HMP Drake Hall

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.

Contents

Overall summary

We carried out an announced focussed inspection on 12 December 2017. This inspection was carried out to follow up on concerns raised during a previous inspection in July 2016, following which we issued two Requirement Notices. We inspected only those aspects detailed in the Requirement Notices dated 9 December 2016. We do not currently rate services provided in prisons.

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 inspect under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

CQC inspected this service with HMIP between the 18 and 22 July 2016. This report can be found by accessing the following website:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/?s&location=drake-hall

We found evidence that fundamental standards were not being met and Requirement Notices were issued in

Summary of findings

relation to Regulation 9 (Person centred care) and Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked the provider to make improvements regarding these breaches. We checked these areas as part of this focussed inspection and found the provider had taken some action to address the issues identified, however further work was needed.

Our findings were:

Are services safe?

We did not inspect the safe domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notices issued as a result of the inspection in July 2016.

We found that the provider had taken some action to improve their systems to help ensure the proper and safe management of medicines, however further improvements were needed.

Systems were in place to ensure that clinical equipment was routinely serviced.

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?

We did not inspect the responsive domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notices issued as a result of the inspection in July 2016.

We found that the provider had taken some action to reduce waiting times for various clinics. However, women waited too long for routine appointments for some clinics. The rates of women not attending for their healthcare appointments was too high and this impacted upon waiting times.

Care planning, long term condition management and the support available to pregnant and post-natal women had improved.

Are services well-led?

We did not inspect the well-led domain at this inspection.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- The provider should accurately monitor and report the total waiting times experienced by women.
- Action should be taken to further reduce the waiting times to see the GP and dentist.
- Action should be taken in partnership with the prison to improve the storage space available for medicines, to reduce the amount of wasted appointments and improve the system for cancelling appointments that are no longer required.
- Action should be taken to remind staff of the importance of completing medicines administration records and improve the system for processing repeat prescriptions.

HMP Drake Hall

Detailed findings

Our inspection team

Our inspection team was led by:

a Health & Justice Inspector.

Background to HMP Drake Hall

HMP Drake Hall is a closed women's prison for adults and young offenders, located in Eccleshall, Staffordshire which can accommodate 340 prisoners. Care UK Rehabilitation Services Limited had been providing healthcare services at the location since it was registered with CQC on 12 April 2016. Care UK Rehabilitation Services Limited provides a range of primary and mental healthcare services to prisoners, generally comparable to those found in the wider community. This includes GP, nurse led and pharmacy services. The location is registered to provide the regulated activities treatment of disease, disorder or injury and diagnostic and screening procedures.

How we carried out this inspection

We reviewed the action plan submitted by the provider in reponse to the Requirement Notices issued in December 2016 and any other information received, such as from the service commissioners. We looked at the waiting times and did not attend (DNA) rates for various clinics as well as the management of long term conditions and support available for pregnant and post-natal women. We spoke with two members of the nursing team, the registered manager and area manager.

We observed the administration of medicines in the afternoon as well as speaking to the pharmacy technician. In addition, we looked at the systems in place for the prescribing, ordering, storage, transportation and administration of medicines. We viewed a sample of medicines administration records and controlled drug registers to ensure that staff were keeping accurate records. We checked the systems in place for the servicing and maintainence of clinical equipment.

Are services safe?

Our findings

During our inspection in July 2016 we found that medicines management arrangements did not ensure the timely ordering and safe storage or administration of medicines. There was a lack of confidentiality for women when receiving their medicines. Risk assessments had not always been completed to determine whether or not women could safely keep their medicines in possession. The limited administration times meant that medicines which have a sedative effect were given too early.

During this inspection we found evidence that the provider had taken some action to address issues relating to the safe storage of medicines. Medicines were organised in alphabetical order by surname. This meant staff could easily and quickly find the correct medicines to administer. Controlled drugs were safely stored in accordance with the relevant legislation. However, the improvements were limited because the storage provided by the prison was not adequate. The majority of storage was on open shelving which meant that any member of staff having access to the room could access the medicines, although women were not able to access this area. Some of the shelving was too high for staff to safely reach. The registered manager told us that they would raise the issue of pharmacy storage again with the Governor in time for it to be considered in the next financial year.

During our visit we observed the administration of medicines and saw that this was done in a well ordered and professional manner by two members of healthcare staff. Two prison officers were present throughout to supervise women while they waited to be seen. Whilst the provider had installed a privacy screen between the two medicines hatches, this did little to improve confidentiality for women when receiving their medicines. However, given the limited space available it was considered that this was the best available solution. We saw that when staff needed to discuss something personal, they ensured that nobody else was in the area at the time. During our visit we checked a random sample of medicines administration records. We saw that staff had not always completed records to confirm whether or not medicines had been administered. This had not been identified by senior staff. The registered manager told us that they would send out a communication to remind staff of the importance of keeping accurate records. They also told us that they would audit a sample of records to see if any patterns could be identified.

There was evidence that the provider had taken action to address issues relating to the ordering of medicines, but further work was needed. Since the previous inspection a pharmacy technician had been recruited who oversaw the ordering of repeat medicines and the general administration of the pharmacy. A regular report was produced which detailed who required a repeat prescription in the coming two weeks. However, we saw that this was a cumbersome system which was open to delay and error. The pharmacy technician had to manually identify and type out a list of medicines required for all women. They then submitted an individual task for each woman's repeat medicines using the electronic patient record system. The tasks were monitored and processed by the 'prescribers group'. On the day of our inspection we saw that two prisoners' medicines were not ready for collection as expected, due to a delay in the prescription being produced. The registered manager and area manager agreed to link the pharmacy technican with a colleague in another prison to develop a more reliable and simpler way of ordering repeat prescriptions.

Nobody was being given night time sedation at the time of the inspection as other methods were used to help women achieve better sleep. A homely remedy to aid sleep was available upon request as well as other support for women who were struggling to sleep. Where it was assessed as being safe to do so, women were given their medicines in possession to keep in their room. This meant that they could take their medicines at an appropriate time. Medicines administration times for supervised medicines were still limited to twice per day. However, the pharmacy technician told us that they would make themselves available to administer medicines outside of the regular hours should somebody be prescribed a medicine that needed to be taken three times per day.

Improvements had been made to the system for carrying out risk assessments of a prisoner's ability to keep their medicines in possession. We viewed a random sample of records and saw that the medicines risk assessment had been completed appropriately and they were within their review date. Where circumstances had changed, a risk assessment was revisited before its review date.

Are services safe?

The provider had secured the services of an external contractor for the annual checks on clinical equipment such as blood pressure monitors and dental equipment. The checks had been carried out since our previous inspection and were scheduled to take place every 12 months.

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

During our inspection in July 2016 we found that women were waiting too long to see various health professionals. There were unacceptable delays for women to access health screening services and there was limited support for women who were pregnant or who had recently given birth. There was limited oversight and management of long-term conditions.

The provider had taken action to reduce waiting times which had seen improvements across most services, however some waiting times remained too long. The wait to see the GP had reduced by several weeks but was still too long at over five weeks. The wait to see the dentist for a routine appointment had recently increased due to an issue with the dental chair which meant clinic time was lost. At the time of the inspection the wait had increased to around 10 weeks for a routine dental appointment. Waiting times for other services such as the physiotherapist and health screening had significantly reduced. An advanced nurse practitioner post had been created since the previous inspection which improved access for patients and reduced demand for GP appointments. In addition, the skill mix of the healthcare team had been improved so that they were better able to meet women's needs in a more timely manner. For example, there were three nurses trained in cervical smears and these were provided at HMP Drake Hall.

The reported waiting times given by the provider were not always accurate because they did not reflect the full amount of time women waited to attend an appointment. This was because the reported waiting time stopped at the point an appointment was booked, it did not take into account the period of time between the appointment being booked and the actual date of the appointment.

The number of appointments wasted due to non-attendance (known as the DNA rate) was too high, despite significant efforts by the provider to encourage women to attend their appointments. Healthcare champions were utilised to emphasise to the women the importance of attending or cancelling appointments. There was a display outlining the amount of hours lost due to DNAs in the healthcare waiting area. Women had generally free access around the site during the core day meaning there were no physical barriers to prevent them getting to the healthcare department.

Everybody received a weekly timetable which included any healthcare appointments that had already been booked. However, their work schedule could interfere with their ability to attend an appointment. There was a tannoy system which was used to call women if they had not attended, however this did not cover all areas of the site. Healthcare staff told us that they sometimes went out to find women if they had not attended. If an appointment was booked after the weekly timetable had already been given out then healthcare staff would produce an appointment slip. These were passed to a health champion who would deliver the slips to the relevant women so they were aware of their appointment. In addition, should somebody wish to cancel an appointment they would have to go to the healthcare department or submit a paper application to do so. This was burdensome and did not encourage the cancellation of appointments that were no longer needed.

Work had recently commenced between the provider and prison senior management to look at ways in which the DNA rates for healthcare appointments could be reduced. This work was still in its infancy and therefore it was not possible to judge the benefits of this partnership working at the time of the inspection.

Healthcare applications were triaged when received by healthcare staff and anything urgent was dealt with appropriately. Urgent appointments were available at every GP and dental clinic. In addition, the advanced nurse practitioner helped to reduce the demand for GP appointments.

Improvements had been made to the management of long term conditions. Staff had been provided with training and support to enable them to identify and support women with various conditions such as asthma and diabetes. Care plans had been developed which detailed the care and support required to manage the condition. These had been developed with the involvement of women and individualised as required. We tracked the care of six women with various long term conditions and saw that they had seen a member of the healthcare team when required. They had also been offered additional appointments and services, such as podiatry and specialist eye screening for women with diabetes.

The provider had worked with the prison management and local NHS partners to produce a care pathway to support pregnant and post-natal women. This included the physical

Are services responsive to people's needs?

(for example, to feedback?)

health, mental health and emotional well-being aspects of a pregnancy, labour and support after a birth. The pathway clearly identified what support women should expect to receive and who was responsible for providing that support. Whilst there had not been any pregnancies at HMP Drake Hall since the last inspection, it was a positive development to have the pathway in place.

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.