HMP Gartree

Inspection report

Gallow Field Road
Gartree
Market Harborough
Leicestershire
LE16 7RP

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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

The five questions we ask and what we found

Are services safe?

We did not inspect the safe domain in full at this inspection. We inspected only those aspects mentioned in the Warning Notice issued on 18 December 2017 and Requirement Notices issued on 14 March 2018, and to follow up on concerns raised by staff whistleblowers.

At this focused inspection we found that whilst some improvements had been made to the mental health service and in relation to the management of long term conditions, we identified new concerns about medicines management and found evidence that medicines were not managed properly and safely.

Are services effective?

We did not inspect the effective domain in full at this inspection. We inspected only those aspects mentioned in the Warning Notice issued on 18 December 2017 and Requirement Notices issued on 14 March 2018.

At this focused inspection we found that Care & Custody (Health) Limited had not taken adequate action to address the concerns identified during our last inspection, and staff still did not receive the appropriate support, training and supervision to enable them to carry out the duties they were employed to perform.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive domain at this inspection.

Are services well-led?

We did not inspect the well-led domain in full at this inspection. We inspected only those aspects mentioned in the Warning Notice issued on 18 December 2017 and Requirement Notices issued on 14 March 2018.

At this focused inspection we found evidence that insufficient improvements had been made and governance systems and processes did not effectively assess, monitor and improve the quality of services provided. A number of risks which we identified during our last inspection had not been acted upon, and we identified significant new concerns during this inspection.

Areas for improvement

Musts

- Care & Custody (Health) Limited must ensure that medicines are managed properly and safely, in particular for responding to medical emergencies and in-possession medicines.
- Care & Custody (Health) Limited must ensure that staff receive the appropriate support, training and supervision to perform their duties.
- Care & Custody (Health) Limited must ensure that the pharmacy service is governed appropriately.
- Care & Custody (Health) Limited must ensure that governance systems and processes assess, monitor and improve the quality and safety of services.

Shoulds

- Care & Custody (Health) Limited should undertake a review of the substance misuse service to include the implementation of relevant policies, a treatment pathway, and increase clinical oversight to assess and monitor the safety of the service.

We do not currently rate services provided within prisons

Our inspection team

Our inspection team was led by a CQC health and justice inspector, accompanied by two CQC health and justice inspectors.

Background to HMP Gartree

HMP Gartree is a high security category B lifer centre holding adult males. The prison is located in the village of Market Harborough in Leicestershire and accommodates up to 707 prisoners. The prison is operated by Her Majesty's Prison and Probation Service.

Care & Custody (Health) Limited is commissioned by NHS England to provide primary health care and clinical substance misuse services at the prison. Care & Custody (Health) Limited is registered with CQC to provide the regulated activities of Diagnostic and screening procedures and Treatment of disease, disorder or injury at the location HMP Gartree.

There is no registered manager for this location

Our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) was completed in November 2017. During that inspection we found breaches of Regulations 17, Good governance and 18, Staffing and issued Requirement Notices on 14 March 2018. We also identified a breach of Regulation 9, Person centred care and took enforcement action in the form of a Warning Notice issued on 18 December 2017. The joint inspection report can be found at:

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

We undertook an announced focused inspection on the 21, 22 & 23 August 2018. This inspection was carried out in order to follow up on the regulatory breaches found during our last inspection.

The purpose of the inspection was to determine if the registered provider, Care & Custody (Health) Limited, was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment.

Our key findings were as follows:

- The management of patients with mental health issues and long term conditions had improved since our last inspection.
- Medicines were not managed properly or safely.
- Staff did not receive appropriate support, training or supervision.
- Social care was not consistently provided in accordance with service users' care plans.
- Governance systems to assess, monitor and improve the quality and safety of the service remained poor.

Before this focused inspection we reviewed a range of information that we held about the service, including action plans we had received from the provider in response to the Warning Notice issued on 18 December 2017, and the Requirement Notices issued on 14 March 2018.

During the inspection we asked the provider to share with us a range of information which we reviewed. We spoke with healthcare staff, prison staff and people who use the service, and sampled a range of records.

Are services safe?

Monitoring risks to patients

At our last inspection we found that the ongoing needs of patients on the mental health caseload were not clear and patients did not receive one to one interventions unless they were in crisis. During this inspection we found evidence that planned improvements had been made and the mental health service for patients had improved. Specifically, we found that:

- Patients' mental health needs were assessed in a timely manner.
- Patients accessing the mental health service received regular one to one interventions with a mental health nurse or other appropriate specialist.
- Patients received personalised care planning to address their mental health needs.

At our last inspection we found that there was no systematic way to monitor patients with long term conditions to ensure the care and treatment they received met their needs. At this inspection we found evidence that Care & Custody (Health) Limited had taken actions to improve the management of long term conditions. These included:

- Registers were in place to identify those patients with long term conditions.
- Patients with long term conditions had personalised care plans.
- A named nurse oversaw the management of long term conditions and although this was an agency position, recruitment was ongoing to recruit a permanent nurse to take on this role.
- Long term condition clinics were held regularly.

At our last inspection we were told that there were six patients with palliative care needs, however their needs were not managed systematically and there was no local pathway in place for end of life care. During this focused inspection we were advised that there were no patients with palliative care needs at the time of our last inspection, and this remained the case now. We found that a draft pathway for end of life care needs was being developed. However, this needed to be finalised to ensure that an agreed pathway was in place for staff to follow should the need arise.

During this inspection we reviewed patient records for prisoners receiving clinical substance misuse interventions and found that patients could not be tested for tramadol in line with the voluntary drug testing compacts they had signed to promote their recovery. Specifically, we found that:

- There had been no testing kits for Tramadol available since May 2018. An order had been placed for these but delivery was delayed and there was no evidence that this had been appropriately followed up.
- During our inspection, the supply of multi-purpose drug testing kits ran out and incorrect kits had been ordered so there were no correct kits available.
- We found examples of four patients who had not been tested in August 2018 in line with their drug testing compact as a result of testing kits being unavailable.

This meant service users using illicit substances on top of their prescribed medication would not be detected, increasing the likelihood of overdose; nor would they receive acknowledgement of compliance with their compact agreement.

Safe track record and learning

During this focused inspection we reviewed medicines management as a result of concerns raised by staff whistleblowers with CQC in July 2018.

We found that the arrangements to manage the risks associated with patients holding their medicines in-possession were inadequate. We found that:

- Staff could not confirm who was responsible for completing in-possession risk assessments. Managers told us that work was needed to identify patients who did not have a risk assessment.
- Data showed that 74% of patients prescribed in-possession medication had a risk assessment completed. This meant that the risk of holding in-possession medication was not adequately assessed for approximately 100 patients.
- Did not attend (DNA) rates for the collection of in-possession medication had been monitored and remained high. Care & Custody (Health) Limited provided no evidence of discussions or action taken with partners to address this issue.
- There were no arrangements in place to follow up patients who did not attend to collect in-possession medication.

Arrangements to deal with emergencies

Are services safe?

During this inspection we reviewed log books for four of the five emergency bags maintained by healthcare staff. We found that:

- The log book for the emergency bag in the separation and progression unit showed that two items had been missing since June 2018. There was no evidence to show staff had taken action to replace these items.
- In the same bag, we found cleaning swabs which expired in July 2018 and no action had been taken to remove or replace them.
- The emergency bag on H wing had a seal tag number which did not correspond with the log book. When we checked the contents, we found additional medication in this bag which was not recorded in the log book. Some medications in this bag had not had their expiry date amended to reflect that they were no longer stored in a fridge.
- Of the four emergency bags we reviewed, we found that a total of 80 daily checks had not been recorded since 1 June 2018.

Our findings meant that there was a risk that staff may not have access to the necessary equipment or medicines to respond to medical emergencies.

Are services effective?

Effective staffing

During our last inspection, we found that there were insufficient numbers of staff deployed to meet the needs of service users. This had resulted in the delivery of care being prioritised around the administration of medicines and crisis management. At this inspection we found that sufficient numbers of staff were deployed and despite the high use of 12 full time agency staff, recruitment was ongoing to fill substantive vacancies.At our last inspection we found that staff did not receive appropriate support, training and supervision to enable them to carry out the duties they were employed to perform. Specifically, this included:

- Care & Custody (Health) Limited had not completed a training needs analysis or agreed a training programme for staff working within the service.
- Staff were not supported to access training and staff had completed only basic life support training since Care & Custody (Health) began providing services at the prison in April 2017.
- The staff skills mix had not been reviewed to help ensure staff were competent and skilled in their roles.
- There was no regular formal clinical or managerial supervision for nursing staff.

During this focused inspection we found that insufficient improvement had been made. Care & Custody (Health) Limited had not taken adequate action to address the concerns identified at the last inspection in November 2017. We found evidence of the following ongoing concerns:

- No training needs analysis had been completed and the staff skill mix had not been reviewed despite this being identified as a completed action on the provider's action plan dated 19 July 2018.
- Training data was not available at the time of the inspection. Information supplied following the inspection demonstrated poor mandatory training compliance levels and staff told us that they did not feel supported to access training.
- A new learning management system had been introduced in July 2018. However, this was not yet populated with staff information and online training courses did not match the mandatory training list provided by Care & Custody (Health) Limited during our inspection.

Not all staff had access to regular supervision in line with Care & Custody (Health) Limited's Supervision policy. No records were available to demonstrate regular supervision for primary care and substance misuse managers, and there were no records to evidence regular supervision for any of the mental health team. One group supervision session had been documented for the mental health team in the last 18 months. This meant that staff were still not sufficiently supervised or supported in their clinical roles.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive domain at this inspection.

Are services well-led?

At our last inspection we found that overall, governance systems were insufficient and the provider did not have adequate oversight of the service. This included:

- There was no audit programme in place to monitor and improve the quality and safety of services.
- Incidents and complaints were recorded appropriately; however, we did not see evidence that lessons were learned from these to inform service delivery.
- Patient feedback was not systematically analysed or used to develop the service.
- Regular team meetings were not in place to share learning and provide an opportunity for staff to express their views.
- There was no safe system for the secondary dispensing of medicines to patients in the segregation unit. This issue was known to management however insufficient action had been taken to improve the process.
- Infection control standards were not met in all clinical areas. Whilst the provider was aware of inadequate standards, no action had been taken to make improvements or seek an alternative arrangement.
- A number of recommendations from a 2016 health needs analysis and an NHS England quality visit in March 2017 had not been met, and the service action plan did not ensure sufficient progress against the actions listed.
- Policies were not sufficiently localised to guide and support staff working within a prison environment.

Continuous improvement

During this focused inspection, we found that Care & Custody (Health) Limited had taken some actions to improve governance systems. For example:

- Staff team meetings had taken place in February, April and August 2018 with a plan in place for further meetings. Staff could bring ideas for improvements to these meetings by adding items to meeting agendas in advance.
- The administration of medicines in the segregation unit was much improved and was now safe for staff and patients. A medicines trolley was now stored securely on the unit and no secondary dispensing was being carried out at the time of our inspection.

We noted that the recommendations from the health needs analysis in 2016, and the NHSE quality visit in March 2017 were no longer relevant to the service due to the changing needs of the prison population.

Overall, we found that a number of concerns had not been addressed from the previous inspection, and Care & Custody (Health) Limited had not taken sufficient action to improve governance systems.

There were no regular audits in place for managers to monitor the quality of the service and identify risks, which was the same as our findings at the last inspection:

- A 2018 draft audit schedule showed 21 audits were due to be completed between January and July 2018; of these only two had been completed at the time of our inspection.
- We found additional audits of staff handwashing had been carried out, which were not included on the schedule.
- Actions from the infection control audit carried out in March 2018 had not been completed.
- We were also concerned that limited audits had been carried out of the pharmacy service to monitor medicine usage. Staff told us that medication could easily be removed from stock undetected.

We found that lessons learned from incidents and complaints were not always acted upon, as at our last inspection. We identified particular concerns about the lack of action in response to incidents and concerns involving medicines:

- The online reporting system Datix was introduced in April 2018. Between April and July 2018, staff had reported 86 incidents of which 38 related to medicines management. The operations director told us that in response to this a medicines management pathway review was planned but this had not commenced at the time of our inspection.
- The March 2018 governance meeting minutes identified that there had been a number of incidents reported regarding the methadone measuring equipment. Although an action was documented for staff to receive training in using this equipment, we found no evidence that this training had taken place.
- The May 2018 governance meeting minutes recorded concerns raised that a number of complaints had been received regarding patients' medicines supply being

delayed or not ready for collection. We found that no action had been documented to address this, and at the time of our inspection patients continued to experience delays.
- In the August 2018 staff meeting minutes, complaints about medicines management were discussed and an action was documented to work towards using patient named medication and to close one clinical room. We discussed this with managers, and despite Care & Custody (Health) Limited being aware and liaising with the prison regarding these concerns, actions were not taken forward in a timely manner.
- Medicines management meetings had been held in February, April, and June 2018. We reviewed minutes from these meetings and found that no incidents or complaints had been discussed by this group.

During this inspection we found that ongoing infection control issues which were known to Care & Custody (Health) Limited had not been addressed since our last inspection. In November 2017, we reported that the medicines administration room on G wing was not compliant with infection control standards in line with the Health and Social Care Act 2008: Code of practice for health and adult social care on the prevention and control of infections and related guidance. These concerns were also identified by the provider's March 2018 Infection, prevention and control audit. No improvement was found at this inspection and there were no firm plans to mitigate or address the associated risks, while waiting for the prison to make improvements.

Seeking and acting on feedback from patients, the public and staff

We found that patient feedback was still not sufficiently analysed or used to inform service delivery and improvement:

- Patient forums had taken place in January, February, March, May and July 2018. A range of information submitted following the inspection suggested that Care & Custody (Health) Limited were beginning to take some actions forward. However, minutes from these meetings did not record that actions had consistently been taken in response to patient feedback. Staff told us that whilst patients put forward valid suggestions for service improvement, there was not enough time to act on their suggestions.
- In May 2018, patients attending the forum said they would like to have access to more group interventions; however, we did not find any documented consideration of this, or plans to commence group interventions.
- Minutes showed that at the July 2018 patient forum patients had raised concerns over the high turnover of health staff, resulting in poor stability of the healthcare team. Patients had also raised concerns that they were not being unlocked by prison staff to attend healthcare appointments. Whilst this was being actively monitored, there was no evidence of these issues being escalated or acted upon.

Governance arrangements

During our 2017 inspection we found that policies to support and guide staff in their work were not sufficiently localised for the setting. During this inspection we identified that policies had not been systematically updated to ensure that they reflect contemporary legislation and guidance. In particular, we found that;

- Of the 31 policies shared with inspectors, only three of these policies were within their stated review date. From additional information supplied following the inspection, 16 of the policy documents should have been reviewed prior to our inspection in August 2018. It was not clear whether these reviews had been completed.
- One key policy intended to ensure the safety of medicines management was in draft; 'Non-medical prescribing.'

This meant that staff did not have access to the appropriate up to date policies to support their practice.

In addition to the ongoing concerns described above, we also identified a number of new concerns in relation to the governance systems within the service during this inspection. In particular we found that:

- There was insufficient clinical oversight and governance of the substance misuse service
- Oversight and monitoring of the pharmacy service was poor
- The service risk register was not fit for purpose

There was no treatment pathway or prescribing policy in place to ensure that patients received appropriate treatment for substance misuse. There were approximately

Are services well-led?

140 patients receiving support from the substance misuse service at the time of our inspection, 26 of whom were receiving clinical interventions. One non-medical prescriber provided clinical input for one day per week and was also tasked with leading the service's multi-disciplinary team meeting and writing the treatment pathway and prescribing policy for the service. We were told that managers had identified concerns regarding the substance misuse service, and hoped to re-structure, increasing clinical input; however, there were no documented plans in place for this at the time of our inspection.

The oversight and monitoring of the pharmacy service was poor and responsibility for this service was held by a manager without relevant knowledge and experience. We were told that a pharmacist visited the service weekly; however, there were no formal assurance arrangements in place and no regular pharmacy audits were completed. Some pharmacy audits were made available to inspectors following the inspection; however, evidence submitted did not clearly demonstrate how audit reports were reviewed, what corresponding actions were taken and whether improvements were monitored. Staff told us that they had shared ideas for audits with senior managers but that they did not always feel able to raise issues regarding the service with some managers. This meant that systems and processes to assess, monitor and improve the service were insufficient.

We reviewed the service risk register and found that this had not been updated since January 2018 and was not fit for purpose. The risk register shared with inspectors was not dated, and no risks had been added to the register since October 2017. No updates to existing risks had been added since January 2018. An action to ensure all service users had an in-possession risk assessment was added to the risk register in January 2017 with a completion due date of December 2017. However, this action had not been completed and remained a concern. Some risks identified at our November 2017 inspection were not documented on the risk register, such as risks associated with staff training, supervision, audits, social care governance, infection control, and medicines management. This meant that risks to patients and staff, which were known to managers were not systematically identified, recorded and actioned to monitor and improve the safety of the service.

At our 2017 inspection we found that the care and treatment of some service users receiving a social care package did not meet their needs, or reflect their preferences and saw evidence that one service user did not receive the care he had been assessed to receive. During this inspection, we found that records for the three service users receiving social care support still did not provide assurance that care was being consistently provided. We reviewed their care plans and the electronic recording system (SystmOne) to determine whether care was carried out in line with the recommendations from the local authority and their care plans. The care plans for all three service users contained significant gaps. Despite requiring daily support, in the preceding four months the three service users had no care recorded on 9, 14 and 18 occasions respectively.

We discussed these omissions with managers who acknowledged that in some cases staff did not record their interventions in individual patient records, but ticked that they had seen the patient on the appointment ledger on SystmOne. We checked SystmOne and found no evidence of the planned care being delivered on the identified dates. This meant that the record keeping for social care patients was insufficient and the provider could not be assured that care was delivered as planned.

We identified further concerns in relation to the governance of social care. The service action plan included an action to hold monthly meetings with the local authority to monitor social care provision, However, evidence of these meetings taking place monthly could not be provided during or after our inspection. The provider was unable to provide evidence that social care was monitored and reviewed monthly. We found that only two meetings had been documented with the local authority, in January and February 2018. This meant that the social care was not monitored and reviewed effectively.

Overall, we found that Care & Custody (Health) Limited had not responded adequately to serious concerns raised during our 2017 inspection, and governance systems remained insufficient to assess, monitor and improve the quality and safety of the service.

This section is primarily information for the provider

Enforcement actions

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. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing