# HMP YOI Feltham

## Inspection report

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Date of inspection visit: 15 Jul to 19 Jul 2019
Date of publication: 23/09/2019

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 Care UK Practices Limited (Care UK) at HMP YOI Feltham between 15 and 19 July 2019, alongside a scheduled joint inspection with Her Majesty's Inspectorate of Prisons.

During our previous joint inspection of Feltham A with Her Majesty's Inspectorate of Prisons in January 2019, we found that the quality of healthcare provided by Care UK at this location required improvement, and we issued a Requirement Notice to the provider under section 29 of the Health and Social Care Act 2008.

The purpose of this focused inspection was to determine if the healthcare services provided by Care UK were meeting the Requirement Notice and Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We do not currently rate services provided in prisons.

At this inspection we found:

- Care UK had acted to address the concerns identified at the January 2019 joint inspection and were now compliant with the Requirement Notice issued on 14 June 2019.
- Systems to assess and monitor the quality of services had improved with qualitative audits and patient feedback mechanisms in place.
- Prison environmental and regime concerns had been escalated appropriately to the partnership board and a newly formed local delivery board.
- Some new risks associated with medicines administration had not been sufficiently assessed or acted upon.

## Our inspection team

Our inspection team was led by a CQC health and justice inspector, accompanied by a healthcare inspector from Her Majesty's Inspectorate of Prisons (HMIP). At the same time, a comprehensive joint inspection of health and social care services was carried out in partnership with HMIP.

Before this inspection we reviewed a range of information that we held about the service. During the inspection we asked the provider to share with us further information, we spoke with healthcare staff, prison staff, commissioners and people who used the service, and sampled a range of records.

## Background to HMP YOI Feltham

HMP YOI Feltham is a prison and young offender institution, located near the town of Feltham within the London borough of Hounslow, West London. The prison accommodates up to 180 children (aged up to 18) and 360 young adults (aged up to 21). The prison is operated by Her Majesty's Prison Service.

Care UK provides primary health care and clinical substance misuse services at the prison. Care UK is registered with CQC to provide the regulated activity of Treatment of disease, disorder or injury, and Diagnostic and Screening procedures at the location HMP YOI Feltham.

Our last joint inspection of Feltham A with Her Majesty's Inspectorate of Prisons (HMIP) was in January 2019. We found breaches of Regulation 17, Good governance at this inspection. The joint inspection report can be found at:

# Are services safe?

At our last inspection we found that risk management systems were not effective in identifying and resolving quality and safety issues. In particular we found that:

- Risks associated with medicines administration had not been identified or acted upon; a member of staff administered a controlled drug without access to either a printed prescription or electronic record at the point of administration.
- A medicines trolley was left unlocked on two occasions, despite concern being raised with the head of healthcare after the first occasion.
- There was no systematic follow up of patients who did not attend for medicines administration or primary care appointments to prevent a risk to their health, or to understand the reasons for their non-attendance and to inform service improvement.

During this inspection we found that:

- Most risks associated with medicines administration had been identified and were recorded on the provider's risk register, which was reviewed by the registered manager on a regular basis.
- If there was no access to SystmOne (patient electronic record system), medicines were administered alongside a copy of the printed prescription and a photograph of the patient was attached to the prescription to provide an additional identity check.
- Medicines trolleys were locked and secured to walls during our inspection.
- The pharmacy team ran a report twice weekly to identify patients who had not attended for their medication, and these patients were followed up promptly.
- Primary care staff followed up patients who missed appointments from regular system reports.

At this focused inspection we identified some new concerns regarding the risks associated with medicines administration. We found that:

- In response to our previous inspection findings the administration of medicines to children had been re-located and a risk assessment had been completed that required further security measures to be put in place.
- The environmental risks associated with medicines administration on Feltham A had not been adequately risk assessed or addressed. The risk assessment in place was due to be reviewed three months after its completion, which was too long and did not allow for high level risks to be identified and acted upon in a timely manner to reduce the risks to patients.
- Medicine prescribed to treat epilepsy was administered with inappropriate intervals between doses meaning that the medicine may not achieve the optimal therapeutic dose, posing an increased risk to the patient.
- The provider did not consider enabling children to manage their own medicines 'in-possession' to enable them to take their medication when most effective.
- On Feltham B some young adult patients received their medicines whilst attending work activities, which was not safe; We observed one patient receiving medication without water to swallow the tablets.

# Are services well-led?

At our last inspection of Feltham A we found that the systems in place to assess and monitor the quality of the service and risks to the health and safety of people using the service were not always effective. In particular we found that:

- There was a schedule of audits completed at the location, however these were quantitative in nature and were not always effective in identifying quality issues or ensuring action was taken.
- There had not been an independent qualitative infection control audit undertaken, and we identified issues with the standard of cleaning and general clutter which had not been identified or acted upon.
- There was no system for children to provide feedback about the quality of healthcare services or raise concerns in order to improve and develop the service.
- Risks relating to the prison facilities and regime that impacted upon medicines administration were not always highlighted with the appropriate prison department or followed up to ensure that remedial works were carried out.
- Medicines were not always administered at the appropriate time. Whilst this was mainly due to the prison regime, it was not clear what action had been taken to try and address this issue with the prison.

During this inspection, we found that:

- Audits which had taken place since our last inspection were qualitative and fed in to service action plans. Audit findings were reviewed at local governance meetings and at the local delivery board to ensure that actions were addressed and escalated where appropriate.
- A comprehensive infection prevention and control audit had been carried out in March 2019 and an action plan had been developed to address identified concerns. The standard of cleanliness had improved, a cleaning schedule was in place and clutter had been removed since our last inspection.
- The provider's national patient engagement lead had commenced work with the prison to implement a pilot with a charity called Peer Power to seek children's feedback. Young adults were able to provide feedback through prison led forums which healthcare attended. Feedback received was recorded on the Datix reporting system, and shared at local governance meetings.
- Risks relating to the prison facilities and regime had been escalated to senior prison managers, and remedial action had been taken to fix a light in one treatment room.
- Medicines administration times had been reviewed and raised with senior prison managers, and a new administration point had been identified to improve punctuality which was in the process of being trialled at the time of our inspection.
- A local delivery board had been established, the first meeting of which took place the week prior to our inspection. This provided a forum for the health provider to escalate any concerns with the prison regime or environment which may be impacting on service delivery.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 (1) HSCA (RA) Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met…<br><br>The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular, some risks associated with medicines administration.<br><br>The provider's risk assessment of the medicines administration area on Feltham A did not fully assess the environmental concerns impacting on medicines administration, and the risk assessment had not been reviewed promptly.<br><br>A patient was given prescribed medication without any water to swallow the tablet.<br><br>Medicines were given at inappropriate intervals:<br><br>One patient received epilepsy treatment at variable intervals and not as prescribed.<br><br>The provider had not considered the use of in-possession medication to enable children to take their medicines when most effective. |