HMP Onley

Inspection report

Onley
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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
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out a focussed announced inspection of healthcare services provided by Practice Plus Group Health and Rehabilitation Services (PPG) at HMP Onley. PPG took over the contract from the previous provider following a joint inspection of the service with His Majesty's Inspectorate of Prisons inspection (HMIP) in June 2022. We undertook a focussed inspection on 31 October 2023 and found the quality of healthcare at this location required improvement. We issued Requirement Notices in relation to Regulation 12, Safe care and treatment and Regulation 17, Good governance to the previous provider.

The purpose of this inspection was to determine if the provider was 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 for the areas which were previously non-compliant.

At this inspection we found that some improvements had been made, however we found that improvements were required for the safe management of medicines and served a requirement notice.

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:

- Staffing levels within the mental health team were safe and patients were being seen promptly and care plans were comprehensive.
- Improvements had been made in some areas of medicines management, however, we found delays in the provision of medicines supplies to patients.
- Medicines policies did not always reflect the practice at this location.

The provider must:

- Ensure that patients receive medicines safely and in a timely way.
- Ensure that medicines policies are updated and reflect the practice expected at this location.

Our inspection team

Our inspection team was comprised of two CQC health and justice inspectors and one CQC medicines optimisation inspector.

How we carried out this inspection

We conducted interviews with staff and the head of healthcare and accessed patient clinical records between 8 and 12 April 2024. We also looked at waiting lists for mental health services.

Before this inspection we reviewed a range of information that we held about the service including notifications and action plan updates. Following the announcement of the inspection we requested additional information from PPG which we reviewed. Documents we reviewed included:

- Meeting minutes
- Medicines policies and incident reports
- Information relating to recruitment and a staffing profile
- Staff rotas
- The provider's action plan submitted after the previous inspection.

Background to HMP Onley

HMP Onley is a Category C training and resettlement prison which accommodates up to 742 men with varying sentences. The prison is located in a rural area near Rugby and is operated by His Majesty's Prison and Probation Service.

Health services at HMP Onley are commissioned by NHS England. The contract for the provision of healthcare services is held by PPG, who took over service provision after the last inspection. PPG is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with HMIP in June 2022 and published on the HMIP website in September 2022. We found a breach of Regulation 12, Safe care and treatment and Regulation 17, Good governance and issued requirement notices to the previous healthcare provider.

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/09/Onley-web-2022.pdf

Inspected but not rated

Are services safe?

Safe and effective staffing

There are appropriate staffing levels and skill mix to make sure people receive consistently safe, good quality care that meets their needs.

At the last inspection, staffing in the mental health team was not sufficient to meet the needs of the population. PPG had made good progress with recruitment and had long term agency providing cover until all newly recruited staff were in post. Prison vetting was taking too long which delayed the provider's ability to progress promptly. There was a lead mental health nurse, supported by agency nurses as well as an art therapist; one of the nurses had recently completed their advanced practitioner training which meant they would be able to assess more complex patients and prescribe some medicines when required.

Between 11 September and 22 October 2023 there were 18 days where there was only one mental health nurse on duty, and 6 days where there were no mental health nurses available. There were 2 substantive and 1 agency mental health nurse which meant there was little resilience to cover for sickness and annual leave. There was a clinical lead for the mental health team, as well as an art therapist and 2 learning disability nurses who each worked 2 days per week at HMP Onley.

Medicines optimisation

Medicines were prescribed by doctors and nurse prescribers employed by the prison. Pharmacy staff arranged for prescriptions to be processed off site. Medicines supplies were delivered to the prison by the pharmacy contractor. Medicines reconciliation was undertaken by pharmacy technicians following initial reception screening and prescribing was tasked to prison clinicians. Staff had prescriptions which they could use out of hours to access medicines supplies in an emergency. Systems to ensure oversight of controlled drugs were in place.

The medicines storage areas that we visited were clean, had access to handwashing facilities and access to hot and cold water. Medicines were stored safely and securely.

At the last inspection, a pharmacist had been recently recruited with a plan to enable patients to see them via an appointment system. At this inspection, that pharmacist had left the organisation and a new pharmacist had been recruited. At the time of this inspection, they were undergoing induction and therefore it was likely to be some time before the full pharmacy service would be functional.

At the last inspection, we saw several fridge and room temperature readings that were outside of the recommended ranges. Staff had not taken any action to safeguard the medicines being stored. At this inspection we saw that when temperature readings were outside of the recommended range, staff took action to safeguard medicines supplies.

At the last inspection, random cell checks had not been implemented since they were stopped during the COVID 19 pandemic. At this inspection, staff told us that random cell checks had now been reinstated.

At the last inspection, we found that equipment to monitor blood sugar levels was not being managed appropriately. At this inspection, we saw records showing that staff had been completing regular checks on equipment used to monitor blood sugar levels.

Inspected but not rated

Are services safe?

At the last inspection, medicines policies were under review as they were not always service specific. At this inspection, the medicines policy had expired and was in the process of being reviewed and updated. We also noted that the emergency response policy states that injectable naloxone should be used. Staff at this site were not trained to give injectable naloxone and used the nasal preparation instead, however, this was not reflected in the organisational policies. The provider was aware of this and was taking steps to update the policy.

At this inspection, we saw evidence of delays in patients being provided with their medicines. There was a backlog of tasks on the electronic system where repeat prescriptions and medicines requiring review had been requested in advance of need, but not processed in a timely manner. There were also occasions when the prison had no prescribers available to process prescription requests. In addition to this, when medicines are requested, they are processed by an off-site pharmacy dispensary, and sent to HMP Onley within 24 – 48 hours which also prolongs the time it takes for medicines to be given to patients. Patients were sometimes left without their medicines for numerous days and sometimes weeks, placing patients at risk of harm. There had also been several complaints made by patients relating to medicines delays.

One patient complained that due to missing a dose of their medicine's substance misuse medication, they had started experiencing withdrawal symptoms. Another patient went without their antidepressant medicines for at least 27 days. One patient was without their antipsychotic medicine and their medicine for the treatment of attention deficit hyperactivity disorder for at least 12 days. One patient came to the prison without any medicines supplies and was without their medicines for at least 15 days. This included a medicine for the treatment of suspected breast cancer as well as their medicines for asthma. One patient missed at least 8 days of their antidepressant medicine. Two patients missed at least 5 days of their antidepressant medicines. One patient missed at least 4 days of both their antipsychotic medicines and their antidepressant medication.

There is a risk of treatment failure if medicines are stopped unintentionally. Antidepressants and antipsychotics should not be stopped abruptly due to the risk of patients experiencing withdrawal symptoms. Patients with asthma should have access to their medicines to minimise the risks associated with the exacerbation of their asthma.

Inspected but not rated

Are services responsive to people's needs?

Equity in access

At the last inspection we found that patients requiring routine mental health support did not always receive this in a timely way. Triage assessments were taking longer than the 5 day target which meant there was a risk that the patient's mental health could deteriorate in the meantime. At this inspection we found that patients were triaged promptly and there was no waiting list to be assessed.

At the last inspection patients that were on the caseload of a mental health nurse were not always seen in line with their care plan. Two patients had not been seen in the 6 to 8 week period since their triage assessment and had no care plan in place. During this inspection we found that patients were seen in line with their care plan.

Inspected but not rated

Are services well-led?

Governance, management and sustainability

At the last inspection we found that patients on the mental health team's caseload were assigned to a member of the team who assumed responsibility for their ongoing care and reviews. However, oversight of the caseloads wasn't sufficient as we saw that not all patients were seen in line with the frequency stated in their care plan. Some patients did not have a plan of care in place at all. At this inspection we found that management had developed an action plan to address the poor level of care patients received and that significant improvement had been made. Patients were seen and assessed regularly with good quality care plans in place.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not always managed in a safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.