HMP & YOI Styal

Inspection 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.

Ratings

Overall summary

We carried out an announced focused inspection of healthcare services provided by Spectrum Community Health C.I.C. on Thursday 18 April 2019.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in May 2018, we found that the quality of healthcare provided by Spectrum Community Health C.I.C. at HMP YOI Styal required improvement. We issued a Requirement Notice in relation to Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this inspection was to determine if the healthcare services provided by Spectrum Community Healthcare C.I.C were meeting the legal requirements of the Requirement Notice and that patients were receiving safe care and treatment. At this inspection we found that some improvements had been made but further improvements were required. We also found new areas of concern.

We do not currently rate services provided in prisons.

At this inspection we found:

- Patients accessed prescribed medicines in a timely way.
- All medicines trolleys were securely fixed to a wall in various treatment rooms located across the prison.
- Medicines were transported around the prison in secure bags and cases.
- Medicine key cabinet logs were still not consistently recorded.
- Maximum and minimum fridge temperatures were still not consistently recorded and when temperatures were not within the accepted range insufficient action was taken to resolve this.
- Out of hours medicines were not sufficiently monitored, dates were not recorded when an out of hours medicine was given and neither was a running total record of the number of remaining medicines.
- We found that records of room temperatures where medicines were stored were not consistently maintained.

We found some new areas of concern

- Checks of medicines and equipment in emergency bags were not consistently completed.
- Medication Administration Records (MAR) were not completed consistently and gaps in MAR records were not monitored.
- Patients sometimes did not collect prescribed medicines for several days; no actions was taken and the reasons for non-attendance were not recorded.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure that emergency equipment is safe to use
- Ensure that medicines are managed safely, administered appropriately and patients' individual records are complete.
- Ensure that effective governance arrangements, assess, monitor the safety and quality of the service, including assurance and auditing systems or processes.

The areas where the provider **should** make improvements are

- In possession risk assessments should be completed promptly to support patients assessed as suitable to manage their own medicines.

Our inspection team

Our inspection team was led by a CQC health and justice inspector, accompanied by a second CQC health and justice inspector.

Before this inspection we reviewed a range of information that we held about the service, for example, an action plan we had received from the provider. Following the announcement of the inspection we requested additional information from the provider, which we reviewed, including, minutes of medicines management meetings, standard operating procedures in respect of managing fridge temperatures and records of medicines incidents for the last 12 months.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff, commissioners and patients.

Background to HMP & YOI Styal

HMP YOI Styal is a women's resettlement prison in Cheshire. It receives women from a wide geographical area covering the North West of England and into Wales and has an operational capacity of 486. The prison is operated by Her Majesty's Prison and Probation Service.

The prison population is complex, ranging from those remanded by the courts and serving short custodial sentences through to women serving life. Many of the women arrive at the prison with significant healthcare need, including those with a history of suicide attempts and self-harm, mental health issues and substance misuse. They are often vulnerable and have experienced trauma, abuse and domestic violence.

Spectrum Healthcare C.I.C provides primary healthcare services at the prison and is registered with the CQC to provide the following regulated activities: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

Our last joint inspection with HMIP was in May 2018. The joint inspection report can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/09/Styal-Web-2018-1.pdf

Are services safe?

At our last inspection, we found that medicines were not always managed safely and some prisoners experienced delays in accessing prescribed medication following their reception into the prison. At this inspection we found that some improvements had been made, others had not and we found several new areas of concern.

Appropriate and safe use of medicines

- At our previous inspection we found that two patients had experienced delays in getting prescribed medicines following their reception into the prison. At this inspection we found that prescribers now accessed patient community summary care records that enabled them to check what had previously been prescribed, which meant that patients received their medicines in a timely manner. A repeat prescription process was in place and this too ensured that patients received their medicines in a timely manner.
- Medicines were transferred safely around the prison in secure locked bags accompanied by a prison officer. Medicines located on prison wings were stored securely, both in locked cabinets and medicines trolleys that were secured to the wall and therefore could not be removed.
- In respect of medicines that required storage in a refrigerator, we found that fridge temperatures were still not always recorded. We previously identified this as a concern at our joint inspection in May 2018. We found that when the maximum and minimum fridge temperatures were found to be out of range insufficient action was taken to ensure the integrity of medicines.
- We sampled medicines administration records and found patients who failed to attend for their medication were not routinely followed up. For example, we looked at the records of one patient who had not received their medicine for three days and the reason for this was not recorded and neither was this incident followed up by nursing staff. In another record we found that the patient had collected their methadone but had not collected other medicines that they were prescribed, and no action was taken to determine the reason for this. Medication Administration Records (MAR) were not completed consistently and gaps in MAR records were not monitored.
- It was a prison led arrangement that patients did not hold their medicines in-possession for the first two weeks, after which an in-possession risk assessment was completed. In-possession risk assessments that we sampled were up to date, though we noticed that some patients waited longer than two weeks before an assessment was completed, and they were able to manage their medicines. Assessments were based on individual patients needs and risks.

Are services well-led?

Governance arrangements

- Effective systems and processes to assess and monitor the safety and quality of the service, were not in place for some areas of governance.
- A weekly, 'Matron's round', was undertaken by a senior nurse to ensure that nurses were completing checks to equipment and fridge temperatures. However, omissions and gaps in records were not always picked up. The process was not effective.
- The monitoring processes for the management of medicines were not effective. Out of hours medicines were not sufficiently monitored, dates were not recorded when an out of hours medicine was given and neither was a running total record of the number of remaining medicines.
- Medicine cabinet key logs were still not completed in a consistent way.
- We found that records of room temperatures where medicines were stored were not consistently maintained.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met. The provider must ensure that equipment is safe to use, medicines must be managed safely and administered appropriately, and patients' individual records are maintained.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met. The provider must ensure effective governance systems and processes to assess, monitor and mitigate any risks relating to the health, safety and welfare of people using the service, are in place.