HMP Stocken

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.

Overall summary

We carried out an announced focused inspection of healthcare services provided by Care UK Health & Rehabilitation Services Limited at HMP Stocken on 10 and 11 December 2019.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in February 2019, we found that the quality of healthcare provided by Care UK Health & Rehabilitation Services Limited at this location required improvement. We issued Requirement Notices in relation to Regulations 9, Person-centred care, 12, Safe care and treatment and 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this focused inspection was to determine if the healthcare services provided by Care UK Health & Rehabilitation Services Limited were meeting the legal requirements of the Requirement Notices that we issued in May 2019. We checked to see if patients were receiving person-centred and safe care and treatment and that governance systems had improved. At this inspection we found that improvements had been made and the provider was meeting the regulations.

We do not currently rate services provided in prisons.

At this inspection we found:

- Risks relating to patients' health and well-being were regularly assessed and steps taken to mitigate risks.
- Steps had been taken to ensure that the management of medicines was safe.
- Waiting times to see the GP, whether for substance misuse reviews or other reasons, had reduced.
- The system for reviewing and triaging patients' healthcare applications had been amended and we saw that patients were booked into the appropriate clinic. Patients with more urgent needs were prioritised.
- Health screening and vaccination activity had increased and eligible patients were identified and offered these services.
- The provider had put support in place to assist the local team to improve quality monitoring arrangements.
- Risks associated with the service delivery were identified and steps taken to mitigate risks.
- Record keeping had improved and the provider had put into place an ongoing programme of auditing and support for staff to ensure improved standards were maintained.
- Incident reporting had improved and we saw that there was an open culture which promoted reporting and learning from errors.
- Patient feedback about the service was sought through surveys and the reinstated patient forum. Action was taken in response to the feedback received and information communicated back to patients.

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

- Follow up all patients that do not attend for three consecutive medicines administration slots.
- Review all care plans relating to pressure area and wound care to ensure they accurately reflect the care and treatment being provided.
- Carry out regular checks of controlled drug stock and the associated records.
- Provide better support to staff through systematic and consistent communication and supervision.

Our inspection team

Our inspection team was led by a CQC health and justice inspector with the support of a second health and justice inspector and a pharmacy specialist.

Before this inspection we reviewed a range of information that we held about the service such as the action plans we had received from the provider and other information received since the last inspection. Following the announcement of the inspection we requested additional information from the provider, which we reviewed. This included minutes of various meetings, audits and information relating to medicines management.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff, the prison's health and well-being lead, commissioners, people who used the service, and sampled a range of patient records.

Background to HMP Stocken

HMP Stocken is a Category C male adult training prison. The prison is located in a rural setting near the town of Oakham. At the last inspection the operational capacity was 842. Since then a new wing has opened, although it was not fully populated, this had added approximately 100 more prisoners to the population. The prison is operated by Her Majesty's Prison and Probation Service.

Care UK Health & Rehabilitation Services Limited is the health provider at HMP Stocken. The provider is registered with the CQC to provide the following regulated activities at the location: Treatment of disease, disorder or injury, Diagnostic and screening procedures, and Personal care.

Our last joint inspection with HMIP was in February 2019. The joint inspection report can be found at:

Are services safe?

Risks to patients

At our last inspection we found that risks to patients who required pressure area care were not routinely assessed and steps to mitigate risks were not consistently taken. Also, the risks associated with patients keeping their own medicines in-possession were not assessed at appropriate intervals.

During this focussed inspection, we found that the necessary improvements had been made to the assessment of risks to patients' health and well-being.

- Any patients identified as being at risk of developing a pressure ulcer or who had a wound that was being treated had a risk assessment in place. Staff reviewed these on a regular basis with the patient and provided appropriate care and treatment based on the level of risk identified.
- When pressure relieving equipment was provided to a patient, such as a pressure relieving mattress, this was checked by staff on a regular basis. Any defects with equipment were reported and resolved in a timely manner.
- Patients with complex and multiple needs were closely monitored through the Multi Professional Complex Case Conference (MPCCC). Weekly meetings were held and attended by the primary care and mental health teams as well as the GP. Notes of the discussions and any changes to a patient's care and treatment were recorded on their electronic patient record. This ensured that all healthcare professionals involved in a patient's care were aware of any changes.
- A regular clinic had been set up for the review of medicine in-possession risk assessments, which were done face to face with each patient. This had resulted in the majority of patients now having an up to date risk assessment in place. Staff were working towards being able to give more patients medicines in their possession, where appropriate. The head of healthcare told us that the clinics would continue to run so that risk assessments could be reviewed on a rolling basis throughout the year, rather than all at the same time.

Appropriate and safe use of medicines

At our last inspection we found that the management of medicines was not proper and safe because medicines were not always stored securely. Staff did not follow up patients who did not attend to collect their medicines and staff were not monitoring the amount of paracetamol that patients had bought, before dispensing more to them.

During this focussed inspection, we found that the necessary improvements had been made and medicines were stored securely. Staff followed up patients who did not attend to collect their medicines and monitored the quantities of paracetamol each patient was receiving.

- Only healthcare staff had access to the rooms where medicines were stored. Medicines were stored securely in lockable storage and the rooms we saw were kept tidy.
- Staff had access to syringes and bungs to enable easier and quicker dispensing of liquid medicines. A bung is inserted into a medicine bottle to make it easier to measure out liquid medicine and reduce wastage. This meant that staff did not have to pour out liquid medicines in advance of patients attending the medicines hatch and only dispensed the required medicine for each individual patient when they attended.
- If patients did not attend three consecutive medicines administration slots a letter was sent inviting them to discuss this with the pharmacist. If necessary, they could see the GP to review if the medicines were still required. This system was an improvement on what we saw at the previous inspection. However, the staff undertaking medicine administration did not always communicate with the pharmacy when a patient had not attended to collect their medicines.
- There was effective follow up of patients who did not attend to collect critical medicines or who were known to be unwell. During the lunchtime meeting, staff asked for welfare checks to be carried out on those patients and staff would make an additional attempt to get the medicines to those patients. There was a list of critical medicines, however this had not been reviewed to ensure it was relevant to patients at HMP Stocken. A review of the list was scheduled to take place shortly after the inspection.
- Staff monitored the amount of paracetamol that patients had bought from the prison canteen, from a weekly report received from the prison. This information was entered onto the electronic patient record and staff checked this prior to giving patients any more paracetamol.

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?

Timely access to care and treatment

At our last inspection we found that patients did not always have timely access to reviews of their substance misuse treatment and routine GP appointments. The system for collecting and triaging healthcare applications meant that patients could experience further delays in accessing an appointment with the appropriate healthcare professional. Screening for chlamydia and NHS health checks was minimal and there had been no MMR vaccinations for a long period of time due to a lack of trained staff.

During this focussed inspection, we found that the necessary improvements had been made and patients had timely access to the services they required.

- The management of the list of patients receiving opiate substitution treatment had been handed over to the substance misuse team. They closely monitored the list and ensured that patients were booked to see the GP at appropriate intervals. We saw that patients were now receiving reviews of their treatment in a timely manner. The position of senior substance misuse nurse was vacant; however, the capacity of GP clinics had been increased. This meant that there was sufficient capacity to meet the demand for reviews of opiate substitution treatment. The provider told us that they were continuing in their efforts to recruit a senior substance misuse nurse who would also be able to carry out reviews.
- The increase in GP clinic capacity, combined with improved management of patient healthcare applications, meant that the waiting time for a routine GP appointment had decreased to two weeks. The provider had also implemented a process to make use of urgent and embargoed GP appointments if they had not been booked by the end of the morning clinic. This involved calling up a patient from the waiting list to attend during the afternoon clinic and meant that an appointment that otherwise would not have been used was allocated. Some patients were seen by the Advanced Nurse Practitioner who could prescribe certain medicines.
- The provider had also started using a service called 'Practice Assist' which gave patients access to a GP appointment by telephone. Patients sat in a healthcare clinic room with a healthcare assistant and spoke to a GP who was working remotely with access to their electronic patient record. There was a list of exclusions where it would not be appropriate for a patient to use Practice Assist, however use of the service had helped to reduce the waiting time for face to face GP appointments.
- Work had been carried out to better understand which patients were eligible for various screening services and vaccinations. This meant that the provider had a more accurate picture of patient eligibility. An 'Under 26' day had been held, targeting patients who were eligible for chlamydia screening. Patients were offered an incentive to attend for a screening and, should any treatment be required, it could be started immediately. Plans were in place to work towards the elimination of Hepatitis C at HMP Stocken by holding a week-long event to offer patients screening and, if required, to commence treatment straight away.
- NHS health check activity had increased and regular clinics were run, alongside other screening and vaccination clinics. Three members of staff had been trained to administer the MMR vaccination and this had led to an increase in the numbers of vaccinations being carried out. Work was ongoing to treat any remaining patients who had already been offered the vaccine.

Are services well-led?

Governance arrangements

At our last inspection we found that governance and audit processes had not detected or resolved issues identified during the inspection, such as with medicines management and record keeping.

During this focussed inspection, we found that improvements had been made and governance processes were used more effectively, although further work was needed. There was better support for the local team from the provider at a regional and national level, as well as more effective provider oversight of the services provided at HMP Stocken.

- Quarterly audits were carried out for general medicines and controlled drugs. This involved a check of the systems for ordering, storing, administering, recording and disposing of medicines. Where any issues had been identified these were resolved and discussed with the relevant staff to try and prevent similar issues occurring again. However, staff were not carrying out more regular checks to ensure that the quantities of controlled drugs matched the records. The pharmacist planned to commence doing regular checks until additional new staff started in post.
- During the inspection we saw that eight FP10s could not be accounted for. An FP10 is the green form used by GPs and other prescribers to issue a prescription for medicines. The pharmacist was able to trace two of these after the inspection. They immediately put into place a new process to ensure that there was better monitoring and oversight of FP10s.
- The provider had implemented an annual schedule of audits which included looking at areas such as infection control, medicines management and record keeping. These were carried out by the relevant lead member of staff and reported back to the Head of Healthcare and provider. Additional training and support for staff had been put into place where required, following audit reports. For example, staff had received training in professional standards including the importance of good record keeping. This had also been discussed with staff in supervision and we saw that this had led to an improvement in the standard of record keeping in the patient records we looked at.
- The provider engaged with their prison partners and attended regular partnership and medicines management meetings. We saw that it was working towards understanding prison related issues that impacted on the delivery of healthcare services. Staff had been working with the prison's health and wellbeing lead to look at the numbers of appointments not attended by patients and the reasons for non-attendance. Different strategies were being trialled to look at how this could be reduced to have a positive impact on waiting times.

Managing risks, issues and performance

At our last inspection we found that risks relating to the supply of medicines had not been identified and addressed which led to some delays in patients receiving medicines. There was also an excessive amount of medicines stored, some of which had expired but not been disposed of. When incidents were reported by staff, they did not always provide enough detail to enable meaningful action to be taken in response.

During this focussed inspection, we found that the necessary improvements had been made and patients now had more timely access to the medicines they required. There had also been improvements to the storage and disposal of medicines. Incident reporting had improved.

- The pharmacist had worked with the medicines supplier to increase the frequency of medicines deliveries. They had also identified a range of medicines that were to be held in stock in appropriate quantities. This gave patients quicker access to medicines than had been the case at the previous inspection.
- Rooms where medicines were stored were kept tidy and medicines were stored in secure cupboards. The frequency of collections of disposed medicines was increased during the week of our inspection from fortnightly to weekly. We did not find excessive quantities of expired medicines and the management of medicines disposal was effective.
- There were regular prescriber's meetings where staff were able to discuss prescribing trends and the findings of audits. The pharmacist had delivered training to staff regarding learning from medicines errors.
- The provider had delivered training to some staff regarding the quality of incident reports and carrying out investigations into any incidents that occurred. The Datix system was used and the incident reports that we viewed during the inspection provided sufficient detail to understand what had happened. Where

investigations had been carried out, these were available to view on the system. Action plans were put in place to learn from incidents and lessons learned were shared with staff.
- The pharmacist had not received this training but was maintaining a separate spreadsheet for medicines related incidents. This had been used effectively to identify trends and learning opportunities. Staff had received support and additional training from the pharmacist to learn from any errors that had occurred.

Appropriate and accurate information

At our last inspection we found that records relating to care and treatment were not always completed contemporaneously and there were gaps where no record had been made.

During this focussed inspection, we found that improvements had been made to the quality and consistency of record keeping, however patients' care plans were not always reviewed and kept up to date.

- Improvements had been made to the quality and consistency of record keeping. Staff recorded each social care visit on the electronic patient record system and the notes contained sufficient detail to understand the care that had been offered and provided. Records relating to healthcare appointments were also completed in a timely manner and most contained the necessary level of detail. The provider had carried out training with staff to support them to complete records to the required standard.
- However, care plans relating to the management of patients with pressure ulcers and other wounds were not always reviewed and kept up to date.

Engagement with patients, the public, staff and external partners

At our last inspection we found that patients' feedback about the quality of the primary care service was not being proactively sought and so could not be used to evaluate and improve the service.

During this focussed inspection, we found that the necessary improvements had been made and there were systems in place to regularly obtain patient feedback. However, the systems to support and hear from staff were not fully embedded.

- A patient forum was held every two months which involved patient representatives from each wing of the prison. We met with three of the representatives who spoke about the positive impact of the patient forum and said that they felt listened to.
- The mental health team manager had attended the previous forum following a request, and the representatives were able to feedback important messages to other people on their wings. The pharmacist was due to attend the next forum.
- Some actions had already been taken by the provider following suggestions made, such as displaying current waiting times for various services. There was also a 'You said, we did' display informing patients of the changes and improvements made as a result of their feedback.
- Patients were also offered the chance to complete a feedback form following healthcare appointments. We saw that there was a high level of satisfaction with the service.
- The support provided to staff was not consistent and some staff did not receive regular, documented supervision. This meant there was a risk that not all staff would feel fully engaged with the service or be kept fully up to date. The provider acknowledged that better structure and consistency was required to ensure all staff were fully supported and engaged with.