Her Majesty's Prison Whitemoor

Inspection report

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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

This inspection was an announced focused inspection carried out on the 05 December 2023 to confirm that the legal provider had carried out their plan to meet the legal requirements in relation to breaches in regulations that we identified on our previous inspection between 12 to 16 December 2022. This comprehensive inspection had been carried out in partnership with His Majesty's Inspectorate of Prisons (HMIP).

During the comprehensive inspection by CQC and HMIP in December 2023, we found that the quality of healthcare provided by Northamptonshire Healthcare NHS Foundation Trust (NHFT) at this location did not meet the fundamental standards. We issued a Requirement Notice in relation to Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this focused inspection was to determine if the healthcare services provided by NHFT were now meeting the legal requirements of the above regulations, under Section 60 of the Health and Social Care Act 2008.

We do not currently rate services provided in prisons.

At this inspection we found:

- Managers had ensured that secondary dispensing was not occurring across the prison including in the segregation unit and the inpatient healthcare unit.
- Nursing staff had stopped pre signing patient medicine records before administering medicines.
- On most occasions Controlled Drugs were administered with second checking in place. Managers had processes in place to help mitigate risks where a second checker was not available.

The areas where the provider **should** make improvements are:

- Ensure that all Controlled Drugs are issued with a second checker.

Our inspection team

Our inspection was carried out by a CQC health and justice inspector with support from another CQC inspector.

Before this inspection we reviewed a range of information that we held about the service. Following the announcement of the inspection we requested additional information from the trust, which we reviewed.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff, observed medicine administration on several wings. We also observed a daily briefing meeting, reviewed systems and procedures, and sampled a range of patient clinical records.

Background to Her Majesty's Prison Whitemoor

His Majesty's Prison Whitemoor is a category A high security dispersal prison that holds around 430 men, all serving long sentences for serious offences. Northamptonshire Healthcare NHS Foundation Trust provides a range of primary healthcare services to prisoners, comparable to those found in the wider community. This includes nursing, GP, mental health, substance misuse and pharmacy services. Dental services are subcontracted. The location is registered to provide the regulated activities: treatment of disease, disorder, or injury, diagnostic and screening procedures and surgical procedures.

CQC previously inspected this location with His Majesty's Inspectorate of Prisons between the 12 – 16 December 2022. We found evidence that fundamental standards were not being met and a Requirement Notice was issued in relation to Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We subsequently asked the trust to make improvements regarding these breaches. We checked these areas, and other relevant joint recommendations, as part of this focused inspection. We found that the provider had addressed the previous breaches of regulations identified that fell within their control and remit.

The report from CQC's comprehensive inspection in December can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-whitemoor-3/

Inspected but not rated

Are services safe?

Appropriate and safe use of medicines

At our last inspection, we found that staff were secondary dispensing medicines to patients located in the segregation unit and the inpatient healthcare unit. Staff were separating individually prescribed medicines into pots and delivering them to patients at an open door or through the cell door inundation point.

During this focused inspection, we found that managers had put arrangements in place to ensure staff were no longer secondary dispensing and were providing medicines safely, and services had improved:

- The provider had responded promptly and put processes in place to safely dispense medicines for all patients located in the segregation unit, the Bridge unit (a small unit that supported prisoners to transition from segregation to the main wings) and the healthcare inpatient unit. These processes included ensuring that patients had an up to date in-possession risk assessment, which meant that where possible, patients could have their own medicines in cell. This reduced the number of patients needing to be seen by staff for medicine rounds.
- The provider now had two healthcare medicine trollies for staff to use to dispense medicines safely, this ensured medicines were also transported safely during administration. There was an up-to-date Standard Operating Procedure in place for these trollies. Staff we spoke with could talk us through the procedures for using the trollies to administer medicines. Staff were positive about the support that they got from prison staff during medicine rounds to ensure that all patient cell doors were opened.
- The Trust's secure services clinical governance group had responded to our concerns and developed policies and operating procedures that were relevant to the establishment. The head of healthcare worked with the prison estates department to ensure that these trollies could be fitted and locked to a secure wall in a safe designated area.
- The prison worked with healthcare staff to stop the movement of prisoners whilst medicines were administered, and trollies were transported.
- The Trust held meetings with the prison Governor to ensure that uniformed staff were aware of the importance of opening cell doors when giving medicines. We found that prisoners were risk assessed for having their cell door opened so that nursing staff could carry about appropriate observations in line with best practice.

At our last inspection, we found that staff were pre signing patient medicine records before administering any medicines to them. This practice was stopped during the last inspection, however we wanted assurance that this poor practice did not continue.

During this focused inspection, we found that managers had put arrangements in place to address this practice.

- During the last inspection, managers held a daily briefing where they informed staff that this practice was to stop. This has been regularly shared with staff in team meetings and through training opportunities.
- The Trust delivered workshops to all staff that administered medicines. Staff we observed and staff we spoke with had an understanding as to why this practice had been stopped.
- When staff were administering medicines in these units, they did so using a medicine trolly and had an up to date copy of individual patient prescriptions. They recorded the administration on these charts and updated electronic records promptly.

At our last inspection, we found that not all Controlled Drugs were being second checked by staff before being administered to patients.

During this focused inspection, we found that managers had put arrangements in place to address this practice.

Inspected but not rated

Are services safe?

- The Trust informed staff that all Controlled Drug medicine administration required there to be a second checker. We saw that staff had shared this message in briefings, team meetings and at training throughout the year.
- The Trust had trained additional staff such as managers and administrators in second checking. Since February 2023 these staff were used regularly to assist with medicine administration across the site. However, there were 7 occasions in the last 6 months where low staffing levels meat that there was not always a second checker available. Staff had incident reported these occasions and managers had highlighted it to the Trust, this was part of their risk register.
- Managers had carried out compliance audits against the Controlled Drugs books and found that at times staff had completed these records differently and were not always logging a second name against each entry. This process was discussed at monthly medicine management committee meetings, and with staff to ensure that they understood the process.
- Since the last inspection, staff administering medicines asked each patient for their ID card and checked the identity against the prescription, which reduced the risk for medicines errors. We saw staff followed appropriate procedures when we observed medicine administration on two wings.
- Staff on shift completed a full controlled drugs count at the start and end of each clinic. Staff checked that the records matched the prescriptions and stock. We saw that there were logs to show that all medicines were accounted for. The Trust were developing a standard process for mitigating against risks when there were limited staffing levels and second checking may be compromised.