HMP Isle of Wight

Inspection report

Albany
Newport
PO30 5RS
Tel:

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services well-led?	**Inspected but not rated**

Overall summary

We carried out a CQC focused follow-up inspection in conjunction with an independent review of progress (IRP)inspection with His Majesty's Inspectorate of Prisons (HMIP) of healthcare services provided by Practice Plus Group Health & Rehabilitation Services Limited (PPG) at HMP Isle of Wight on 5 to 7 June 2023. This was in response to a joint HMIP and CQC comprehensive inspection carried out in October 2022 when we found the quality of care required improvement. We issued one Requirement Notice in relation to Regulation 17: Good governance.

At this inspection we found:

- Overall governance processes had been improved and reviewed. Audits and action plans ensured better oversight with improved accountability.
- Oversight of pharmacy medicines, including controlled drugs was improved.
- Improved policies and procedures ensured out of date stock or excessive returned unused medicines were not retained on site.
- The quality of care records had improved.

Our inspection team

Our inspection team was led by a CQC health and justice inspector supported by one HMIP inspector.

How we carried out this inspection

We conducted a range of interviews with staff and reviewed a range of information that we held about the service including notifications.

During the inspection we spoke with staff and patients including:

- Head of healthcare
- Pharmacy leads
- Primary care nurses
- Regional pharmacist
- Pharmacy staff
- Paramedics
- Patients
- Regional manager
- Support staff

We also spoke with NHS England (NHSE) commissioners and requested their feedback prior to the inspection. We observed medicines administration, and accessed patient clinical records during our onsite visit.

We asked the provider to share a range of evidence with us. Documents we reviewed included:

- Risk registers
- Audits
- Meeting minutes
- Quality improvement and assurance plans
- Training activity
- Policies and procedures

Background to HMP Isle of Wight

HMP Isle of Wight is a category B training prison for adult males. It holds both remand and sentenced prisoners with an operational capacity to hold 1000 prisoners. Two former prison sites of HMP Parkhurst and Albany are now known simply as HMP Isle of Wight.

Practice Plus Group Health & Rehabilitation Services Limited (PPG) is the prime provider of health care at HMP Isle of Wight for primary care, with subcontracted services for dental provision and mental health.

PPG is registered to provide the following regulated activities at the location: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

Inspected but not rated

Are services well-led?

Medicines optimisation and pharmacy services

At this inspection we found the required improvements had been made and the provider was meeting the regulations.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At our previous inspection we found that case records were not always contemporaneous; we found some specific case notes that were missing or written retrospectively up to 5 days later. Despite managers being alerted to these deficits, they had not been addressed promptly.

Pharmacy services lacked sufficient oversight and controls to ensure that medicines were managed efficiently.

Most medicines were stored and transported safely. But controlled drugs (CD) were transported across both sites using a sealed bag, with no security escort.

The overall management of CDs in the pharmacy was not sufficiently robust. There were some expired CDs among up-to-date stock, and significant quantities of obsolete and patient-returned CDs needed to be destroyed. Running balances of CDs were not audited at regular intervals and a balance check of morphine sulphate tablets did not match the recorded balance. The controlled drug cabinets in both clinic rooms were too small to hold CDs safely.

There was no reconciliation procedure or audit trail of emergency medicines.

Staff reported incidents on Datix but reviews and learnings to mitigate similar events in the future were not robust.

Patients who did not attend for medication were not always followed up in line with the provider's Local Operating Procedure.

However, at this inspection we found:

The evidence provided, and on-site inspection activity revealed significant investment and changes to working practices. This resulted in improved controlled drug security and safer working practices.

Healthcare records we reviewed had improved ensuring better continuity of care. However, some notes lacked detail or did not reflect if the review was face-to-face or paper based. We no longer found instances of missing case notes.

Overall governance processes had been improved and reviewed. Audits with associated action plans had better oversight with improved accountability. We were able to identify improvements to the service which stemmed from these changes. For example, pharmacy staff had completed medicines reconciliation training and were actively embedding the learning in their work.

Governance processes were now linked at local, regional, and national level to ensure ongoing comprehensive oversight of pharmacy practices. Evidence demonstrated issues were shared from on site through the required channels and back down to site.

Inspected but not rated

Are services well-led?

Oversight of pharmacy medicines, including controlled drugs was improved. New technology, processes and equipment had been installed and updated. For example, daily controlled drug balance checks and auditing for compliance were evident. New controlled drug cabinets had been provided for both prisons. These were well set out and monitored appropriately.

The provider had invested in lockable, secure hard cases to transport controlled drugs across the two prisons. The cases ensured medicines were as secure as possible meeting the recognised IP67 (ingress protection) against water and particulates. As well as meeting military approval ratings for strength and security.

Improved policies and procedures ensured minimal out of date stock or excessive, unused medicines were retained on site. Records demonstrated all were destroyed in a timely and appropriate manner. During the inspection we found no out of date medicines across the two sites. Minimal unused stock was retained onsite awaiting collection.

Patients who missed their medicines were now followed up with a telephone call by the pharmacy team or face-to-face visit if appropriate. Improving compliance to medicines therapies and safety of patients. Work was ongoing to improve the monitoring of critical medicines for example those on heart medicines. The provider had been engaging with wing staff to be aware of those prisoners who may need additional support or monitoring for compliance.

Incidents and near misses within the pharmacy department were well recorded. Meeting minutes showed reviews of the previous months near misses which were discussed and shared. Regular reports were generated and audited to identify areas that were developing potential risk with appropriate steps taken to reduce or remove those risks.