HMP Garth

Inspection report

Wymott Prison
Ulnes Walton Lane
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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 safe?	**Inspected but not rated**

Overall summary

We carried out an unannounced focused inspection of healthcare services provided by Greater Manchester Mental Health (GMMH) NHS Foundation Trust to follow up on concerns regarding medicines management.

The purpose of this focused inspection was to determine if the healthcare services provided by GMMH NHS Foundation Trust were meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that patients were receiving safe care and treatment.

At this inspection we found that GMMH NHS Foundation Trust were managing medicines safely at this location.

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 this inspection we found:

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- We found that systems for recording and monitoring the content of emergency bags were not always effective.

We found areas where the provider needed to make improvements. The provider **should:**

- Ensure there is a robust system to monitor and record checks of emergency bags and equipment.

Our inspection team

The inspection was carried out by a CQC health and justice inspector and a member of the CQC medicines optimisation team.

How we carried out this inspection

We conducted a range of interviews with staff, observed medicines administration, and accessed the patient record system on 10 August 2022.

Before this inspection we reviewed some information that we held about the service including notifications and action plan updates, and quality visit reports from commissioners. We asked the provider to share a range of evidence with us.

During the inspection we spoke with:

- 4 members of pharmacy staff
- 3 nurses

We also spoke with NHS England (NHSE) commissioners and requested their feedback prior to the inspection and spoke with the prison governor regarding the management of medicines in the prison.

Background to HMP Garth

HMP Garth is a Category B male prison located in the village of Ulnes Walton, in Lancashire, England. HMP Garth is operated by HM Prison Service and is situated next to HMP Wymott.

Health services at HMP Garth are commissioned by NHSE. The contract for the provision of healthcare services is held by GMMH NHS Foundation Trust, who are registered with CQC to provide the regulated activities of diagnostic and screening procedures, personal care, and treatment of disease, disorder or injury.

Inspected but not rated

Are services safe?

Safety systems and processes

We found that systems for recording and monitoring the content of emergency bags were not always effective. We saw evidence of daily checks that the relevant emergency bags were present. We checked the contents of the emergency bags on one wing and found that no items were missing, and items were within their expiry dates. However, staff were unable to provide evidence of content and expiry date checks. Therefore, we were not assured that the emergency bag monitoring systems were effective.

Appropriate and safe use of medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Pharmacy technicians and nurses administered medicines from the wings twice a day. Staff spoke with prisoners who did not take their medicines and escalated concerns. They followed current national practice to check patients had the correct medicines. Medicines records were complete and contained details on dose, when patients received them, and controlled drugs were double checked. The prison was developing a new regime that would increase the time interval between morning and afternoon medicines administration times. However, asymmetrical doses would still be required, which is difficult to achieve for some medicines.

Whilst medicines queues were supervised by prison officers, their effectiveness in ensuring only one prisoner was at the medicines administration hatch at a time was variable. Therefore, confidentiality and the risk of diversion was not always managed effectively.

Staff stored and managed medicines in line with the service's policy. Medicines were in date and excess medicines had been returned to the issuing pharmacy at HMP Wymott. All medicines were stored safely and kept within their recommended temperature ranges.

A limited number of cell checks to confirm patients complied with their medicines' regime were undertaken. These were reactive when prisoners started to receive medicines in possession or in response to intelligence, however a structured approach was lacking.

Prisoners had had access to medicines without the need to see a doctor through a minor ailment policy and patient group directions (PGDs) (which authorise appropriate health care professionals to supply and administer prescription-only medicine).

Staff provided specific advice to prisoners about their medicines at the medicines administration point. Prisoners were unable to access pharmacy-led clinics for more specialist advice. Processes were in place to ensure medicines were available out of hours, for transfer, release and court appearances.