Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Risley Prison - IDTS

Warrington Road, Risley, Warrington, WA3 6BP

Date of Inspections: 16 July 2013
15 July 2013

Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Management of medicines	✗ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	CRI (Crime Reduction Initiatives)
Registered Manager	Mrs. Joanne Townley
Overview of the service	Risley Prison – Integrated Drugs Treatment Service (IDTS) was provided by CRI (Crime Reduction Initiatives) within HMP Risley. CRI (Crime Reduction Initiatives) is a health and social care charity that works with individuals, families and communities across England and Wales that are affected by drugs, alcohol and crime. They deliver services in the community and prisons. The service at HMP Risley provided support and treatment to prisoners with a history of substance misuse.
Type of service	Prison Healthcare Services
Regulated activities	Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 15 July 2013 and 16 July 2013, observed how people were being cared for, talked with people who use the service and talked with staff. We reviewed information given to us by the provider and took advice from our pharmacist.

What people told us and what we found

We carried out this inspection alongside Her Majesty's Inspectorate of Prisons (HMIP). The Care Quality Commission and HMIP routinely coordinate inspections of prisons and healthcare providers.

The integrated drugs treatment service (IDTS) at HMP Risley provided interventions to enable prisoners to recover from their drug or alcohol addiction and also provided a maintenance service to other prisoners. The IDTS aimed to enable prisoners to participate positively in their local communities upon release from prison.

Prisoners told us: "This is a brilliant service". One prisoner described the service as 'spot on'.
Another prisoner told us: "They're (staff) doing a good job, I'm happy with my treatment".

We found that, CRI (Crime Reduction Initiatives) worked closely with other healthcare organisations based in HMP Risley.

We looked at what substance misuse services were available to prisoners. We found that prisoners had access to a good range of information that informed them of services that were available at HMP Risley.

We found that prisoners at HMP Risley accessed treatment and support from one or more service providers who operated from within the prison, including GP services, a range of medical services and mental health services and that they received a co-ordinated response.

We had a number of concerns about the way CRI managed medicines including methadone across the prison site and about record keeping. We found that there were insufficient auditing arrangements in place to ensure the safe management of medication.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 29 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People who use the service understood the care and treatment choices available to them.

Reasons for our judgement

A prisoner told us: "This is a brilliant service".

We looked at what substance misuse services were provided to prisoners at HMP Risley. We wanted to know how prisoners accessed these services, what information was provided to prisoners about the treatments available and how prisoners' dignity and privacy was supported.

The integrated drugs treatment team was located on one wing in HMP Risley and comprised two teams. One team was a recovery team, providing psychosocial support and counselling to prisoners who wanted to recover and or reduce their addiction. The team also worked with prisoners who were drug free. A second team, providing clinical support to prisoners, was made up of nursing staff and drug recovery workers and provided maintenance and detox services to prisoners who were prescribed methadone and other opiate substitutions.

The nursing team were responsible for the dispensing and administration of methadone to prisoners. We saw that the majority of methadone was dispensed to prisoners on C wing, where there was a facility for prisoners to receive their medication in privacy and without interruption. The privacy and dignity of prisoners using this facility on C wing was upheld.

We found that some prisoners received their methadone on other wings across the prison. We found that facilities on G wing and B wing compromised prisoners dignity and respect. The area on B wing had been previously used for voluntary drugs testing and on the day of our inspection we found this area to be dirty, including a sink area that was used to obtain drinking water to assist prisoners taking their medication. The registered provider may wish to consider along with HMP Risley how they ensure facilities provided for prisoners taking their medication are suitable and promote people's privacy, respect and dignity.

During our inspection we observed a range of information on substance misuse services displayed in the main healthcare area of HMP Risley. Prisoners told us that when they

were first received into the prison they were given information about what substance misuse services were available and how to access the services. We saw that prisoners underwent an initial health screen when they were first received into the prison and this included a review of any alcohol or substance dependency past or present. We saw that information from the health screen was shared with the integrated drugs treatment team who made contact with the prisoner and offered support and/or treatment. This meant that there were a number of ways in which prisoners were informed of what substance misuse facilities were available to them at HMP Risley.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

One prisoner who used the service told us: "They're (staff) doing a good job, I'm happy with my treatment".

Another prisoner said: "...these staff are alright, they look after me".

CRI has been responsible for clinical services at HMP Risley since 2009 and psychosocial services since January 2013.

We spoke with the lead commissioner for offender healthcare in the Northwest from NHS England Lancashire. They told us they had been responsible for commissioning recovery services at prisons across the Northwest since 1 April 2013 and they had not yet had the opportunity to look at the services provided at HMP Risley, though they were not aware of any issues or concerns.

The independent drugs treatment service at Risley was provided by CRI and was available Monday to Thursday between the hours of 7:30am and 7:30pm, and between Friday and Sunday from 7:30am till 3:30pm. There was no out of hours service and any medical emergencies were dealt with by healthcare services.

The aim of the nursing team was to support and assist prisoners to reduce their dependency on methadone and other opiate substitutions and or support prisoners on a maintenance programme. The service lead told us there were approximately 56 prisoners currently undertaking a detox programme and approximately 56 prisoners on a maintenance programme within HMP Risley.

In addition to being referred to the service, prisoners could also 'self-refer' to the service, and other healthcare partners and prison staff could also make referrals on prisoners behalf. We were told that prisoners transferring into HMP Risley could also access the service. This mean that prisoners requiring on going treatment and support with substance misuse were guaranteed continuity of care and support in HMP Risley.

Following an initial screen a treatment plan was developed. We looked at a selection of

treatment plans. We found that treatment plans were held electronically on Systm One, which was a recording and monitoring system for patient healthcare within the prison. We found that all staff who had contact with a prisoner concerning their health recorded their involvement on the system. This meant that all staff involved with a prisoner were fully aware of what treatment was taking place, what (if any) risks a prisoner presented along with information about future appointments and review dates.
We saw that recordings on treatment plans were clear, specific and individualised to each prisoner's care and treatment needs. This meant that prisoners were assured their needs were assessed and treatment was planned and delivered in line with their individual treatment plan.

Following an assessment, prisoners who engaged with the service had access to a range of recovery programmes and therapies including art based therapies. A peer mentoring scheme was in place and this assisted prisoners to remain focused and in treatment. Prisoners in treatment were seen every day and met with a support worker at least once per week for a 30 minute support session. Prisoners told us they found the service beneficial.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

Prisoners at HMP Risley had access to treatment and support from one or more service providers that operated from within the prison. These registered providers met on a regular basis with prison staff to discuss and plan a coordinated response to prisoners' health and social care needs. This ensured that prisoners had access to a good range of drug and alcohol support services as well as medical and mental health services.

We saw that all registered healthcare providers met daily to discuss a coordinated response to prisoners' health and social care needs. The registered manager for the service told us they had good working relationships with other partner agencies across the prison including prison staff. This meant that prisoners were assured good joint working arrangements were in place around their care and treatment.

CRI assisted prisoners, if they wanted; to access external support agencies upon discharge from prison, including links with CRI community based resources in order to continue in recovery or maintenance programmes. This meant that prisoners were assisted and supported to successfully remain in treatment once in the community.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not sufficiently protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

One prisoner who used the service said: "They (staff) make sure you get your methadone".

We looked at the way CRI dispensed and administered methadone to prisoners at HMP Risley.

We saw that on C wing methadone was dispensed using a Methasoft Treatment Management System. This is a system used for the automatic dispensing of methadone for substance misuse treatment. Methasoft is a computer-based software programme. It incorporates all of the steps required to support responsive and reliable methadone dispensing. Patients are identified using fingerprint recognition. The methadone is dispensed using an electronic pump and all legally required records are saved automatically.

We saw that for prisoners on wings D and E, methadone was stored in controlled drugs cabinets, which was dispensed directly from a bottle and measured. We observed nursing staff working together and confirming the correct dosage had been dispensed.

For other prisoners across the prison site, methadone was dispensed using the methasoft system directly into safety proof capped bottles which were labelled appropriately. We observed nursing staff working together checking the accuracy of the labelling fixed to the bottles. This meant there were systems in place to ensure medications were suitably labelled.

We saw that the majority of methadone was dispensed to prisoners on C wing, where there was a facility for prisoners to receive their medication in privacy and without interruption. The privacy and dignity of prisoners using this facility on C wing was upheld.

We saw that prisoners on D and E wings received their medication in privacy as much as it was practical to do so within the limitations of the prison environment. We saw that a

number of other prisoners received their medication at their cell door on various wings across the prison.

In all instances we saw staff correctly observing patients taking their medication as in line with CRI's policy on supervised consumption. However we had concerns about the way staff completed medication administration records.
We observed that nursing staff on C wing completed medication administration records before a prisoner had taken their methadone. We discussed this with nursing staff on the day who acknowledged that they should only complete the record once the prisoner had consumed the medication.

We were concerned to see that one person was not on the wing when nursing staff arrived with their methadone. We saw that this methadone was returned and placed in the controlled drugs cabinet on C wing. We had a discussion with staff and the registered manager about this as nursing staff had already signed medication records to say the prisoner had received the medication, when in fact it had not been administered. This meant that there was a risk that if this medication went missing, was lost or mislaid a clear and precise audit of what had happened to the medication could not be provided. It also meant people were at risk of not receiving their medication as prescribed as records indicated the person had already received their medication when they had not.

We looked at medication records for prisoners that were not resident on C wing and found gaps in the completion of the records. When a controlled drug is administered two staff signatures were required to confirm the dose that had been administered. We observed a number of gaps in the records over a three month period. Nursing staff and the registered manager were unable to explain these gaps; they were unable to explain why signatures were missing. We were told that medication administration records were not audited on a regular basis. Staff we spoke with on the day of our inspection confirmed that they were up to date with medication training. This meant that prisoners were not sufficiently protected from the unsafe administration of medicines with HMP Risley.

We had concerns about the way medication was transported across the prison site. For prisoners not on C wing methadone was transported across the prison site daily by two nurses, one of whom was in radio control and accompanied by a prison officer.

We saw 13 bottles of methadone, in varying quantities being prepared for transportation to prisoners across the prison site. We were told by the lead nurse that these bottles of methadone were transported in a locked metal container and carried across the site in a bag.

We accompanied nursing staff and a prison officer during their daily medication round across the prison. We observed this process and saw that container in which methadone was transported was a metal petty cash box and the bag being used to carry the container was a worn shopping carrier bag.

We saw that the locked metal container was not big enough to hold all 13 bottles and one bottle was put loosely into the shopping carrier bag. We saw that the metal container which methadone was carried in was dirty and sticky with medication residue. The container was also used to store other medication.

During the 'medication round', we observed a number of prisoners around the prison site whilst nursing staff walked from wing to wing dispensing methadone. We were concerned

about the safety and risk attached to this process and asked if there had ever been any incidents or near misses whilst staff were dispensing methadone across the prison site. We were told there had never been any incidents or near misses.

We had a discussion with the registered manager for the service about our concerns, and the risks associated with the transporting of methadone and other medicines across the prison. The registered manager told us there was a standard operating procedure in place across the prison for transporting controlled drugs to other sites across the HMP Risley. We reviewed this document and noted it was invalid as the commissioner for the service had changed on the 1 April 2013. This meant the registered provider did not have current procedures in place for the safe transportation of controlled drugs across the prison.

We spoke with the registered provider for the service who told us that a number of measures would be put in place in response to our findings. These included an immediate medication audit, a review of medication records to identify staff responsible for omissions observed on records, a review of staff training and the introduction of weekly medication audits undertaken by the registered manager.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We spoke with the registered manager for the service who held the post of service lead. We wanted to know what systems were in place to monitor the quality of services provided at Risley. We were told that CRI tried to ensure that prisoners had the same access to services available to people who lived in the community.

The registered manager told us that the service was well supported by the prison; they had good working relationships with prison officers and senior staff across the prison.

We saw that CRI met regularly with partner agencies, commissioners and prison staff to discuss working practices and there were good working relationships between CRI and other partnership agencies and with prison staff.

We saw that a Joint Prison Health Partnership Board meeting was held every 3 months. This was attended by all partnership agencies, commissioners and senior prison staff. The meeting provided an opportunity to review death in custody incidents, future commissioning arrangements and untoward and complex incidents and complaints. This meant that there were joint arrangements in place to assess and review the health and social care needs of prisoners, to consider risk and to plan for their future care needs to which CRI was part of.

Other measures in place to monitor service delivery included daily handover sessions and a professionals lunch time meetings was held when information concerning patients was shared.

We found that the strength of the service was its commitment to supporting and empowering prisoners to become drug free. However we found that there were insufficient audits in place around the administration of methadone and other medicines to prisoner across the prison site.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not sufficiently protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. (Regulation 13.)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 29 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk