have supplies of prescribed medicines in their personal possession whenever safe and appropriate, and to provide appropriate alternative treatment when this is not possible.
- Working with the prison to improve nursing staff's night time access to patients requesting painkillers.

Reviewing patients' prescribed medicine which needs to be taken more than twice a day, or those with sedating properties, to ensure that they are receiving the most appropriate treatment, and prescribing extended release preparations or long acting doses where appropriate.

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.

Foston Hall Prison (Health Care Centre)

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was completed by a CQC health and justice inspector who had access to specialist advice.

Background to Foston Hall Prison (Health Care Centre)

HMP & YOI Foston Hall operates as a women's local resettlement prison, housing approximately 340 female offenders. Levels of need in the population is very high, with nearly all the women arriving at prison with mental and physical health concerns, such as depression, suicidal thoughts, mental health issues and drug and alcohol misuse. More than half the women have children aged under 18, and for a similar number it is their first time in prison.

Health care services are commissioned by NHS England, and provided by Care UK Clinical Services Limited which provides a range of healthcare services to prisoners, comparable to those found in the wider community, and has sub contracts in place to ensure that prisoners have access to services such as dental care.

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 22 and 25 June 2016. We found evidence that essential standards were not being met and two Requirement Notices were 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: http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/

Why we carried out this inspection

We carried out a scheduled joint inspection of Foston Hall Prison (Health Care Centre) with HMIP in June 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The full report of the inspection of HMP & YOI Foston Hall can be found on the HMIP website at: www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-yoi-foston-hall. During the inspection, we found issues related to medicine management which were in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How we carried out this inspection

We undertook a desk-based focused inspection of Foston Hall Prison (Health Care Centre) between March and May 2017. The purpose of the inspection was to follow up on

Detailed findings

the Requirement Notice that was issued following the June 2016 inspection, and to check that the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The provider submitted documentary evidence to show that improvements had been made and how performance was being monitored. We reviewed the evidence submitted and made an assessment against our regulations.

Are services safe?

Our findings

At our previous inspection in June 2016, we found concerns around medicines management. Following the inspection the provider sent us an action plan detailing how it would address the issues of concern, and has now provided an update on the progress it has made to undertake these actions.

Overview of safety systems and process

On inspection in June 2016, We found that the registered person had not ensured that care and treatment was provided in a safe way for service users. Service users were not protected against the risks of receiving inappropriate treatment, associated with the proper and safe management of medicines. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks associated with the proper and safe management of medicines were not identified or mitigated effectively. Limited medicines administration times encouraged the inappropriate use of medicines.

We found that from Monday to Thursday medicines were administered three times a day, in the morning, midday and afternoon. Medicines due to be administered at night were either not administered, or administered too early. On Fridays, weekends and bank holidays medicines were administered twice a day, in the morning and afternoon. Medicines due to be administered at midday or at night were either not administered or administered too early.

These omitted or early medicines administrations could result in the following depending on the medicine:

• Ineffective levels of antibiotics in the person leading to infections not responding to the treatment and increasing antibiotic resistance

• Inadequate pain relief for patients due to administration gaps or a lack of access to pain relief

• Medicine to aid sleep or those medicines that can make people sleepy as a side effect may be taken too early in the day resulting in people being sleepy during the evening rather than at night.

The provider has now put in place systems, processes and practices to mitigate the risks in the following ways:

- Antibiotics are included within the new in-possession policy as suitable for patients to have up to one week's supply in personal possession to take at the times directed, to allow effective levels of efficacy.
- Patients who require pain relief during the night are now able to receive this. The provider has reviewed arrangements with the prison so that nursing staff can access patients during the night if painkillers are requested.
- A review of all patients on medicines that need to be taken more than twice a day has been undertaken, with changes made where appropriate to allow the optimum use of medicines to meet each patient's needs. All patients on medicines that need to be taken four times a day who cannot keep these medicines in personal possession have access at the medication hatch at appropriate times seven days a week to do this.
- When sedating medicines are prescribed, GPs assess for in-possession suitability against an updated policy which identifies medicines appropriate to be given in-possession following completion of a medicines risk assessment. .To reduce the likelihood of patients receiving night medicines too early in the day, a review is currently being completed of the in-possession risk assessment policy.
- The lead GP and healthcare team have conducted a review of medications which might be used by vulnerable patients to self harm if they have it in possession. Clear guidance has been made available on when medication can be prescribed, support to access alternative treatment and the risk assessment process to allow patients to have medication in possession.
- To mitigate risks where a patient might need medication outside the medicine administration times but is unable to have these in possession, the lead GP, wherever possible, prescribes extended release preparations or long acting doses.
- The provider ran a medicines management workshop in August 2016 attended by all healthcare staff, members of the regional team, senior Care UK managers, and partners including the pharmacy provider and the prison. The purpose of the workshop was to review current medicines management provision and to consider developments that could be introduced to enhance and improve service delivery.

Are services safe?

A weekly conference call takes place between NHS England, the healthcare centre management team and Care UK senior management, including the regional medical director to assess progress against the action plan drawn up following the 2016 inspection.

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.