HMP Liverpool

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. (Spectrum) at HMP Liverpool to follow up on the requirement notice issued after our last inspection in July 2022. 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 regulations.

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.
- Managers had improved quality assurance processes to ensure changes in service delivery are embedded and effective.

Our inspection team

This inspection was carried out by 2 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.
- Seven other staff members; including nurses, healthcare assistants and pharmacy staff.
- Observed the administration of medicines and reviewed 10 clinical records and associated medicines in possession risk assessments.

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

- Provider action plan
- Medicines management meeting minutes
- Learning bulletin
- Clinical governance meeting minutes
- Standard operating procedures
- Medicines data and risk assessments

Background to HMP Liverpool

HMP Liverpool is a local reception and resettlement prison for adult males. The prison is located in Walton, Liverpool and accommodates approximately 800 prisoners. The prison is operated by HM Prison and Probation Service.

Health services at HMP Liverpool are commissioned by NHS England. 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 July 2022 and published on the HMIP website on 15 November 2022.

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/11/Liverpool-web-2022.pdf

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 systems did not ensure the proper and safe management of medicines. We observed staff secondary dispensing medicines (when medicines are removed from the container in which it was received from the pharmacy and put into a different one prior to administration) in the in-patient unit, nurses were "potting up" medicines, delivering door-to-door and were relying on printed prescriptions.

At this inspection we found staff safely managed the administration of medicines on the in-patient 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 the in-patient unit. Managers issued a patient safety incident alert to all staff, detailing the legal requirements of medicines administration and individual staff responsibilities. In addition, managers completed several actions to mitigate any further risk. These included one to one medicines' competency training with all staff and regular training with a pharmacist during clinical handovers relating to updated medicines standard operating procedures. This ensured all staff had received up to date information of the provider's procedures and expected standards of practice. All staff received clinical supervision.

We observed information on display in treatment rooms regarding safe medicines administration.

Staff had opportunities to discuss medicine related concerns at a daily safety huddle and during clinical handover. This meant staff could raise any concerns quickly and managers could respond promptly. Managers also provided a regular drop-in session for staff. Staff we spoke with spoke confidently about the changes made following the last inspection.

Staff reported medicine related incidents, and these were discussed regularly by managers in medicines management and quality and risk meetings. We reviewed minutes from these meetings and incidents reported by staff were discussed and outcomes from investigations actioned. Spectrum have continued to issue monthly 'Learning Round-up' bulletins to staff, capturing incidents and learning in relation to medicines.

Staff confirmed they had access to the service quality improvement plan, a central document capturing information relating to serious incidents, investigations and service risks. This meant all staff could access up to date information, learning and other patient safety information.

At the last inspection we identified some other concerns in relation to medicines. Issues included late delivery of in-possession medicines, irregular reviews of in-possession risk assessments and the frequency of prescribing tradeable medicines. We also had concerns regarding the increased risk during methadone administration, the medicines' reconciliation process and availability of in-cell lockable storage.

At this inspection we discussed with staff what progress had been made. Staff told us processes have improved and patients mostly received their in-possession medicines on time.

We reviewed 10 clinical records in relation to medicines in-possession risk assessments. All patients had the required initial assessment and subsequent reviews, we also noted reviews of risk assessments following a change in circumstances, such as deterioration in mental health or act of deliberate self-harm. Staff completed regular compliance checks on those patients with in-possession medicines.

Inspected but not rated

Are services safe?

Staff had taken a proactive approach to reducing the use of tradeable medicines. At the last inspection approximately 25% of the prison population were prescribed tradeable medicines, this had reduced significantly to 10% by June 2023. Prescribers within the service had completed targeted work around specific types of medicines but acknowledged further work was required to manage this robustly.

At the last inspection we identified there was potential risk during the administration of methadone. At this inspection we observed improvements in practice, there was a safer, co-ordinated approach to methadone administration and clear collaborative working between health and prison staff.

At the last inspection we found there were no reconciliation procedures for stock medicines on the wings. Staff had made improvements and medicines reconciliation was completed generally within 24 hours of arriving at HMP Liverpool and pharmacy staff managed the reconciliation of stock medicines on the wings.

The availability of in-cell lockable storage for medicines had not progressed.

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 procedures. Staff received bespoke training and clinical supervision.

Staff attended daily meetings, at which they could raise concerns, report incidents, and receive feedback. Managers had oversight of medicines management processes and related incidents through an established meeting schedule.

Managers continued to seek assurance regarding medicines management through a recent review (May 2023) of pharmacy provision by managers from the wider Spectrum team. This reflected the provider's commitment to learn and improve patient safety.