HMP Wymott

Inspection report

Wymott Prison
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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 information that we have received regarding concern around 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 not managing medicines safely at this location.

Following this inspection, the trust was served with a Section 29A warning notice as the Care Quality Commission formed the view that the quality of health care provided within this service required significant improvement. The trust was required to take immediate action to make improvements within this service.

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:

- Medicines were not managed safely within the service.
- Medicines administration points within the prison were visibly dirty and some did not have sufficient facilities for handwashing.
- We found 32 loose tablets in treatment rooms or on a medicines trolley.
- The 'task' system to request staff to take action was not robust.
- Medicines were not kept at the correct temperature.
- There was no robust process for the management of controlled drugs.
- There was a lack of governance to support the safe use of FP10 prescription forms.

Our inspection team

Our inspection team was led by a CQC inspector supported by two CQC pharmacist specialists.

How we carried out this inspection

We conducted a range of interviews with staff and accessed patient clinical records on 10 and 11 August 2022. We also had remote access to clinical patient records on 17 August 2022.

Before this inspection we reviewed a range of information that we held about the service including notifications.

During the inspection we spoke with staff including:

- Administration staff
- Cleaning contractors
- Lead pharmacist
- Head of operations
- Pharmacy technicians
- Primary care nurses
- Prison officers
- Service manager

We also spoke with NHSE commissioners and requested their feedback prior to the inspection. We spoke with numerous patients across the prison and observed morning and afternoon medicines administration.

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

- Audits relating to medicines
- Missed medicines dose reports
- GMMH Risk register
- Patient Group Directives
- Supervision matrix and appraisal compliance records.

Background to HMP Wymott

HMP Wymott is a Category C prison near Leyland, Lancashire. Wymott is operated by HM Prison Service. It is situated next to HMP Garth and provides medicines to HMP Garth.

Health services at HMP Wymott are commissioned by NHSE. The contract for the provision of healthcare services is held by Greater Manchester Mental Health (GMMH) NHS Foundation Trust. GMMH is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Inspected but not rated

Are services safe?

Appropriate and safe use of medicines

The service did not have robust systems for appropriate and safe handling of medicines.

We found that medicines administration points within the prison were visibly dirty with dust and stains on the floor. The person employed by the prison who was responsible for this had left 3 months prior to this inspection and had not been replaced. A 'weekly area/equipment cleaning checklist' had been developed by the provider (excluding the floors) had recently been implemented but we found it had not been used and so were not assured that cleaning had occurred. Not all medication administration points had hot water or sufficient water pressure. This meant that healthcare staff did not always have access to adequate hand washing facilities before and after medicines administration. Although the provider is not directly responsible for carrying out the cleaning of the floor or ensuring sufficient hot water, it does have a responsibility to ensure that the environment is fit for purpose to allow them to carry out regulated activities.

We found 24 loose tablets either on the floor or in cupboards in 5 out of 6 medicines administration points. In the medicines trolley for the segregation unit we found 8 loose tablets. This meant that we could not be assured that medicines were stored safely or that records made for the administration of medicines were accurate given the quantity of medicines we located outside of its packaging, or that people were receiving their medicines in line with the prescription.

We found a patient who had not been administered methadone prior to his transfer from the sending prison (due to being involved in an incident) had arrived at HMP Wymott at 3.20pm but was not administered his required methadone. The electronic patient record system stated this was due to the lack of availability of staff to countersign the administration of the medicine, and lack of prison officers to escort the patient for medicines administration. No welfare checks were recorded on the patient overnight. Therefore, we were not assured that medicines were administered to meet the patient's needs, or if not administered, that adequate monitoring was undertaken to ensure patient safety.

We were informed that action had been taken to address the removal of unused controlled drugs from medicines administration points. However, in one controlled drug cupboard, we found a large number of controlled drugs, one of which was dispensed in November 2021, which were no longer in use. Some of these medicines were not recorded in registers in line with the providers. policies. This meant that patients' medicines were not being appropriately recorded or destroyed.

Policies relating to controlled drugs had been ratified between 2021 and 2022, despite the provider commencing the contract in 2020. None of these policies set out adequate quality assurance processes. We were informed that regular auditing of controlled drugs had taken place, however, we found that this did not routinely occur. We also found that the printed label on a controlled drug box was different from the register and number of tablets in stock. This meant we were not assured that processes ensured the safe management and oversight of controlled drugs.

According to the provider's records, 3 paper prescriptions (FP10's) were unaccounted for and the recording process was not robust. Paper prescriptions were stored in a safe, however the safe code was not sufficiently complex given the nature of the environment. This meant we could not be assured that the provider had adequate measures in place to safely store, securely record and adequately audit FP10s prescriptions. In addition, the address on 5 of the prescriptions was incorrect. This created a risk that if used and the dispensing community pharmacy had a query, they would contact staff at another location who would have no knowledge of the prescription.

The task system (an electronic system where staff can request action be taken by other staff) on the electronic patient record was not effective. There were 1047 open pharmacy tasks on the system and 5 dated back to 2020. Of these tasks,

Inspected but not rated

Are services safe?

331 were 'red flagged' which means urgent action was required. However, ownership of tasks was unclear, meaning that tasks may have not been completed and potentially exposing patients to risk. We were not assured that the process and use of the tasks was robust and there was a risk given the large quantities of tasks remaining open that something would be missed. We were not assured that there was a robust system in place to maintain oversight and action of pharmacy tasks and scanned letters.

Two out of 3 administration staff posts were vacant, and this had created a backlog of work as a result. At the time of the inspection there were 135 letters, discharge summaries or appointment letters which had been scanned on to the electronic system, but not marked as actioned. We reviewed 17 patient records and found that letters or discharge summaries had been actioned but had not been marked as complete and so remained on the task list. This meant that it was hard for staff to see what action needed to be taken.

We could not be assured that the provider had a system in place for effectively managing unused medicines and clinical waste. We saw 16 tote boxes (boxes used by suppliers to deliver medicines to pharmacies) full of medicines waiting to be destroyed or re-used. We also found 14 green waste bins full of medicines waste awaiting collection. In the infection, prevention and control storeroom we saw approximately 45 yellow burn bins awaiting collection for destruction. These bins were not correctly closed, and date of closing was not recorded. This meant we were not assured clinical waste was managed effectively.

We observed 5 prisoners accompanied by a prison officer being brought to the pharmacy area to collect the confidential waste. The confidential waste was in clear bags and contained empty medicines boxes which still had the patient label on them. The prisoners were supervised by an officer; however, the pharmacy was fully operational and open when the prisoners passed through. No risk assessment was in place for this. This meant that confidentiality of patients was compromised, and the pharmacy area was not securely closed when prisoners passed through.

Non-controlled drugs medicines were transported around the prison in various sized black suitcases. Although risk assessments were in place for this, they did not consider the implications for staff of transporting them including carrying them up several flights of stairs.

We found that the process for keeping medicines which required fridge storage was not robust. For example, we observed medicines arriving at the prison from the wholesaler which had been kept cold. However, when they were transferred from the prison gate to the pharmacy they were not maintained at the required temperature. This was also the case for medication being taken from HMP Wymott to other locations. We found that these medicines were warm to touch on arrival and the lack of cold chain which risked the efficacy of the medicine.

We found that processes to monitor the safe storage of medicines were ineffective. Fridge temperatures were not recorded daily and were not always within the necessary range which may have affected the efficacy of the medication. For example, we identified that a fridge used to store medicines had potentially been out of range since 28 July 2022 with a maximum temperature recorded of 17.4C, and a second fridge also used to store medicines had potentially been out of range since 29 June 2022 with a maximum temperature recorded of 16.9C.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not assured the proper and safe management of medicines. Enforcement action we took: A Section 29A warning notice was issued. The trust was required to take immediate action to make improvements within this service.