HMP Wormwood Scrubs

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.

Overall summary

We carried out an announced focused inspection of healthcare services provided by Care UK Health & Rehabilitation Services Limited (Care UK) at HMP Wormwood Scrubs on 29 and 30 October 2018.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in July and August 2017, we found that the quality of healthcare services provided by Care UK at this location required improvement. 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 Care UK were meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment.

We do not currently rate services provided in prisons.

At this inspection we found that while some improvements had been made, medicines were not always managed safely and consistently:

- Oversight of medicines management had increased, including greater input from pharmacy technicians and further training for staff.
- Two new local operating procedures supported staff in moving and administering medicines.
- Arrangements for the safe management of medicines on the wings had generally improved, although some controlled drugs were not stored safely.
- Medicines for men who had moved or left the prison were no longer retained in wing cabinets.
- Regular stock reconciliation was now completed on every wing.
- Staff checked each patient's identity before administering medicines.
- A safe process for patients self-administering treatments was not embedded.
- Staff transported medicines around the prison securely.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- A safe process to support men self-administering medication must be fully embedded.

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

- Storage of controlled drugs should be secure to ensure safety and comply with relevant legislation.
- Local Operating Procedures should be read and signed by all staff responsible for administering medicines.
- Compliance checks of the wing treatment rooms should be routinely recorded.

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) health and justice inspector, accompanied by a second health and justice inspector.

Before this inspection we reviewed a range of information that we held about the service, including an updated action plan we had received from the provider.

During the inspection we asked the provider to share further information with us, which we reviewed. We spoke with healthcare staff, prison staff, commissioners, and people who used the service, and sampled a range of records. We also reviewed additional information supplied by the provider following the site visit.

Background to HMP Wormwood Scrubs

HMP Wormwood Scrubs is a local Category B prison in inner West London which holds up to 1279 adult males in the early stages of custody, remanded from local Magistrates and Crown Courts. The prison is operated by Her Majesty's Prison and Probation Service.

Care UK is the primary health provider at HMP Wormwood Scrubs, and is registered with the CQC to provide the following regulated activities at the location: Treatment of disease, disorder or injury, and Diagnostic and screening procedures.

Our last joint inspection with HMIP was in July and August 2017. The joint inspection report can be found at:

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

Are services safe?

Appropriate and safe use of medicines

At our last inspection, we found that medicines were not always managed safely:

- Stock medicines, medicines for minor ailments and named patient medicines were not well labelled or clearly separated which increased the likelihood of administration errors.
- Medicines for patients who had left the prison were stored with stock medicines in wing cabinets.
- There were no stock reconciliation procedures on the wings, except for out-of-hours medicines.
- All strengths of buprenorphine were seen out of their original packaging, increasing the likelihood of administration errors.
- Nurses did not always adequately check each patient's identity before administering medicines.
- Patients completed their own diabetes blood sugar test while the nurse continued to administer medicines from the treatment room. Cabinets containing medication were left open, presenting a risk of diversion or theft of stock from the cabinet.
- Staff moved medication through the prison in an unlocked trolley box, during times when men were either being escorted or unlocked on association. This presented risks around diversion and staff safety.

During this focused inspection, we found that the provider had acted to address most of the risks identified previously:

- The provider had implemented twice-yearly, comprehensive wing audits to monitor medicines management across the prison. The first audit was completed in May 2018, followed by training for all staff in areas where concerns were identified. An action plan was shared with staff, and the provider planned to display this in wing treatment rooms to improve compliance.
- Pharmacy technicians now had a greater input in management and oversight of medicines management across the prison, and provided support to other healthcare staff.
- Senior managers told us that they were now conducting regular compliance checks on the wings, although the findings of these checks were not yet being routinely recorded.
- The provider had introduced two new local operating procedures in October 2018 to set out guidelines for staff moving and administering medicines. The document detailing administration competencies was not signed by all staff who administered medicines, so it was not clear if staff had read and understood the guidance.
- Arrangements for the safe management of medicines on the wings had improved. Stock medicines, medicines for minor ailments and named patient medicines were now clearly labelled and separated, which reduced the risk of patients receiving incorrect medicines. The provider had placed 'What good looks like' posters in each treatment room to support staff in storing medicines safely.
- Medicines for men who had moved or left the prison were no longer retained in wing cabinets, and were appropriately returned to the pharmacy. Pharmacy technicians regularly monitored compliance.
- Regular stock reconciliation was currently being completed on every wing. Compliance over the last 12 months was inconsistent and the provider had recently improved monitoring, with staff now required to return stock reconciliation books to the pharmacy for regular checks, to ensure compliance.
- Buprenorphine tablets were now stored in their original packaging.
- All staff we observed checked patients' identity cards before administering medicines, which reduced risks around safety and diversion. When patients did not have identity cards, staff made appropriate checks to confirm the men's identity before administering medicines, and escalated missing identity cards to the prison.
- Staff now transported medicines around the prison in locked boxes, which reduced risks around diversion and staff safety. Staff we spoke to were aware of the correct process to follow and had read the relevant local operating procedure. Daily checks of the boxes were implemented in December 2017, although compliance had been very inconsistent. Since October 2018, the pharmacy team had improved monitoring processes and compliance had started to improve.
- The provider told us that patients now only entered treatment rooms for diabetic blood sugar tests and other treatments from 10.30am, once morning medicines administration was complete. Most staff we spoke to explained how they would manage this treatment safely.
- However, on B wing we again observed a patient completing their diabetes blood sugar test unsupervised while a nurse continued to administer medicines to other prisoners from the treatment room.

Are services safe?

Cabinets and a fridge containing medication were left open, presenting a risk of diversion or theft of stock, and risk to patient and staff safety. While senior managers addressed this specific incident during the inspection, we were not assured that a safe process was fully embedded in practice.

During this focused inspection, we also found that some new areas of medicines management that required further improvement:

- Cabinets used for storing controlled drugs in the Reception and B wing treatment rooms had missing or broken locks. Staff told us that these cabinets had not been fully secure for some months. The provider had recently ordered a replacement cabinet for B wing, and was sourcing a replacement cabinet for Reception. The provider had raised incident reports regarding both locations.
- Staff told us that they often completed controlled drugs administration on their own, which was evidenced in the controlled drug log books. This carried a risk of errors being made. Senior managers told us this was due to a combination of staff shortages, and some individuals not complying with local policy.
- On E wing, we saw evidence of Diazepam and Pregabalin not stored safely, with individual tablets taped down or reinserted back into a blister pack. This stock of Pregabalin was not recorded in the controlled drug log book, although the recording of controlled drug stock across the prison had improved.

Are services effective?

We did not inspect the effective key question at this inspection.

Are services caring?

We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive key question domain at this inspection.

Are services well-led?

We did not inspect the well-led key question at this inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Despite some improvements in the management and oversight of medicines, the systems or processes currently in place did not fully monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: We were not assured that a safe process to support patients self-administering medication was fully embedded in practice. As at our last inspection, a patient completed their diabetes blood sugar test unsupervised while a nurse continued to administer medicines to other prisoners from the same treatment room, leaving medicines storage open.