G4S Forensic and Medical Services (UK) Limited

HMP Northumberland

Inspection Report

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Date of inspection visit: 2 May 2018
Date of publication: 09/07/2018

Overall summary

This inspection was an announced focused inspection carried out on 2 May 2018 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection between 31 July and 4 August 2017. The July – August 2017 comprehensive inspection was carried out in partnership with Her Majesty's Inspectorate of Prisons (HMIP) under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions in accordance with our published methodology. CQC issued two Requirement Notices under regulations 12 and 17 of the Health and Social Care Act to G4S Health Services (UK) Limited. These can be found in Appendix 2 of the joint inspection report. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-northumberland-2/

This focused inspection report covers our findings in relation to those aspects detailed in the Requirement Notices dated 21 November 2017. We do not currently rate services provided in prisons.

Our key findings were as follows:

- Medicines were now transported safely around the prison.
- Fridge temperatures were now monitored to ensure the integrity of medicines
- The local policy for the completion of electronic in possession risk assessments was not being followed, however, where paper risk assessment templates were completed they were scanned into clinical records promptly.
- Staff received regular supervision.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

Improve governance arrangements to provide adequate assurance that the service is being assessed and monitored and that improvements to the quality and safety of the service are being made including:

- Reviewing medicine storage arrangements and monitoring in line with relevant guidance.
- Monitoring the embedding of new systems and processes, progress against action plans and taking appropriate action where progress is not as expected.
- Ensuring that managers have sufficient knowledge and understanding of new processes, regulations and national guidance to effectively support staff and monitor the safety and quality of the service.

Summary of findings

- Working cohesively with other registered healthcare providers to ensure shared governance and audit arrangements are fully effective around areas of joint responsibility.

Background to HMP Northumberland

HMP Northumberland is a category C training prison which was formed in 2011 from the amalgamation of HMP Acklington and HMYOI Castington. The site covers several square miles with health services delivered from several locations across the prison. During our visit HMP Northumberland was holding around 1,340 male prisoners.

Health services at HMP Northumberland are commissioned by NHS England. The contract for the provision of primary healthcare is held by G4S Health Services (UK) Limited. This report covers our findings in relation to those aspects detailed in the Requirement Notices issued to G4S in November 2017. We do not currently rate services provided in prisons.

CQC inspected this location with HMIP between the 31 July and 4 August 2017. We found evidence that fundamental standards were not being met and two Requirement Notices were issued:

- Regulation 12, Safe care and treatment
- Regulation 17 Good governance

These were for breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked the provider to make improvements regarding this breach.

How we carried out this inspection

This inspection was carried out by one CQC health and justice inspector and one CQC pharmacist specialist with guidance from a CQC specialist clinical advisor.

During this inspection we reviewed the action plan submitted by G4S to demonstrate how they would achieve compliance with. We reviewed documentary evidence including minutes of meetings, reports generated from the electronic patient clinical record system and made observations of the areas of risk identified at the last inspection. We reviewed patient clinical records and spoke with healthcare staff, managers and the prison governor.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services. We asked the following question(s).

Are services safe?

We did not inspect the safe key question in full at this inspection. We inspected only areas identified in the Requirement Notices in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 5 December 2017.

Medicines were now stored and transported safely.

There had been improvements made in conducting risk assessments for patients in receipt of in possession medicines but there remained further improvements required.

Are services effective?

We did not inspect the effective key question in full at this inspection. We inspected only areas identified in the Requirement Notices in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 5 December 2017.

We found that the areas of concern identified in July 2017 had been addressed.

The provider had improved staff supervision arrangements.

Are services caring?

We did not inspect this key question during this focused follow up inspection.

Are services responsive to people's needs?

We did not inspect this key question during this focused follow up inspection.

Are services well-led?

We did not inspect the well-led key question in full at this inspection. We inspected only areas identified in the Requirement Notices in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 5 December 2017.

We found that whilst most of the areas of concern identified in July 2017 had been addressed, there were further improvements required to fully embed and monitor the effectiveness of new systems to ensure patients were safe.

Are services safe?

Our findings

At our previous inspection in August 2017, we found a number of breaches of regulation in relation to the safe management of medicines. These included:

- Medicines were being transported insecurely around the prison.
- Fridge temperatures in rooms where medicines were stored were not being recorded to ensure the safety of medicines.
- There was a three week backlog of in possession medication risk assessments waiting to be scanned onto the electronic patient clinical record system.
- Medication in possession risk assessments were not being carried out for patients including patients in receipt of controlled drugs.

These arrangements had significantly improved when we undertook a follow up inspection in May 2018.

Safety systems and processes

During this inspection we found that new systems had been put into place to transport medicines around the large site. New standard operating procedures had been implemented to address the previously identified risks. The improvements which had been made included the use of a prison vehicle to move medicines around the different medicines administration areas twice daily at appropriate times as well as the provision of appropriate lockable boxes and containers.

Nurses were able to move medicines in locked wheeled trolleys through secure corridors safely in part of the site.

Medicine fridge temperatures were now checked daily and a log was kept of these. However, we found that not all the relevant guidance for safe storage of medicines requiring refrigeration had been clearly implemented. Room temperatures were not consistently recorded and the procedures did not include instructions on resetting thermometers. The provider began to review this policy during our inspection.

Safe and appropriate use of medicines

During this inspection, we reviewed the provider's action plan to ensure that where prisoners were given medicines to keep in possession, a risk assessment had been undertaken. This included nurses completing a risk assessment template within the electronic patient clinical record system whilst they conducted reception screening for newly arrived prisoners. Managers told us they had completed a review of all patients which ensured risk assessments were completed for patients who did not have them.

Managers told us that staff had attended training in the completion of in possession risk assessments jointly with the provider of GP services in January 2018. Managers also informed us there had been issues with the roll out of the template in the electronic record system, and a new national template was to be introduced imminently.

We reviewed 19 patient clinical records and found that in possession risk assessments were not routinely completed in line with local policy. Completing the risk assessment and ensuring that medicines were prescribed safely was a shared responsibility with the provider of GP services. The electronic risk assessment had only been completed in three of the records we looked at. Copies of scanned in, hand completed, in possession medication risk assessments were included in only 10 records. These were now scanned into patient records within 24 hours which was a significant improvement. The reception screening template completed by nurses for every prisoner who arrived at HMP Northumberland had the relevant questions around risks of medicines being held in possession. We found that there were slight variations in the wording between the reception screening template questions and the electronic in possession risk assessment template. However, the information recorded in reception screening was sufficient for clinical decision making and had been completed for each of the patient records we checked where patients had arrived since January 2018.

Evidence demonstrated that the electronic risk assessment template was not being completed in line with G4S action plan, and managers were unaware of this.

We found evidence in local and regional medicines management meeting minutes as well as details of joint training which showed that the providers were working together to address this issue, despite the electronic risk assessment template being routinely not completed.

At the time of our visit, staff were discussing the imminent introduction of a new national reception screening template and in possession risk assessment tool.

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

At our previous inspection in August 2017, we found a number of breaches of regulation in relation to effective staffing. We found that nurses and healthcare support workers did not have access to regular structured supervision, including nurses who worked in isolation.

During our inspection in May 2018 we reviewed the provider's action plan intended to ensure that staff were appropriately supervised. We also reviewed supervision records and spoke with staff.

Staff informed us that supervision arrangements had improved since our last inspection. Records showed that all staff received managerial supervision at least once every three months. Clinical supervision was peer led, with staff able to access group supervision sessions, regular team meetings and daily handovers where clinical/practice issues were discussed. There was a management audit of staff records to ensure that records of supervision were being maintained.

We saw arrangements were in place for training nursing staff in the completion of the new reception screening and risk assessment tool. We observed discussions of this at a daily handover meeting.

Are services caring?

Our findings

We did not inspect this key question during this focused follow up inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect this key question during this focused follow up inspection.

Are services well-led?

Our findings

At our previous inspection we found the provider's governance arrangements did not effectively support joint working with the provider of GP services.

We also found that there was no monitoring of the completion of in-possession medicines risk assessments or managerial and clinical supervision for nursing staff.

Governance arrangements

During this inspection we found that a range of improvements had been made to the joint governance arrangements. All healthcare providers were supported by the prison director who chaired the local clinical governance meetings.

The purpose of the local governance meeting and attendance had been reviewed in February 2018 with providers agreeing the top priorities and risks around healthcare provision to work together to address. Providers had agreed to make improvements to the structure of local and regional meetings since March 2018 to improve communication and attendance at local meetings.

There was also evidence that the healthcare manager would have the opportunity to attend the regional governance meeting but this had not yet happened.

G4S governance arrangements and audits had failed to identify that the agreed new process, intended to ensure all prisoners had a current medication risk assessment in place, were not implemented. We found managers were unclear about what was happening in practice, and unaware of audits carried out by the GP service provider. There were insufficient G4S governance and audit processes in place to monitor, assess and review whether the new processes had been effectively implemented.