The Regulation and Quality Improvement Authority

Hydebank Wood Young Offenders' Centre and Ash House Women's Prison

Unannounced Inspection of Prison Healthcare

21-25 March 2011

Strictly Embargoed until 12.01am
Monday 10 October 2011

informing and improving health and social care
www.rqia.org.uk

Contents

List of Abbreviations

ADEPT	Alcohol and Drug Educational Programme and Training
A&E	Accident and Emergency
ASIST	Applied Suicide Intervention Skills Training
BBV	Blood-Borne Virus
BLS	Basic Life Support
BSO	Business Services Organisation
CAB	Challenging Anti-Social Behaviour
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behaviour Therapy
CHD	Coronary Heart Disease
CJI	Criminal Justice Inspection Northern Ireland
COSHH	Control of Substances Hazardous to Health
CPA	Care Programme Approach
CPR	Cardiopulmonary Resuscitation
DH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety
D&TC	Drug and Therapeutics Committee
EHSSB	Eastern Health and Social Services Board
EMIS	Egton Medical Information System
ETI	Education and Training Inspectorate
GP	General Practitioner
GSL	General Sales List
GUM	Genitourinary Medicine
HIV	Human immunodeficiency virus
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service
HPV	Hepatitis B Vaccination
HSC	Health and Social Care
NIAS	Northern Ireland Ambulance Service
NICE	National Institute for Health and Clinical Excellence
NIPS	Northern Ireland Prison Service
NMC	Nursing and Midwifery Council
NPM	National Preventive Mechanism
NPSA	National Patient Safety Agency
NVQ	National Vocational Qualification
OCN	Open College Network
OPCAT	United Nations Optional Protocol to the Convention Against Torture
PECCS	Prisoner Escorting and Court Custody Service
PGD	Patient Group Direction
PHA	Public Health Agency
PID	Pelvic Inflammatory Disease
POCVA	Protection of Children and Vulnerable Adults
PPE	Personal Protective Equipment
PSNI	Police Service of Northern Ireland
QOF	Quality and Outcomes Framework
RMN	Registered Mental Nurses
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incidents

SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedures
SPAR	Supporting Prisoners at Risk
SRE	Sex and Relationship Education
SSU	Special Supervision Unit
STI	Sexually Transmitted Infection
STORM	Skills-based Training on Risk Management
UK	United Kingdom
UNOCINI	Understanding the Needs of Children in Northern Ireland
WASP	Women's Awareness Staff Programme
YOC	Young Offenders' Centre

Chief Executive's Foreword

This inspection is the first of its type, and the first time RQIA has provided a detailed overview of prison healthcare in Hydebank Wood Young Offenders Centre and Ash House Women's Prison. RQIA recognises that prison healthcare is undergoing a transformational change programme, driven by the Health and Social Care (HSC) Board, as commissioner, and by the South Eastern Health and Social Care Trust (SEHSCT) as the provider of prison healthcare services. This change programme is incomplete. It needs a sustained commitment from policy leads, commissioners and service providers if it is to realise the benefits intended from the change process.

The inspection looked at prison healthcare at a point in time along the pathway to transformation. This report makes 113 recommendations where further change and improvement is required. The number of recommendations reflects the detailed nature of the inspection. The report should be used by the SEHSCT, the HSC Board and Northern Ireland Prison Service (NIPS), as a vehicle to promote and facilitate further improvements in service delivery.

There were a number of issues identified during the inspection which are of particular concern and which have been highlighted throughout the report as priorities. These matters have already been brought to the attention of those with responsibility for oversight of the service. There are four key areas where immediate attention is required. These are: governance and accountability arrangements; safety and information sharing; mental health service provision; and change to working practices.

RQIA believes that a firm commitment from all parties will be required to deliver the necessary further improvements in prison healthcare. RQIA will carry out further announced and unannounced follow up inspections in the Young Offenders Centre and in Ash House, to monitor progress against these recommendations.

RQIA would like to thank those who participated in the inspection process.

Members of the RQIA inspection Team:

Mrs Liz Colgan - Senior Inspector, RQIA (Lead)
Ms Helen Daly - Pharmacy Inspector, RQIA
Mr Gerry Colgan - Senior Sessional Officer Mental Health Team, RQIA
Mrs Paula Hendron - Children's Inspector, RQIA

RQIA would also like to thank the following people who contributed to the preparation for the inspection and the finalising of the report.

Dr Noel McCune - Child and Adolescent Consultant Psychiatrist, SHSCT
Mr Phelim Quinn - Director of Operations and Chief Nurse Advisor, RQIA
Mr Jim McElroy - Project Manager, RQIA
Miss Claire Richardson - Project Manager, RQIA
Mrs Louise Curran - Project Administrator, RQIA

Profile of Hydebank Wood Young Offenders' Centre (YOC) and Ash House

Hydebank Wood Young Offenders' Centre (YOC)and Ash House are located in south Belfast and employ 382 staff. The YOC accommodates all young male offenders aged between 17 and 21 years on conviction, serving a period of four years or less in custody. At the time of the inspection, there were a total of 203 young offenders in the YOC.

Ash House is a self-contained unit within Hydebank Wood young male offender centre (YOC) and accommodates all women prisoners in Northern Ireland. At the time of the inspection there were 49 women prisoners.

Healthcare

At the YOC and Ash House, healthcare is the responsibility of SEHSCT and is provided 24 hours a day, seven days a week.

The healthcare team includes qualified nurses, healthcare officers and healthcare assistants. The healthcare centre was recently refurbished and provides separate accommodation for male and female patients.

Young Offenders Centre (YOC)

Under the terms of the Treatment of Offender's Act (Northern Ireland) 1968, a male offender can remain at the YOC up until the day prior to his twenty-fourth birthday.

Arrangements can be made to accommodate younger people at the YOC. Legislation also permits that young offenders from 15 years old can be held in the YOC if their crime is deemed to be of a very serious nature.

Accommodation

The YOC comprises five self-contained houses, each of which can hold about 60 young offenders, mostly in single cell accommodation. Each house comprises four landings, each of which has a shower/ toilet room and recreation/ dining areas.

The four houses for male young offenders are Beech, Cedar, Elm and Willow. A substantial refurbishment programme has been undertaken to provide in-cell sanitation within Beech and Cedar. Elm and Willow already have these facilities.

Cedar House: has five landings for those on enhanced regime (Prisons operate an Incentives and Earned Privileges Scheme (IEP) with three levels basic, standard and enhanced regime). This houses (enhanced regime) prisoners who have passed drug tests and whose attitude, behaviour and willingness to participate in programmes to address offending behaviour, is rewarded with improved recreational facilities and a more relaxed regime.

Elm House: contains young male adults on all regime levels and can accommodate up to 90 prisoners in single and double occupancy cells. This unit is to be refurbished when funds are available.

Willow House: contains young adults and juveniles and can accommodate up to 69 prisoners in single and double occupancy cells. Willow 1 and 2 function as the juvenile unit and can accommodate up to 35 prisoners within single occupancy cells. Willow 3 accommodates young adults on basic, standard and enhanced regime levels.

Beech House: contains young male adults and can accommodate up to 90 prisoners in single and double occupancy cells. The ground floor has recently been refurbished to provide classrooms. The induction landing is on the first floor - Beech 1, and the assessment unit is on Beech 2.

The Special Supervision Unit (SSU) in Willow House comprises eight rooms.

Ash House Women's Prison

Ash House opened for women on 21 June 2004 following a major refurbishment programme. Further refurbishments including the installation of in-cell sanitation were completed in April 2007.

Accommodation

Ash House is a stand-alone residential unit within Hydebank Wood and is adjacent to the male accommodation. It contains five self-contained landings, each with dining and association areas and four landings with integral sanitation in the cells. A2 is used as a first night centre and for prisoners on induction. A3 and A4 are enhanced landings and A5 (which is deemed to be the accommodation of the highest standard) houses long-term prisoners who are given the opportunity to cook their own meals and is effectively self-contained. A1 holds women on basic level. There are two mother and baby cells on A4 and two cells adapted for women with disabilities on A2. The ground floor has two multifunctional rooms and a medical facility. There is a new purpose-built female reception adjoining Ash House.

Section One: Introduction and Background

Executive Summary

In March 2011, RQIA took part in two joint inspections of Hydebank Wood Young Offenders Centre (hereafter referred to as the YOC) and Ash House, Hydebank Wood, Women's Prison (hereafter referred to as Ash House) in partnership with the Criminal Justice Inspection Northern Ireland (CJI), Her Majesty's Inspectorate of Prisons (HMI Prisons) and the Education and Training Inspectorate (ETI). These inspections were carried out as a follow up to inspections which took place in 2007. Joint reports on each inspection have been prepared by the four inspectorates. RQIA has prepared this supplementary report, which focuses on the findings of the inspection in relation to prison healthcare at the two facilities.

The responsibility for prison healthcare transferred from the Northern Ireland Prison Service (NIPS) to Health and Social Care Services (HSCS) in 2008. Since 2009 prison healthcare is now commissioned by the Health and Social Care (HSC) Board and provided by South Eastern Health and Social Care Trust (SEHSCT).

The findings of the report are divided into three sections

- Organisational Systems and Governance
- Protecting and Promoting Health and Wellbeing
- Accessible, Responsive and Effective Care

Organisational Systems and Governance

The overall findings of the RQIA inspection in relation to the prison healthcare organisational systems and governance framework would indicate that there has been some progress made in developing these systems and frameworks. However, there are still significant deficits and gaps which need to be addressed, to ensure that young offenders and women have at least the equivalent standard of healthcare as the general public.

The joint clinical and social care governance arrangements between the NIPS and SEHSCT need to be improved to facilitate continuous service development. An analysis of key information sources, such as critical incidents, complaints, multiprofessional audit, audits of deaths in custody and HMI Prisons action plans provided limited evidence of communication of service improvements. There are many challenges which still need to be addressed to ensure that the partnership arrangements are sufficiently robust to allow for joint decision making, effective management of resources, effective information sharing, audit and service development.

Developments and Improvements Since the Last Inspection

- A draft Prison Healthcare Strategy has been devised by SEHSCT which outlines a vision for Northern Ireland Prison Healthcare.

- A Prison Health Care Partnership Board meets on a bi-monthly basis and has the responsibility for developing and agreeing prison healthcare policy and standards.

- A Service Improvement Board for Hydebank Wood has been established. Its purpose is to provide leadership and direction in the development of work streams, and to provide a focus for continuous improvement.

- A Regional Prison Health Governance Committee is in place, which reports to both the Prison Service Management Board and the SEHSCT Governance Committee.

    - SEHSCT has developed an audit process based on Her Majesty's Prison Service (HMPS)/ Department of Health (DH) Prison Health Performance Indicators and the Prison Health Governance Plan.

- Complaints are discussed at the Regional Prison Health Clinical Governance Committee and there was evidence that action was being taken in this regard.

Key Areas for Improvement

- The HSC Board should complete as a matter of priority, the "Commissioning Statement of Intent", to enable the draft Prison Healthcare Strategy to be finalised.

- The findings of RQIA's inspections undertaken in 2011 would indicate that there has been limited progress in addressing the recommendations of the previous inspection in the YOC. However in Ash House, progress was evident in some areas.

- The SEHSCT, although responsible for the provision of healthcare services within prison, has no direct authority for healthcare staff employed by the prison service. The transfer for the direct responsibility for staff is planned for April 2012. This system creates difficulties not only with performance management, but can also leave staff professionally isolated. The SEHSCT and the NIPS should provide clarity in respect of accountability arrangements, for both professional and employment issues and a collaborative approach taken in these issues when necessary, pending the transfer of staff.

- The poor attendance at the Regional Prison Health Governance Committee, is of concern and provides little assurance that a robust and proactive governance system is in place, future participation of senior trust staff at the Regional Prison Health Governance Committee is strongly recommended.

- Prison healthcare should be standing item on the agenda of the SEHSCT Governance Assurance Committee to strengthen clinical governance arrangements.

- A prison healthcare performance audit should be undertaken in Hydebank Wood. Given the findings of the inspections, RQIA would recommend that this is undertaken immediately.

- Complaints are not a standing item on the agenda of acting healthcare managers or staff meetings, and these are not monitored to identify emerging patterns or trends. A formalised process to monitor and share learning from complaints should be implemented.

- An information sharing policy has not been developed for either establishment, which is vital to safeguard and promote the welfare of both the young people and women within these respective units.

- A workforce plan should be developed and a capacity and demand analysis undertaken. A training needs analysis should be carried out and a system put in place which ensures that all staff attend mandatory training.

Protecting and Promoting Health and Wellbeing

The RQIA inspection of the systems in place for the prevention of suicide and self-harm encompassed both the main prison and the healthcare centre. The areas reviewed related to the recommendations of the previous report in 2007. Whilst some of the areas reviewed were not fully part of prison healthcare, it was important to ensure that the systems in place within both establishments were robust. Inspectors sought assurance that the appropriate measures were in place to ensure that individual prisoners are protected from harm by themselves or from others and that healthcare staff are adequately involved in this process.

The overall findings of the RQIA inspection team in relation to protecting and promoting health and social wellbeing as part of a healthy prison policy would indicate that there is still a considerable amount of work required to reduce or mitigate the effects of unhealthy or high risk behaviours. There needs to be a more cohesive approach to the prevention of suicide and self-harm and evidence of collaborative working and information sharing. This is, to ensure that the appropriate steps are taken to protect young offenders and women from harm to themselves or by others.

The joint reports from CJI, HMI Prisons, RQIA and ETI highlight that the NIPS continues to accommodate young men under the age of 18 in Hydebank Wood. The report also highlights some improvements in the care of young people at Hydebank Wood. This includes improvements to the environment, evidence of greater interaction between staff and young people and improved access to activities. However, inspectors found that young offenders still spend too much time locked in their cell.

The conclusion of the four inspection teams is that Hydebank Wood does not have the resources and is not an appropriate place to deal with the most troubled and troublesome children and young people in the criminal justice system. While the provision of these services continues at Hydebank Wood, services should be appropriately resourced, with dedicated accommodation and a regime capable of meeting the needs of this specific cohort of young offenders.

In Ash House, despite efforts by the NIPS to meet the specific needs of female prisoners (which has included the adoption of gender-specific standards), remains an unsuitable environment. The restrictive and cramped accommodation on a site

shared with young men means that the needs of women prisoners cannot be appropriately met.

It is particularly sad that one young man and one woman were found dead at the YOC and Ash House shortly after the inspections. The circumstances of both deaths are currently being investigated by the Prisoner Ombudsman.

Developments and Improvements Since the Last Inspection

- The Suicide and Self-Harm Prevention Policy was revised in 2011 and is applicable to all prisons within Northern Ireland.

- The Gender-Specific Standards for Women Prisoners and a Working with Women Prisoners: A Guide for Staff were published in November 2010.

- The Supporting Prisoners At Risk (SPAR) process has been introduced. The SPAR process enables staff to provide immediate assistance and provides a mechanism through which staff can work together to provide individual care to prisoners who are in distress.

- Training has commenced and is ongoing for staff in Applied Suicide Intervention Skills Training (ASIST).

- Some support systems and therapeutic responses are available such as: Opportunity Youth, Alcohol and Drug Educational Programme and Training (ADEPT) for drug and alcohol counselling, art therapy, psychology sessions, Cruse and Cognitive Behaviour Therapy (CBT).

- Young people and women prisoners are able to contact free telephone helplines including the Samaritans.

- A new strategy on challenging anti-social behaviour (CAB) is undergoing a six-month pilot in Ash House.

- In the YOC, a comprehensive Safeguarding Children Framework and Guidance policy has been devised, which includes a Safeguarding Children Protocol with each of the HSC trusts and the NIPS.

- Prison medicines management is a distinct component of the local delivery plan of the SEHSCT. The Drugs and Therapeutic Committee meets three times per annum to ensure accurate and evidence-based prescribing and to agree protocols.

Key Areas for Improvement

- The corporate suicide and self-harm prevention policy does not fully reflect the distinct and specific needs of children and young adults or women at Hydebank Wood. To date, all aspects of the policy have not been fully implemented due to funding restraints.

- A more cohesive approach is required in the prevention of suicide and self-harm, which ensures that this is the responsibility of all staff within both establishments. There should be clear evidence of collaborative working between the Safer Custody lead and the Healthcare lead, as well as evidence of managed information sharing between healthcare and the prison staff, to reduce the risk of suicide and self-harm.

- The joint reports from CJI, HMI Prisons, RQIA and ETI strongly recommends that Suicide Prevention Coordinators are appointed exclusively for the young offenders centre and the women's prison, with sufficient allocated time to carry out these respective roles.

- Although there were some counselling services and therapeutic responses inspectors found that they were not sufficient to support young people and women at risk at Hydebank Wood.

- All prison staff including healthcare staff should have Applied Suicide Intervention Skills Training (ASIST), to ensure that they are equipped with the required knowledge and skills.

- A key worker system should be introduced to ensure that staff are identified to work alongside young people at risk of self-harm or suicide.

- There appears to be two systems running in parallel in relation to serious adverse incidents (SAIs). The governance arrangements are not sufficiently robust in relation to the sharing of and learning from SAIs to provide assurance that recommendations will be addressed. A system should be established which ensures that there is two-way communication in relation to SAIs and that all relevant information is shared in a timely manner across the prison service.

- Detailed risk assessments of ligature points of cells had not been undertaken in either establishment. Despite a death and the recent suicide attempt having occurred in the YOC, which used the old metal style beds as a ligature, these beds have not been replaced. The joint inspection report strongly recommends that a detailed written risk assessment should be carried out as a matter of urgency in conjunction with SEHSCT, which includes an action and management plan. The metal style beds bolted to the floor in Elm and Willow Houses should be removed as a priority.

- The inspections highlighted that both Ash House and the YOC have some way to go to improve the profile of anti-bullying and violence reduction and to ensure that effective interventions to support victims and challenge bullies are introduced. SEHSCT must ensure that healthcare staff are included in training and play an active role in the implementation of the new strategy.

- In the YOC there was little evidence to indicate that the Safeguarding Children Framework and Guidance policy was being followed.

- The multidisciplinary safer custody steering group does not always link with other multiagency meetings concerning children and young people, and neither the prison nor the health and social care trusts are managing referrals correctly. It is imperative that the protocol detailing inter-agency working is fully implemented.

- An audit of child protection case files revealed that referrals are not always made to trusts using the appropriate Understanding the Needs of Children in Northern Ireland (UNOCINI) form, and trusts do not always respond, as required under the child protection procedures. Monitoring or analysis of child protection referrals to identify patterns or trends is not undertaken.

- There remain some significant gaps in the number of staff receiving child protection training. Given the issues associated with protection and safeguarding, greater emphasis must be placed on child protection training, including refresher training for staff.

- An improvement is required to assure the safety and effectiveness of the healthcare environment. Environmental cleanliness and infection prevention and control audits are not being undertaken. Advice and guidance should be sought from the infection prevention and control team in SEHSCT.

- There appears to be a reluctance to admit patients to the healthcare unit, particularly in relation to self-harm and detoxification. Inspectors would recommend that the placement of patients, including admission to the healthcare centre, should be reviewed to ensure that women and young people receive effective support, particularly during the first days of a detoxification programme.

- Inpatient beds should not form part of the prison's certified normal accommodation, and there should be more day services available for those less able to cope with prison life. There was little evidence to suggest that healthcare staff have identified individual needs in this area or are proactive in developing services such as support groups.

- Healthcare staff need to ensure that emergency drugs and equipment are fit for purpose and checked regularly. There should be documented evidence of such checks in line with agreed protocols.

- The procedures in place for confirming current medication, and for prescribing medication at committal must be reviewed, as the current practice is unsafe and does not meet the Nursing and Midwifery Council (NMC) guidelines.

- Records for the disposal of medicines are not maintained and records of administration are not audited. A clear audit trail does not exist which may result in medication incidents going undetected.

- The risk assessment used for medicines to be held in possession by young offenders and by women prisoners should be fully completed and updated. Inspectors found that decisions made regarding the supply of in possession medicines were often subjective.

- The management of the controlled drug key and out of date and discontinued controlled drugs awaiting destruction should be reviewed. Controlled drugs which are dispensed in daily issue bags should be stored in a suitable container in the controlled drug cabinet.

- Healthcare staff were unable to confirm that those entering prison are always offered the Hepatitis B vaccination.

- Although there was evidence of progress in the provision of sexual health services, inspectors were concerned that information, education, screening and confidential advice were not actively promoted in a planned manner.

- Young offenders and female prisoners did not have the appropriate levels of physical exercise and opportunities for outdoor activity. Those spoken with commented that association time was often cancelled at short notice.

Accessible, Responsive and Effective Care

The findings of the RQIA inspection team in relation to providing accessible, effective and responsive services, would indicate that improvements are required in the provision of prison healthcare: to ensure that there are comprehensive and innovative services available to address a complex range of mental health disorders; to promote effective links with health and social services in the community; and, to improve continuity of care.

Developments and Improvements Since the Last Inspection

- Completion of a general or in-depth health assessment is undertaken in both establishments. This assessment is an important tool, as it offers an opportunity to assess individuals and provide treatment for previously untreated conditions.

- The prison healthcare centre has a contract in place with a local GP surgery that provides clinics during the week. At the time of the inspection, a new clinical lead had been appointed who was due to review the systems in place regarding medical workforce planning to ensure continuity of service.

- The regional risk assessment used by all psychiatric services in Northern Ireland is applied when required.

- At the time of the inspection, the SEHSCT had secured funding from the HSC Board for the appointment of two nurses to develop services for those with a personality disorder.

Key Areas for Improvement

- Inspectors found that up-to-date health needs assessment had not been undertaken. This would include the gathering of information about the health profile of prisoners to facilitate the planning and future development of appropriately targeted healthcare provision.

- The inspection highlighted that since the transfer of responsibility for prison healthcare to SEHSCT, the provision of some healthcare services in Hydebank Wood had decreased, most notably psychiatric services. This was due in part to staff vacancies and the reorganisation of services to create new posts.

- Mental health services are under resourced and the overall findings would indicate that current provision of psychiatric support services is inadequate. RQIA would recommend that the provision of psychiatric support services should be reviewed as a matter of priority.

- The provision of Cognitive Behaviour Therapy (CBT) services and the availability of other appropriate therapies specifically for personality disorders, does not fully meet the needs of these vulnerable groups.

- Women and young offenders have access to a GP but primary care services are not structured or managed to ensure efficient use of resources. Currently the provision of appointments operates within the timescales of the lock down system.

- The inspection evidenced that young offenders and female prisoners wait longer than one week for a first appointment with the mental health team. In some instances the waiting time was eight weeks or more from when a referral was made until the individual was assessed. RQIA strongly recommends that this deficit is addressed immediately.

- There was no evidence that the mental health regional risk assessment is shared appropriately with other disciplines or agencies, or that enhanced risk assessments requiring multidisciplinary meetings are initiated.

- Currently there are no specialist Child and Adolescent Mental Health Services (CAMHS). Also, there is no evidence that the SEHSCT/ YOC partnership is working effectively to ensure that children and young people in the YOC have access to a comprehensive forensic multidisciplinary service. It is concerning that the most challenging young people are sent to the YOC, and cannot be cared for in Woodlands Juvenile Justice Centre. The inspection team would strongly recommend that this situation is reviewed by SEHSCT and DHSSPS as a matter of priority, as the current regime at the YOC is not appropriately resourced, or capable of meeting the needs of this particular category of offender.

- An up-to-date drug and alcohol strategy was not available, nor was there evidence of multidisciplinary addictions meetings having taken place in the YOC or Ash House.

- Addiction services are under resourced, with only one session a week and the addiction services nurse has only five patients on her case load. All of these were from Ash House and the lack of referrals from the YOC needs to be investigated and rectified.

- Given the findings of the most investigation by the Prisoner Ombudsman into the death in custody of Allyn Baxter, inspectors were concerned that the protocol for those undertaking clinical alcohol detoxification does not require admission to the healthcare centre.

1.1 Introduction

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvement in the quality of those services.

RQIA's main functions are:

- To inspect the quality of health and social care provided by health and social care (HSC) bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies.

- To regulate (register and inspect) a wide range of health and social care services delivered by HSC bodies and the independent sector. The regulation of services is based on minimum care standards, which ensure that service users know what quality of services they can expect to receive, and service providers have a benchmark against which to measure quality.

RQIA is responsible for the oversight of health and social care in prisons, children's secure accommodation and mental health and learning disability facilities. Given this role, RQIA has been designated as a national preventive mechanism (NPM) by the United Kingdom (UK) government to ensure the protection of the rights of those in places of detention.

In keeping with the aims of RQIA, the team adopted an open and transparent method for inspection. The inspection operated within RQIA's core values:

- **Independence -** upholding our independence as a regulator in order to maintain public confidence in the services we deliver

- **Inclusiveness -** promoting public participation and building effective partnerships internally and externally

- **Integrity -** being honest, open, transparent and consistent in all our dealings with our stakeholders

- **Accountability -** being accountable and taking responsibility for our actions

- **Professionalism -** providing professional, effective and efficient services in all aspects of our work (internally and externally)

- **Effectiveness -** being an effective regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services.

RQIA's Corporate Strategy 2009-12 provides the context for the representation of RQIA's strategic priorities. Four core activities which are critical to the success of the strategy are:

- **Improving care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care

- **Informing the population:** we publicly report on the safety, quality and availability of health and social care

- **Safeguarding rights:** we act to protect the rights of all people using health and social care services

- **Influencing policy:** we influence policy and standards in health and social care.

1.2 Background and Context of the Inspections

The inspections of the YOC and Ash House were carried out in partnership with CJI, HMI Prisons and inspectors from the ETI. Whilst the inspections were carried out by all four agencies and will be reported on collectively, RQIA has produced this specific and more detailed report on the outcome of its assessment of prison health and social care, as commissioned by the HSC Board and provided by SEHSCT. This report from RQIA also outlines findings which relate directly to the Northern Ireland Prison Service (NIPS). The recommendations relating to these findings will only be included in the joint report from the four agencies. Subsequent to the inspection, as a result of the findings in relation to ligature points, RQIA and CJI met with the Governor of Hydebank Wood and were provided with an assurance that this matter would be dealt with as a priority. In addition, a separate meeting was also organised with senior representatives from SEHSCT to discuss issues identified at the inspection pertaining to health care.

The terms of reference for the inspections required the completion of a short follow-up unannounced inspection of each establishment, to determine the progress made in addressing the recommendations of the following reports:

- Report of the Announced Inspection of Hydebank Wood Young Offenders Centre by HM Chief Inspector of Prisons and the Chief Inspector of Criminal Justice in Northern Ireland November 2007

- Report of the Announced Inspection of Ash House Hydebank Women's Prison by HM Chief Inspector of Prisons and Chief Inspector of Criminal Justice in Northern Ireland November 2007.

The key findings of the announced inspections undertaken in 2007 of Hydebank Wood YOC and Ash House are presented below.

Findings of the Announced Inspection of Hydebank Wood YOC 2007

The announced inspection of Hydebank Wood YOC 2007 identified that, despite progress made, the young offender centre was struggling to adequately deal with the complex and competing tasks of managing a variety of remanded and sentenced juvenile and young adult men, on a site that also contained a women's facility. The plight of juveniles was of particular concern. Problems with regard to service management were compounded by poor industrial relations and anomalous staffing arrangements.

The inspection report recognised the difficulties of a custodial setting with so many competing risks and vulnerabilities in one small site. It recommended that it should remain the goal of the NIPS to house juveniles and women in separate, dedicated establishments that can address their particular needs.

Findings of the Announced Inspection of Ash House 2007

The announced inspection of Ash House in 2007 found that it was generally providing a safe environment, but that it remained inherently unsatisfactory that women were held within a male establishment. While some improvements had been made, there was insufficient focus on the particular needs of women, which meant that the unit fell short of the HMI Prisons expectations for a respectful, purposeful establishment that effectively addressed resettlement needs.

The 2007 report indicated that staff at Ash House had made commendable efforts to mitigate the inappropriate location of a women's prison within a male young offenders' centre. However, the inadequacies of the current arrangement remained all too apparent and the report again recommended that NIPS works towards creating a separate and dedicated women's facility.

The recommendations of the inspections undertaken in 2007 are contained within corresponding inspection reports which are available via CJI's website[1].

[1] The CJI reports are available online as follows:

Ash House Women's Prison:
http://www.cjini.org/CJNI/files/3c/3ca1e4a3-649a-491d-bb54-f59b80fff6b5.pdf

Hydebank Wood YOC:
http://www.cjini.org/CJNI/files/74/743c0eb6-5bc1-4a27-b08f-e0d17ad490e3.pdf

1.3 Inspection Methodology

Prior to the inspections, the inspection team undertook a literature review to determine current best practice standards in relation to prison healthcare. The following documents provided the inspection team with a benchmark for best practice:

- Prison Health Performance and Quality Indicators: HMPS/DH
- Prison Health Performance Indicators for Northern Ireland
- Prison and Young Offenders Centre Rules (Northern Ireland)
- The Criminal Justice (Northern Ireland) Order 2008
- Her Majesty's Inspectorate of Prisons: Expectations (Criteria for assessing the conditions in prisons and the treatment of prisoners)
- Her Majesty's Inspectorate of Prisons: Expectations (Criteria for assessing the treatment and conditions for children and young people held in prison custody).

The RQIA inspection team based its inspection methodology on HMPS/DH Prison Health Performance and Quality Indicators and draft Prison Health Performance Indicators for Northern Ireland.

The draft Prison Health Performance Indicators for Northern Ireland are based on the Prison Health Performance Indicators compiled by the DH and HMPS in 2007 (and updated in 2009). The Northern Ireland indicators have been developed by the HSC Board, the Public Health Agency (PHA), SEHSCT and the NIPS. The review of both documents would indicate that certain elements and sections of the DH document have not been included in the Northern Ireland document or have yet to be fully developed, such as the Healthcare Environment, Services for Children and Adolescents and Services for Adult Women.

Given that the inspections were of a young offenders centre and of a women's prison, RQIA developed draft Quality Indicators for this inspection based on these documents.

The draft Quality Indicators (which were used as a basis for the inspections) comprise the following three sections:

- Organisational Systems and Governance
- Protecting and Promoting Health and Wellbeing
- Accessible, Responsive and Effective Care.

Each section has a number of indicators. However, due to the limitations of the inspections, it was not possible to review all of the indicators or criteria within each indicator.

On 31 March 2009, both RQIA and CJI became designated NPMs in accordance with Article 17 of the Optional Protocol to the Convention Against Torture.

The United Nations Optional Protocol to the Convention Against Torture (OPCAT) has been described as "an innovative human rights instrument to assist States to meet their obligations to prevent torture and other forms of ill-treatment" and is "primarily concerned with preventing violations". As a consequence of the dual system of preventive monitoring instituted by the protocol in Northern Ireland, RQIA and CJI are two of the four appointed NPMs to assist the United Nations Subcommittee for the Prevention of Torture. RQIA conducts inspections of places of detention across both the criminal justice and health sectors in Northern Ireland. CJI inspects facilities in the criminal justice system.

The inspection team was advised to give due consideration to RQIA's responsibilities as a NPM when carrying out the inspections.

An overall consensus was reached by all the inspection teams at the end of the inspections as to the number of previous recommendations that had been achieved, partially achieved or not achieved.

Table 1 – The YOC

Results of the review of the previous recommendations	Overall total 171
Achieved	50
Partially achieved	33
Not achieved	87
No longer relevant	1
Overall total carried forward	***120***

At the previous inspection of the YOC in 2007, there were a total of 24 recommendations made in relation to prison healthcare, excluding substance misuse. Of the 24 recommendations made, eight have been achieved, three have been partially achieved, one was no longer relevant and 12 have not been achieved.

Table 2 – Ash House

Results of the review of the previous recommendations	Overall total 147
Achieved	40
Partially achieved	41
Not achieved	64
No longer relevant	2
Overall total carried forward	***105***

At the previous inspection of Ash House in 2007, there were a total of 27 recommendations made in relation to prison healthcare, excluding substance misuse. Of the 27 recommendations made, seven have been achieved, eight partially achieved, one was no longer relevant and 11 have not been achieved.

Section Two: Prison Healthcare Organisational Systems and Governance

Governance in healthcare can be described as the systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services. These systems and processes must provide assurance that quality care is delivered, organisational objectives are being met and that commitment to improve is present and evidenced.

This section includes the following elements:

- Corporate Governance
- Clinical Governance
- Information Governance
- Workforce Planning.

Corporate Governance: Corporate governance for a trust/ Prison Health Partnership Board can be defined as a robust process, to ensure clarity of purpose, transparency in decision-making and clear lines of accountability. The transfer of responsibility for healthcare services was completed in April 2008 and a separate governance structure has been developed for the management of healthcare within the NIPS. Since April 2009 there has been full devolution of responsibility for the provision of prison healthcare to the SEHSCT. The trust is expected to work closely with the NIPS to discharge this responsibility in a way that meets both the health and custodial needs of prisoners.

Clinical Governance: Clinical governance is a system through which health and social care organisations are accountable for continuously improving the quality of services and safeguarding high standards of care, through the creation of an environment in which excellence in clinical care will flourish. Clinical governance includes both clinical and non-clinical staff and acknowledges everyone's contribution to patient experience. For example, in prison healthcare, good integrated governance creates a consensus around the concerns of clinical staff, security staff, managers, patients and their families.

Information Governance: The effective management of records and information is an integral component for the delivery of safe, secure and effective healthcare. For children, young people and women, information sharing is vital to safeguard and promote their welfare. Information governance should be managed through systems based on human rights, data protection and mental capacity legislation.

Workforce Planning: Staff groups delivering healthcare to prisoners come from a variety of organisations and professional backgrounds, therefore it is necessary to have a joint approach to planning and training. Recruitment and retention have often been problematic within prison health. Modernising the way in which staff work and the roles they undertake will help to achieve optimum workforce capability.

2.1 Corporate Governance

Quality Indicator

There is a responsibility for the trust and the prison to have formal arrangements in place to ensure that service provision fulfils all the tenets of good governance. The prison/ trust partnership should target investment and improvement on priorities, based on local health needs assessments and local planning processes. This should include other providers of services, such as the local mental health service provider or for young offenders, children's services as required.

Expected Outcome

The partnership arrangements should be sufficiently robust to ensure joint decision-making, effective management of resources, effective information sharing, audit and service development and these arrangements should ensure compliance with the joint aims and objectives of both parties.

2.1.2 Findings of the Inspections

The following information was obtained relating to the organisational systems in place for prison healthcare.

2.1.3 Prison Health Care Strategy

The draft Prison Health Care Strategy 2010-2015 highlights that SEHSCT is committed to:

- ensuring that prisoners have at least the equivalent standard of healthcare as the general public, with the most effective use of resources and performance measured against best practice
- promoting health and social wellbeing as part of a healthy prison policy in order to reduce or mitigate the effects of unhealthy or high-risk behaviour
- providing comprehensive and innovative services to address the range of mental health disorders evident in prisons and to promote effective links with health and social services in the community to improve continuity of care.

The draft strategy reflects these underpinning principles and has been shaped by the outcome of numerous discussions with both healthcare and operational managers, staff and key stakeholders. A wide range of services are described within the document which aims to establish a five-year strategy, based on best practice models for healthcare delivery within a prison setting.

The range and depth of services commissioned will be determined by the resources available, as well as the priorities set by the Prison Health Care Partnership Board. The Prison Healthcare Strategy recognises that there should be a vision for Northern Ireland to ensure that health and social care

services are designed to meet the challenging range of needs presented by offenders and their families.

This strategy cannot be finalised until the HSC Board Commissioning Statement of Intent is made available. This issue has been identified on the corporate risk register of SEHSCT. RQIA recommends that the HSC Board completes this commissioning statement as a priority and that the draft strategy is updated and completed to assist with the effective management of resources and information sharing, audit and service development, and to improve the health and wellbeing experience for every prisoner in a custodial setting.

2.1.4 Prison Health Care Partnership Board

The Prison Health Care Partnership Board meets on a bi-monthly basis and is chaired by the Director of Adult Services of SEHSCT. The membership of this Board includes representatives from DHSSPS, HSC Board, SEHSCT and the NIPS.

The Partnership Board has the responsibility for developing and agreeing prison healthcare policy and standards. Copies of the Prison Health Care Partnership Board minutes for November 2010 and January 2011 indicated that there was appropriate representation from all the key parties. The Prison Health Performance and Quality Indicators upon which current performance is based, recommend that the Partnership Board is co-chaired by the Governing Governor and the Chief Executive of the trust (or appropriate deputies). This was not evident in the minutes of the Prison Health Care Partnership Board minutes for November 2010 and January 2011. The minutes indicated that there was appropriate representation from all the key parties. However, without this joint responsibility, it would be difficult to ensure that there is effective joint decision-making. RQIA would recommend that a Governing Governor or appropriate deputy is appointed as co-chair of the Partnership Board.

2.1.5 Prison Health Delivery Plan

Discussion with the Assistant Director of Prison Health indicated that the Prison Health Delivery Plan cannot be devised as the prison healthcare strategy is still in draft. However the trust has developed a governance plan which clearly outlines specific objectives for the year from April 2010 to March 2011. Some of the objectives have been completed, but others relate solely to Maghaberry Prison. The review of this plan evidenced that there were many areas that still required action and inspectors found insufficient evidence that the commitment to improvement had been as clearly focused on the YOC, Hydebank Wood and Ash House.

2.1.6 Contracts

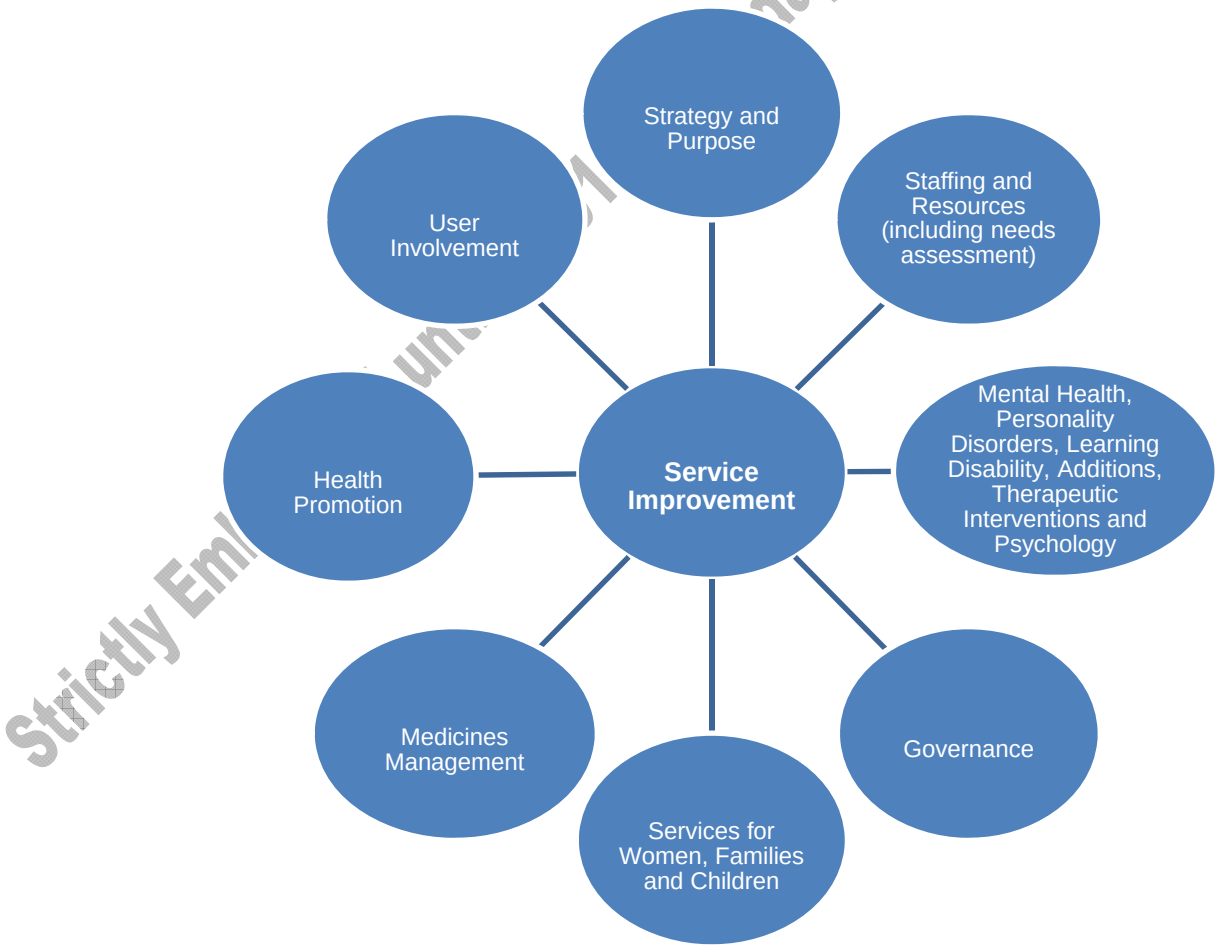
The HSC Board commissions the delivery of Prison Health Services, which are provided under contract by SEHSCT. The review of the key performance indicator documentation highlighted that SEHSCT does not have all the

appropriate contracts in place for the delivery of Prison Health Services with NIPS, other trusts and independent sector providers. These contracts should contain details of governance arrangements and of the performance monitoring arrangements, in accordance with the monitoring framework detailed in the contracts. The contracts should also contain details of the requirements regarding incident reporting.

2.1.7 Service Improvement Board for Hydebank Wood

A Service Improvement Board for Hydebank Wood has been established and met for the first time in January 2011. The purpose of the Improvement Board is to provide leadership and direction in the development of workstreams and to provide a focus for continuous improvement. The aim is to transform healthcare, to improve the health of prisoners and to engender a culture of continuous improvement.

The work streams in development are:



RQIA commends this initiative and recommends that appropriate timescales are set for the completion of this work. The findings of the inspections would indicate that the provision of the healthcare services to Hydebank Wood has not improved in some important areas, and the level of psychiatric services input has decreased. There are many challenges which still need to be addressed to ensure that the partnership arrangements are sufficiently robust to allow for joint decision making, effective management of resources, effective information sharing, audit and service development.

2.1.8 Recommendations

1. **RQIA recommends that the HSC Board completes the Commissioning Statement of Intent as a priority.**

2. **The draft prison healthcare strategy should be finalised to ensure that there is effective management of resources, effective information sharing, audit and service development to improve the health and wellbeing experienced by every prisoner in a custodial setting.**

3. **RQIA recommends that a Governing Governor or appropriate deputy, is appointed as co-chair of the Partnership Board.**

4. **A prison healthcare delivery plan should be in place.**

5. **The prison healthcare governance plan should clearly identify achievements for each prison.**

6. **The appropriate contracts should be in place for the effective delivery of prison healthcare.**

2.2 Clinical Governance

Quality Indicator

There should be joint clinical and social care governance arrangements in place between the NIPS and SEHSCT, which facilitate continuous service improvement by analysis of key information sources such as critical incidents, complaints, best practice, multi-professional audit, audit of deaths in custody and HMI Prisons action plans.

There should be evidence of communication of improvements across the organisation.

Expected Outcome

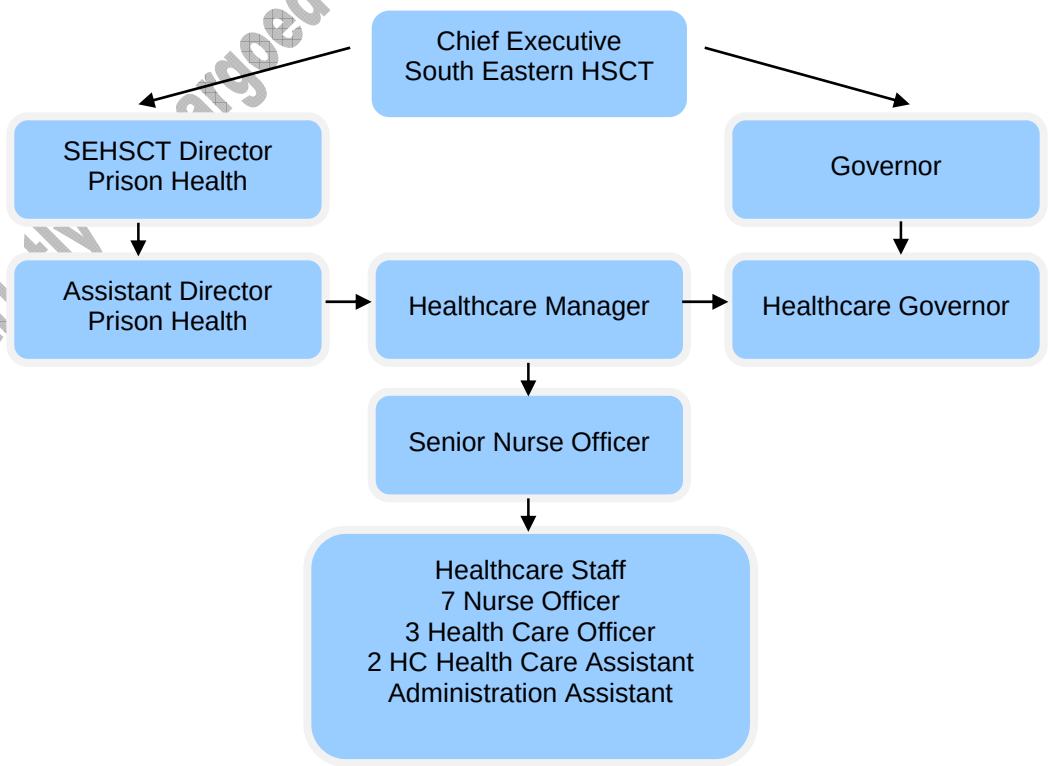
Joint clinical and social care governance arrangements are in place between the NIPS and SEHSCT which facilitate continuous service improvement and there is evidence of communication of these improvements across the organisation.

2.2.1 Findings of the Inspections

The following areas were reviewed to establish the current clinical governance arrangements in place in the YOC and Ash House.

2.2.2 Organisational Structure

The organisational structure indicates that there are joint responsibilities and lines of accountability for healthcare staff.



SEHSCT is accountable for the provision of healthcare services within the prison setting but does not have direct authority for staff who were employed by the prison service prior to the transfer of functions. Consequently, not all healthcare staff are managed by SEHSCT and therefore some staff are not subject to the trust's clinical governance and supervision arrangements. However, the trust has a responsibility to ensure that nurses work within the codes of practice and guidelines of the NMC. Both organisations should provide clarity in respect of accountability arrangements for both professional and employment issues, and a collaborative approach should be taken to addressing those issues, where necessary, pending the transfer of staff.

Discussion with staff indicated that the transfer of direct responsibility for prison healthcare staff is planned for April 2012. Some staff spoken with expressed concern regarding this transfer and some indicated that they did not feel adequately supported by SEHSCT.

During the inspections, issues relating to the performance of healthcare staff were raised by the governor and by the inspection team. The current arrangements would appear to fall short of robust and effective clinical governance, as the inspection team was not informed of any actions taken to address under-performance. RQIA would support the transfer of staff to SEHSCT to ensure that clear lines of accountability, specific roles and reporting structures are in place.

2.2.3 Risk Management

SEHSCT has a comprehensive risk management strategy which includes the production of risk registers of both corporate and directorate risks. The strategy indicates that risks, priority levels and an explanation of actions required with corresponding timescales should be identified.

A review of the corporate risk register indicated that the trust has listed some existing control measures which are not in place for all prisons. These include a Key Prison Performance Indicators Baseline Audit, and a lead nurse for prisons, who is not in post currently. In some instances, the action plan of further control measures relates only to Maghaberry Prison. An explanation of actions required with timescales has been identified and these were updated on a regular basis. The trust should ensure that identified control measures are in place in all prisons. The inspectors were informed that each prison has a risk register which was confirmed by the Prison Healthcare Governance Plan.

The Lessons Learned Group meets monthly in Prison Services Headquarters. All recommendations from reports are tabled with an action plan including the action, those responsible, date of completion and evidence of implementation.

2.2.4 Regional Prison Health Governance Committee

A Regional Prison Health Governance Committee is in place, which reports to both the Prison Service Management Board and the SEHSCT Governance Committee. The trust's governance committee is jointly chaired by the

Director of Adult Services, SEHSCT and by a non-executive director. The non-executive director has resigned from this role and at the time of the inspection, a replacement appointment had not been made. It was indicated that the terms of reference for this group were to be reviewed.

A copy of the minutes from the meeting in December 2010 evidenced that only four people had attended this meeting, with apologies having been received from 19 people. Nine people attended the meeting in March 2011 and apologies were received for four people. The minutes available outlined that the membership of this group is to be reviewed and updated. The poor attendance at the Regional Prison Health Governance Committee is of concern and provides little assurance that a robust and proactive system is in place.

A review of the SEHSCT Governance Assurance Committee minutes indicated that prison healthcare is not a standing item on the agenda, however, updates are provided. It is recommended that the current clinical governance systems are strengthened by including prison healthcare as a standing item on this agenda.

2.2.5 Policies and Procedures

The prison healthcare centre operates within the policies and procedures provided by the trust. A wide range of policies and procedures are available, but not all have been reviewed to ensure that they are applicable to prison healthcare.

Policies which were spot-checked by the inspection team were up-to-date, however, the review of medication practices indicated that these were not in line with current policies. The Healthcare Manager confirmed that staff would be able to access the policies on the trust intranet during the week following the inspections, as part of the transition to the trust Egton Medical Information System (EMIS).

Currently a system does not exist to ensure that staff have read and signed to confirm their understanding of the corresponding policies and procedures.

2.2.6 Clinical Supervision

Participating in clinical supervision is a clear demonstration of how an individual can exercise their responsibilities under clinical governance requirements. Clinical supervision should be part of the overall clinical governance system and not undertaken as an isolated activity. There are two clinical supervisors trained to undertake this role, however, discussion with these supervisors indicated that they do not have protected time to undertake clinical supervision. Therefore, there has been little opportunity to develop this process.

Inspectors were informed that a clinical lead has recently been appointed for prison healthcare who will be responsible for reviewing the current arrangements for medical staff.

2.2.7 Audits

SEHSCT has developed an audit process based on HMPS/ DH- Prison Health Performance Indicators and the Prison Health Governance Plan, which should be commended. A review of the HMPS/ DH Prison Health Performance Indicators indicated that not all of the standards available in this document had been adapted for use. In addition there are various sections within the Statutory Rules of Northern Ireland, Prison and Young Offenders Centre Rules (Northern Ireland) 1995 and statutory amendments, for example physical welfare, which have not been included. The audits are mainly systems based. SEHSCT is undertaking further work to strengthen the audit to review how the systems and process have been implemented into practice.

Two prison healthcare performance audits have been undertaken at Maghaberry prison. However, at the time of the inspection, none had been undertaken at the YOC or Ash House. The review of documentation indicated that an audit had been planned for August 2011. It is important that this is undertaken in the appointed timeframe to provide a baseline of healthcare provision within both establishments.

2.2.8 Serious Adverse Incidents

There appears to be two systems running in parallel in relation to Serious Adverse Incidents (SAIs). Investigations are carried out by the trust and by the prison service.

SAIs in the prison are reported to and investigated by prison service headquarters. An incident report and corresponding recommendations are forwarded to the governor and then on to the staff. The inspectors recommended that SAI reports in relation to suicide and self-harm should also be forwarded to the Director of Prison Health at SEHSCT.

SAIs in the healthcare centre are investigated by SEHSCT and where required, an independent panel is appointed. An incident report is compiled and disseminated to staff including the Governor of Hydebank Wood.

The current governance arrangements do not appear to be sufficiently robust to ensure that the recommendations from all SAIs are being addressed.

A review of some of the SAIs is included within the Patient Safety section of this report (section 3.3), which also includes recommendations for future practice.

2.2.9 Complaints

All complaints are reported in line with SEHSCT policies and procedures. Discussion with the acting healthcare manager and senior officer indicated that whilst the numbers of complaints are recorded, they are not monitored to identify emerging patterns or trends. Complaints are discussed at the Regional Prison Health Clinical Governance Committee and there was evidence that action was being taken in response to the issues raised. However, inspectors noted that complaints are not a standing item on the agenda of the acting healthcare manager meetings or staff meetings, and that a formalised process is not in place to share learning from complaints with staff.

RQIA reviewed the complaints process in one of the houses within the YOC. On each wing there is a post box in which a complaint may be lodged. The inspector was informed that complaints are collected each morning by a member of prison staff who then checks and monitors their content. Complaints are forwarded to the senior officer attached to the juvenile wing to investigate, whilst any complaint alluding to an allegation of misconduct against a member of staff is investigated by a named prison governor.

Young men within the YOC advised that they were aware of the system for making complaints. However, it was indicated that they were reluctant to make a complaint due to a lack of faith in the prison complaints system. They either did not receive a response, or were told that following investigation, insufficient evidence was found to substantiate their complaint. Furthermore, young men stated that confidentiality was not always maintained when they submitted a complaint.

During the group session undertaken within Ash House, women stated that they were informed of how to make a complaint during induction, and that information on the complaints system was displayed in association areas and that complaints forms were available in a range of languages. Women prisoners confirmed that they felt confident in making a complaint. Women are able to post completed forms in a locked box on the unit which is emptied on a daily basis by an operational support grade. The inspectors were advised that day-to-day complaints are forwarded to the senior officer, whilst any complaint alluding to an allegation of misconduct against a member of staff is investigated by a named prison governor.

The inspector was advised of an incident where a prisoner at the YOC had made a complaint, the nature of which constituted alleged staff misconduct. The complaint led to the involvement of the Police Service of Northern Ireland (PSNI). This member of staff advised that they had been requested to attend a meeting, where in the presence of four prison officers, the prisoner withdrew the complaint.

The findings and recommendation of the joint inspection report for the YOC would raise questions as to the independence of the current system for making complaints. This would suggest that the complaints policy needs to be reviewed to provide a more objective and independent process.

Joint clinical and social care governance arrangements are in place between the NIPS and SEHSCT, however, these need to be improved to facilitate continuous service improvement. The inspectors found that processes to analyse information from key sources, such as complaints and critical incidents were not fully developed, and arrangements to communicate lessons learned needed improvement.

2.2.10 Recommendations

7. **SEHSCT and NIPS should provide clarity in respect of accountability arrangements, for both professional and employment issues. A collaborative approach should be taken in these issues when necessary, pending the transfer of staff.**

8. **The trust should ensure that where appropriate, control measures identified on the corporate risk register are applicable to all prisons.**

9. **The Terms of Reference and membership of the Regional Prison Health Governance Committee should to be reviewed and updated.**

10. **Prison healthcare should be a standing item on the agenda of the SEHSCT Governance Assurance Committee.**

11. **A system should be in place to ensure that staff have read and signed that they understand all relevant policies and procedures.**

12. **Clinical Supervision should be fully introduced and the clinical supervisors should be given protected time to undertake these duties.**

13. **A Prison Healthcare Performance Audit should be undertaken to provide a baseline of healthcare provision in Hydebank Wood.**

14. **Complaints should be a standing item on the agenda of healthcare managers and staff meetings. Complaints should be monitored to identify emerging patterns or trends, and a formalised process established to share learning from complaints with staff.**

15. **The independence around the current system for making complaints and the complaints policy should be reviewed to provide a more objective and independent process.**

2.3 Information Governance

Quality Indicator

There should be a systematic and planned approach to the management of records to ensure that from the moment a record is created until its ultimate disposal, the organisation maintains information, so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

There should be protocols in place relating to effective information sharing, and to ensure that appropriate consent is obtained from prisoners in relation to the use of confidential information, and staff should receive regular training in the appropriate management of patient information.

Expected Outcome

Prison Healthcare has a systematic and planned approach to the management of information

2.3.1 Findings of the Inspections

The only aspects of information governance reviewed related to clinical records.

The inspectors reviewed a number of care records on EMIS, an information technology software system used by many healthcare organisations. The quality of recording varied: some entries were poor and the times of interventions were not always recorded, which is not in line with NMC guidance on record keeping[2]. Other entries reviewed were comprehensive and gave an excellent account of the care provided. Regular audits of healthcare records with documented actions have yet to be implemented.

The acting healthcare manager and senior officer were unaware of the back-up system for computerised records and indicated that there can at times be system failures. Neither of the staff consulted were aware if the back-up arrangements would ensure that all clinical information is saved if such a circumstance arose. The computer system in the healthcare centre is being moved to the EMIS system within the trust. It will be the acting healthcare manager's responsibility to ensure that the system is capable of securing this information in accordance with NMC guidance and data protection principles.

The review of the governance plan for prison healthcare indicated that care planning has been identified as an area requiring improvement and that all nurses are to be given training in the assessment, planning, implementation and evaluation of nursing care in line with NMC guidance. The target date for this was January 2011, however, at the time of the inspection this had not yet been achieved.

[2] NMC Record Keeping: Guidance for nurses and midwives: http://www.nmc-uk.org/Documents/Guidance/nmcGuidanceRecordKeepingGuidanceforNursesandMidwives.pdf

Information sharing is vital to safeguard and promote the welfare of both young people and women prisoners. Inspectors found that an information sharing policy has not been developed, however, the acting healthcare manager advised that a working group has been set up to develop this policy. There are processes in place to obtain patient consent for the sharing of information, yet there was little evidence to indicate that information was being shared appropriately.

2.3.2 Recommendations

16. **All nurses should be provided with the necessary training to allow them to effectively assess, plan, implement and evaluate nursing care in line with NMC guidance.**

17. **There should be regular audits of healthcare records with documented actions.**

18. **The acting healthcare manager should ensure that the EMIS system is capable of securing clinical records in accordance with NMC guidance and data protection principles.**

19. **An information sharing policy should be developed for children, young people and women prisoners, as information sharing is vital to safeguarding and promoting their welfare.**

20. **There should be documented evidence to indicate that information on patient consent has been shared with other disciplines.**

2.4 Workforce Planning

Quality Indicator

A joint workforce plan should be in place which is coherent with the prison health delivery plan. The plan should be based on up-to-date demand assessment, review of recruitment and retention, current workforce reviews and include optimising opportunities for joint training across organisational boundaries.

Expected Outcome

A joint workforce plan is in place which is coherent with the Joint Delivery Plans of the Prison Health Partnership Board.

2.4.1 Findings of the Inspections

The findings of the inspections indicate that a workforce plan is not in place and a capacity and demand analysis has not been undertaken for Hydebank Wood, nor has a training needs analysis been undertaken to ensure that staff have been trained in all aspects of their work.

2.4.2 Staffing

At the time of the inspections, the staffing profiles in the healthcare centre included an acting healthcare manager, a senior officer, seven registered nurses (two of whom are also Registered Mental Nurses (RMN), three healthcare officers and two healthcare assistants, to cover both establishments.

A number of the documents reviewed during the course of the inspections, highlighted that staffing levels were insufficient. However, during the course of the inspections, when the inspectors were present in the healthcare centre at Hydebank Wood, it only appeared to be busy on a few occasions and there was only one inpatient at the time of the inspection. RQIA recommends that a demand and capacity analysis should be undertaken. In contrast, the small treatment room located within Ash House was busy during the inspection visit. On one occasion, the nurse allocated to the treatment room had a caseload of 16 women, whereas the staff within the main healthcare centre appeared to be under-utilised during the same shift.

During the inspections, discussion with the two RMNs highlighted that they have a dual clinical role in providing care within Hydebank Wood. The nurses indicated that priority is given to their primary duties and that they have little or no allocated time to undertake mental healthcare related work. It is recommended that the staffing levels should be routinely monitored and reviewed on a needs basis to allow time for mental health referrals to be completed,. At the time of the inspection there were more than 20 people on a waiting list for mental health support assessments. It can be up to eight

weeks, or in some instances longer, from the time a referral is sent to the point where the person is seen and assessed, which is unacceptable.

2.4.3 Training

There are training programmes in place for annual resuscitation and child protection training. Only twenty-two per cent of staff have received training in child protection. An SAI report completed in March 2011 regarding two incidents in the healthcare centre recommends that all nurses complete the anaphylaxis and Patient Group Direction (PGD) training online through the Beeches, they must also complete their annual Basic Life Support (BLS) training which has been achieved prior to the incident occurring.

During the course of the inspections, the RMN staff indicated that they needed more regular updates on mental health issues, which included new developments in treatments and medications. They also highlighted that additional training was required in carrying out risk assessments, such as Skills-based Training on Risk Management (STORM) and the care of young people with personality disorders and substance misuse. Inspectors were informed that one of the mental health nurses attended STORM training in January 2011 and both permanent mental health nurses were trained in Promoting Quality Care Risk Assessment.

RQIA was advised that a training needs analysis is to be undertaken. This should ensure that mandatory training in prison healthcare is in line with the training provided in other services within the trust, and should include service specific training needs. Currently attendance at training is recorded and the returns forwarded to the training department on a monthly basis. Mandatory training is monitored and a quick reference notice board is maintained, however, these records do not indicate the ratio of staff uptake of the training. The SEHSCT should review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.

2.4.4 Recommendations

21. A workforce plan should be in place, and a capacity and demand analysis should be undertaken for prison healthcare.

22. The organisation of the workload should be reviewed to allow RMN staff sufficient allocated time to undertake mental health referrals.

23. A training needs analysis should be undertaken to ensure that staff are trained in all aspects of their work.

24. The SEHSCT staff should attend mandatory training and improve the recording and monitoring systems in place to ensure compliance with mandatory training requirements.

Section Three: Promoting and Protecting Health and Wellbeing

Promoting health and wellbeing enables people to increase control over, and to improve their health by making informed choices. Protecting health and providing a safe environment is fundamental to the delivery of high quality care.

Both young offenders and women prisoners should feel confident that they will be protected from avoidable harm and be treated with dignity and respect.

During the inspections information was obtained relating to the organisational systems in place. This section includes the following elements:

- Healthcare Environment
- Suicide and Self Harm Prevention
- Patient Safety
- Services for children, young people and women prisoners: Environment and Relationships
- Services for children and young people: Safeguarding
- Management of Medication
- Management of In-Possession Medication
- Management of Controlled Drugs
- Hepatitis B Vaccination
- Sexual Health
- Exercise

Healthcare Environment

The HSC system in Northern Ireland is working to promote best practice. This includes looking at a whole systems approach to the reduction of healthcare-associated infections, and working to identify ways to improve confidence about the safety and effectiveness of the healthcare environment.

Suicide and Self Harm Prevention

CJI's report, Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland[3], highlighted that four self-inflicted deaths have occurred in recent years and tragically one young man and one woman were found dead at the YOC and Ash House shortly after these inspections took place. Therefore, it is vital that robust systems are in place to ensure that young people and women prisoners are protected from harm inflicted by themselves or by others.

Patient Safety

Healthcare organisations protect patients through the use of systems that identify and learn from all patient safety incidents and other reportable incidents. It is important to identify the root cause of incidents to avoid the likelihood of repetition, the potential of adverse incidents occurring in the future, and to improve safety for prisoners and staff alike.

[3] http://www.cjini.org/CJNI/files/24/24d6cd45-20bb-4f81-9e34-81ea59594650.pdf

Services for Children, Young People and Women Prisoners: Environment and Relationships

The provision of effective health and social care is essential in promoting the safety and wellbeing of young offenders and women prisoners, as well as representing a fundamental human right. As such, it cannot be restricted solely to a review of the healthcare environment. Services need to be planned to take account of an individual's particular requirements, to safeguard human rights and to provide a high standard of personalised care and service. Staff need to have an understanding of the distinct needs, preferences and choices of the populations which they serve.

Inspection of the general environment provides information on the fabric of the building, as well as the physical security arrangements, which can have a very direct influence on the daily life of young offenders and women prisoners. It also assists in obtaining an impression of the atmosphere and relationships within the establishments.

Services for Children and Young People: Safeguarding

Legislation and the associated guidance has established that health services, health staff and all staff working within the YOC have a duty to safeguard and promote the welfare of children. Within a secure setting, safeguarding covers issues such as suicide, self-harm, bullying, harm from staff and visitors, and promoting emotional wellbeing. Safeguarding should be embedded within all aspects of the regime.

Management of Medication

Prisoners should have access to medicines, medicinal products and equipment that mirrors provision in the community. This should include the services available in community pharmacies, health centres, general practitioner (GP) practices and hospitals.

Systems should provide assurance that: medicines are stored and handled safely and securely; medicines are administered safely and in accordance with the prescribing practitioner's instructions; and all medicine records comply with legislative requirements and current best practice, as well as providing a clear audit trail.

Management of In-Possession Medication

Medication in-possession supports the HSC principle of empowering young offenders and women prisoners to take an active role in managing their own care. The engagement and involvement of young offenders and women prisoners in their treatment can facilitate more effective medicine compliance and can help maximise the benefits to be derived from medicines whilst in prison and on discharge.

Management of Controlled Drugs

The DHSSPS has introduced new monitoring and inspection arrangements for controlled drugs within the Health Act 2006. The Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009 introduced Standard Operating Procedures (SOPs) for the use and management of controlled drugs as one of the practical measures that will help to ensure good practice throughout the health and social care system.

Hepatitis B Vaccination

Hepatitis B is an infection caused by a blood-borne virus (BBV) and is transmitted by exposure to infected blood or body fluids. A significant number of prisoners may be infected with hepatitis B and prisoners at risk of infection can be offered a safe and effective Hepatitis B vaccine (HBV).

Sexual Health

The sexual health of prisoners should be addressed as there is a clear link between sexual ill health, poverty and social exclusion. Genital chlamydia trachomatis is the most common sexually transmitted infection (STI). Genital chlamydial infection is a significant reproductive health problem, for example 10-30 per cent of women infected develop pelvic inflammatory disease (PID). A significant proportion of infected women are asymptomatic and are liable to remain undetected, putting them at risk of developing PID. Evidence would suggest that some groups, including prisoners, need targeted sexual health information as they are vulnerable and at higher risk of infection.

Exercise

The importance of physical activity as a means of promoting good physical and mental health and preventing disease is supported and endorsed by the National Institute for Health and Clinical Excellence (NICE). Consequently there is a need to develop comprehensive and innovative approaches to promoting physical activity as part of daily life. Physical activity also has a range of benefits beyond direct health outcomes, such as contributing to community cohesion and addressing the needs of vulnerable groups and communities.

3.1 Healthcare Environment

Quality Indicator

The prison healthcare and clinical areas should be fully integrated within the trust's environmental monitoring systems.

There should be evidence of regular infection control audits.

The healthcare centre should not be the default location for prisoners with physical disabilities.

The rights of detainees to privacy and confidentiality should be respected in all consultations.

Emergency equipment available is checked and serviced in accordance with manufacturer's instructions.

Expected Outcome

Systems are in place to assure the safety and effectiveness of the healthcare environment.

3.1.1 Inpatient Provision

The inpatient bed provision has been reduced from nine to six beds, however this remains part of the prison certified normal accommodation. Healthcare staff should liaise and discuss this issue with the NIPS.

The reorganisation and refurbishment of the healthcare centre has provided four beds for males and two beds for females, however the layout of the accommodation does not promote the privacy or dignity of patients. Males and females are still cared for on the male side of the prison, which creates difficulties with the provision of personal hygiene and free association. At the time of the inspection there was only one young man accommodated as an inpatient. However, during the week prior to the inspection two males and one female had been accommodated on the male side of the healthcare centre.

Admission to the inpatient unit at the time of the inspection was based on clinical need. However, there appears to be a reluctance to admit patients to the healthcare centre, particularly in relation to self-harm and detoxification.

Day services are not available for those less able to cope with prison life. There was little evidence to suggest that healthcare staff had identified needs in relation to this area or had been proactive in developing services such as support groups.

3.1.2 Environmental Cleanliness

At the time of the inspection, the healthcare centre and other areas within the two establishments were clean and tidy. Some young offenders and women prisoners have the opportunity to work as orderlies and have the responsibility to keep the environment clean. The inspectors observed that colour coding for cleaning equipment is in place, however, this was not in line with the National Patient Safety Agency (NPSA) colour coding system. This issue should be reviewed to ensure that the NPSA standards are in place throughout all trust facilities.

3.1.3 Infection Prevention and Control

The inspectors were informed that the acting healthcare manager is the designated link infection prevention and control person for the unit. The manager confirmed that they do not undertake environmental or infection control audits. The inspectors noted that advice and guidance had been sought from the infection prevention and control team within the trust.

The healthcare centre has two holding areas where patients wait to be seen by the nurse or the doctor. Whilst a toilet and wash hand basin are provided, there was an absence of soap or a paper towel dispenser to allow patients to wash their hands.

The management of sharps and waste was not fully reviewed, however, sharps are locked away and sealed prior to disposal. Clinical waste is also retained in a locked area prior to collection.

The healthcare centre has its own laundry facilities for personal clothing, whereas bed linen is sent to the central laundry. Linen is not stored within the unit, therefore new admissions are issued with a bed pack. The appropriate laundry bags are used for infective or soiled linen.

Personal protective equipment such as disposable gloves and aprons was available. There was a hoist in the main healthcare centre which had not been used for some time. Staff need to ensure that this is kept clean and serviced on a regular basis, in accordance with manufacturer's instructions.

3.1.4 Emergency Equipment

Emergency equipment is available in the healthcare centre and in the treatment room in Ash House. There are defibrillation units in various locations in each of the houses. Inspectors were informed that the equipment is checked on a weekly basis. However, lapses were observed in the recording, which would indicate that emergency equipment is not always checked according to the agreed protocol. This protocol must ensure that times for checking of defibrillation equipment are in line with the manufacturer's instructions. Checking of the defibrillation units has only commenced in the houses and is the responsibly of the Residential Governor who is responsible for healthcare. In addition, some prison officers had not received training on the maintenance and use of this equipment. An SAI

report completed in March 2011 regarding two incidents in the healthcare centre recommends that all nurses complete the Anaphylaxis and PGD training online through the Beeches Management Centre. They must also complete their annual BLS training which had been achieved prior to the incident occurring. However, the incidents highlight that all healthcare staff must receive regular update training and competency assessment in relation to the appropriate actions to be taken in an emergency.

The resuscitation grab bag, the separate portable oxygen and suction equipment are all heavy, which may create difficulties with moving and handling in an emergency.

The resuscitation grab bag did not contain emergency drugs, personal protective equipment (PPE) or a blood spills kit. The portable suction canister was not charged and did not have a disposable liner to ensure the safe disposal of suction waste. A review of the contents of this bag should be undertaken by the trust's Resuscitation Officer, in conjunction with the Northern Ireland Ambulance Service (NIAS), to determine the appropriateness of the current equipment and contents.

3.1.5 Emergency Codes

All inspectors were provided with a small laminated card of tannoy call codes and emergency telephone numbers to alert them to various issues. Healthcare inspectors noted that a code for medical emergencies was not included within this list. The acting healthcare manager should consult with the Governor to consider if inclusion of a code for medical emergencies is possible.

3.1.6 Recommendations

25. **SEHSCT and the NIPS should ensure that the inpatient beds do not form part of the prison's certified normal accommodation.**

26. **All prisoners requiring a clinical alcohol detoxification should be admitted to the inpatient unit.**

27. **Day services should be available for those less able to cope with prison life.**

28. **The colour coding for cleaning equipment should be in line with the NPSA colour coding system.**

29. **All equipment should be kept clean and serviced on a regular basis, according to the manufacturer's instructions.**

30. **Advice and guidance should be sought from the trust's infection prevention and control team in relation to commencing environmental and infection prevention and control audits.**

31. **Healthcare staff must receive regular refresher training and competency assessment in the appropriate action to be taken in an emergency.**

32. **All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose, and documented evidence of such checks should be kept, in accordance with the relevant protocols.**

3.2 Suicide and Self-Harm Prevention

Quality Indicator

There should be evidence of collaborative working between the safer custody lead and the healthcare lead.

There should be explicit reference made to the prevention of suicide strategy and the effective management of self-harm within the prison health delivery plan.

There is evidence of managed information sharing between the prison and healthcare staff to reduce the risk of suicide.

All healthcare staff should work as part of the multidisciplinary team and attend case conferences. They should provide recommendations on the use of observation cells and be given the opportunity to attend debriefing sessions.

Expected Outcome

There should be appropriate steps taken to ensure that individuals are protected from harm by themselves and others.

3.2.1 Findings of the inspections

The review of the systems in place for the prevention of suicide and self-harm encompassed both the main prison and the healthcare centre. The areas reviewed related to the recommendations of the previous report in 2007. Whilst some of the areas reviewed were not fully part of prison healthcare, it was important to ensure that the systems in place within both establishments were robust. Inspectors sought assurance that the appropriate measures were in place to ensure that individual prisoners are protected from harm by themselves or from others and that healthcare staff are adequately involved in this process.

3.2.2 Suicide and Self-Harm Prevention Policy

The Suicide and Self-Harm Prevention Policy was revised in 2011 and is applicable to all prisons within Northern Ireland. The policy outlines individual roles and responsibilities and standard operating procedures. The section entitled Recognising Risk indicates that more detailed information and guidance on juveniles and women will be made available to staff in Hydebank Wood. Inspectors did not see any evidence of this guidance for young offenders during the inspection. The NIPS and SEHSCT should work together to develop in-depth guidance.

For women prisoners information is contained in other documents such as the Gender-Specific Standards for Women Prisoners and Working with Women Prisoners: A Guide for Staff, which had been published in November 2010. These documents include sections on safer custody and outline some of the

essential and different needs of women, as well as referring to the additional pressures and difficulties for women prisoners.

To date, all aspects of the Suicide and Self-Harm Prevention policy have not been fully implemented across either unit due to funding constraints. In relation to the YOC, inspectors found that there were limited counselling services available and a lack of therapeutic responses to support young people at risk. In addition, inspectors found that the counselling services and therapeutic responses to support women at risk within Ash House should be improved.

The role of healthcare staff in the management of suicide and self-harm is outlined within the suicide and self-harm prevention policy. Healthcare staff should determine and deliver appropriate healthcare services to prisoners from committal to discharge. When a young person or woman prisoner is residing in the healthcare centre, the acting healthcare manager or senior nurse on duty assumes responsibility for the Supporting Prisoners at Risk (SPAR) process.

3.2.3 Gender-Specific Standards for Women Prisoners

The publication of these standards indicates a commitment by the NIPS to addressing the gender specific needs of women prisoners. In addition is a key outcome of the strategy for the management of women offenders (Women's Offending Behaviour in Northern Ireland: A Strategy to Manage Women Offenders and Those Vulnerable to Offending Behaviour 2010 – 2013[4]), published by the Minister of Justice in October 2010.

This strategy identifies that there is a need for a tailored approach to the management of women in custody. The standards aim to ensure that the services and interventions delivered to women in custody are tailored appropriately to their needs, and are responsive to the considerable vulnerabilities which they often present. The standards seek to address all areas of the regime, from committal through to release and resettlement in the community. The standards therefore set a challenging benchmark for the NIPS in the development of its gender-specific approach to custody.

All sections in the standards contain key audit baselines, with the exception of section four which relates to healthcare, for which only the required outcome is noted. SEHSCT should work with the NIPS to develop this section.

3.2.4 Supporting Prisoners at Risk (SPAR)

The inspections undertaken included the review of a random selection of SPAR documents which had been introduced since the previous inspections.

The SPAR process is a means through which staff can identify symptoms or behaviours at an early stage that suggest a young person or a woman may be suffering a personal crisis and would therefore require immediate support and

[4] http://www.dojni.gov.uk/index/media-centre/final_draft_for_print-_a_strategy_to_manage_women_offenders_and_those_vulnerable_to_offending_behaviour.pdf

care. The SPAR process enables staff to provide immediate assistance and provides a mechanism through which staff can work together to provide individual care to prisoners who are in distress.

SPAR documentation can be opened by any member of staff and follows the individual, whether in the healthcare centre or prison accommodation until it is closed. Therefore the recommendations in relation to recording within the SPAR documentation are applicable to all staff.

The SPAR documentation contains the following sections:

Section One	Referral Form Immediate Action Plan Authorisation for Special Accommodation (CRC1)
Section Two	Information Sharing Agreement Assessment Interview Suicide/Self-Harm Summary of Information
Section Three	Initial Case Review/Care Plan and Subsequent Case Reviews/Care Plans
Section Four	Ongoing Record (of significant events, conversations and observations)

3.2.5 Review of SPAR Documentation

SPAR documentation indicates that all staff working with young offenders and women prisoners, who have concerns about any prisoner, must talk to the person about this concern. They must listen to what they have to say and if they still have concerns, to inform them that a SPAR document will be opened. The immediate action plan contains a section to be completed by healthcare staff in respect of their initial assessment, and a more detailed section on the healthcare review.

When a CRC1 (Use of Safer/ Observation Cell Authorisation Booklet) is required, healthcare staff carry out an assessment prior to the use of an observation cell/ segregation unit or the use of protective (anti ligature) clothing.

The SSU in the YOC is only to be used for young people at risk of self-harm in exceptional circumstances. Inspectors were informed that the SSU had been used on eight occasions for seven young offenders during the six months prior to the inspection being undertaken (September 2010 to March 2011). In one instance a young person at risk had been placed in the SSU without evidence having been recorded that any alternative had been considered. There was evidence that managers took immediate action when this came to their attention.

Inspectors were also informed that observation rooms had been used 20 times over the same six month period involving 10 different women. In

addition, one woman had remained within an observation room for 19 days. Although the use of protective (anti ligature) clothing has reduced, some women prisoners still believe that the threat of being placed within an observation room and the use of this type of clothing is a deterrent to disclosing vulnerability.

Inspectors found that the numbers of young people placed in the observation rooms in healthcare and the SSU, as well as how often observation rooms were used for women prisoners each month are monitored. However, the length of time spent in these units, which was a recommendation of the previous inspection report, is not monitored. Inspectors also found that alternative therapeutic responses to the use of observation rooms and strip clothing have not been developed.

A listener scheme involving other young offenders looking out for those deemed at risk was unsuccessful. It was felt by some prison staff that the recent traumatic incidents in Northern Ireland's prisons has led to staff placing young people on SPARs very quickly.

Similarly, the listener scheme developed in 2009 in Ash House was only in place for approximately four months. Inspectors were informed that there were problems with maintaining confidentiality in a small prison and there were not enough women who met the criteria to be enlisted as listeners.

There is a sharing agreement where young people and women prisoners are given information regarding the SPAR process. They also give consent as to whether relevant information can be shared with family, significant others or carers. The documents reviewed by inspectors provided evidence that the young offenders were fully involved in the care planning and SPAR process.

An assessment interview must be completed before the initial case review, which must take place within 48 hours of the concern being raised. The case review brings together the multidisciplinary team in order to consider the needs of the individual and the care required. Individualised care plans are devised, which identify specific needs, encourage purposeful activity and minimise risk. In the YOC, inspectors noted that in some SPAR documents the information summary had not been completed and the designation of staff members attending multidisciplinary reviews had been omitted. Inspectors identified the need to improve recording in care plans.

In Ash House, inspectors found that some SPAR care plans reviewed in relation to women prisoners evidenced good recording of detail, and that plans contained the named individuals responsible for ensuring agreed actions were taken forward. However, in a number of care plans actions required were delegated to all staff. The care plans did not always clearly identify the main concerns , and there was still a need to develop a more therapeutic approach. Care plans for women at risk of suicide or self-harm should identify all issues associated with a woman's vulnerability and document the action required to address these issues

Whilst a young person or women continues to be under the SPAR process, a log book is maintained, which highlights that all entries must be meaningful. A recording of no change is not acceptable.

Within the SPAR documents examined in relation to young people, there was evidence of meaningful entries, in particular during the daytime period. It was clear that staff were talking with the young person as part of this process. During the night, entries appeared to be more observational. Before a SPAR document is closed, a post closure review is carried out by the multidisciplinary team.

Inspectors noted that the quality of entries varied in the SPAR documents reviewed in relation to women prisoners,. A number of entries within the daily supervision records indicated good engagement with prisoners at risk and showed staff had asked how prisoners at risk were feeling. Other entries were made at regular and predictable times. Each page of the SPAR document included space for a required management check. In most cases, the manager had signed to confirm they had completed the check, but had not included any comment on the quality of the care provided. All closed SPAR documents included notes of a follow-up interview undertaken seven days later.

3.2.6 Discussion of Findings

The suicide and self-harm prevention policy indicates that section one of the SPAR document, which contains areas to be completed by the healthcare staff, should be completed in the first 48 hours in order to assess and protect the young offender. Of the nine SPAR documents examined, eight showed evidence of healthcare involvement. A SPAR document which had been in place for four days without healthcare involvement, related to a young man with homicidal and suicidal ideation. In this instance, there was no adverse effect as a result of this lack of involvement.

In the SPAR care plans reviewed, problems were clearly identified, the action required was recorded and the frequency of conversation and observation checks were clearly documented during day time hours.

Inspectors found that some of the SPAR documents had evidence of good quality recording and provided detail of staff spending time talking with the prisoner deemed at risk. Conversations with young offenders indicated that they felt more comfortable speaking with the staff on day duty. Some sections within the SPAR were not fully completed and, in some instances, the designations of staff had not been stated. In a number of SPAR documents at the YOC, the content was poor in relation to ongoing recording of conversations, observations or significant events especially at night. During the night shift young offenders spend much of this time asleep, but there are opportunities available to staff prior to young offenders retiring and first thing in the morning for meaningful conversations to take place. In one document there was no reference that a young offender with dual mental health and addiction problems had been subject of a dual diagnosis referral.

It was previously recommended that follow-up interviews should be conducted following the closure of PAR1 forms (now called SPAR). The inspectors were informed that a senior officer on the wing organises the case reviews, and pre-closure of SPAR reviews have now been introduced.

There are systems in place for senior officers to check on the quality of the recording in these documents, but there is no record of a checking process being maintained. A record of checks should commence and include the actions taken to address any deficiencies with the relevant staff. The Safer Custody Officer receives all completed SPAR documentation. This officer then audits the SPARs and sends an email to responsible officers, which includes healthcare officers, with recommendations on how to improve the quality of the documentation. RQIA would recommend that the audit process should be extended to include SPAR documents which are open and in use by staff.

Staff informed the inspectors that some SPARs are only live for one or two days, and indicated that since the death of prisoner Colin Bell, staff are more likely to initiate a SPAR. Inspectors would recommend that there should be more staff trained in mental state assessment who could carry out this assessment on those deemed at risk. Inspectors were also informed of a young person on the basic regime, with no access to television, who was able through the SPAR process, to get himself into an observation cell where a television was available. In incidents like this, a mental state assessment would have been beneficial.

3.2.7 Safer Custody Officer

The Safer Custody Officer organises weekly safer custody meetings. These meetings are multidisciplinary and there was evidence of healthcare staff involvement. Inspectors were informed that SPAR reviews for young men and women prisoners are held twice weekly, or more frequently if required.

In relation to women prisoners, there was some evidence of good quality fortnightly safer custody case reviews. However, when inspectors raised concerns about a particular women prisoner (discussed in section 3.3.7), staff could not remember if these incidents had ever been discussed. This is of particular concern as there had been five incidents regarding this prisoner since November 2010.

The safer custody meetings are well attended by a range of staff which have resulted in the development of action plans to address relevant issues.

The Safety Custody Officer is also the Suicide Prevention Officer, with responsibility for both Ash House and the YOC. It was indicated that insufficient time is allocated to the role of the suicide prevention coordinator. There were two officers undertaking this work until approximately three to four months prior to the inspection having been undertaken, when one of these officers was taken from this role and assigned to other duties. It was recommended following the previous inspection in the YOC that a suicide prevention coordinator should be appointed for the YOC, with sufficient

allocated time to carry out this role. This recommendation has not been achieved and has been restated in the joint report from the four regulatory authorities.

3.2.8 Training

Inspectors noted that over the past two years, more than 70 per cent of staff within the YOC and more than 90 per cent of staff within Ash House have had Applied Suicide Intervention Skills Training (ASIST). RQIA would recommend that due to shift changes, absences and annual leave, that all staff including healthcare staff, should be equipped with the appropriate knowledge and skills required. In the minutes of the Safer Custody Steering Group of January 2011, there was a comment about the level of ASIST carried out. The minutes recorded that in March 2010, only 50 per cent of staff had received this training and that since then only a further three per cent had been trained. This information does not concur with the list of staff presented as having completed the training at the time of the inspections.

In Ash House, there was evidence that indicated that a number of staff had also completed the Women's Awareness Staff Programme (WASP) training.

At the previous inspection it was recommended that trained senior officers should provide continuity in the management of cases. Inspectors were informed that with days off and annual leave, it is not always possible for a trained senior officer to provide continuity in the management of cases. This recommendation has not been achieved and has been restated in the joint report.

3.2.9 Support Systems and Therapeutic Response

Inspectors were informed that there are some support systems and therapeutic responses available. These included: Alcohol and Drug Educational Programme and Training (ADEPT) for drug and alcohol counselling (provided by Opportunity Youth),, art therapy, psychology sessions, Cruse and Cognitive Behaviour Therapy (CBT).

The staff informed the inspectors that they aim to keep offenders gainfully occupied but that there are not enough places available. Staff also stated that they try to get the young men and women out to work, even if they are on a SPAR, depending on the level of risk involved. They stated that it was difficult to obtain a psychiatric assessment or psychological support. Day care provision was not available at the time of the inspection and the CBT service had been reduced to one part-time person. it was noted that the post holder had been on long -term absence prior to the inspection. The staff also stated that there is no trust input in relation to the prevention of self-harm.

During the inspections, one of the inspectors met with the assistant manager of Opportunity Youth which works from within the Offender Management Unit in the prison. In addition to the provision of ADEPT, Opportunity Youth provides emotional and behavioural support to prisoners to help them develop coping mechanisms and alternative methods of dealing with stress. Requests

for the service are received through the induction process, self-referrals, from prison officers, and through resettlement officers.

The inspector was advised that services offered include mentoring, using a motivational interviewing approach, which could provide an intensive and consistent intervention over a six-week period. An advocacy service is provided for juvenile offenders and group work is provided, which can result in Open College Network (OCN) accredited programmes. A youth advice clinic for juvenile offenders is organised most Fridays.

The Prince's Trust xl programme[5] is organised on the juvenile wings each week. This includes developing skills in subjects such as horticulture and fencing and can result in the award of a certificate. The Safer Lives programme has been developed as a method of intervention with young men, including those on remand who have been involved in sexually harmful behaviours.

An effective key worker system is not in place to work alongside and support young people and women at risk of self-harm or suicide.

The previous report also recommended that peer support should be improved, with a clear programme of training and regular support meetings for insiders (The insider scheme involves training selected prisoner volunteers to provide basic information and reassurance to new committals shortly after they arrive in prison).. Within Ash House, five women had recently been recruited as insiders and were providing good peer support, but at the time of the inspections they had not received any training. A recommendation relating to the provision of training has been made in the joint report. It was indicated that insiders talk to all women prisoners on the day of their arrival, using an information checklist. Managers were also available on an informal basis to discuss any difficulties with the scheme.

The inspection highlighted that the YOC is in the process of developing an insiders programme of. At the time of inspection four male prisoners were coming up to release who had been identified to provide peer support to other prisoners. There is no formal training for the role, but inspectors were advised that training needs will be identified in the near future. The programme commenced in January 2011 and at the time of inspection was not fully developed, therefore this recommendation has been noted as not achieved.

Young people and women prisoners are able to contact the Samaritans. A range of free telephone helplines were advertised at the landing telephones in an initiative introduced in recent weeks. The list included the Samaritans number. All helplines can be contacted using a published personal identification number linked to an account, paid for by NIPS.

[5] The Prince's Trust xl programme provides young people with the space and attention they need to learn skills and confidence as well as to form a sense of ownership over their work and own development. It aims to re-engage young people in education by ensuring learning becomes accessible, valid, relevant and attractive.

A listener scheme was also developed, however, inspectors were informed that it was unsuccessful. YOC staff indicated that the listeners felt they had their own problems to deal with and did not feel able to cope with other people's difficulties. In Ash House there were difficulties in maintaining confidentiality in a small prison. In Northern Ireland the meetings of the safer custody forum in 2010, outlined a commitment which included ministerial support to develop listener schemes in all prisons. The report from the four agencies involved in the inspection recommends that efforts should be made by all staff to develop the listener scheme, which will require full commitment from all involved.

There needs to be a more cohesive approach to the prevention of suicide and self-harm which ensures that this is the responsibility of all staff within the YOC and Ash House. There should be clear evidence of collaborative working between the Safer Custody lead and the healthcare lead and evidence of managed information sharing between the prison and healthcare staff to reduce the risk of suicide and self-harm.

It should be noted that tragically a young women in Ash House and a young man in the YOC were found dead shortly after the inspection. The circumstances of these deaths are currently being investigated by the Prisoner Ombudsman. A new initiative to reduce the potential use of cell door handles as ligature points had been introduced. It is also strongly recommended that a detailed risk assessment of all cells in relation to ligature points is undertaken and monitored on a regular basis. The risk assessment should include a detailed action and management plan, which should be undertaken as a matter of urgency by the NIPS in conjunction with SEHSCT.

3.2.10 Bullying and Violence Reduction

Neither establishment had an effective anti-bullying and violence reduction strategy. In the YOC, the 2005 strategy was still being used, and the draft anti-bullying strategy for women developed in 2007 had not been implemented within Ash House. A new strategy on challenging anti-social behaviour (CAB) is undergoing a six-month pilot in Ash House and there were plans in the YOC to roll out this strategy. Evidence of staff or prison training in relation to anti-bullying and violence reduction was not found as part of the inspections.

In the YOC, some investigations were undertaken thoroughly but not all allegations were pursued, particularly if the alleged victim refused to make a statement. No-one was being monitored under the anti-bullying strategy during the inspection. The centre operates an integrated regime and it was not clear if sex offenders and other vulnerable prisoners were being protected. Staff have not received training in the existing anti-bullying strategy and expressed concerns at the lack of training in the CAB strategy that was due to be introduced.

In Ash House there have been three investigations under the new procedure. Two investigations have resulted in no further action and one woman was placed on a monitoring booklet. Staff have not been trained in this strategy, therefore they are reluctant to fully implement the strategy until training is

provided. Furthermore, the strategy had not been explained to women prisoners, nor had there been any interventions to support its implementation. Concerns in relation to these factors had been raised consistently through the safer custody steering group meetings.

The safer custody steering group meets monthly and is reasonably well attended. However, it was noted that there was not always a representative from healthcare or security, and prisoner representatives do not attend this group. Basic data about bullying and anti-social behaviour, self-harm, supporting SPAR procedures and the use of the observation cells had only been presented to the safer custody steering group meeting in a systematic way a short time prior to the inspections. Similarly, discussions had only recently taken place as to how best to provide the appropriate attention to the two separate establishments.

In the YOC, the psychology department has delivered some challenging anti-social behaviour awareness sessions to new arrivals during induction. In Ash House meetings held by staff two years previously had been supported by the psychology department. However, these had stopped after one particularly difficult meeting had led to conflict between some women. Staff did not feel sufficiently skilled to run these meetings.

In Ash House women prisoners spoken with felt that bullying is well controlled. Young men however were reluctant to report bullying for fear of reprisals. More work is required to challenge bullying, intimidation and other anti-social behaviour. In both establishments there were no effective interventions to support victims and to challenge bullies to change their behaviour. The main response was to move the victim or perpetrator to other landings or units.

Overall, the inspections highlighted the fact that both Ash House and the YOC have some way to go to improve the profile of anti-bullying and violence reduction and to ensure that effective interventions to support victims and challenge bullies are introduced. SEHSCT must ensure that healthcare staff are included in training and play an active role in the implementation of the new strategy.

3.2.11 Recommendations

33. There should be a more cohesive approach to the prevention of suicide and self-harm, which ensures that this is the responsibility of all staff, and provides clearer evidence of collaborative working and managed information sharing.

34. The Suicide and Self-Harm Prevention Policy must be fully implemented and sufficient funds provided. Detailed information and guidance should be made available to staff in the YOC to ensure that all staff are fully equipped to recognise specific risks relating to young offenders.

35. Counselling services and therapeutic responses to support young people and women at risk should be improved.

36. **SEHSCT should work with the NIPS to develop the healthcare section of the gender specific standards for women prisoners.**

37. **The length of time that young people and women are placed in the observation rooms in healthcare, as well as the length of time that young people are placed within the special supervision unit, should be monitored and recorded.**

38. **Alternative therapeutic responses to the use of observation rooms and strip clothing should be developed.**

39. **All sections of the SPAR document should be fully completed and should clearly detail ongoing recording of conversations, observations or significant events, particularly at night.**

40. **Care plans for women at risk of suicide or self-harm should identify all issues associated with a woman's vulnerability and document the action required to address these issues.**

41. **The system in place to check on the quality of the recording in SPAR documents should be improved, a record of checks maintained, and any improvements required disseminated to the relevant staff.**

42. **When a SPAR is opened, documentation should always be completed by the healthcare staff in the first 48 hours, to risk assess and protect young offenders.**

43. **Young offenders with mental health and addiction problems should have a dual diagnosis referral.**

44. **The Safer Custody Officer should carry out audits on current as well as completed SPAR documents to ensure that there is full compliance in this area. Healthcare should be informed of any deficits in recording.**

45. **There should be additional staff trained in Mental State Assessment within Hydebank Wood.**

46. **All staff should be provided with training in ASIST.**

47. **A key worker system should be in place to ensure that staff are identified to work alongside young people and women at risk of self-harm or suicide.**

48. **As a priority, a detailed risk assessment of cells in relation to ligature points should be undertaken as a matter of urgency by the NIPS in conjunction with SEHSCT and should include a detailed action and management plan.**

49. There should be more effective systems in place in Hydebank Wood, to improve the profile and management of anti-bullying and violence reduction.

3.3 Patient Safety

Quality Indicator

Prison healthcare should have a formal system in place that protects patients through the identification and learning from all patient safety incidents and other reportable incidents. The system should seek to identify the root cause and likelihood of repetition, the potential to avoid incidents in the future and ensure improvements are made in practice, based upon local and national experience and from information derived from the analysis of such incidents.

Expected Outcome

There is a formal system in place which protects patients through identifying and learning from all patient safety incidents and other reportable incidents, and improvements are made in practice based upon local and national experience and information derived from the analysis of such incidents.

3.3.1 Findings of the Inspections

The findings of the inspections would indicate that the systems outlined below are in place.

Serious adverse incidents in the prison are reported to and investigated by the prison service headquarters. A report of the incident and recommendations are forwarded to the Governor and then on to the staff. The joint report recommends that SAI reports in relation to suicide and self-harm should also be forwarded to the Director of Prison Health at SEHSCT.

Serious adverse incidents in the healthcare centre are investigated by SEHSCT and an independent panel is appointed as required. A report of the incident is compiled and disseminated to staff, including the Governor of Hydebank Wood.

From the documentation reviewed, governance arrangements in place need to be strengthened to ensure the recommendations are being fully addressed.

Inspectors reviewed a number of the reports of investigations undertaken in relation to serious adverse incidents for both establishments. The findings are considered below, firstly in terms of the YOC, followed by five incidents relating to one prisoner in Ash House.

3.3.2 Report One - YOC

On committal to the YOC no thoughts of self-harm were noted and the young man was referred to the doctor regarding his physical health. The medical assessment stated that he was not apparently suffering from any physical or mental condition, however, he had a history of drug abuse, and was referred to ADEPT. He subsequently tied a ligature to the steel bed rail on the top bunk in his cell. He was found unconscious by staff and died later in hospital.

The investigation report by the prison investigating officer stated that a "worrying issue that is already on the radar of things to review, is the matter of Hydebank still using the old army style metal bed frames in some parts of the centre". The replacement of these beds should be considered a priority.

SEHSCT has also undertaken a detailed review of this case, for which the report was available in final draft format. To date, only one recommendation for improvement has been made which highlighted that the committal health assessment should include routine contact with a prisoner's GP on the next working day following committal, to ascertain/ corroborate health care history. The report does not make reference to the risk assessment of cells or the risks posed by the beds or that the report will be shared with the NIPS.

3.3.3 Report Two - YOC

A young man was found unconscious in his cell. He had used his laces as a ligature secured to his bed. Staff were able to remove this ligature and the young man recovered. The report stated that the steel bed anchored to the floor was a potential ligature point and, in the recommendations for improvement, the report stated that the refurbishment of this wing will address most of the concerns highlighted regarding the safety of the young offenders in their cells. This is concerning, as the previous report had highlighted that five months earlier, a young man had committed suicide in similar circumstances.

It is also very concerning that the replacement of these beds was identified as a risk prior to the first incident in 2010 and yet at the beginning of 2011 a similar fatality could have happened. Information received by RQIA on 1 April 2011 from SEHSCT, indicated that it is unlikely that any new risk assessment of the cells in Elm and Willow houses will be completed in the short-term. These houses are next in line to be refurbished and, on completion of this work, a risk assessment will be undertaken as part of the hand back procedure from contractors. The metal beds will be replaced as part of this planned refurbishment. Whilst this issue is the responsibility of the NIPS, it has a direct impact on the health and wellbeing of young offenders, as these beds provide a readily available ligature point. The lack of a detailed risk assessment of cells in relation to ligature points is of particular concern.

Subsequent to the inspection, RQIA and CJI met with the Governor of Hydebank Wood and an assurance was given that these beds would be replaced as a priority.

3.3.4 Report Three - YOC

A young man was found unconscious in his cell. He had placed his head into a twisted sheet attached to a chair. He had marks on his neck but no long term injuries. A nursing officer was on the scene quickly. The investigation report stated that the door surround has a metal lip that could, with considerable effort, be prised forward to permit a ligature. The recommendations from the report stated that there were minor concerns

regarding wall mounted picture boards and the cell door surround, and that a cell sharing risk assessment was not completed. RQIA would not agree that these were minor concerns and would recommend that a detailed risk assessment of ligature points be undertaken with the involvement of SEHSCT.

The prisoner was receiving counselling support from Lifeline but there was no evidence in the report that he had been referred for mental health support.

3.3.5 Report Four - YOC

An incident occurred where an RMN was on night duty alone. A patient was psychotic and disturbed. The RMNs first point of contact was the on-call GP, the nurse was concerned about the medication prescribed by the GP and made a professional judgement to call the consultant forensic psychiatrist at home for guidance. Inspectors consider that this incident highlights gaps in the provision of care, for example the training needs of staff, and the need to have a protocol in place for patients in need of emergency psychiatric care. The SEHSCT should review this issue, develop a protocol and, where necessary provide additional training and guidance for staff in this area.

3.3.6 Discussion on the Findings Specific to the YOC

Within the space of five months, there were three serious adverse incidents investigated by the NIPS. As RQIA is unaware of the number of SAIs that are investigated each year it cannot make comparisons. Information has been requested from the trust in relation to the number of healthcare related incidents and the percentage of those that were classified as serious adverse incidents. RQIA has subsequently met with senior trust representation to discuss these issues.

3.3.7 Reports for Patient a - Ash House

The review of the SAI reports relating to one woman prisoner indicated that she had a significant history of self-harm.

First Incident

The first SAI report documented that this woman prisoner had attempted to hang herself in a holding cell at Laganside Court whilst awaiting transportation to Ash House. A SPAR was commenced at the court by the escorting prison staff. The prisoner was admitted directly as an inpatient to an observation cell in the healthcare centre after committal to Hydebank Wood. A liaison and addictions risk assessment was completed prior to discharge from the healthcare centre. The report indicates that neither a mental health assessment nor regional mental health risk assessment tool were completed.

Second Incident

The report of this incident states that the prisoner had taken lighter fluid from a drawer in the sluice room.. The prisoner had been allowed to go into the sluice unsupervised, to obtain cleaning materials to clean her cell.

At 20.30 hours the nurse on duty stated that there was a concern about the prisoner's behaviour. Camera observation was increased, however, this was not documented. At 22.30 hours the nurse requested a medical unlock, however, the prison officer in the main prison was involved in another incident which delayed the unlock until 23.41 hours. The nurse observed at 23.30 hours that the prisoner had a container of lighter fluid in the cell. The nurse contacted the GP on call who advised that the prisoner's pulse and respirations should be checked and that the prisoner should be encouraged to drink milk to dilute the stomach contents. The prisoner was not admitted to hospital but observed overnight in the healthcare centre. However, there was no evidence of the poisons information system (TOXBASE) having been accessed to identify relevant signs and symptoms.

There can be significant signs and symptoms following the ingestion of lighter fluid, dependent upon the amount swallowed and damage can continue for several weeks after the poison has been swallowed. There is no indication that the nurse, the author of the incident report, or the doctor had considered this as a factor in the care of this prisoner. The investigation could not find any evidence as to why the lighter fluid was not kept under locked conditions in compliance with Control of Substances Hazardous to Health (COSHH) regulations.

Third Incident

Two days later this prisoner injected herself with a syringe of long acting insulin. She stated that she had retrieved the insulin pen from the fridge in the treatment room in the healthcare centre two days earlier. The prisoner stated that the treatment room was never locked, and was always held wide open with a door wedge. She stated on the day she took the insulin she was able to enter the treatment room, open the drug fridge where she saw the insulin pen and subsequently removed it from the fridge. She then took time to retrieve an insulin needle from one of the drawer units beside the fridge. In the period of these two days there were two cell searches undertaken and the insulin was not found. Staff interviews confirmed that it was routine practice for the door of the treatment room to be wedged open. Staff also confirmed that the lock on the drug fridge door was faulty and could be opened even though it was locked. No member of staff had reported this and one member of staff stated the lock had been faulty from the day it was delivered.

There was a significant time delay of one hour and 23 minutes between the healthcare staff identifying that the prisoner had taken a lethal dose of insulin and her transportation to a hospital Accident and Emergency (A&E) Department. The explanation for the time delay given by the nurse was that there was a need to arrange escorting staff and have an escape pack made up. The senior officer on duty in the prison was asked by the Residential

Governor of Ash House to provide an account of the events of the evening but they declined. There were no other incidents in the prison that night to explain why this delay had occurred. It is potentially dangerous to have such a delay. During this delay there was only one set of observations undertaken and the amount of insulin taken was not checked on the TOXBASE system to identify the appropriate interventions.

Following admission to hospital she received care for four days before being discharged back to Ash House.

The post incident review report was completed four months after these (second and third)incidents . There are significant recommendations for staff practice. Nursing staff did not adequately ensure that this prisoner was protected from harm. It is recommended that the actions highlighted within this report should be acted on with immediate effect.

The report notes that some actions have been undertaken following these incidents. For example, an access keypad for the treatment room door has been put in place and the drug fridge has been replaced. The incident review report makes 16 recommendations to SEHSCT and the Governor of Hydebank Wood.

Fourth Incident

The same female prisoner inflicted a deep laceration to her lower left arm. SEHSCT was not initially informed about this incident, however, when the Safer Custody Officer saw the recommendations of the report he advised the trust by email.

This incident was investigated by a member of staff from prison headquarters. There were three recommendations made by its investigating officer as a result of this incident:

- "Other than basic access to work and verbal support there seems to be no diversionary activities that case managers can access for care planning."

- "More involvement is required from healthcare professionals in the community to provide support for the healthcare staff in Ash House."

- "Perhaps it is time to rethink the strategy of care for this prisoner and those like her. "She is, in my opinion, a suicide waiting to happen.""

This women had been seen by a Forensic Psychiatrist who had proposed that she be transferred to specialist unit outside Northern Ireland, however, funding for this is difficult to achieve. At the time of the inspection, there was no input to this woman's care by the mental health nurses. It is recommended that the trust explore alternative approaches and therapies for this prisoner in the interim to ensure that all possible steps are taken to protect her from further harm.

Fifth Incident

During the period of the inspection this prisoner cut her left forearm with the edge of a soft drink can and was subsequently transferred to the healthcare centre. On admission, she her behaviour was settled and she responded to mental health support.

3.3.8 Discussion on the Findings- Ash House

The inspectors became aware of these incidents during the inspection visits in March 2011. A short summary report was sent by RQIA to SEHSCT to ensure that they were aware of the incidents and that the appropriate investigations had been undertaken.

SEHSCT advised RQIA that the incidents involving the inhalation and consumption of lighter fluid and the woman prisoner's theft and subsequent overdose of long acting insulin from the treatment room were not reported to the HSC Board as SAIs. However, they were subject to local review by the trust. Although these were near miss incidents, they had the potential to cause serious harm to the prisoner. In light of these concerns, the reporting of SAIs should be reviewed.

In addition, the serious breaches in staff practice are particularly concerning. All nurses have a duty to abide by the NMC's professional code, namely The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives.[6]

Nurses are required to be professionally accountable for their actions and for omissions in their practice and to justify their decisions. SEHSCT should investigate and consider whether any action is necessary to address the deficits in nursing practice identified in these incidents.

[6] http://www.nmc-uk.org/Documents/Standards/The-code-A4-20100406.pdf

3.3.9 Overall Discussion on the Findings

When SAIs occur in the prison they are investigated and the report is forwarded to the Prison Governor/ Deputy Governor, the local Safer Custody Group and the Prison Headquarters Safer Custody Group. Following a telephone conversation with the Prison Services Investigating Officer, inspectors learned that these reports are not routinely shared with SEHSCT. Inspectors were assured that, in future, these reports will be shared with the trust.

There is a Lessons Learned group and meetings are held in prison headquarters. Information was not provided on this during the inspection and was subsequently requested and received from the trust. The information indicated that the system is just commencing. RQIA welcomes this development and believes that it is a necessary additional safeguard.

SAIs are discussed at the meetings of acting healthcare managers. In the minutes of the meeting held on the 22 March 2011, managers stated that: the investigations are time consuming; there is no administrative support; and that the process is lengthy in terms of obtaining statements and paperwork. The managers felt that serious consideration should be given to the setting up of a group which would include clearly identified roles and responsibilities. RQIA would also recommend that a formal system is put in place, which protects patients through identifying and applying the learning from all adverse incidents and other reportable incidents.

The Prison Service Suicide and Self-Harm Prevention Policy 2011 states that the role of healthcare staff is to determine and deliver appropriate healthcare services to prisoners from committal to discharge. However, investigations of SAIs appear to be led by prison staff with limited involvement of healthcare staff.

The inspectors found that governance arrangements were not sufficiently robust in relation to the sharing of information and learning from SAIs to ensure that recommendations are addressed. A system should be in place to ensure two-way communication in relation to SAIs and that all relevant information is shared in a timely manner across the prison service. As an urgent priority, a detailed risk assessment of cells in relation to ligature points should be undertaken by the NIPS, in conjunction with SEHSCT, and monitored on a regular basis. The risk assessment should include a detailed action and management plan and there should be immediate replacement of the old style metal beds in both Elm and Willow houses within the YOC.

3.3.10 Recommendations

50. **The governance systems in place should ensure there is effective and timely sharing and learning from SAIs and that any recommendations made are fully addressed.**

51. **SEHSCT should investigate and take action to address the deficits in care identified in the local review report of incidents relating to women prisoners to ensure that all nurses comply and abide by the Nursing and Midwifery Council's professional code.**

52. **The reporting of SAIs to the HSC Board should be reviewed.**

53. **Healthcare staff should be more involved in the review of serious adverse incidents. Reporting systems should be improved to ensure that patients are protected, through identifying and learning from all safety incidents and other reportable incidents.**

54. **SEHSCT should develop a protocol for emergency psychiatric care and, where necessary, provide additional training and guidance for staff in this area. The medical lead for the prison service should undertake a training needs analysis for medical staff.**

3.4 Services Specific to Children and Young People and Women Prisoners: Environment and Relationships

Quality Indicator

Services should be planned to take account of an individual's needs and requirements, to safeguard human rights and to provide a high standard of personalised care and service.

Staff should have an understanding of the distinct needs, preferences and choices of the population they serve and young offenders and women prisoners should receive care and services that are not unnecessarily restricted by security arrangements.

The general environment should be clean, tidy and in good repair.

Expected Outcome

Young offenders and women prisoners are held in conditions that provide the basic necessities of life and health and they are treated in a manner which respects their dignity.

3.4.1 Findings of the Inspections

NIPS continues to provide services to young offenders under the age of 18 within the YOC and to women prisoners in Ash House. Whilst the provision of these services continues on the same site, they should be appropriately resourced with dedicated accommodation. The regime should also be capable of meeting the needs of the two prison populations. Recommendations have been made in relation to this in the joint report by the four regulatory authorities involved in these inspections. Further detail on the arrangements in place at each unit, as identified through the inspection visits, is outlined below.

The YOC

At the time of the inspections, there were 17 young men under the age of 18 being held in the YOC, 12 of whom were on remand and five who were serving sentences.

These young men were accommodated in two adjoining prison wings in single cell accommodation. Shower areas were basic and lacked privacy. Each wing has a kitchen/ dining/ communal area where meals can be eaten and where association takes place. In each communal area, games equipment was provided, which included pool tables on both wings, a table tennis table on one wing (although this was noted to be damaged and in need of repair or replacement), a television and, on one wing, a Nintendo Wii games console. The inspector observed young men and staff engaging in games of pool and there was an air of relaxation and positive interaction.

On the evening of 22 March 2011, the inspector visited the two juvenile wings from 17.00 to 19.30 hours. The inspector noted that with the exception of two young offenders who were undertaking orderly duties, all other young offenders were placed on lock up. The inspector was advised by staff on the wings that this was due to staff shortages and that this was not unusual. The inspector was advised by staff that there were occasions when young men needed to be locked up at alternative times during association, to keep them safe from each other.

On another occasion the inspector noted that one young man was locked in his cell whilst two others enjoyed association. These two young offenders had threatened to harm the first. The inspector was advised that the first young offender would be permitted to leave his cell once the two other young men were placed on lock up. Essentially, these young men lose their leisure association time as a result of staff shortage and, at other times, lock up is being used as a management and control strategy.

The inspector was concerned with the excessive time young men spend locked in their cells and the consequential impact this may have on their mental health. The inspector would regard this practice as unacceptable.

Ash House

At the time of the inspection, there were 49 women prisoners being held in Ash House, 20 of whom were on remand, 28 were serving sentences and one was an immigration detainee.

The overall environment within Ash House was satisfactory, in that it was clean, it was generally in good repair and efforts had been made to improve the appearance with the use of art work. Each woman had a single cell and was content with the privacy this affords. However, some women spoken to by inspectors stated that the beds are uncomfortable and the mattresses are stained. The mattress frequently slips off the bed and women end up lying on the floor. The cell windows are sealed and women can only smoke in their bedrooms which is very uncomfortable. The women stated that have requested at the monthly landing meeting permission to smoke outside. The toilets are partially screened, however female staff do not knock before coming into the cells, which women prisoners find very embarrassing. It was indicated that the showers are generally acceptable, on the basis that women prisoners are allowed daily showers which are taken in private.

The women prisoners reported that there are frequent lock-downs. There are many vulnerable women and if one requires additional help, then all the landings tend to be locked down. It was suggested that there should be a landing dedicated to vulnerable prisoners or that they should be transferred to the healthcare centre. They also reported lock downs during staff shortages. In an emergency, women prisoners can activate an emergency bell, however, the women prisoners said emergency bells were often not answered for 30 minutes.

Women felt that most staff are fair, however, some staff could be aggressive, tended to use unnecessary force and acted too quickly in some situations. Two women were unaware of the liaison officer, whilst one said she saw her liaison officer too often. However, they all noted that the role was not fully explained to them. When asked about complaints, women prisoners stated that complaint forms were available and that they felt confident about making a complaint. They felt that adjudication is usually fair. However, women prisoners felt that it was unfair that in a dispute between prisoners, the innocent party is also adjudicated. Women prisoners felt that bullying is well controlled.

The previous inspection report recommended that mother and baby rooms should be improved and should not contain an open toilet. On inspection of the mother and baby room, which was unoccupied at the time of the inspection, it was clear that staff had made an effort to create a pleasant environment. Further improvement in relation to the size and space of this room would require significant investment

The room is divided in two by a wall which is approximately two thirds of the length of the room. One side of the room contains the bed and a cot, the other side has a toilet, a washbasin and some equipment for a baby. The wing officer confirmed that baby feeds are not prepared in the room. Whilst this room is small and cramped for the amount of equipment required, all areas of the room and equipment were clean.

From an infection prevention and control perspective the toilet should be supplied with a lid. The main risk identified is the close proximity of the toilet to the equipment and the aerosol spray generated by the toilet flush. Placing the lid down, prior to flushing, should minimise this risk to an acceptable level.

There should be an information leaflet devised for mothers to raise awareness of prevention and control of infection. This should highlight the importance of washing hands after using the toilet and before and after caring for their baby. Advice should also be sought from the infection prevention and control team of SEHSCT.

3.4.2 Recommendations

55. The use of lock up is not an appropriate means by which to manage and control young people or women, nor in response to staff shortages. Hydebank Wood should review the use and frequency of lock up, to ensure the health and wellbeing of prisoners.

56. Advice should be sought from the infection prevention and control team of SEHSCT in relation to the mother and baby rooms.

3.5 Services Specific to Children and Young People: Safeguarding

Quality Indicator

Safeguarding of young offenders includes issues such as suicide, self-harm, bullying, harm from staff and visitors, and promoting emotional wellbeing.

The principles of safeguarding need to be embedded within all aspects of the regime.

The YOC's safeguarding committee should include representatives from healthcare and specialist mental health staff.

Expected Outcome

Systems are in place to ensure that young people are supported through age appropriate services.

3.5.1 Findings of the Inspection

The findings of the inspection would indicate that the following systems and governance arrangements are in place.

3.5.2 Safeguarding Children Framework and Guidance

A comprehensive Safeguarding Children Framework and Guidance policy is in place. This includes a Safeguarding Children Protocol with each of the five health and social care trusts and with PSNI.

There is a multidisciplinary Safer Custody Steering Group which meets monthly within which child protection is a standing agenda item. At these meetings, the child protection coordinator reports on the number and status of child protection cases. Although the Safer Custody Steering Group has clear reporting lines into senior management decision making forums, it does not always link with other multiagency meetings concerning children and young people in the establishment. The safeguarding committee meets regularly with good attendance by representatives from healthcare and specialist mental health staff.

The previous inspection report recommended that a formal request be made for the Governor of the Hydebank Wood to become a member of the area child protection committee. Discussion with staff indicated that this recommendation had not been addressed at the time of the inspection.

An appropriate forum for the strategic development of child protection has been established. There is a Safeguarding Children Protocol with each of the five health and social care trusts, and with PSNI. However, there was no evidence of direct liaison between Hydebank Wood staff and social services personnel from the local health and social care trusts.

RQIA would strongly recommend that the existing protocol detailing inter-agency working which focuses on communication, thresholds for referral, access to consultation and advice, and the sharing of monitoring and case management review outcomes, becomes fully operational.

3.5.3 Audit of Case Files

An audit of six child protection case files was undertaken. The files revealed that referrals are not always made to trusts using the appropriate Understanding the Needs of Children in Northern Ireland (UNOCINI) forms. Also, trusts do not always respond as required, under the provisions of the requisite child protection procedures.

The inspector was particularly concerned about one case which detailed an incident of a child protection nature. This had been witnessed and reported by staff in the visitors centre. A comprehensive record of the incident was contained in the child protection file. This case was of significant concern because a child protection referral had not been made to social services. However social services had been contacted by letter for guidance in respect of the incident. There was no evidence of a response from the trust, as required under the child protection procedures.

A decision was made that this incident should be escalated in accordance with RQIA's Escalation Policy and a further visit to the prison was made on 25 March 2011 following the final feedback session. This revealed that an earlier incident involving the same child had occurred in the visitors centre and a UNOCINI referral had been completed. There was no evidence on the file as to how the trust had responded to either of these two incidents. The trust has received written notification from RQIA requesting clarification about how these matters have been addressed.

The child protection coordinator advised that monitoring of child protection referrals was not being undertaken by NIPS, nor was there any analysis which might have identified patterns or trends. The previous inspection report recommended that child protection referrals should be monitored and analysed for patterns or trends. Given the issues detailed in this report, it is concerning that this recommendation has not been addressed. RQIA would reiterate this recommendation and would strongly recommend that immediate steps are taken to ensure that effective measures are implemented.

3.5.4 Child Protection Training

All staff who come into contact with children should have comprehensive multidisciplinary child protection training. The need for child protection training for staff is referenced in the NIPS Safeguarding Children Framework and Guidance.

The inspector was advised that staff whose duties brought them into direct contact with children and young people were prioritised for training. However, the training officer advised that child protection training is not mandatory. Of

the total staff in post, only 42 per cent have received training in child protection.

Given the issues emerging through this inspection, the inspector would consider that greater emphasis must be placed on ongoing child protection training, including refresher training for staff. RQIA would further recommend that child protection training becomes mandatory.

3.5.5 Access NI Disclosures

The inspection confirmed that the appropriate systems are in place to provide assurance in this area. The inspector confirmed that 279 of 287 staff have had up-to-date clearance checks from Access NI and that the remaining eight checks were being processed.

3.5.6 Recommendations

57. Greater emphasis must be placed on child protection training including refresher training for staff. RQIA would further recommend that child protection training be made mandatory.

58. Immediate steps should be taken to ensure that child protection referrals are monitored and that patterns or trends are identified.

59. RQIA recommends that the existing safeguarding children protocol detailing inter-agency working, which focuses on communication, thresholds for referral, access to consultation and advice, and the sharing of monitoring of case management review outcomes becomes fully operational.

3.6 Medicine Management

Quality Indicator

Prisons medicine management, including sections on medicines handling, and risk assessment of in-possession practice should form a distinct element of SEHSCT's local delivery plan.

Medicines management should meet the standards described in the Quality and Outcomes Framework Organisational Indicators.

Prison medicines management should be included in SEHSCT's operational plan to ensure that there is effective commissioning, monitoring and delivery of medicines management services in prisons.

Effective delivery of the trust's operational plan should be monitored by the Prison Medicines Management Committee which is linked to the Medicines Management Committees within SEHSCT.

Expected Outcome

Systems are in place to provide the necessary assurance that medicines are stored and handled safely and securely, medicines are administered safely in accordance with the prescribing practitioner's instructions, all medicine records comply with legislative requirements and current best practice and provide a clear audit trail.

3.6.1 Findings of the Inspections

The findings of the inspections would indicate that the following systems and policies were in place.

3.6.2 Organisational Medication Management

The prison pharmacist advised that prison medicines management forms a distinct element in the local delivery plan of SEHSCT. The responsibility for the safe and secure handling of medicines is clearly defined and there are clear lines of accountability throughout the organisation.

Evidence was available to confirm that the Drugs and Therapeutic Committee, (which includes the involvement of SEHSCT) meets three times per annum to ensure accurate, evidence-based prescribing and the agreement of protocols (including disease management guidelines), discretionary list policies and a local formulary for the administration of medicines, either by health services staff or when prisoners self-medicate.

NIPS has a prescribing policy in place. The prison pharmacist confirmed that the DHSSPS Clinical Effectiveness Programme is used and that the prescribing guidelines are adopted by the NIPS, for example, recent updated guidance on anti-depressant prescribing. As prescribing policies are agreed,

the prison pharmacist updates the NIPS Prescribing Formulary on EMIS. This is then available online in bold print when the prescriber is choosing a drug selection. There is a generic substitution policy in place across all three prisons and this is continued in the new pharmacy contract. All the NIPS Prescribing Policies make reference to National Institute for Health and Clinical Excellence (NICE) and Northern Ireland community prescribing guidelines. If a standard community guideline is appropriate for prisons, it is adopted by the Drugs and Therapeutic Committee.

Prescribing reports(COMPASS)[7] for prisons have been provided by Business Services Organisation (BSO) via the current pharmacy provider. These reports had been presented and reviewed at the Drugs and Therapeutic Committee meetings. However, this arrangement has ceased due to resource/ cost factors. Prescribing reports are, however, still available via both EMIS and the pharmacy dispensing system and are part of the new pharmacy contract. Exact report requirements were to be agreed by the senior prison pharmacist and the trust from May 2011 onwards.

The prison, trust and service provider must ensure that the reporting system collects quality aggregated prescribing data in order to inform effective medicines management and clinical governance and to demonstrate value for money. Staff must ensure that information is recorded accurately on EMIS to facilitate this process. If necessary, additional training should be provided.

3.6.3 Medication on Committal

The procedures in place for confirming current medication and prescribing medication at committal must be reviewed. It is acknowledged that within the prison setting there are considerable challenges due to the out-of-hours committal of vulnerable patients. However, written confirmation of current medication regimes and written confirmation of remote instructions from the prison doctor should be obtained before any medication is administered by nurse officers, in accordance with NMC guidance. At present, nurse officers verify medication regimes with the community prescriber's receptionist via telephone, which is deemed to be an unsafe practice by inspectors.

It is also routine practice that following an initial assessment by the nurse officer, the prison doctor is contacted via telephone. A verbal instruction is obtained for the administration of medication. This is then recorded on EMIS and a prescription is generated on EMIS within a maximum of 72 hours. The medication is dispensed from the medicines held as emergency stock and records of administration are maintained. This practice is routine, rather than by exception. Hence, there should be a system in place to enable the prescriber to confirm telephoned instructions in writing, for example, by fax.

[7] These reports provide feedback to medical practitioners on their prescribing. They are generated for individual practices, locality groups, area health boards and Northern Ireland as a whole for each quarter and each financial year. Practice reports are circulated to all practices each quarter. The report allows practices to see how their prescribing compares to that of other practices in Northern Ireland and how they have changed compared to the previous year.

3.6.4 Medicines Policies and Procedures

Written policies and procedures cover most aspects of the activities associated with the management of medicines. These policies are reviewed bi-annually or after any significant change or incident.

All policies are ratified by the Drug and Therapeutic Committee (which meets three times per annum) and are updated in Standard Operating Procedure (SOP) format. The acting healthcare manager sends updated policies to the relevant healthcare staff via electronic mail and corresponding read receipts are used to confirm understanding and compliance. It is acknowledged that all nurses have accountability for their own practice. However, in accordance with recognised safe practice, healthcare staff should be requested to sign that they have read and understood the policies and procedures for the prison setting. In addition, a robust audit tool should be developed and used at specified intervals to measure compliance with the SOPs and to implement, any necessary and/ or corrective actions.

Procedures are in place to ensure that prisoners receive their prescribed medications in strict accordance with prescriber's instructions (for example when going to court or transferring between prisons). During the inspection an incident occurred whereby an incorrect medicine was sent with a prisoner when attending court. The acting healthcare manager advised that this would be investigated.

Observations made during the inspection indicated that medicines were made available to prisoners within 24 hours of the prescription being requested. Following an initial review or assessment by the prison doctor, a pharmacist is available to take referrals from and provide advice to patients with complex pharmaceutical needs. The initial assessment of and prescribing for any young offender or women prisoner is undertaken by the prison doctor.

Procedures are in place to ensure that General Sales List (GSL) and pharmacy only medicines (POM) are available to prisoners, following an assessment with a nurse officer or healthcare officer, (i.e. discretionary list medicines). Medicines are not, however, available in the tuck shop.

3.6.5 Medication Audits

Currently the senior prison pharmacist carries out a quarterly controlled drugs audit for all prisons in Northern Ireland. A treatment room audit check on all areas in the prison where medicines are held is also completed quarterly. This audit includes a date and balance check of the emergency drugs cupboards. Any discrepancies are reported on the trust IR1 incident report form. In addition, healthcare staff carry out weekly checks of all stock drugs.

The prison pharmacist advised that three major healthcare audits had been completed recently (namely audits in relation to Chlamydia, In-Possession Medication and Medication Administration Records). Action plans had been developed following these audits.

3.6.6 Management of Medication Incidents

The prison pharmacist confirmed that prescribing and dispensing incidents/ errors are reported in accordance with the NIPS and SEHSCT procedures. The acting healthcare manager advised that all medication related incidents are reported and that staff are made aware of any necessary actions via team meetings.

It was noted that records for the disposal of medicines are not maintained and that records of administration are not audited. This does not permit a clear audit trail and may lead to medication incidents going undetected.

3.6.7 Medicine Records

It is recommended that the records for the receipt, administration and disposal of medicines are reviewed in order to provide a clear audit trail. Staff were unable to confirm how long records for the receipt of medication are maintained. The recording system used for medication administration had been piloted and an updated version developed.

The following further improvements are necessary in the medication recording sheet:

- only one record should be in use for each prisoner
- the quantity of medicine received should be recorded
- all currently prescribed medicines should be recorded
- discontinued /obsolete medicines should be recorded as discontinued
- a record of disposal should be maintained

A complete record for the disposal of all medicines (including those which have been removed from prisoners at committal, those remaining after prisoner release, and those discontinued and date expired) should be maintained.

3.6.8 Storage of Medicines

At the time of the inspection, the majority of medicines were observed to be stored securely under conditions that conform to statutory and manufacturers' requirements. Due to the quantity of controlled drugs held in stock, it is recommended that a larger capacity controlled drug cabinet is obtained.

The establishment retains a supply of emergency drugs. There is a system for checking the expiry dates of emergency drugs on a weekly basis. However, a review of these records indicated that this frequency is not always achieved.

3.6.9 Recommendations

60. The prison, trust and service provider must ensure that there is a system in place to collect quality aggregated prescribing data in order to inform effective medicines management and clinical governance and to demonstrate value for money.

61. Staff should receive appropriate training on the use of the EMIS system to ensure that all information is correctly entered.

62. The procedures for confirming current medication regimes and prescribing medication at committal must be reviewed. In accordance with NMC guidance, written confirmation of current medication regimes and remote instructions from the prison doctor should be obtained before any medication is administered by nurse officers.

63. A robust audit tool should be developed and used at specified intervals to measure compliance with the Standard Operating Procedures and any necessary corrective action should be implemented.

64. The length of time for retaining records for the receipt of medicines must be confirmed.

65. The necessary improvements on the medication administration records should be implemented.

66. Clear records for the disposal of all medicines must be maintained (include date of disposal, quantity, reason and signature).

67. The contents of the emergency drugs pack should be checked in line with agreed timescales.

3.7 Management of In-Possession Medication

Quality Indicator

The YOC and Ash House should have a policy and risk assessment criteria developed through the Drug and Therapeutics Committee (D&TC), for determining on an individual basis, when medicines and related devices may or may not be held in possession.

There should be appropriate systems in place that promote and support the move towards prisoners having medication in-possession as standard, which is based on the use of risk assessment criteria.

Expected Outcome

Based on risk assessment, medicines in use, together with associated monitoring and administration devices, are held in the possession of prisoners.

3.7.1 Findings of the Inspections

The findings of the inspections would indicate that the following systems and policies were in place.

3.7.2 In-Possession Policy

The prison pharmacist advised that there has been a move towards most medicines being held in possession of young offenders and women prisoners, following the appropriate risk assessment.

A copy of the multidisciplinary clinical audit project, which was carried out in 2007 to audit in-possession procedures, was provided for review. The audit aimed to assess compliance with the policy standards, define key measures for monitoring the policy and offered the opportunity to reassess the policy's benefits and risks. Following this audit, a revised in-possession policy was developed which included an updated risk assessment tool.

The In-Possession Policy is now reviewed annually and ratified by the Drug and Therapeutics Committee. The current policy was adopted and issued in November 2010.

3.7.3 In-Possession Risk Assessment

The in-possession policy states that a healthcare officer or nurse officer, will complete an in-possession risk assessment for every prisoner receiving medication. The risk assessment is reviewed on the basis of identified trigger factors and monitoring checks. The risk assessment tool uses a scoring system based on patient related factors, clinical/ medication-related factors and environmental factors. The policy also stipulates the records which must be maintained following the initial assessment.

Observations made during the inspections indicated that while there is an updated risk assessment tool, staff were using the previous version. Staff spoken with indicated that the decision to give in-possession medication was subjective, i.e. “we know the prisoners”. The risk assessments had not been completed fully on all occasions and there was little evidence that any had been reviewed. The required frequency of random monitoring checks to confirm compliance was not being achieved, although there was evidence of some checks having been carried out in February and March 2011.

There was no evidence that the acting healthcare manager had monitored the adherence of healthcare staff to the in-possession policy.

Records of the transfer of medicines to prisoners for in-possession administration were well maintained and were signed and dated by both the healthcare staff and prisoner which should be acknowledged as good practice. One nurse officer advised that compliance was monitored verbally at each transfer of medication, however corresponding records were not maintained.

Although there was a clear audit trail for the transfer of medicines to patients, records for the disposal of medicines were not being maintained at the time of the inspections. Staff were unable to confirm the length of time records of receipt had to be maintained.

Observation of dispensed medicines in the treatment room indicated that all medicines issued were accompanied by a patient information leaflet.

3.7.4 Recommendations

68. The acting healthcare manager must ensure that all healthcare staff have received and understood the updated in-possession policy.

69. Training on the objective completion of the risk assessment tool should be provided for all healthcare staff.

70. The acting healthcare manager must audit compliance with the updated policy to ensure that all assessments are fully completed and that the required frequency of random monitoring audits is achieved.

3.8 Management of Controlled Drugs

Quality Indicator

A controlled drugs policy and Standard Operating Procedures (SOPs) which covers the management of controlled drugs such as the ordering, transport and receipt, safe storage, administration, disposal, record keeping, and management of errors and incidents is available.

Records of the prescribing, supply, administration, safe custody and destruction of controlled drugs are maintained in accordance with good practice guidelines and providing a clear audit trail.

The SEHSCT Accountable Officer ensures that the prison has suitable arrangements in place for the safe management and use of controlled drugs.

The healthcare professionals in charge of the healthcare department in the prison take responsibility for the day-to-day management of controlled drugs and regularly audit adherence to the SOPs.

A discharge management plan is in place which includes referral to addiction teams, and discharge supply.

Expected Outcome

Controlled drugs are managed in accordance with legislation and good practice guidance.

3.8.1 Findings of the Inspections

The findings of the inspections would indicate that the following systems and policies are in place.

3.8.2 Management of Controlled Drugs

The controlled drug policy was written in November 2010. It is due for review in November 2011.

SOPs cover the following areas of the management of controlled drugs: ordering, transport and receipt, safe storage, administration, disposal, record keeping, and management of errors and incidents.

The SEHSCT Accountable Officer has the responsibility to assure that the prison has suitable arrangements in place for the safe management and use of controlled drugs. The senior prison pharmacist completes a controlled drug audit at quarterly intervals. The outcomes of this audit activity are forwarded to the SEHSCT Accountable Officer.

The acting healthcare manager within the prison takes responsibility for the day-to-day management of controlled drugs. However, it is the senior prison pharmacist who audits adherence to the SOPs at quarterly intervals.

3.8.3 Audit of Records

A sample of records of the prescribing, supply, administration, safe custody and destruction of controlled drugs was reviewed. These were found to be maintained in accordance with good practice guidelines and provided a clear audit trail. Previous poor record keeping had been identified by the senior prison pharmacist and corrective action had been taken.

3.8.4 Discharge Management Plan

Staff advised that a discharge management plan is in place. If a prisoner is on a substitute prescribing programme, a referral to a community addiction team is arranged via the prison addictions nurse. If a prisoner who has been on a controlled drug prescription leaves the prison, they receive their final dose of controlled drug medication on the day of leaving. The nurse officer advised that a list of current medications would be provided for the prisoner. However, the inspectors were unable to ascertain if there was a medication on discharge policy, or if discharge letters were provided for all patients.

3.8.5 Administration and Storage

All young offenders and women prisoners attend the prison's healthcare centre for the administration of Schedule 2 and Schedule 3 controlled drugs. At the time of the inspection, Schedule 2 and Schedule 3 controlled drugs prescriptions were prescribed for named patients. However, plans were in place for the use of stock controlled drugs. This was documented in the current controlled drug policy.

Controlled drugs are reconciled twice daily. The controlled drug key is locked in the prison key safe overnight. The controlled drug key is transferred between nurse officers during the day shift. Staff advised that it would be impractical to reconcile the control drug balance throughout the day. It is recommended that one nurse officer should be accountable for the contents of the controlled drug cabinet during each shift.

A number of out-of-date and discontinued controlled drugs awaiting destruction were observed by inspectors. These had not been clearly marked and segregated from current stock in the controlled drug cabinet.

Controlled drugs which are issued in daily bags are not stored securely. A number of these bags were observed to fall out of the controlled drug cabinet when the door was opened. An appropriate container should be obtained and a larger capacity controlled drug cabinet is required.

3.8.6 Recommendations

71. **The management of the controlled drug key should be reviewed to ensure that one nurse is accountable for the contents of the controlled drug cabinet during the day shift.**

72. **Out-of-date and discontinued controlled drugs awaiting destruction should be clearly marked and segregated in the controlled drug cabinet.**

73. **Controlled drugs, which are dispensed in daily issue bags, should be stored in a suitable container in the controlled drug cabinet.**

74. **A larger capacity controlled drug cabinet should be obtained.**

3.9 Hepatitis B Vaccination

Quality Indicator

The prison undertakes surveillance to indicate that they have achieved Hepatitis B vaccine uptake of 80 per cent or more of all new eligible and consenting prisoners received into the establishment.

An immunisation policy should be available which states that all new committals, where there is no verifiable evidence of previous vaccination, are offered Hepatitis B vaccine or where a course has been started, it is completed.

Expected Outcome

Hepatitis B vaccination is provided for all those who are eligible on committal.

3.9.1 Findings of the Inspections

The findings of the inspections would indicate that the following systems and policies are in place.

The review of the Management of Opioid Dependence Policy (February 2011) indicates that all people entering prison are offered Hepatitis B vaccination. The policy states that vaccination is to be carried out under patient group direction (PGD) using a super-accelerated 21-day schedule and that on prison discharge, the patient's GP is always contacted to ensure the fourth dose at 12-months is followed up.

Healthcare staff were unable to confirm whether or not all people entering prison were offered Hepatitis B vaccination.

The PGD for Hepatitis B Vaccination was issued in May 2010 and is due for review in May 2012. A PGD file is held in the prison healthcare centre. The copy observed had not been completed by all signatories. Nurse officers advised that only one nurse officer is responsible for the administration of the Hepatitis B vaccine and that the super-accelerated 21-day schedule had been stopped due to a perceived stock supply problem.

The acting healthcare manager and pharmacist had not been made aware of this decision. The acting healthcare manager advised that it would be recommenced from the day of the inspection onwards. It is recommended that the acting healthcare manager monitors staff compliance with the prison's policy for the super-accelerated Hepatitis B vaccine at regular intervals. This includes: confirmation that all those who are eligible have been offered Hepatitis B vaccine at committal: that information has been provided to young offenders and women prisoners; consent forms are completed on all occasions; vaccine uptake is accurately recorded on EMIS; and, community GP referrals are made, in accordance with the requirements of the policy.

3.9.2 Recommendations

75. **The PGD for Hepatitis B should be reviewed immediately and signed off by all relevant signatories to ensure validity.**

76. **The acting healthcare manager must ensure that all appropriate nurse officers have been made aware of the PGD and that relevant training has been provided.**

77. **The acting healthcare manager must monitor staff compliance with the prison's policy for the super-accelerated Hepatitis B vaccine, at regular intervals and must be made aware of all stock supply problems which impact on prisoner health.**

3.10 Sexual Health

Quality Indicator

The sexual health of young offenders and women prisoners should be addressed to support the overall strategy for preventing the spread of communicable diseases in prison, offering harm minimisation information and treatment for substance misusers.

Expected Outcome

The sexual health of young offenders and women prisoners is supported as appropriate. Information, education, screening and confidential advice are actively promoted.

3.10.1 Findings of the Inspections

The findings of the inspections would indicate that the following systems and policies were in place.

Although there is evidence of progress in this area, information, education, screening and confidential advice on sexual health are not actively promoted in a planned manner.

Notice boards are available in the healthcare centre and in each house. They are updated monthly and reflect local and national campaigns.

The healthcare officer advised that they provide sexual health information meetings on the landings on an ad hoc basis. Sample pots are provided at these discussions to facilitate screening uptake. Young offenders and women prisoners do not have access to social and life skills modules on sex and relationship education (SRE). However, they do have access to chlamydia and STI screening programmes and a genitourinary medicine (GUM) service, when requested. Inspectors were informed that young offenders do not have access to barrier protection and lubricants.

3.10.2 Recommendations

78. **There should be a formalised plan in place for the active promotion of information, education, screening and confidential advice on sexual health. Adherence to this plan should be monitored.**

79. **Health promotion clinics should be arranged at regular intervals. These should include information on STIs, social and life skills, sex education and relationship education.**

80. **Young offenders and women prisoners should have access to chlamydia and STI screening programmes, on committal and at annual health assessments. Adherence to these screening processes should be audited at least annually to monitor uptake.**

81. Young offenders should have access to barrier protection and lubricants. They should be made aware of the means of accessing condoms.

3.11 Exercise

Quality Indicators

There should be evidence of joint working with prison and healthcare staff to promote recovery and health-related activities appropriate to the individual's health needs. The programmes should be developed and operated in consultation with the prison healthcare centre and contain a range of interventions which are tailored to support the cardiovascular, respiratory, physical rehabilitation, weight management and the mental health wellbeing of prisoners.

Expected Outcome

All young offenders and women prisoners are offered the opportunity to engage in a range of physical exercise programmes appropriate to their health needs.

3.11.1 Findings of the Inspections

The two groups of prisoners described different experiences in relation to access to opportunities to exercise.

YOC

Young men stated that they have opportunity to attend regular allocated education and training. They were, however, not satisfied with the level of exercise offered, or the opportunity to be outside in the fresh air. During a group session held on 21 March 2011, young men commented that they mostly got fresh air when they are going to church services or putting out rubbish. The young men indicated that they were not always able to access gym equipment. Prison staff confirmed this was the case. Discussion with the sports therapist indicated that health services staff do liaise and refer young people to the physical education department when required.

In another group, the young men also reported a lack of purposeful activities within the prison. There are education courses and prison work that they could apply for, but often they have to wait for months for courses or work to become available. In these instances young men reported that they just stay in their cells all day. Inspectors observed a group of young men on the new astroturf pitch and they confirmed that sometimes they have gym and football on a Saturday.

Ash House

The women consulted during the inspection stated that they do not have the appropriate opportunity to spend time in the open air each day or attend regular allocated education and training sessions and that association was often cancelled at short notice. During a group session held on 21 March 2011, the women commented that the outside space was tiny and there is

nothing to do on the landings. The gym is often cancelled and there is a lack of physical activity. There are two gym sessions each week but there is no rota system.

It was noted that a female gym instructor has been recruited since the previous inspection. This has increased the development of activities that are more suited to the needs of women prisoners, including the purchasing of Spinning equipment.

Discussion with the sports therapist indicated that health services staff do liaise and refer women prisoners to the physical education department when required.

The women's group also stated that there were few prisoners who were locked in their cells during the day. However, the women identified too many lockdowns as one of the negative aspects of life at Ash House. Women prisoners were regularly unlocked late and locked up early.

The women also reported that all education is linked to qualifications and that there is nothing of interest offered. There are courses in hairdressing, gym and catering. However, the women reported that timetables had been restructured, resulting in two women being removed from their National Vocational Qualification (NVQ) hairdressing training with no explanation. Inspectors did not observe the new astroturf pitch being used by women prisoners during the time of the inspection.

Inspectors would maintain that in relation to their physical and emotional wellbeing, both young offenders and women prisoners must have appropriate levels of physical exercise and opportunities for outdoor activity.

3.11.2 Recommendations

82. The appropriate levels of physical exercise and opportunities for outdoor activity should be provided to promote physical and emotional wellbeing.

Section Four: Accessible, Responsive and Effective Care

To meet the service needs and to narrow inequalities in health and social wellbeing, the trust should take account of the current and anticipated needs of young offenders. There should be meaningful engagement with all relevant parties in all stages of the service planning and decision-making cycle. Assessment of need should be undertaken in partnership with the statutory, voluntary, private and community sectors. This should be informed by: the collation and analysis of information about the current health and social wellbeing status of the local population; unmet need; legislative requirements; evidence of best practice; and, review of current service provision. Service planning should also take account of local and regional priorities, and the availability of resources.

The section includes the following elements:

- Health Needs Assessment
- General Health Assessment
- Access to Primary Care
- Access and Waiting Times
- Access to Specialist Mental Health Services
- Care Programme Approach
- Children and Adolescent Mental Health Services(CAMHS)
- Substance Misuse Activates
- Chronic Disease Management
- Equality and Human Rights

Health Needs Assessment

Prisoners have complex health needs and a higher burden of disease than their peers in the community, e.g. human immunodeficiency virus (HIV) infection, other blood-borne virus infections and respiratory tract infections etc. Prisoners also experience higher levels of mental health problems and addictions to drugs and alcohol. Prisoners often have had poor access to structured primary care services in the community prior to detention. Imprisonment represents an opportunity to understand their health needs and meet those needs appropriately, both in prison and beyond. The aims of a health needs assessment are to gather information to plan, negotiate, change services for the better, to improve health in other ways, and to build a picture of current services.

General Health Assessment

The DH Prison Performance and Quality Indicators highlight that studies show that on entering the prison system, prisoners have complex health needs and their health status is generally poorer than a comparable non-prisoner population. The studies would also suggest that a large proportion of prisoners are either not registered with a GP or do not have active records with a GP. The general health assessment screen offers an opportunity to assess these individuals and to provide treatment for previously untreated conditions. The health screen also supports the placement of the individual within the establishment and provides information to allow effective planning and targeting of future services. It is recognised that individuals may refuse to have a health screen, but it must be recorded that they have been offered and

refused it, including the reason for refusal. This will allow the prison to develop strategies for improving the uptake of the general health assessment.

Access to Primary Healthcare

The assessment and delivery of appropriate and effective healthcare can be challenging. The ability of a service to direct clients to primary health practitioners provides significant opportunity for enhanced recovery and positive outcomes. The concept of equivalence of access to healthcare should be applied. The GP plays a central role in this access and provision and recognises the support necessary for primary care practitioners to provide a comprehensive service. The service should ensure that young offenders have access to primary healthcare equal to that experienced by the local population and is not unnecessarily restricted by security procedures. This should include the ability to have access to urgent triage /consultations and booked appointments on an equitable basis.

Access and Waiting Times

Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably. Prisoners are members of the population and, as such, are entitled to the same level of service as the general population. Difficulties arise due to the significant amount of movement that many prisoners are subject to around the prison estate. Such movement should not be allowed to have a detrimental effect upon their access to services and subsequent waiting times.

Access to Specialist Mental Health Services

Surveys have shown that as many as 90 per cent of prisoners have a diagnosable mental illness and/or substance misuse problem. Among young offenders and juveniles that figure is 95 per cent. It has also been shown that mental illness can contribute to reoffending and problems of social exclusion. The NIPS working with SEHSCT should look critically at the mental health needs of young offenders, and consider how far existing provision meets those needs.

Care Programme Approach (CPA)

The Care Programme Approach (CPA) should be applied to all prisoners subject to Providing Quality Care: Good Practice Guidance on the assessment and Management of Risk in Mental Health and Learning Disability Services (DHSSPS, 2009). All organisations involved , should work together to adopt integrated care pathway approaches to service delivery. They should also work to improve information sharing and establish local protocols for joint working between different planning systems and provider agencies. The role of commissioners is key in ensuring that there is a range of services to meet service users' needs and choices. The quality of assessment and care planning should be focused on improving outcomes. To ensure equitable outcomes for all, there should be local audit and performance management.

Continuity of care is essential when the care setting changes, and is often identified as having been lacking when untoward incidents have occurred. The care

coordinator has a key role in the management of the care pathway. The care plan should be the key reference document, irrespective of where care is being delivered. This should be added to and amended by the care coordinator, as dictated by the care needs in each setting.

Child and Adolescent Mental Health Services (CAHMS)

DHSSPS is committed to the development of a fully comprehensive child and adolescent mental health service. The mental health needs of young people in secure settings are known to be considerable, severe and complex. These young people manifest the full range of mental health problems and disorders, with rates of psychosis, self-harm and suicide well above those for other groups of children and young people. It is therefore very important that young people in young offender centres should have access to a comprehensive service. This should explicitly cover mental health promotion, prevention, early intervention, treatment and the management of problems that have been identified as a result of expert assessment.

Substance Abuse

There is firm evidence that opioid maintenance programmes can prevent blood-borne virus transmission, reoffending and drug-related deaths. An integrated approach to drug dependence is widely recognised as the most effective intervention method. A number of research studies have indicated that the use of alcohol and illegal drugs by young people is linked to mental health problems.

Chronic Disease Management

The systems in place should ensure that prisoners achieve healthcare benefits that meet their individual needs. Healthcare decisions and services should be based on what assessed research evidence has shown provides effective clinical outcomes.

The Quality and Outcomes Framework (QOF) indicator seeks to assure commissioners of services that work is in progress to ensure that services delivered within prisons are of an equal standard to those delivered within the wider community.

Equality and Human Rights

Within the Prison Health Performance Indicator for equality and human rights, there are six strands of diversity: age, gender, sexual orientation, disability, race and religion. In order to provide a service that is both equitable and sensitive to individuals' requirements, reference to the diversity of the population served by healthcare providers within prisons needs to be made. Not only do services need to be planned to take account of an individual's requirements and to safeguard human rights, but to provide a high standard of personalised care and service. Staff need to have an understanding of the distinct needs, preferences and choices of the populations they serve.

4.1 Health Needs Assessment

Quality Indicator

A baseline health needs assessment has been completed using a structured assessment tool.

There is evidence that the health needs assessment has been reviewed and amended within the last 12 months by the trust.

The assessment contains agreed annual health priorities, which are included in the local prison health delivery plan and signed off by the Prison Governor and the Chief Executive of the trust.

Expected Outcome

The health and social care needs of the prison population are reviewed annually at each establishment. This information is used to plan service delivery.

4.1.1 Findings of the Inspections

Discussion with staff and the SEHSCT Assistant Director of Prison Health indicated that a baseline health needs assessment had been carried out in 2009. This combined the results of the previous needs assessments with prevalence data for the Northern Ireland population, adjusted where UK prison data shows an increased prevalence of a particular condition.

The HSC Board in partnership with SEHSCT and other HSC agencies was to undertake an annual health care needs assessment. Evidence received from the Assistant Director of Prison Health after the inspection confirmed that no current health needs assessment has been undertaken.

Healthcare staff confirmed that there are systems in place to collect some of the relevant data to inform this assessment. However, the outcomes of the inspection would indicate that this data may be flawed as there are current issues with referrals to mental health, the addictions service and the collection of data regarding chronic conditions.

4.1.2 Recommendations

83. A revised health needs assessment should be undertaken.

4.2 General Health Assessment

Quality Indicator

All prisoners received into custody for the first time should receive an initial health screening following.

All prisoners are offered a general health assessment.

A record is maintained of the uptake of this assessment or the reason for the prisoner not accepting the health screen is recorded.

Expected Outcome

All first receptions into custody receive an initial health screening. A further in depth health assessment is completed 72 hours following reception.

4.2.1 Findings of the Inspection

Inspectors were able to spot-check the initial assessment and the in-depth health assessment available on the EMIS system. The inspectors found that, in the records reviewed, an initial reception screen was undertaken by healthcare staff and a further screen was undertaken within 72 hours.

4.2.2 Recommendations

No recommendations in this section.

4.3 Access to Primary Healthcare

Quality Indicator

Prisoners have access to primary healthcare which is as good as that experienced by the local population.

Prisoners receive healthcare services that are not unnecessarily restricted by security procedures.

Prisoners at all locations should have access to urgent triage/ consultations and booked appointments on an equitable basis.

Expected Outcome

Access to primary healthcare which is as good as that experienced by the local population.

4.3.1 Findings of the Inspections

The prison healthcare centre has a contract in place with a local GP surgery that provides clinics during the week. At the time of the inspection, a new clinical lead had been appointed who was due to review the systems in place regarding medical workforce planning to ensure continuity of service.

During normal working hours (07.30 to 18.30 hours), emergency care is provided by contracted GPs and the prison healthcare staff. Out-of-hours emergency services are provided by the on-duty nursing staff and the local out-of-hours GP service. Prisoners requiring acute hospital services are transported by emergency ambulance. Discussions are currently taking place regarding the expansion of emergency service provision in prison healthcare across Northern Ireland. This should not take place until all staff are appropriately trained and competency assessments have taken place.

The findings of the inspections for each unit have been outlined in the following paragraphs.

YOC

Within the YOC, nurses undertake a triage system for referral to the GP. There is no internal appointment system. Young people are not always seen on the day of request or they are unsure of how long they will have to wait. This can create problems for officers on the wings and can heighten tensions. Some young people spoken with indicated that it is difficult to get past the nurses to see a doctor. Consideration should be given to a self-referral system, as the process in place would not be in line with arrangements within the community, where all have the right to see a GP.

The current standard states that young offenders who report sick should be triaged by a healthcare officer/ nurse within 24 hours. One prisoner indicated

that on one occasion, when he had a chest infection it was a couple of days before he could see the doctor. Young offenders go to prison officers in the first instance to make a request to be seen. It was two days before a nurse came to see him to ascertain if he required medical attention.

At the time of the inspections having been undertaken, the provision of appointments operated within the timescales of the lock down system for both establishments. Discussions with the young men and women within both units indicated that there were frequent lock-downs. The reasons for these varied from staff shortages to the use of lock-up as a management and control strategy and in the event of emergencies. Such scenarios place additional pressures on the provision of effective healthcare services. The cognitive behaviour therapist indicated that her time was not being used effectively because of the lock-down system. As a result, the amount of sessions that she can offer is reduced accordingly.

Ash House

At the time of the inspection, the allocation of nursing staff to Ash House occurred on a six-month rotational basis. However, it was noted that these nursing staff were not always available during the day due to other commitments, such as night duty.

The allocation of specific staff would allow for the development of skills in the specific management of the needs of women. It was noted that the regime in place at the time of the inspection would have made this difficult to achieve. It is recommended that link nurses are identified to enable the development of more in-depth knowledge with regards to the specific needs of women, including older women. Staff should be allocated on the basis of need and this should be monitored on a day-to-day basis. On the day of the inspection visit the treatment room within Ash House was extremely busy, in comparison to the healthcare centre. Therefore, the allocation of nursing staff to Ash House should be reviewed.

Within Ash House, nurses undertake a triage system for referral to a GP. Internal clinics do not have an appointment system. This can create problems for the officers on the wings and can also heighten tensions among prisoners. As such, the provision of an appointment system would assist officers on the landings, as well as providing assurance to women that they will be seen by a GP.

During a meeting between a group of remand prisoners and an inspector on 21 March 2011, the inspector noted that a wound dressing on one of the prisoners was stained. The woman and the wing officer confirmed that despite the fact that healthcare staff had been contacted on several occasions on that day in relation to the matter, a response had not yet been forthcoming (i.e. healthcare staff had not attended to the woman or called her to the treatment room).

Following the group session in Ash House, the inspector informed a nurse in the treatment room about the prisoner's dressing and asked for it to be checked. In response the nurse confirmed on three occasions that the prisoner's dressing would be checked prior to going off duty. The inspector checked with the wing officer the following day to ascertain whether the

prisoner's dressing had been checked by the nurse the previous evening. The wing officer indicated that the nurse had not attended to the dressing the previous evening but that it had been redressed that morning. This incident was subsequently reported to the Healthcare Manager and Assistant Director, on the basis that all nurses have a duty to abide by the NMC professional code of practice.

A key element within the code of practice is that patients receiving care from a nurse must be able to trust the nursing professional with their health and wellbeing. In order to justify that trust, the nursing professional must make the care of individuals their primary concern, through adherence to high standards of practice and care at all times, and acting with honesty and integrity. The inspector noted that these principles were not applied on this occasion.

Some of the women prisoners consulted during the inspection indicated having experienced difficulties in accessing GPs. Two of the prisoners indicated that nurses had made decisions in relation to their medication without consulting a doctor. Consideration should be given to the implementation of a self-referral system, in line with community arrangements i.e. where all patients have the right to access a GP directly. The women prisoners also indicated that one doctor in particular had rejected all of their requests, whereas the nursing staff were generally deemed to be more receptive and approachable than the doctors.

The minutes of the Regional Prison Health Clinical Governance Group meeting in March 2011 indicated that there had been four incidents relating to GPs. However, these did not indicate in which prison the incidents had occurred. The minutes also indicated that there had been five complaints which had progressed to stage two of the complaints procedure regarding a GP's attitude and medical care. Similarly, the prison involved was not identified and the inspectors were unable to make a judgement with regards to this matter.

4.3.2 Recommendations

84. The expansion of emergency service provision in prison healthcare across Northern Ireland should not take place until all staff are appropriately trained and competency assessments have taken place.

85. An internal appointment system should be in place to ensure that young offenders have access to booked appointments on an equitable basis. Consideration should be given to the introduction of a self-referral system for medical appointments.

86. All young offenders who report sick should be triaged by a healthcare officer/ nurse within 24 hours.

87. Young offenders should receive healthcare services that are not unnecessarily restricted by security procedures.

88. There should be clear indication within the minutes of regional group meetings of which issues affect individual prisons.

4.4 Access and Waiting Times

Quality Indicators

Access and waiting times for outpatient first appointments, following written referrals of prisoners, to clinics within and outside the prison setting, are equivalent to those experienced by the local population and fall within the specific DHSSPS targets for health and social care .

Expected Outcome

Access and waiting times are equivalent to those experienced by the local population.

4.4.1 Findings of the Inspection

Young offenders and women prisoners have to wait longer than one week for a first appointment with the mental health team. When the inspections were undertaken, the waiting time was a minimum of eight weeks, from referral to assessment, which is unacceptable

The meeting of the Regional Prison Health Clinical Governance Group held on 2 March 2011 indicated that there had been an increase in the number of cancellations of outside hospital appointments by the Prisoner Escorting and Court Custody Service (PECCS) Group. Discussion with the Senior Officer indicated that a record is kept of cancellations of outside hospital appointments. This information was requested by inspectors, but was not provided.

A review of the minutes of the Prison Health Care Partnership Board also indicated concerns regarding cancellations which have been raised at regional groups and at the Partnership Board. It was indicated that there was an intention to discuss the transfer of funds to the trust to undertake these arrangements. RQIA recommends that improvements are made to transport arrangements to ensure a reduction in the number of cancelled hospital appointments.

Discussion with the women prisoners indicated that during outside hospital appointments, the male escorts often refused to leave the treatment room during the medical examination, which can cause embarrassment to the prisoners. The DHSSPS standards on Improving the Patient Client Experience"[8] should be followed by healthcare staff to ensure the privacy and dignity of women prisoners when attending hospital appointments is respected, greater efforts should be made to provide a female to accompany them. Inspectors are aware that healthcare staff have no control over external escorting staff procedures. However this should be brought to the attention of PECCS.

[8] http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

4.4.2 Recommendations

89. Access and waiting times for assessments carried out by the mental health team must be improved as a matter of urgency.

90. Healthcare staff, should ensure that women prisoners are accompanied by female staff to hospital appointments.

91. A review of the escort arrangements should be undertaken to ensure that there is a reduction in the number of cancelled hospital appointments.

4.5 Access to Specialist Mental Health Services

Quality Indicator

The Young Offenders Centre should have access on a needs-led basis, to all of the following specialist mental health services: Dual Diagnosis; Personality Disorder Services; Child and Adolescent Mental Health Services; Early Intervention in Psychosis; Crisis Resolution; Home Treatment ;Learning Disability Services; and Brief/ Structured Psychotherapeutic Interventions.

Expected Outcome
The prison has access, on a needs-led basis, to a range of specialist mental health services:

4.5.1 Findings of the Inspections

Since the previous inspections, the level of psychiatric input from specialist services has decreased in some areas. When the inspections were undertaken in March 2011, the psychiatric consultant post was vacant and a staff grade doctor was covering both the YOC and Ash House on two afternoon sessions per week. A forensic psychiatric consultant is available on request and the trust is considering the appointment of a permanent forensic psychiatric consultant.

Discussions with RMNs highlighted that they may not be on duty when the staff grade is in attendance, due to shift or leave arrangements. It is therefore important that regular multidisciplinary meetings are organised to ensure that there is continuity of care and to develop and formulate strategies for care (to include patients with addictions). Staff confirmed that in the event of an emergency the forensic psychiatric consultant can be contacted at any time day or night, seven days per week.

When the inspections were undertaken, there were two nurses with RMN qualifications in post who have a dual clinical role in providing care within the healthcare at Hydebank Wood. Discussions undertaken with the nurses indicated that their primary duties had to be covered first and they did not have any allocated time to undertake mental healthcare. This was further substantiated by the long waiting list of mental health referrals which were outstanding at the time of the inspection. During periods such as summer leave, there may not be any clinical time allocated to mental health.

It was indicated that each RMN carried a caseload of patients, some of whom were seen on a regular basis, whilst others were in receipt of monitoring visits. When the inspection was undertaken, there were in excess of 20 people on a waiting list for mental health support assessments. It was indicated currently it is up to eight weeks or more from the point of referral until an assessment, which is unacceptable.

Inspectors observed that healthcare centre was not generally busy and that healthcare staff could have been reorganised to free up the mental health

nurses to undertake the outstanding referrals, some of which dated back several months.

The inspectors did not identify any evidence to suggest that any therapeutic activities were being organised by the mental health staff.

4.5.2 Cognitive Behaviour Therapy (CBT)

Prior to the transfer of services to SEHSCT, Hydebank Wood was in receipt of input from three CBT nurses. When the inspection was undertaken, there was one CBT nurse in attendance one day per week. Discussion with the CBT nurse indicated that she had only returned following an extended absence and that temporary cover had not been provided during her absence. The CBT nurse also confirmed that the referral system in operation allowed her only to see patients referred from a psychiatrist or from mental health nurses.

The CBT nurse also indicated that her time was not being used effectively due to the lock-down system which resulted in a reduction in the number of clinical sessions delivered. On account of these constraints, it was also indicated that the CBT nurse was not able to offer any enhanced treatments such as mindfulness and dialectical behaviour therapy which can be beneficial in working with borderline personality disorder.

Discussion with a female prisoner on remand who was at risk of self-harm indicated that she had waited five months for referral to CBT and anger management.

4.5.3 Personality Disorders

A formal agreement has been in place between DHSSPS and NICE since 2006. As a result, NICE clinical guidelines are applied in Northern Ireland following local review. Two NICE clinical guidelines on borderline personality disorder and anti-social personality disorder were issued in January 2009. Progress against the implementation of these guidelines in Northern Ireland is to be monitored by RQIA.

DHSSPS published Personality Disorders – A Diagnosis for Inclusion, Northern Ireland Personality Disorder Strategy[9] in June 2010. This strategy made specific recommendations for trusts and for healthcare services within the criminal justice sector.

It was recognised by SEHSCT that a problem existed in this area with regard to Hydebank Wood, which resulted in it being identified as a work stream for improvement. At the time of the inspection, the trust had secured funding from the HSC Board for the appointment of two nurses to develop these services within prison healthcare.

Overall it was concluded that the provision of psychiatric services had decreased, which is in part due to vacant posts. It is recommended that the

[9] http://www.dhsspsni.gov.uk/northern-ireland-personality-disorder-strategy-june-2010.pdf

provision of psychiatric services should be reviewed as a matter of urgency. In relation to CBT services and other available therapies, specifically for personality disorders, it is vital that the trust increases the range and volume of services provided to ensure that the needs of this vulnerable client group can be appropriately met.

4.5.4 Recommendations

92. RQIA recommends that the provision of psychiatric services be reviewed as a matter of urgency.

93. The appointment of a permanent forensic psychiatric consultant should be afforded priority.

94. There should be regular multidisciplinary meetings to ensure continuity of care and to develop and formulate strategies of care, including for patients with addictions.

95. The number of available RMN staff should be reviewed to ensure sufficient capacity to fulfil the needs of the service.

96. The RMN staff in post should have allocated time to undertake mental healthcare, to ensure that the waiting time for mental health referrals is in accordance with the agreed timescale of one week.

97. The CBT services and available therapies should be reviewed and increased to meet the needs and requirements of the service.

98. In devising the service for women and young offenders with personality disorders it is vital that the trust ensure that there is sufficient input to meet the needs of these vulnerable client groups in Hydebank Wood.

4.6 Care Programme Approach

Quality Indicator

The Care Programme Approach (CPA) should be applied to all prisoners subject to Providing Quality Care: Good Practice Guidance on the assessment and Management of Risk in Mental Health and Learning Disability Services (DHSSPS, 2009).

A formal CPA audit has been undertaken within the last 12 months, based on robust information and multiagency involvement and an action plan developed that assigns responsibility and provides evidence of evaluation and outcomes.

Expected Outcome

A care programme approach is in place which is monitored and evaluated.

4.6.1 Findings of the Inspection

The RMN staff confirmed that the regional risk assessment is carried out. There was no evidence of this information having been shared with other disciplines or agencies or that an enhanced risk assessment was undertaken which necessitates the initiation of multidisciplinary meetings.

For all patients who have had the regional risk assessment carried out, a care plan is devised. Written copies of both documents are retained, whilst all other documentation pertaining to patients is recorded on EMIS.

When the inspection was undertaken, young offenders and women prisoners subject to 2009 guidance had not been involved in their care planning. However, plans were underway to review the documentation to reflect the requirements of good practice guidance.

Care planning has been identified as an area requiring improvement and in line with NMC guidance all nurses require training in the assessment, planning, implementation, and evaluation of nursing care.

An audit has been developed and a working group was to be set up to consider the results of the audit and establish new documentation which is in line with 2009 guidance. At the time of the inspection this has not been achieved.

Young offenders and women prisoners are referred to the discharge liaison team based at Maghaberry prison prior to discharge. One female prisoner indicated that she was to attend a court hearing during the same week the inspection occurred, however, she was unsure as to whether she would be released or sentenced. The prisoner also indicated that plans had not been made in the event of her being released and so did not know where she would go following release.

Maghaberry Prison is currently working with HSC trusts to establish discharge protocols. RMN staff had started to attend multidisciplinary team meetings outside the prison, however this process was yet to be fully developed.

4.6.2 Recommendations

99. There should be evidence of the sharing of the regional risk assessment with other disciplines and agencies.

100. Enhanced risk assessments should be undertaken when required to ensure that the necessary multidisciplinary meetings are initiated.

101. Young offenders and women subject to 2009 guidance should be involved in their care planning and appropriate documentation should be introduced in line with this guidance.

102. Discharge protocols should be established to ensure that women and young offenders with complex needs have a multidisciplinary discharge plan. The process for attendance at multidisciplinary team meetings held outside the prison should be formalised.

4.7 Child and Adolescent Mental Health Services (CAMHS)

Quality Indicator

The trust and the partnership board should be working together, to ensure, as a priority, that children and young people in the YOC have access to a comprehensive Child and Adolescent Mental Health Service (CAMHS). There should be systems in place to ensure that young people have seamless transition through age appropriate services.

Expected Outcome
There is access to comprehensive CAMHS within Hydebank Wood.

4.7.1 Findings of the Inspection

The previous report of the YOC in 2007 recommended that young males should not be housed in Hydebank Wood, or that appropriately resourced dedicated accommodation with a regime capable of meeting the needs of this population should be in place. This has not been achieved, as there were 17 young males under the age of 18 years held within the YOC at the time of the inspection. It should be noted that girls under 18 years are no longer held at Ash House, therefore a child and adolescent psychiatric service is not required.

Specialist CAMHS staff are not providing a regular service to the YOC. Whilst young males continue to be detained in Hydebank Wood, there must be input from a forensic multidisciplinary service. The Bamford Review of 2006 recommended that the DHSSPS develop a forensic multidisciplinary service which would cover all sectors, including Northern Ireland's prisons. This recommendation has not been addressed.

It is concerning that the most challenging young men that cannot be cared for in Woodlands Juvenile Justice Centre (provided by the Youth Justice Agency of Northern Ireland) are sent to the YOC at Hydebank Wood, which does not have a specialist service in place. Last year, Woodlands took the initiative to fund a single part-time consultant who now provides unidisciplinary CAHMS input. The inspection team recommends that the situation in Hydebank Wood is reviewed as a matter of urgency by SEHSCT, HSC Board and DHSSPS.

During the inspection, there was no evidence found that the SEHSCT/ YOC Partnership is working effectively, to ensure, as a priority, that children and young people in the YOC have access to a comprehensive CAMH service.

4.7.2 Recommendations

103. DHSSPS, HSC Board and SEHSCT should urgently review the lack of input from specialist CAMHS staff at Hydebank Wood YOC.

104. Whilst young males continue to be detained in Hydebank Wood, there must be input from a forensic multidisciplinary service.

4.8.0 Substance Abuse

Quality Indicator

The YOC should provide a range of clinical and psycho-social interventions, which address the needs of prisoners who substance misuse.

There should be access to detoxification, maintenance and Naltrexone prescribing in prison and evidence of collaborative working with mental healthcare teams and addictions teams.

Expected Outcome

The prison provides a range of clinical and psychosocial interventions, which address the needs of prisoners who substance misuse.

4.8.1 Addictions Services

The previous inspections conducted in 2007 recommended that the drug and alcohol strategy should be informed by a comprehensive needs assessment to identify gaps in service, and to consider those which had been achieved when the follow up inspection was undertaken in 2011.

An up-to-date drug and alcohol strategy was not in place, nor was there evidence of any multidisciplinary meetings having taken place at either the YOC or Ash House.

When the inspection was completed, there was a perceived low level of addiction within the two establishments. They also noted a lack of communication between the healthcare team, the addictions team, ADEPT and security teams. Drug and alcohol strategy meetings were not taking place between the various teams to facilitate a comprehensive drug and alcohol programme.

A prison-led addictions team was in place which was deemed to be under-resourced. At the time of the inspections, there were two addictions nurses to cover the three prisons in Northern Ireland, one of whom provided a one day service each week for the women prisoners and young offenders. A consultant specialising in addictions is employed for one day a week to cover the three prisons. Therefore, consultant input into Hydebank Wood occurs one day every three weeks. Discussion with the addiction nurse indicated that if required the consultant could be asked to attend more frequently.

The needs assessment for the addictions team is referral-led but inspectors found that young people are not being referred to the addictions team. As a result evidence of demand is understated. The addictions nurse has no waiting list and has currently no young males on her caseload. The nurse indicated that she would not have time to take a proactive approach to obtaining referrals and there appears to be an issue regarding staff making referrals to this service. Inspectors found that young men with addiction

problems prior to committal were not being referred to the addictions service for assessment and care.

Women prisoners are referred to the addictions team nurse at the discretion of the duty nurse. The addictions nurse carries out a comprehensive assessment and is able to organise stabilisation, maintenance or detoxification regimes for individual women, in collaboration with the addictions consultant. However, some women indicated that not everyone with addiction problems prior to committal is referred to the addictions service for assessment and care.

If referrals are not made to the addictions services, this can have an adverse impact on the wellbeing of the young male and female prisoners, in terms of support and recovery. Furthermore this could also adversely impact upon the need for service improvement in this area..

The inspectors highlighted that decisions regarding the need for specialist care for both young offenders and women prisoners should be made by specialist staff within the addictions team. The level of service provided should also be reviewed to ensure that a more proactive approach is taken.

ADEPT, the drug and alcohol counselling service, operates within Hydebank Wood. It can provide one-to-one counselling as well as solution-focused therapy and a pre-release course. Women and young offenders are also encouraged to undertake an Open College Network (OCN) Level 1 drug and alcohol awareness course. Inspectors were informed that women and young people are made aware of ADEPT at the time of committal, however, referral to the addictions team is not routine practice

There appeared to be little communication in relation to information-sharing between teams, despite young offenders and women prisoners having signed a consent form at committal to permit the sharing of this information.

Prisoners are regularly tested for illicit drugs. Security staff do not ascertain if the young offenders or women prisoners are on prescribed medicines, which may influence test results. Inspectors suggested that a form should be introduced stating the drug detected and asking whether the young offenders or women prisoners were prescribed a particular medication. The acting healthcare manager advised that while such a form is in place, it is not used. Security staff stated they were unaware of this procedure.

4.8.2 Detoxification programmes

It was indicated that drug testing is not carried out on women or young offenders arriving at Hydebank Wood and that they are not assessed by specialist staff. For those who were on an established opioid substitution programme in the community, inspectors were advised that staff contact the community addictions team or community GP. A list of currently prescribed medicines is received verbally and the programme is continued at committal. Staff advised that for women and young offenders who are not on an established programme, the duty nurse completes an initial assessment using

withdrawal assessment scales. The inspection evidenced that these assessments are not used or completed fully on all occasions and are used at the discretion of the nurse on duty. There is no evidence that they are audited to monitor compliance.

When deemed appropriate by the duty nurse, the prison doctor is contacted and a verbal instruction is obtained for the administration of symptomatic relief for women prisoners. This is recorded on EMIS and a prescription generated within a maximum of 72 hours. The medication is dispensed from the Medicines held as emergency stock and records are maintained. Clinical observations are completed by a healthcare officer. If deemed necessary by the nurse on duty, an appointment is made with the prison doctor/ addictions team on the day following committal.

In the majority of cases, both young offenders and women prisoners undergo clinical detoxification from alcohol or drugs on the landings rather than in the healthcare centre. It is acknowledged that there is a move in the community to provide this service at home or in day care settings where patients have suitable family/ friend to provide support and supervision. However, there can be additional problems associated with committal to prison. The care delivered by the detoxification programme should also include physical problems, particularly during alcohol withdrawal and any social problems, including anxieties or mental health issues. Inspectors would therefore recommend this area is reviewed to ensure appropriate treatment including admission to the healthcare centre.

At the time of the inspection there was one young man in healthcare suffering from psychosis, due to using a street drug known as blues. This young person was being monitored for benzodiazepine dependence on the first night of his committal. Clinical observations were being completed by the healthcare officer/nurse officer.

Specialist staff do not complete a comprehensive assessment on the day after committal. The young person is referred to the prison doctor on the day after committal only if the duty nurse feels that it is appropriate. Nurses on duty during the inspection advised that they require further training to enable them to undertake comprehensive assessments at committal so that appropriate referrals are made on all occasions. At present, no young people have been referred to the addictions team. Substitute prescribing protocols and detoxification protocols are in place. If a young person is referred to the prison doctor or addictions team, any prescribing protocols can be overridden at the discretion of the prescriber.

4.8.3 Recommendations

105. The drug and alcohol strategy should be updated and informed by a comprehensive needs assessment to identify gaps in the service provided.

106. Drug and alcohol strategy meetings should be held to improve communication and promote better understanding between the healthcare, addictions, ADEPT and security teams.

107. There should be a more proactive approach by the addictions team to obtaining referrals for those who have addiction problems prior to committal. This should inform the level of addiction services required to ensure that the needs of these vulnerable groups are met.

108. Following screening and testing all those who require first night treatment/ symptomatic relief should have it prescribed and administered. Women and young people who arrive with ongoing dependence should be carefully assessed and monitored before any detoxification regime is commenced.

109. Inspectors would recommend that the placement of patients, including admission to the healthcare centre, should be reviewed to ensure that women and young people receive effective support during the first days of the detoxification programme.

110. Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes.

111. There should be improved information sharing between healthcare and security staff in relation to results of failed illicit drugs tests to determine if the drug is related to prescribed medication.

4.9 Chronic Disease and Long-Term Conditions Care

Quality Indicator

Trust commissioned services in prison (including commissioned social care services) are working towards the delivery of chronic disease care being at the same standard of process and outcomes as is required by the National Service Frameworks for diabetes, coronary heart disease (CHD) and long-term conditions, mental health etc. A formal approach has been developed and is being implemented

Expected Outcome

Delivery of chronic disease care is of an equivalent standard to that in the community

4.9.1 Finding of the inspections

The inspectors noted that chronic disease and long-term conditions care has not been identified as a specific issue in the draft prison strategy for overall care delivery, but has been mentioned in the section on primary care. The review of the governance plan for prison healthcare would indicate that the delivery of chronic disease care is not of an equivalent standard to that in the community. Inspectors found that chronic disease management clinics had not been introduced and that all young offenders and women prisoners with a chronic disease had not been identified. This was evidenced on the review of care records on EMIS where several young men with asthma had not been included on the register, and all women with a chronic disease had not been identified.

4.9.2 Recommendations

112. All young offenders and women with a chronic disease should be identified and included on the appropriate register.

113. Chronic disease management clinics should be introduced.

4.10 Equality and Human Rights

Quality Indicator

The planning and delivery of healthcare within the prison makes direct reference to the needs of the diverse population, with specific reference to Section 75 of the Northern Ireland Act 1998 which requires that the trust, in carrying out its duties, has due regard to the need to promote equality of opportunity.

The planning and delivery of healthcare within the prison meets the needs of the individual and the diverse prison population, with specific reference to the six strands of equality and diversity.

Expected Outcome

The planning and delivery of healthcare within the prison meets the needs of the individual and the diverse prison population

4.10.1 Finding of the inspection

Inspectors only reviewed the following issue in relation to Ash House.

During the inspection a spot check was undertaken of the patients on the waiting list for mental health referrals to determine the waiting times.

This review identified an incident relating to a female prisoner from Ash House who was asked to interpret for a young male of the same nationality in a matter which related to description of intimate parts of the male body. Within the culture of these two individuals, speaking about these issues is not acceptable and the female prisoner was embarrassed and shocked by her experience.

Two inspectors undertook a private interview with the female prisoner. The interview indicated that she is still being asked to interpret, however, she did not experience any long-term distress relating to the incident. During the interview the inspectors took the opportunity to ask if she had been referred for a mental health assessment, she indicated that a referral had been made. An assessment had not taken place but the prisoner had been able to see the GP and was on anti-depressants. It is of note that the date of this mental health referral was September 2010, six months prior to this inspection.

The joint report recommends that staff should use professional interpreting services and not rely on using other prisoners to interpret.

Section Five: Conclusion and Recommendations

5.1 Conclusion

The unannounced follow-up inspection of Hydebank Wood Young Offender Centre (YOC) and Ash House Women's Prison a self-contained unit within Hydebank Wood, was undertaken by HM Inspectorate of Prisons on behalf of Criminal Justice Inspection Northern Ireland (CJI). The inspection was supported by CJI inspectors, staff from the Education and Training Inspectorate of Northern Ireland and from the Regulation and Quality Improvement Authority (RQIA). The inspection focused on the progress made in implementing the recommendations arising from the inspections in 2007.

The reports of the joint inspection state that health services had not improved sufficiently since the 2007 inspections, despite the transfer of responsibility for the service to the South Eastern Health and Social Care Trust (SEHSCT). Inspectors found that health services were under-resourced, poorly managed and there was sometimes unsatisfactory attention to the needs of patients. The mixing of children, young adult men and women in the health centre made it difficult to provide an appropriate regime. Inspectors were also concerned that first night treatment and symptomatic relief for substance-dependent young men and women was not sufficiently robust . They were particularly concerned that those undertaking alcohol detoxification were put at risk because they were not always admitted to the health centre. Addiction services were found to be under-resourced.

The joint reports have recommended that there should be a clear commitment to house young people under 18 in a separate establishment, or make fundamental changes to the regime at Hydebank Wood that would make it suitable to hold this age group. The joint report also recommends that the Northern Ireland Prison Service (NIPS) should work towards creating a separate and dedicated women's facility, without which the needs of this vulnerable population are unlikely ever to be properly met. From a health perspective, RQIA strongly endorses these recommendations.

This supplementary RQIA report provides more detailed findings of the RQIA inspection of prison healthcare. Whilst this was an inspection undertaken in Ash House and the YOC, there are also implications and recommendations in the report for the provision of healthcare in all other prisons in Northern Ireland. The findings of the inspection are divided into three sections

- Organisational Systems and Governance
- Protecting and Promoting Health and Wellbeing
- Accessible, Responsive and Effective Care.

Organisational Systems and Governance

The inspection demonstrated that considerable work is required to improve the overall governance arrangements to ensure that women and young offenders have the equivalent standard of healthcare as the general public. Joint clinical and social care governance arrangements in place between the NIPS and SEHSCT need to be strengthened to facilitate immediate service

improvement. Analysis of key information sources should be routinely used to measure and communicate improvement across the organisation. There remain many challenges which need to be addressed to ensure that the partnership arrangements are sufficiently robust to allow for: joint decision making; effective management of resources; effective information sharing; audit; and, service development.

Some positive initiatives are being introduced such as the joint SEHSCT /NIPS Service Improvement Board and the auditing of key performance indicators. These provide the necessary focus and structure to support service improvement in prison healthcare, the benefits of which should become evident over the coming years.

Protecting and Promoting Health and Wellbeing

The findings of the inspection in relation to promoting and protecting health and wellbeing demonstrate that there needs to be a more cohesive approach to the prevention of suicide and self-harm. Evidence of collaborative working and information sharing to ensure that the appropriate steps are taken to protect women and young offenders from harm by themselves and others is also required. This includes the need for a detailed ligature risk assessment and management plan.

As a result of some of the findings in relation to patient safety and staff performance, RQIA met with the Governor of Hydebank Wood Prison and YOC and senior SEHSCT staff to highlight and discuss these issues. These discussions indicated that both organisations have started to make improvements in these areas.

Accessible, Responsive and Effective Care

The inspections evidenced that improvements are required to ensure that the service is comprehensive and innovative to address the range of complex mental health disorders evident in the prison population. To facilitate continuity of care, improvements are also required to ensure effective links with health and social services in the community are made.

In conclusion, this report highlights the significant challenges faced by SEHSCT as it works towards a vision of ensuring that services are designed to meet the complex range of needs of the prison population. RQIA recommends that there is a continued emphasis on strong leadership and team-working to sustain improvements in practice. RQIA believes that this report can be used to inform future improvements in the delivery of services to this vulnerable group.

5.2 Summary of Recommendations

In this section the recommendations 1-113 are clustered in accordance with those organisations to which they refer.

Department of Health, Social Services and Public Safety and the Health and Social Care Board

1. **RQIA recommends that the HSC Board completes the Commissioning Statement of Intent as a priority.**

92. **RQIA recommend that the provision of psychiatric services be reviewed as a matter of urgency.**

93. **The appointment of a permanent forensic psychiatric consultant should be afforded priority.**

98. **In devising the service for women and young offenders with personality disorders it is vital that the trust ensure that there is sufficient input to meet the needs of these vulnerable client groups in Hydebank Wood.**

103. **DHSSPS, HSC Board and SEHSCT should urgently review the lack of input from specialist CAMHS staff at Hydebank Wood YOC.**

104. **Whilst young males continue to be detained in Hydebank Wood, there must be input from a forensic multidisciplinary service.**

Prison Health Care Partnership Board

3. **RQIA recommends that a Governing Governor or appropriate deputy, is appointed as co-chair of the Partnership Board.**

Northern Ireland Prison Service and South Eastern Health and Social Care Trust

7. **SEHSCT and NIPS should provide clarity in respect of accountability arrangements, for both professional and employment issues. A collaborative approach should be taken in these issues when necessary, pending the transfer of staff.**

9. **The Terms of Reference and membership of the Regional Prison Health Governance Committee should to be reviewed and updated.**

15. **The independence around the current system for making complaints and the complaints policy should be reviewed to provide a more objective and independent process.**

19. **An information sharing policy should be developed for children, young people and women prisoners, as information sharing is vital to safeguarding and promoting their welfare.**

20. **There should be documented evidence to indicate that information on patient consent has been shared with other disciplines.**

26. **All prisoners requiring a clinical alcohol detoxification should be admitted to the inpatient unit.**

27. **Day services should be available for those less able to cope with prison life.**

32. **All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose, and documented evidence of such checks should be kept, in accordance with the relevant protocols.**

33. **There should be a more cohesive approach to the prevention of suicide and self-harm, which ensures that this is the responsibility of all staff, and provides clearer evidence of collaborative working and managed information sharing.**

34. **The Suicide and Self-Harm Prevention Policy must be fully implemented and sufficient funds provided. Detailed information and guidance should be made available to staff in the YOC to ensure that all staff are fully equipped to recognise specific risks relating to young offenders.**

35. **Counselling services and therapeutic responses to support young people and women at risk should be improved.**

36. **SEHSCT should work with the NIPS to develop the healthcare section of the gender specific standards for women prisoners.**

37. **The length of time that young people and women are placed in the observation rooms in healthcare, as well as the length of time that young people are placed within the special supervision unit, should be monitored and recorded.**

38. **Alternative therapeutic responses to the use of observation rooms and strip clothing should be developed.**

39. **All sections of the SPAR document should be fully completed and should clearly detail ongoing recording of conversations, observations or significant events, particularly at night.**

40. **Care plans for women at risk of suicide or self-harm should identify all issues associated with a woman's vulnerability and document the action required to address these issues.**

41. **The system in place to check on the quality of the recording in SPAR documents should be improved, a record of checks maintained, and any improvements required disseminated to the relevant staff.**

43. **Young offenders with mental health and addiction problems should have a dual diagnosis referral.**

44. **The Safer Custody Officer should carry out audits on current as well as completed SPAR documents to ensure that there is full compliance in this area. Healthcare should be informed of any deficits in recording.**

46. **All staff should be provided with training in ASIST.**

47. **A key worker system should be in place to ensure that staff are identified to work alongside young people and women at risk of self-harm or suicide.**

48. **As a priority, a detailed risk assessment of cells in relation to ligature points should be undertaken as a matter of urgency by the NIPS in conjunction with SEHSCT and should include a detailed action and management plan.**

49. **There should be more effective systems in place in Hydebank Wood, to improve the profile and management of anti-bullying and violence reduction.**

50. **The governance systems in place should ensure there is effective and timely sharing and learning from SAIs and that any recommendations made are fully addressed.**

53. **Healthcare staff should be more involved in the review of serious adverse incidents. Reporting systems should be improved to ensure that patients are protected, through identifying and learning from all safety incidents and other reportable incidents.**

55. **The use of lock up is not an appropriate means by which to manage and control young people or women, nor in response to staff shortages. Hydebank Wood should review their use of lock up to ensure the health and wellbeing prisoners.**

56. **Advice should be sought from the infection prevention and control team of SEHSCT in relation to the mother and baby rooms.**

57. **Greater emphasis must be placed on child protection training including refresher training for staff. RQIA would further recommend that child protection training be made mandatory.**

58. **Immediate steps should be taken to ensure that child protection referrals are monitored and that patterns or trends are identified.**

59. **RQIA recommends that the safeguarding children protocol detailing inter-agency working, which focuses on communication, thresholds for referral, access to consultation and advice, and the sharing of monitoring and case management review outcomes becomes fully operational.**

60. **The prison, trust and service provider must ensure that there is a system in place to collect quality aggregated prescribing data in order to inform effective medicines management and clinical governance and to demonstrate value for money.**

67. **The contents of the emergency drugs pack should be checked in line with agreed timescales.**

81. **Young offenders should have access to barrier protection and lubricants. They should be made aware of the means of accessing condoms.**

82. **The appropriate levels of physical exercise and opportunities for outdoor activity should be provided to promote physical and emotional wellbeing.**

85. **An internal appointment system should be in place to ensure that young offenders have access to booked appointments on an equitable basis. Consideration should be given to the introduction of a self-referral system for medical appointments.**

87. **Young offenders should receive healthcare services that are not unnecessarily restricted by security procedures.**

91. **A review of the escort arrangements should be undertaken to ensure that there is a reduction in the number of cancelled hospital appointments.**

105. **The drug and alcohol strategy should be updated and informed by a comprehensive needs assessment to identify gaps in the service provided.**

106. **Drug and alcohol strategy meetings should be held to improve communication and promote better understanding between the healthcare, addictions, ADEPT and security teams.**

South Eastern Health and Social Care Trust

2. **The draft prison healthcare strategy should be finalised to ensure that there is effective management of resources, effective information sharing, audit and service development to improve the health and wellbeing experienced by every prisoner in a custodial setting.**

4. **A prison healthcare delivery plan should be in place.**

5. **The prison healthcare governance plan should clearly identify achievements for each prison.**

6. **The appropriate contracts should be in place for the effective delivery of prison healthcare.**

8. **The trust should ensure that where appropriate, control measures identified on the corporate risk register are applicable to all prisons.**

10. **Prison healthcare should be a standing item on the agenda of the SEHSCT Governance Assurance Committee.**

11. **A system should be in place to ensure that staff have read and signed that they understand all relevant policies and procedures.**

12. **Clinical Supervision should be fully introduced and the clinical supervisors should be given protected time to undertake these duties.**

13. **A Prison Healthcare Performance Audit should be undertaken to provide a baseline of healthcare provision in Hydebank Wood.**

14. **Complaints should be a standing item on the agenda of healthcare managers and staff meetings. Complaints should be monitored to identify emerging patterns or trends, and a formalised process established to share learning from complaints with staff.**

16. **All nurses should be provided with the necessary training to allow them to effectively assess, plan, implement and evaluate nursing care in line with NMC guidance.**

17. **There should be regular audits of healthcare records with documented actions.**

18. **The acting healthcare manager should ensure that the EMIS system is capable of securing clinical records in accordance with NMC guidance and data protection principles.**

21. **A workforce plan should be in place, and a capacity and demand analysis should be undertaken for the prison healthcare.**

22. **The organisation of the workload should be reviewed to allow RMN staff sufficient allocated time to undertake mental health referrals.**

23. **A training needs analysis should be undertaken to ensure that staff are trained in all aspects of their work.**

24. **The SEHSCT staff should attend mandatory training and improve the recording and monitoring systems in place to ensure compliance with mandatory training requirements.**

25. **SEHSCT and the NIPS should ensure that the inpatient beds do not form part of the prison's certified normal accommodation.**

28. **The colour coding for cleaning equipment should be in line with the NPSA colour coding system.**

29. **All equipment should be kept clean and serviced on a regular basis according to the manufacturer's instructions.**

30. **Advice and guidance should be sought from the trust's infection prevention and control team in the trust in relation to commencing environmental and infection prevention and control audits.**

31. **Healthcare staff must receive regular refresher training and competency assessment in the appropriate action to be taken in an emergency.**

42. **When a SPAR is opened, documentation should always be completed by the healthcare staff in the first 48 hours, to risk assess and protect young offenders.**

45. **There should be additional staff trained in Mental State Assessment within Hydebank Wood.**

51. **SEHSCT should investigate and take action to address the deficits in care identified in the local review report of incidents relating to women prisoners to ensure that all nurses comply and abide by the Nursing and Midwifery Council's professional code.**

52. **The reporting of SAIs to the HSC Board should be reviewed.**

54. **SEHSCT should develop a protocol for emergency psychiatric care and, where necessary, provide additional training and guidance for staff in this area. The medical lead for the prison service should undertake a training needs analysis for medical staff.**

61. **Staff should receive appropriate training on the use of the EMIS system to ensure that all information is correctly entered.**

62. **The procedures for confirming current medication regimes and prescribing medication at committal must be reviewed. In accordance with NMC guidance, written confirmation of current medication regimes and remote instructions from the prison doctor should be obtained before any medication is administered by nurse officers.**

63. **A robust audit tool should be developed and used at specified intervals to measure compliance with the Standard Operating Procedures and any necessary corrective action should be implemented.**

64. **The length of time for retaining records for the receipt of medicines must be confirmed.**

65. **The necessary improvements on the medication administration records should be implemented.**

66. **Clear records for the disposal of all medicines must be maintained (include date of disposal, quantity, reason and signature).**

68. **The acting healthcare manager must ensure that all healthcare staff have received and understood the updated in-possession policy.**

69. **Training on the objective completion of the risk assessment tool should be provided for all healthcare staff.**

70. **The acting healthcare manager must audit compliance with the updated policy to ensure that all assessments are fully completed and that the required frequency of random monitoring audits is achieved.**

71. **The management of the controlled drug key should be reviewed to ensure that one nurse is accountable for the contents of the controlled drug cabinet during the day shift.**

72. **Out-of-date and discontinued controlled drugs awaiting destruction should be clearly marked and segregated in the controlled drug cabinet.**

73. **Controlled drugs, which are dispensed in daily issue bags, should be stored in a suitable container in the controlled drug cabinet.**

74. **A larger capacity controlled drug cabinet should be obtained.**

75. **The PGD for Hepatitis B should be reviewed immediately and signed off by all relevant signatories to ensure validity.**

76. **The acting healthcare manager must ensure that all appropriate nurse officers have been made aware of the PGD and that relevant training has been provided.**

77. **The acting healthcare manager must monitor staff compliance with the prison's policy for the super-accelerated Hepatitis B vaccine, at regular intervals and must be made aware of all stock supply problems which impact on prisoner health.**

78. **There should be a formalised plan in place for the active promotion of information, education, screening and confidential advice on sexual health. Adherence to this plan should be monitored.**

79. **Health promotion clinics should be arranged at regular intervals. These should include information on STIs, social and life skills, sex education and relationship education.**

80. **Young offenders and women prisoners should have access to chlamydia and STI screening programmes, on committal and at annual health assessments. Adherence to these screening processes should be audited at least annually to monitor uptake.**

83. **A revised health needs assessment should be undertaken.**

84. **The expansion of emergency service provision in prison healthcare across Northern Ireland should not take place until all staff are appropriately trained and competency assessments have taken place.**

86. **All young offenders who report sick should be triaged by a healthcare officer/ nurse within 24 hours.**

88. **There should be clear indication within the minutes of regional groups of which issues affect individual prisons.**

89. **Access and waiting times for assessments carried out by the mental health team must be improved as a matter of urgency.**

90. **Healthcare staff, when applicable should ensure that women prisoners are accompanied by female staff to hospital appointments.**

94. **There should be regular multi-disciplinary meetings organised to ensure continuity of care and to develop and formulate strategies of care, including for patients with addictions.**

95. **The number of available RMN staff should be reviewed to ensure sufficient capacity to fulfil the needs of the service.**

96. **The RMN staff in post should have allocated time to undertake mental healthcare, to ensure that the waiting time for mental health referrals is in accordance with the agreed timescale of one week.**

97. **The CBT services and available therapies should be reviewed and increased to meet the needs and requirements of the service.**

99. **There should be evidence of the sharing of the regional risk assessment with other disciplines and agencies.**

100. **Enhanced risk assessment should be undertaken when required to ensure that the necessary multidisciplinary meetings are initiated.**

101. Young offenders and women subject to 2009 guidance should be involved in their care planning and appropriate documentation should be introduced in line with this guidance.

102. Discharge protocols should be established to ensure that women and young offenders with complex needs have a multidisciplinary discharge plan. The process for attendance at multidisciplinary team meetings held outside the prison should be formalised.

107. There should be a more proactive approach by the addictions team to obtaining referrals for those who have addiction problems prior to committal. This should inform the level of addiction services required to ensure that the needs of these vulnerable groups are met.

108. Following screening and testing all those who require first night treatment/ symptomatic relief should have it prescribed and administered. Women and young people who arrive with ongoing dependence should be carefully assessed and monitored before any detoxification regime is commenced.

109. Inspectors would recommend that the placement of patients, including admission to the healthcare centre, should be reviewed to ensure that women and young people receive effective support during the first days of the detoxification programme.

110. Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes.

111. There should be improved information sharing between healthcare and security staff in relation to results of failed illicit drugs tests to determine if the drug is related to prescribed medication.

112. All young offenders and women with a chronic disease should be identified and included on the appropriate register.

113. Chronic disease management clinics should be introduced.

Appendix One: Service User Groups

As part of the inspection process RQIA inspectors had the opportunity to accompany the inspectors from HMI Prisons and to take part in service user groups in Beech and Willow houses within the YOC, and two group sessions within Ash House.

The discussions which took place within these groups are summarised as follows:

1 Group Session with Young Offenders in Beech House

Initially only three prisoners had requested to meet with inspectors, but this increased to nine when RQIA inspectors spoke with staff and prisoners on the landings. Prisoners seemed at ease with the inspectors and spoke at length about their experiences in Hydebank Wood.

Most related that the journey from court to prison was not a pleasant experience. They felt the prison vans were dirty and cold. One young man said he was in the van at midday until arriving at Hydebank Wood at 16.50 hours with nothing to eat. He said he requested a lunchbox but was refused.

At reception in Hydebank Wood all young offenders are strip-searched with two prison officers in attendance. The procedure in place ensures the prisoner is never completely naked. They are given prison clothes until their families bring their own clothes to the YOC.

The young offenders felt they did not get a proper induction. They were told to read a list of prison rules, however, many prisoners have literacy and numeracy difficulties.

The group stated that they were allowed one phone call on their first night. A public telephone is available on the landing, calls cost £1.00 per minute and the call must be booked in the morning.

Young offenders were not complimentary about the quality of food they receive, although two days each week they get a fry, which they enjoy.

Cells are sparsely furnished with a toilet, sink and bed. They described the mattresses as hard and filthy. All newly committed young offenders are issued with a bed pack (bed linen). Laundry facilities are provided on the landings and they are provided with the opportunity to wash their own bed sheets once a week.

In an emergency, they can activate an emergency bell in the cell, but most young offenders said that prison officers can take a long time to respond.

They generally reported that there was a lack of activities within Hydebank Wood. There are education courses and prison work, and gym and football on Saturday, when these are available,. However, often they have to wait for some months for courses or work to become available. Whilst they are

waiting for work or educations they reported that they remain in their cells all day.

The young men reported that are locked in their cells each day between 08.00 hours to midday and again from 13.30 – 17.00 hours . They can associate with each other from 17.00– 19.30 hours. However, the young men reported that most days it is 17.30 hours or later before cells are unlocked. During most of this time the electricity to the cells is switched off. Television is only permitted at weekends and many reported that when on the basic regime they are not allowed out of their cell for the one hour each day. If they break the rules they can be put back on to the basic regime, with loss of privileges - which could mean that they cannot associate with others for up to two weeks.

When asked about complaints the young men reported that they felt that these "fell on deaf ears" and they felt that they did not receive a proper response to their complaints.

From the conversations with the young men in Beech House it would seem that illicit drugs are being smuggled into prison – primarily cannabis and sleeping tablets. Some were aware that a detoxification programme for diazepam dependency was available if needed.

The young men spoke at length about difficulties in accessing healthcare. One young person reported that when being seen by the doctor he was asked to leave for using inappropriate language. Discussion with this young man would indicate that such language is part of his normal speech pattern. The young man was then subject to the adjudication process by a prison officer. Others said that it could be a few days from making a request to a prison officer to see a doctor until they get to see the doctor. They said that the prison officer decides whether or not they get to see a doctor. One young man said he had a chest infection for two days before a nurse came to see him.

The young men do not have a personal officer, so feel that they have no-one to talk over problems with, except each other. They said that if you are feeling low or depressed the only way to get the attention you need is to wreck the cell. Overall they said that relationships with most of the prison officers are generally good, however, some were deemed to be unapproachable and intimidating. They reported that they found the female officers easier to talk to and more approachable, however, many of the female officers have been moved to the women's prison.

Discussion regarding resettlement indicated that they do not see sentence management. They felt that there is no great preparation for release or follow up when they get out of prison.

When asked to name three good things about prison most replied: fry; tuck shop; gym (when they can get to it).

The three negative aspects of prison life that they responded:
staff; food; no yard time and the length of time locked in their cells.

2 Group Session with Young Offenders in Willow House

On the first morning of the inspection, a group discussion was facilitated by inspectors from RQIA and HMI Prisons for young people in Willow House. The purpose of the group was to advise the young people of the inspection and to listen to any issues which the young people chose to raise.

Six young people were present who were representative of the juvenile wings. Discussion centred around: daily routines; their interactions and relationships with staff on the wings; visiting; making complaints; the menu; work and educational opportunities.

The young people described their day-to-day routines. They highlighted that a proportion of each day (was spent in their cells on lock-up. The young people spoke of having four to five hours each day out of their cell and little opportunity for physical exercise.

The young people said that they normally had a work or education allocation each day. One young person advised that he had obtained an NVQ Level 1 qualification in industrial cleaning. Other work opportunities included painting and decorating, joinery, bricklaying and plumbing. The young people were generally positive about these activities.

However, they were unhappy that they tended to be shifted between work allocations, for example from joinery to plumbing, rather than being able to focus on learning a particular skill.

Five of the six young people stated that they had been subject to the prison's adjudication process. The general view shared by the young people was that this process was too strict. There was group consensus that staff were inconsistent in their approaches to adjudication and one young person stated that some staff "bring their own rules". Dependent on the member of staff, young people said that for similar misdemeanours they might either be warned or charged, and they found this confusing. Some said that they felt that resulting sanctions could be overly punitive , such as periods of up to 14 days loss of association. One young person stated that he thought being in prison was punishment enough, and that he should be helped to cope rather than be punished for wrongdoings and learned habits. The young people were aware that they could have an advocate present at adjudications. They were less certain about any right of appeal.

There were varying opinions about relationships between staff and young people. The young people said that there were some staff that they could "get on with" and others that they "just had to get on with". The young people reported that if they were worried or upset they would not tell staff. They further stated that previous experiences of sharing concerns and anxieties with staff was not handled confidentially. The young people said that they would use the landing phone to speak to someone outside the prison in such situations. The young people also said that there were often staff working on their wing providing cover, whom they did not know or have a relationship

with. This made it additionally difficult if they needed to talk to someone about a problem or anxiety.

The young people raised an issue regarding visiting times. They said that if they were delayed in arriving for visits, the time would not be extended to ensure that it lasted one hour, and in effect the visit was cut short.

With regard to access to healthcare, some young people said that they thought they should have additional support in dealing with habits developed, such as misuse of alcohol and drugs.

The young people were generally dissatisfied with the meals provided which they said were "cooked too early" and that food was often "soggy" by the time it was served. They were happy with their access to the tuck shop, where they said they could purchase additional snacks. The young people advised that they were able to access a kitchen on their wing.

When asked to name three good things about the YOC most replied: going to bed; gym; and education.

When asked to name three poor or negative things about YOC most replied: staff; food; and time for activities.

The issues raised by the young people were shared with staff in Willow House.

3 Group Session 1 - Ash House

On the first morning of the inspection, a group discussion was facilitated by inspectors from RQIA and HMI Prisons for women prisoners in Ash House. The purpose of the group was to advise the women of the inspection and to listen to any issues raised.

Eight women were present who were representative of the wings. Discussion centred around daily routines; their interactions and relationships with staff on the wings; visiting; making complaints; the menu; and work and educational opportunities.

The women related that prison/transfer information was not provided at court and the holding cells at court were cold. Some women stated that they travelled with male prisoners and reported verbal abuse and sexual harassment. Women confirmed that they were not hand-cuffed during the journey from court, however, some had travelled with males who were handcuffed.

On reception they had been provided with coffee and were allowed to make a free phone call. The free phone call has been made available in the last two months at the recommendation of the insiders group.

All women had been strip searched, this had been done sensitively. The women stated that they received a DVD and an induction booklet. An insider is available on the committal landing every evening to answer any queries.

They related that all cosmetics and medicines had been removed and some women advised that they had been without medication for two days. They also advised that some women undergo withdrawal systems from alcohol or drugs without any help, this is very frightening. However, they stated that if on an addiction program in the community, this is continued in prison.

Each woman has a single cell. A pack is provided to make up their bed. They are given prison clothes if necessary until their families bring clothes in at the committal visit. They stated that the beds are uncomfortable and the mattresses are stained. The mattress frequently slips off the bed and women end up on the floor. The cell windows are sealed and women can only smoke in the bedrooms, which is very uncomfortable. The women related that at the monthly landing meeting they have requested permission to smoke outside.

Toilets are partially screened however female staff do not knock before coming into the cell, which is very embarrassing. The showers are fine, they are allowed daily showers, which are private. Laundry facilities are provided on the landings, and they are provided with the opportunity to wash their own bed sheets. They stated there is rota and that they help each other.

The women reported that there are frequent lock-downs. There are many vulnerable women and if one needs extra help then all landings are locked down. They suggested that there should be a landing dedicated to vulnerable prisoners, or that they should be transferred to the healthcare centre. They also reported lock-downs if there are staff shortages. In an emergency they can activate an emergency bell in the cell, but the women said often bells not answered for 30 minutes.

The group were not complimentary about the quality of food they receive and described the food as disgusting. It was cold and tasteless, as it is in a trolley for 60 - 90 minutes. Women related that they are often very hungry on a Sunday evening as dinner is served at 16.00 hours. They felt that they needed a meal or snack at 19:30 hours. A small flask is provided each night but this is insufficient as they may be in cell from 16.00 hours. They do not get five pieces of fruit or vegetables each day. The fruit in the tuck shop is of much superior quality, however, the tuck shop is too expensive. They have asked for alternative remedies to be stocked in the tuck shop but this request has been ignored. There is a limit to the amount that can be spent. Outside purchases are available once weekly, but they cannot avail of promotion offers in the shops.

Women felt that most staff are fair. They can sense that staff are frustrated with the management. Staff cannot use their common sense as they have to stick to the rules. Two women were unaware of the liaison officer, while one said she saw her liaison officer too often. However, they all felt that the role of the liaison officer was not fully explained to them. The women reported that it was easy to contact their solicitor, but not to change their solicitor. When asked about complaints they stated that forms are available and they felt confident that they could complain.

They felt that adjudication is usually fair, however, they felt that it was unfair that in a dispute between prisoners the innocent party was also adjudicated. The group stated that some staff were very aggressive and used unnecessary force, and they acted too quickly in some situations. They felt that bullying is well controlled. From the conversations with women in Ash House it would appear that illicit drugs are being smuggled into prison. The amount of drugs available depends on the prisoner population at any time.

Generally the women felt that there was no benefit to being on the enhanced regime unless you have visitors. They stated that enhanced prisoners can get extra visits and money, however, money can only be left in at visits. You can only receive money by post if you have no visitors. Women felt that they were not made fully aware of their entitlements - most is by word of mouth only. If this topic had been discussed at induction they had not understood.

They stated that phone calls are too expensive. They are only allowed two letters each week, even if you have children. The quota at visits is two adults and three children per visit. Therefore if a woman has four children she cannot see them all.

The group were generally dissatisfied with healthcare. They felt that the nurses are more receptive and approachable than doctors.

The women discussed going to hospital for appointments, they said that when they are escorted by male officers they often refuse to leave the treatment room.

They also noted that the timetables for clinics in the healthcare room are not always correct.

The gym is often cancelled. There are two sessions each week but no rota system. Timetables had been restructured. Two women had been taken off the hairdressing NVQ with no explanation. All education is linked to qualifications and nothing of interest is provided. The women stated all they have is hairdressing, gym and catering. The outside space is tiny, there is nothing to do on the landing and there is no physical activity.

The group stated that there were two Polish women in the prison who have been separated for no reason. There is no information available in Polish and no Polish liaison officer.

There was little time to discuss resettlement. Women advised that it was planned via the probation team. They said that Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) was very good. Women advised that they could attend Alcoholics Anonymous (AA) on Sundays. They advised that they would like more CBT and anger management counselling to help with their resettlement.

When asked to name three good things about Ash House most replied: Staff on landings 2 and 5. The women in the group could not think of any more positives.

When asked to name three poor or negative things about Ash House most replied: healthcare; too many lockdowns; and physical activities.

4 Group Session 2 – Ash House

On the afternoon of 21 March 2011 an impromptu meeting was held by a RQIA and CJI inspector with three remand prisoners, for two of these females this was their first visit to prison. One of the female prisoners had been in prison in England- she felt there were better opportunities for work and education in the English prison. However, relationships with wing officers, in Ash House were better and she felt that the staff do try to help.

One of the first-time prisoners stated that she had been in Ash House for seven weeks and that there were no education classes or work as you have to wait a long time for these. The lack of activity was making her feel distressed.

Self-harm was evident in two of the female prisoners and one stated that healthcare do not listen when you need help, she had to wait for five months to receive CBT and anger management care. They all felt that the nurses play a big part as to whether they could see a doctor. One prisoner stated that despite receiving care from mental health professionals prior to committal she had not seen a psychiatrist in the two and a half months she had been in Ash House. Two of the prisoners stated that nurses had made decisions about their medication without seeing a doctor.

One of the prisoners felt that there was no one they could go to and that self-harm was the only way to get the attention they felt they needed.

They stated that there is no management plan or referrals to support services if you are on remand, and these are available only when you get sentenced. One prisoner who was to attend court hearing that week, was unsure if she would be released or sentenced. If she was released she stated that no plans had been made and that she did not know where she would go.

Appendix Two: Action Plan

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
Department of Health, Social Services and Public Safety and the Health and Social Care Board				
1.	RQIA recommends that the HSC Board completes the Commissioning Statement of Intent as a priority.			
92.	RQIA recommend that the provision of psychiatric services be reviewed as a matter of urgency.			
93.	The appointment of a permanent forensic psychiatric consultant should be afforded priority.			
98.	In devising the service for women and young offenders with personality disorders it is vital that the trust ensure that there is sufficient input to meet the needs of these vulnerable client groups in Hydebank Wood.			
103.	DHSSPS, HSC Board and SEHSCT should urgently review the lack of input from specialist CAMHS staff at Hydebank Wood YOC.			
104.	Whilst young males continue to be detained in Hydebank Wood, there must be input from a forensic multidisciplinary service.			
Prison Healthcare Partnership Board				
3.	RQIA recommends that a Governing Governor or appropriate deputy, is appointed as co-chair of the Partnership Board.			
Northern Ireland Prison Service and the South Eastern Health and Social Care Trust				
7.	SEHSCT and NIPS should provide clarity in respect of accountability arrangements, for both professional and employment issues. A collaborative approach should be taken in these issues when necessary, pending the transfer of staff.			
9.	The Terms of Reference and membership of the Regional Prison Health Governance Committee should to be reviewed and updated.			
15.	The independence around the current system for making complaints and the complaints policy should be reviewed to provide a more objective and independent process.			
19.	An information sharing policy should be developed for children, young people and women prisoners, as information sharing is vital to safeguarding and promoting their welfare.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
20.	There should be documented evidence to indicate that information on patient consent has been shared with other disciplines.			
26.	All prisoners requiring a clinical alcohol detoxification should be admitted to the inpatient unit.			
27.	Day services should be available for those less able to cope with prison life.			
32.	All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose, and documented evidence of such checks should be kept, in accordance with the relevant protocols.			
33.	There should be a more cohesive approach to the prevention of suicide and self-harm, which ensures that this is the responsibility of all staff, and provides clearer evidence of collaborative working and managed information sharing.			
34.	The Suicide and Self-Harm Prevention Policy must be fully implemented and sufficient funds provided. Detailed information and guidance should be made available to staff in the YOC to ensure that all staff are fully equipped to recognise specific risks relating to young offenders.			
35.	Counselling services and therapeutic responses to support young people and women at risk should be improved.			
36.	SEHSCT should work with the NIPS to develop the healthcare section of the gender specific standards for women prisoners.			
37.	The length of time that young people and women are placed in the observation rooms in healthcare, as well as the length of time that young people are placed within the special supervision unit, should be monitored and recorded.			
38.	Alternative therapeutic responses to the use of observation rooms and strip clothing should be developed.			
39.	All sections of the SPAR document should be fully completed and should clearly detail ongoing recording of conversations, observations or significant events, particularly at night.			
40.	Care plans for women at risk of suicide or self-harm should identify all issues associated with a woman's vulnerability and document the action required to address these issues.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
41.	The system in place to check on the quality of the recording in SPAR documents should be improved, a record of checks maintained, and any improvements required disseminated to the relevant staff.			
43.	Young offenders with mental health and addiction problems should have a dual diagnosis referral.			
44.	The Safer Custody Officer should carry out audits on current as well as completed SPAR documents to ensure that there is full compliance in this area. Healthcare should be informed of any deficits in recording.			
46.	All staff should be provided with training in ASIST.			
47.	A key worker system should be in place to ensure that staff are identified to work alongside young people and women at risk of self-harm or suicide.			
48.	As a priority, a detailed risk assessment of cells in relation to ligature points should be undertaken as a matter of urgency by the NIPS in conjunction with SEHSCT and should include a detailed action and management plan.			
49.	There should be more effective systems in place in Hydebank Wood, to improve the profile and management of anti-bullying and violence reduction.			
50.	The governance systems in place should ensure there is effective and timely sharing and learning from SAIs and that any recommendations made are fully addressed.			
53.	Healthcare staff should be more involved in the review of serious adverse incidents. Reporting systems should be improved to ensure that patients are protected, through identifying and learning from all safety incidents and other reportable incidents.			
55.	The use of lock up is not an appropriate means by which to manage and control young people or women, nor in response to staff shortages. Hydebank Wood should review their use of lock up to ensure the health and wellbeing prisoners.			
56.	Advice should be sought from the infection prevention and control team of SEHSCT in relation to the mother and baby rooms.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
57.	Greater emphasis must be placed on child protection training including refresher training for staff. RQIA would further recommend that child protection training be made mandatory.			
58.	Immediate steps should be taken to ensure that child protection referrals are monitored and that patterns or trends are identified.			
59.	RQIA recommends that the existing safeguarding children protocol detailing inter-agency working, which focuses on communication, thresholds for referral, access to consultation and advice, and the sharing of monitoring of case management review outcomes becomes fully operational.			
60.	The prison, trust and service provider must ensure that there is a system in place to collect quality aggregated prescribing data in order to inform effective medicines management and clinical governance and to demonstrate value for money.			
67.	The contents of the emergency drugs pack should be checked in line with agreed timescales.			
81.	Young offenders should have access to barrier protection and lubricants. They should be made aware of the means of accessing condoms.			
82.	The appropriate levels of physical exercise and opportunities for outdoor activity should be provided to promote physical and emotional wellbeing.			
85.	An internal appointment system should be in place to ensure that young offenders have access to booked appointments on an equitable basis. Consideration should be given to the introduction of a self-referral system for medical appointments.			
87.	Young offenders should receive healthcare services that are not unnecessarily restricted by security procedures.			
91.	A review of the escort arrangements should be undertaken to ensure that there is a reduction in the number of cancelled hospital appointments.			
105.	The drug and alcohol strategy should be updated and informed by a comprehensive needs assessment to identify gaps in the service provided.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
106.	Drug and alcohol strategy meetings should be held to improve communication and promote better understanding between the healthcare, addictions, ADEPT and security teams.			
South Eastern Health and Social Care Trust				
2.	The draft prison healthcare strategy should be finalised to ensure that there is effective management of resources, effective information sharing, audit and service development to improve the health and wellbeing experienced by every prisoner in a custodial setting.			
4.	A prison healthcare delivery plan should be in place.			
5.	The prison healthcare governance plan should clearly identify achievements for each prison.			
6.	The appropriate contracts should be in place for the effective delivery of prison healthcare.			
8.	The trust should ensure that where appropriate, control measures identified on the corporate risk register are applicable to all prisons.			
10.	Prison healthcare should be a standing item on the agenda of the SEHSCT Governance Assurance Committee.			
11.	A system should be in place to ensure that staff have read and signed that they understand all relevant policies and procedures.			
12.	Clinical Supervision should be fully introduced and the clinical supervisors should be given protected time to undertake these duties.			
13.	A Prison Healthcare Performance Audit should be undertaken to provide a baseline of healthcare provision in Hydebank Wood.			
14.	Complaints should be a standing item on the agenda of healthcare managers and staff meetings. Complaints should be monitored to identify emerging patterns or trends, and a formalised process established to share learning from complaints with staff.			
16.	All nurses should be provided with the necessary training to allow them to effectively assess, plan, implement and evaluate nursing care in line with NMC guidance.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
17.	There should be regular audits of healthcare records with documented actions.			
18.	The acting healthcare manager should ensure that the EMIS system is capable of securing clinical records in accordance with NMC guidance and data protection principles.			
21.	A workforce plan should be in place, and a capacity and demand analysis should be undertaken for the prison healthcare.			
22.	The organisation of the workload should be reviewed to allow RMN staff sufficient allocated time to undertake mental health referrals.			
23.	A training needs analysis should be undertaken to ensure that staff are trained in all aspects of their work.			
24.	The SEHSCT staff should attend mandatory training and improve the recording and monitoring systems in place to ensure compliance with mandatory training requirements.			
25.	SEHSCT and the NIPS should ensure that the inpatient beds do not form part of the prison's certified normal accommodation.			
28.	The colour coding for cleaning equipment should be in line with the NPSA colour coding system.			
29.	All equipment should be kept clean and serviced on a regular basis according to the manufacturer's instructions.			
30.	Advice and guidance should be sought from the trust's infection prevention and control team in the trust in relation to commencing environmental and infection prevention and control audits.			
31.	Healthcare staff must receive regular refresher training and competency assessment in the appropriate action to be taken in an emergency.			
42.	When a SPAR is opened, documentation should always be completed by the healthcare staff in the first 48 hours, to risk assess and protect young offenders.			
45.	There should be additional staff trained in Mental State Assessment within Hydebank Wood.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
51.	SEHSCT should investigate and take action to address the deficits in care identified in the local review report of incidents relating to women prisoners to ensure that all nurses comply and abide by the Nursing and Midwifery Council's professional code.			
52.	The reporting of SAIs to the HSC Board should be reviewed.			
54.	SEHSCT should develop a protocol for emergency psychiatric care and, where necessary, provide additional training and guidance for staff in this area. The medical lead for the prison service should undertake a training needs analysis for medical staff.			
61.	Staff should receive appropriate training on the use of the EMIS system to ensure that all information is correctly entered.			
62.	The procedures for confirming current medication regimes and prescribing medication at committal must be reviewed. In accordance with NMC guidance, written confirmation of current medication regimes and remote instructions from the prison doctor should be obtained before any medication is administered by nurse officers.			
63.	A robust audit tool should be developed and used at specified intervals to measure compliance with the Standard Operating Procedures and any necessary corrective action should be implemented.			
64.	The length of time for retaining records for the receipt of medicines must be confirmed.			
65.	The necessary improvements on the medication administration records should be implemented.			
66.	Clear records for the disposal of all medicines must be maintained (include date of disposal, quantity, reason and signature).			
68.	The acting healthcare manager must ensure that all healthcare staff have received and understood the updated in-possession policy.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
69.	Training on the objective completion of the risk assessment tool should be provided for all healthcare staff.			
70.	The acting healthcare manager must audit compliance with the updated policy to ensure that all assessments are fully completed and that the required frequency of random monitoring audits is achieved.			
71.	The management of the controlled drug key should be reviewed to ensure that one nurse is accountable for the contents of the controlled drug cabinet during the day shift.			
72.	Out-of-date and discontinued controlled drugs awaiting destruction should be clearly marked and segregated in the controlled drug cabinet.			
73.	Controlled drugs, which are dispensed in daily issue bags, should be stored in a suitable container in the controlled drug cabinet.			
74.	A larger capacity controlled drug cabinet should be obtained.			
75.	The PGD for Hepatitis B should be reviewed immediately and signed off by all relevant signatories to ensure validity.			
76.	The acting healthcare manager must ensure that all appropriate nurse officers have been made aware of the PGD and that relevant training has been provided.			
77.	The acting healthcare manager must monitor staff compliance with the prison's policy for the super-accelerated Hepatitis B vaccine, at regular intervals and must be made aware of all stock supply problems which impact on prisoner health.			
78.	There should be a formalised plan in place for the active promotion of information, education, screening and confidential advice on sexual health. Adherence to this plan should be monitored.			
79.	Health promotion clinics should be arranged at regular intervals. These should include information on STIs, social and life skills, sex education and relationship education.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
80.	Young offenders and women prisoners should have access to chlamydia and STI screening programmes, on committal and at annual health assessments. Adherence to these screening processes should be audited at least annually to monitor uptake.			
83.	A revised health needs assessment should be undertaken.			
84.	The expansion of emergency service provision in prison healthcare across Northern Ireland should not take place until all staff are appropriately trained and competency assessments have taken place.			
86.	All young offenders who report sick should be triaged by a healthcare officer/ nurse within 24 hours.			
88.	There should be clear indication within the minutes of regional groups of what issues affect individual prisons.			
89.	Access and waiting times for assessments carried out by the mental health team must be improved as a matter of urgency.			
90.	Healthcare staff, when applicable should ensure that women prisoners are accompanied by female staff to hospital appointments.			
94.	There should be regular multi-disciplinary meetings organised to ensure continuity of care and to develop and formulate strategies of care, including for patients with addictions.			
95.	The number of available RMN staff should be reviewed to ensure sufficient capacity to fulfil the needs of the service.			
96.	The RMN staff in post should have allocated time to undertake mental healthcare, to ensure that the waiting time for mental health referrals is in accordance with the agreed timescale of one week.			
97.	The CBT services and available therapies should be reviewed and increased to meet the needs and requirements of the service.			
99.	There should be evidence of the sharing of the regional risk assessment with other disciplines and agencies.			
100.	Enhanced risk assessment should be undertaken when required to ensure that the necessary multidisciplinary meetings are initiated.			

Rec No.	Recommendations	Designated department	Action required	Date for completion/ timescale
101.	Young offenders and women subject to 2009 guidance should be involved in their care planning and appropriate documentation should be introduced in line with this guidance.			
102.	Discharge protocols should be established to ensure that women and young offenders with complex needs have a multidisciplinary discharge plan. The process for attendance at multidisciplinary team meetings held outside the prison should be formalised.			
107.	There should be a more proactive approach by the addictions team to obtaining referrals for those who have addiction problems prior to committal. This should inform the level of addiction services required to ensure that the needs of these vulnerable groups are met.			
108.	Following screening and testing all those who require first night treatment/ symptomatic relief should have it prescribed and administered. Women and young people who arrive with ongoing dependence should be carefully assessed and monitored before any detoxification regime is commenced.			
109.	Inspectors would recommend that the placement of patients, including admission to the healthcare centre, should be reviewed to ensure that women and young people receive effective support during the first days of the detoxification programme.			
110.	Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes.			
111.	There should be improved information sharing between healthcare and security staff in relation to results of failed illicit drugs tests to determine if the drug is related to prescribed medication.			
112.	All young offenders and women with a chronic disease should be identified and included on the appropriate register.			
113.	Chronic disease management clinics should be introduced.			

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel: (028) 9051 7500
Fax: (028) 9051 7501
Email: info@rqia.org.uk
Web: www.rqia.org.uk