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.

Overall summary

We carried out an announced focused inspection of healthcare services provided by Spectrum Community Health C.I.C. at HMP & YOI Styal on 5 February 2020.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in April and May 2018, we found that the quality of healthcare provided by Spectrum Community Health C.I.C. at this location 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. We carried out a focused inspection in April 2019 and we found that improvements were still required. We issued Requirement Notices in relation to Regulations, 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 Spectrum Community Health C.I.C were meeting the legal requirements of the Requirement Notices that we issued in April 2019. We checked to see if patients were receiving 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:

- Checks of medicines fridge and room temperatures were carried out.
- Stock of homely remedies was appropriately managed.
- Emergency equipment and medicines were regularly checked.
- Patients' medicines in-possession risk assessments were carried out when they arrived at the prison.
- There was a system to follow up patients not attending for their medicines, which was mostly effective.
- Governance systems had improved and there was regular assurance of staff practice relating to medicines management.

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

- Follow up all patients who don't attend for their medicines for three consecutive days.
- Amend the expiry date of certain medicines when required.
- Complete medicines administration records accurately to reflect the reasons why medicines were not administered to patients.

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.

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 and information relating to medicines management.

During the inspection we asked the provider to share further information with us, such as staff training records. We spoke with healthcare staff, commissioners and sampled a range of patient records.

Background to HMP & YOI Styal

HMP & YOI Styal is a closed category prison for female adults and young offenders, located in Styal, Cheshire. The capacity of the prison is 486 and it holds sentenced prisoners as well as those on remand. The prison is operated by Her Majesty's Prison and Probation Service.

Spectrum Community Health C.I.C is the health provider at HMP & YOI Styal. 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 Family planning.

Our last joint inspection with HMIP was in April and 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

Our follow up inspection was in April 2019 and the inspection report can be found at:

https://www.cqc.org.uk/location/1-670182083/reports

Are services safe?

Appropriate and safe use of medicines

At our last inspection we found that the management of medicines was not proper and safe because staff did not always follow up with patients who did not attend for their medicines. Staff did not always complete medicines administration records. Sufficient action was not always taken to monitor storage temperatures and action was not always taken when temperatures were out of the appropriate range.

During this focussed inspection, we found that many improvements had been made although further improvements could still be made.

- If patients did not attend three consecutive medicines administration slots there was a procedure in place which staff followed. This involved visiting the patient to see if the medicine was still required and if any other support was needed. We saw evidence of staff discussing this during a lunchtime handover meeting which was recorded on the electronic patient record system. However, we saw that for one patient this handover had not happened. Although there was a reason why the patient had not received their medicines, it had not been appropriately followed up by staff.
- Staff carried out regular checks of room and fridge temperatures where medicines were stored. Action was taken when the temperatures were out of the appropriate range. For example, two fridges had been replaced since the previous inspection.
- The stock of homely remedies was checked on a regular basis and a member of staff was responsible for replacing any items that had been given out. This meant staff could be assured there would always be sufficient stock available to give out to patients. The registered manager was working with prison staff to have additional storage cabinets installed for homely remedies. This would mean that homely remedies would be available to collect in different places across the prison.
- At the previous inspection it was common practice that new patients would not be given their medicines in-possession for two weeks because of a lack of secure in-cell storage for medicines. This had changed and staff now carried out an in-possession risk assessment when patients first arrived at the prison. However, due to the nature of the prison buildings and cells, it was not always appropriate for some patients to keep their medicines in their possession. The registered manager was working with the prison to provide lockable boxes for each patient to keep in their cell.

Are services well-led?

Governance arrangements

At our last inspection we found that effective systems and processes to assess and monitor the safety and quality of the service were not in place. During this focused inspection, we found that many improvements had been made although further improvements could still be made.

- Regular checks of the emergency equipment and emergency medicines were carried out and action taken to replace any items that had been used or passed their expiry date. The date for one medicine in each of the four emergency bags had not been adjusted when it had been removed from a fridge and placed in the bag. The pharmacist was aware of this and planned to take the appropriate action to adjust the expiry date accordingly.
- A newly recruited pharmacy technician carried out checks of medicines storage and stock and dealt with any issues that arose. Following our previous inspection, weekly 'Matrons checks' were introduced to help ensure staff were carrying out all required checks of medicines. These checks had stopped temporarily due to staff turnover. However, it was planned to reintroduce the checks following our inspection.
- We checked a sample of 12 patient records and saw the recording of medicines administration had greatly improved with very few gaps in records. However, staff did not always record the correct reason for a patient not receiving their medicines. The registered manager said that further training and support for staff would be provided to help ensure medicines administration records were correctly completed.

Engagement with patients, the public, staff and external partners

- Following our previous inspection, the registered manager implemented various staff meetings, such as primary care staff and a prescribers meeting. These meetings were used to inform staff of what was required of them as well as discussing learning from any incidents and errors. They were also used as a forum for staff to raise any concerns and suggestions they may have.
- A range of different training courses had been provided to staff or were planned for shortly after our inspection. Several of these courses focussed on various issues identified during our previous inspection, such as record keeping, incident reporting and Cold Chain training (the Cold Chain is the process for transporting and storing medicines and vaccines that require refrigerated storage).
- Supervision meetings had also been used to discuss the standards required of staff as well as to discuss any further training requirements.