Care Quality Commission

Care UK Health & Rehabilitation Services Limited

HMP YOI Moorland

Inspection report

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Overall summary

We carried out a desk-based review of healthcare services provided by Care UK Health & Rehabilitation Services Limited at HMP YOI Moorland in July 2020. Following a joint inspection of HMP YOI Moorland with Her Majesty's Inspectorate of Prisons (HMIP) in February 2019, we found that the quality of healthcare provided at this location did not meet regulations. 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.

The purpose of this review was to determine if the healthcare services provided by Care UK Health & Rehabilitation Services Limited were now meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008. We found that improvements had been made and the provider was no longer in breach of the regulations.

At this inspection we found that:

- Medicines administration records were regularly audited, and any ommissions found were followed up.
- Patients who failed to collect their medicines were quickly followed up by nursing or pharmacy staff.
- The repeat prescription process had been reviewed.
- Patient information on the repeat prescription process and access to emergency medicines had been reviewed and updated.

Our Inspection team:

This desk-based review was carried by a CQC health and justice inspector in discussion with the manager for the health and justice team. We did not visit the prison to carry out this inspection because we were able to gain sufficient assurance through the documentary evidence provided and a telephone conference with relevant service/ CUK managers.

We reviewed an action plan submitted by Care UK Health & Rehabilitation Services Limited which demonstrated how they intended meet regulatory breaches we identified in February 2019. We requested a range of information to analyse and evaluate as part of this review. Evidence included:

A range of audits;

- Medicines stock audits
- Audit of daily omitted doses
- Responsibilities and prescribing audit
- Administration, errors, incidents and recall audit
- Omitted doses prescription record audit
- Audit of emergency stock medicines
- Audit of FP10s
- Medication Delays Quality Assurance Audit
- Medication task audit

A selection of local operating procedures;

Summary of findings

- Local Operating Procedure - Managing Omitted Doses of Medication
- Local Operating Procedure Repeat Prescription Requests
- Local Operating Procedure – Access to Emergency Medicines Management.

Patient information;

- Repeat prescriptions leaflet
- Immediate implementation/corrective action letter sent to patients on the 22/02/2019 regarding medicines management; change in process and access to emergency stock and in possession (IP) medicines

Information for staff;

- Recording non-attendance for medication collection – flow chart advising staff on correct procedure to follow when a patient fails to attend
- Flow chart for the supply and administration of IP medicines

Other information;

- Minutes of the Medication Quality Assurance and Improvement Meeting
- Concerns register 2019/2020
- Medication concerns register 2019/2020

A meeting was held remotely with the head of healthcare and the deputy regional manager for Yorkshire on 3 July 2020 to discuss action and improvements.

Background to HMP YOI Moorland

HMP/YOI Moorland is a category C adult and young adult men's resettlement prison situated near Doncaster. Health services at HMP YOI Moorland are commissioned by NHS England. The contract for the provision of healthcare services is held by Care UK Health & Rehabilitation Services Limited.

Care UK Health & Rehabilitation Services Limited is registered with CQC to provide the regulated activities of diagnostic and screening procedures, and treatment of disease, disorder or injury.

Our last joint inspection with HMIP was in February 2019. The joint inspection report can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/Moorland-Web-2019.pdf

This report covers our finding in relation to those aspects detailed in the Requirement Notices issued to Care UK Health & Rehabilitation Services Limited February 2019. We do not currently rate services provided in prisons.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?

Are services safe?

Our findings

We did not inspect this key question in full during this focused follow up inspection. We reviewed areas identified in the Requirement Notice issued to Care UK Health & Rehabilitation Services Limited in April 2019.

At our last inspection in February 2019 we found that the provider had not done all that was reasonably practicable to ensure that care and treatment was provided in a safe way for patients.

We found that medicines were not always managed properly and safely.

In particular:

- Medicines administration records were not routinely audited.
- Omissions in medicines records were not routinely monitored. Consequently, risks relating to the supply of medicines were not identified.
- During the inspection patients complained of not receiving their medicines. Examination of their records confirmed that some of these patients had not received their medicines or had not received them in a timely manner.
- Despite the repeat prescription process being well advertised across the prison on wings and in healthcare, patients did not always follow the process which meant that some were late in submitting requests. The provider did not have appropriate systems in place to monitor or follow up patients who failed to collect their repeat medicines, or address the risks this posed to some patients.

Appropriate and safe use of medicines

At this desk-based review we found the provider was providing safe care and treatment in accordance with the relevant regulations. Specifically, we found the provider had taken all reasonable action to ensue that medicines were managed in a safe and proper way.

We found from our discussions with the provider and review of evidence, that systems and processes to support the management of medicines were embedded across the service.

We found that the provider now completed regular audits of medicines records, additional audits of serious incidents concerning medicines were undertaken and any subsequent actions were also reviewed. The provider had developed a new process which identified daily prescribed medicines that had not been collected by a patient. These were then discussed at daily patient handover meetings and followed up by nursing and/or pharmacy staff and, in particular, ensured that any critical medicines were issued. We reviewed a range of audits the provider shared with us, which demonstrated regular audits of omitted medicines doses were happening and, where ommissions occurred, these were followed up and patients received their medicines.

The provider developed several local operating procedures (LOPs) to support changes they put in place to improve medicines administration. A LOP is a set of step-by-step instructions to help staff carry out complex routine operations. LOPs had been developed for following up omitted doses, repeat prescription requests and access to emergency medicines. This ensured all nursing staff were aware of the new processes including, how to obtain medication outside of standard operating hours. The provider also developed a flow chart to assist staff in what action they were to take when a patient failed to attend for their medicines.

Following the joint inspection in February 2019, the provider developed and issued an updated patient leaflet about healthcare services to all patients and displayed copies in healthcare areas including the reception area. Similarly they updated a range of patient information and this ensured that patients were aware of changes to repeat prescription medicines and access to emergency medicines processes. The new patient leaflet, along with a letter was sent to all patients informing them of the changes in the process and how to access and request the repeat medicines process. Updated information posters on the medicines administration process were displayed on prison wings and in the reception area.

The provider introduced monthly medicines management meetings to review the newly introduced systems and processes and any patient concerns. This provided the opportunity for staff to assess the impact of new medicines processes.

Since 1 June 2020 we have been contacting providers and heads of healthcare at prison locations to set up an Emergency Support Framework (ESF) conversation with the heads of healthcare to discuss how COVID-19 is impacting

Are services safe?

on the service and its staff. We undertook an ESF discussion with the provider on the 27 July 2020 during which managers assured us that the Covid pandemic had not adversely impacted on the provider's arrangments for safe medicines management.