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 rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out an announced focused inspection of healthcare services provided by Spectrum Community Health C.I.C. at HMP and YOI Styal to follow up on the requirement notice issued after our last inspection in October 2021. At the last inspection, we found the quality of healthcare provided by Spectrum at this location required improvement. We issued a requirement notice in relation to Regulation 12, Safe Care and Treatment.

The purpose of this focused inspection was to determine if the healthcare services provided by Spectrum were meeting the legal requirements of the requirement notice; regulations under Section 60 of the Health and Social Care Act 2008 and that patients were receiving safe care and treatment.

At this inspection we found the required improvements had been made and the provider was meeting the requirements for Regulation 12, Safe Care and Treatment.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection we found:

- Staff managed medicines safely

However;

- Managers had not fully implemented quality assurance processes to ensure changes in service delivery are embedded and effective.

The areas where the provider SHOULD make improvements:

- The provider should ensure systems and processes that enable the registered person to assess, monitor and improve the quality and safety of the services continue to be embedded.

Our inspection team

This inspection was carried out by two CQC health and justice inspectors.

How we carried out this inspection

Before this inspection we reviewed some information that we held about the service including notifications and action plan updates.

During the inspection visit, the inspection team spoke with:

- Head of healthcare and North West cluster manager.
- Seven other staff members; including nurses, healthcare assistants and pharmacy staff.
- Observed the administration of medicines.

We asked the provider to share a range of evidence with us. Documents we reviewed included:

- Provider action plan
- Medicines management meeting minutes
- Patient safety incident alert
- Service action plan
- Standard operating procedures
- Staff induction booklet.

Background to HMP & YOI Styal

HMP and YOI Styal is a prison for female adults and young offenders. The prison is located in Styal, Cheshire and accommodates approximately 420 prisoners. The prison is operated by HM Prison and Probation Service.

Health services at HMP and YOI Styal are commissioned by NHS England & Improvement. The contract for the provision of healthcare services is held by Spectrum. Spectrum is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with HM Inspectorate of Prisons (HMIP) in October 2021 and published on the HMIP website on 12 January 2022.

Report on an unannounced inspection of HMP & YOI Styal by HM Chief Inspector of Prisons 20 September and 4-8 October 2021 (justiceinspectorates.gov.uk)

We found a breach of Regulation 12, Safe Care and Treatment.

Inspected but not rated

Are services safe?

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

At our last inspection we found there was no proper and safe management of medicines. We observed staff secondary dispensing medicines (When medication is removed from the container in which it was received from the pharmacy and put into a different one prior to administration) in the segregation unit, nurses were "potting up" medicines, delivering door-to-door and were relying on printed prescriptions. In addition; methadone was also being delivered in this way and was observed to be delivered on the segregation unit and Waite wing while prisoners were unlocked, which was an insecure and poor practice.

At this inspection we found staff safely managed the administration of medicines on Waite wing and on the segregation unit. Staff followed systems and processes to administer medicines and completed medicines records accurately and kept them up to date.

Following our previous inspection managers took immediate action to stop the practice of secondary dispensing and the unsafe administration of medicines on Waite wing and on the segregation unit. Managers issued a patient safety incident alert to all staff, detailing the legal requirements of medicines administration and individual staff responsibilities.

Managers told us they re-issued the standard operating procedures relevant to medicines to all staff, including agency staff. This ensured all staff had an up to date copy of the provider's procedures and expected standards of practice. We observed that staff had signed the master documents to confirm they had read and understood the procedures.

Managers purchased portable, secure medicines trolleys and lockable medicines boxes to ensure the safe transportation of medicines on Waite wing and the segregation unit. We observed staff using both secure medicine boxes and trolleys to administer medicines.

For those patients unable to collect their medicines on Waite wing, staff used a secure medicine box to deliver medicines securely to patients in their cell. To enhance the safety of this process, pharmacy staff introduced the use of dosette boxes to dispense medicines, this meant staff were not secondary dispensing medicines. Although a small number of other prisoners were present on the wing at the time of administration, prison staff were present and supported nurses to safely administer patient medicines.

We observed staff safely prepare medicines, including methadone, for administration to patients on the segregation unit. Staff still relied on daily printed medicine administration charts and took all practicable steps to ensure these were current and up to date. Staff appropriately measured the correct dose of methadone, labelled the bottle and using the portable, secure medicine trolly, administered medicines to patients at their cell door. Staff completed records of medicine administration in a timely manner.

To mitigate the risk of using printed medicine administration charts, managers have purchased several laptops for staff to securely access patient care records, particularly on the segregation unit. However, connectivity and other IT related issues have delayed this service improvement. Managers told us they are continuing to seek a solution to this.

Staff reported medicine related incidents, and these were discussed in the regular medicines' management meeting. We reviewed minutes for this meeting and incidents reported by staff were discussed and outcomes from investigations actioned.

Inspected but not rated

Are services well-led?

Good Governance

Governance processes operated effectively at team level and performance and risk were managed well. This improved patient safety and service delivery.

At this inspection we found managers had made changes to the service to ensure the safe and proper administration of medicines, including updates to medicines processes and staff induction and the use of secure medicines boxes and portable trolleys. Managers had oversight of medicines management processes and related incidents.

However, managers had not fully implemented quality assurance processes; including the audit of dosette boxes, staff induction packs and spot checks by managers to ensure consistent use of lockable medicine boxes and secure medicine trolleys. This meant managers were not fully assured of the impact and quality of the changes made to service delivery.