HMP Channings Wood

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.

Key findings 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 key question in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in October 2016.

Robust systems were in place to monitor and follow up on patients who failed to attend health appointments.

An increase in staff within the pharmacy team and new systems which had been put in place helped prevent patients experiencing delays in receiving their repeat prescriptions. This significantly reduced the likelihood of gaps in treatment occurring.

Are services effective?

We did not inspect the effective key question in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with HMIP in October 2016.

Patients with long term conditions were well managed. However, more work needed to be done to ensure all patients with such conditions had individualised care plans in place.

Are services caring?

We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive key question in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with HMIP in October 2016.

Healthcare boxes installed on the wings meant prisoners could make complaints confidentially.

Are services well-led?

We did not inspect the well-led key question in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with HMIP in October 2016.

A comprehensive audit programme was in place that was being adhered to.

Summary of findings

Staff received good clinical and managerial support and all appropriate checks to ensure staff were suitable for their role had been carried out.	

HMP Channings Wood

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was carried out by one CQC Health and Justice Inspector who had access to remote specialist advice if required.

Background to HMP Channings Wood

HMP Channings Wood is a Category C training prison, which was built on the site of a Ministry of Defence base by a combination of contract and prison labour. Work commenced in 1973 and the prison officially opened in July 1974. Further accommodation was added in 1991 and 2004. A new 64 bed unit was opened in 2007; this houses the specialist Recovery Community Therapeutic Community (TC) which tackles drug misuse issues. The prison houses offenders serving a wide range of sentence lengths, and predominantly receives new arrivals from local prisons across the South West Area.Care UK Health & Rehabilitation Services Limited provides a range of healthcare services to prisoners, comparable to those found in the wider community.

The location, HMP Channings Wood is registered to provide the regulated activities, diagnostic and screening procedures and treatment of disease, disorder or injury. The Care Quality Commission (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 and HMIP inspected this service with HMIP in October 2016, at that time Dorset Healthcare University NHS Foundation Trust were registered to provide regulated activities. We found evidence that essential standards were not being met and a Requirement Notice was issued in relation to Regulation 17 Good governance, 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-channings-wood-2/.

As of the 1 April 2017 Care UK Health and Rehabilitation Services Limited (Care UK) were registered to provide regulated activities.

Why we carried out this inspection

On the 7 and 9 March 2018 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 Act and specifically whether the areas for improvement as identified in the Requirement Notice previously issued to Dorset Healthcare University NHS Foundation Trust, as a result of the inspection in October 2016, had been addressed.

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.

Detailed findings

Evidence reviewed included an updated action plan from Care UK for HMP Channings Wood.

Are services safe?

Our findings

At our previous inspection in October 2016, we found concerns related to poor monitoring of patients' failure to attend health care appointments and inconsistencies in medicines management.

These included:

- There were no systems in place to monitor failure to attend health appointments. This meant staff could not be certain that patients' needs were being met.
- Patients did not always receive their medicines promptly. This resulted in unacceptable gaps in treatment, which posed a risk to patients'' health.

When we carried out our focused inspection we found a number of changes had been made to address the concerns and improve service delivery.

Staff were responsible for monitoring patients who did not attend their planned appointments. Patients were spoken with where possible to ascertain the reasons for their failure to attend and if appropriate were re-booked into the next available clinic. The number of missed appointments were being collated and shared at the local integrated quality assurance and improvement meetings. Whilst plans were in place to analyse this information to identify further improvements, reduce the number of failures to attend and improve service delivery, this was not currently being undertaken. The head of healthcare confirmed this would happen immediately and was on the agenda for the next patient forum.

A number of measures including a comprehensive audit programme had been put in place to improve medicines administration procedures and mitigate the identified risks of patients experiencing gaps in their treatment. Staffing levels had increased with the appointment of two pharmacy technicians and two pharmacy assistants. The establishment of a medicines management team and a pharmacy team, led by a pharmacist had resulted in a more consistent and well-managed medicines administration processes. SystmOne, (The case management system holding the electronic patient record) 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.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in October 2016, we found concerns related to the care of patients with long term conditions and that care records were inadequate.

These included:

- There were no systems in place to manage and monitor patients with long term conditions.
- The quality of patients records on SystmOne was inadequate. There were no up to date personalised care plans in place for people with long term conditions.

When we carried out our focused inspection we found a number of changes had been made to address the concerns and improve service delivery.

Patients with long term conditions were well manged by the GP with support from the nursing team. Specific long term conditions clinics were due to be implemented and run dependent on the need of the population. We saw evidence that there was a developing system in place to train nursing staff to hold specialist leads roles in identified common long term conditions, and take over the management of this from the GP.

Daily care records were of an appropriate standard. However, more needed to be done to ensure patients with long term conditions had individualised care plans that reflected how their needs could be met, as currently not all patients had this. Well-developed plans were in place to address this. Designated nurses would hold a caseload for their respective long term condition lead role and ensure each patient had a comprehensive personalised care plan in place that reflects the National Institute for Health and Care Excellence (NICE) guidance.

Are services caring?

Our findings

We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection in October 2016, we found concerns related to a lack of management and oversight of waiting lists for clinics, unacceptable waiting times to see health care professionals and management of complaints.

These included:

- No monitoring in place for clinic waiting lists and unacceptable waiting times to see health care professionals.
- No system in place to ensure complaints could be made confidentially.
- Complaints were not responded to in a timely manner.

At this focused inspection we found that there was an effective system in place for managing and monitoring waiting lists. The administration team had undertaken work to communicate with patients who were on waiting lists and confirm with them if they still wished to attend. Waiting lists had been rationalised to remove duplicate entries and patients no longer at the prison. As a result, waiting times were now equivalent to the community and access to healthcare professionals was good.

Healthcare boxes had been installed on each wing so that prisoners were able to make complaints confidentially. Care UK had implemented a separate healthcare complaint form and these were made available and prisoners were using them.

Complaints were responded to in a timely manner and prisoners who had made complaints were seen to face to face to help resolve their concerns. Systems for managing and monitoring complaints had been put in place and were effective. A written outcome of the resolution had been clearly recorded.

Are services well-led?

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

Our findings

At our previous inspection in October 2016, we found there were no systems in place to help ensure quality and effectiveness and monitor the service provided, and staff did not receive managerial or clinical supervision.

These included:

- No process in place to identify where quality and/or safety was being compromised and respond appropriately.
- Staff appraisals and supervision had not been completed.

Care UK had a comprehensive audit programme in place. This had been embedded in practice. Actions had been taken following audits to change processes, enhance service delivery and improve quality and outcomes for patients.

Healthcare Forums were held with prisoner representation from each wing to discuss the service and ask for ways in which outcomes for the men who attend healthcare could be improved. Patient feedback surveys were also being utilised to identify ways of improving service delivery.

The outcome of incidents was being shared amongst the staff team and lessons learned were being communicated to help ensure they did not happen again.

There was a robust system in place to help ensure staff supervision and appraisals took place in accordance with Care UK's policy. We saw evidence staff had received their periodic managerial and clinical supervision and staff told us they felt well supported.