HMP Chelmsford

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
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out an announced focused inspection of healthcare services provided by Health Care Resourcing Group (HCRG) Medical Services Limited at HMP Chelmsford on 10 August 2022 and between 15 and 17 August 2022.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in August 2021, we found that the quality of healthcare provided by HCRG Medical Services Limited at this location required improvement. We issued *a Requirement Notice in relation to Regulation 12, Safe Care and Treatment and Regulation 17, Good governance, 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 were meeting the legal requirements of the Requirement Notices that we issued in November 2021and to find out if patients were receiving safe care and treatment. At this inspection we found that some improvements had been made, however the provider continued to be in breach of the regulations and more work was needed.

We do not currently rate services provided in prisons.

At this inspection we found:

- Staff had not assessed risks to patients or developed adequate care plans.
- Medicines administration was not managed well for patients on the enhanced care unit. Staff did not always record sufficient detail when patients were not administered their medication in line with their prescription.
- Multidisciplinary meetings for patients on the enhanced care unit were not held regularly and staff had not adequately considered for the risks to patients who lacked capacity to make decisions for themselves.
- The service had enough pharmacy staff on the wings (prison wings are where the general prison population are housed) to ensure patients received their medication.
- Staff treated patients with compassion and kindness and respected their privacy and dignity.
- Managers were supportive of staff and provided clinical support when required.
- Significant improvement had been made to medicines reviews, with 98% of all prisoners now having a review within 72 hours of arriving.

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

- The provider must ensure staff develop suitable risk assessments and care plans for patients in relation to their healthcare treatment needs.
- The provider must ensure that there are effective processes in place so that patients are administered essential medication as prescribed.
- The provider must ensure that when medicines are not administered to a patient, a narrative explanation is recorded.
- The provider must ensure that patients who lack capacity to make decisions about their care have a best interest meeting and specific decisions made on their behalf.
- The provider must ensure that patients with complex healthcare needs are discussed regularly at multi-disciplinary team meetings.

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

- The provider should ensure that guidance on the administration of controlled drugs is reviewed and updated and that staff comply with the provider's guidance.

Our inspection team

Our inspection team was led by a CQC inspector with support from a pharmacist inspector as well as an HMIP healthcare inspector.

Before this inspection we reviewed a range of information provided by the service including the requirement notice action plan, meeting minutes, medication policies, management information, as well as medication records for some patients.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff, prison staff, people who used the service, and sampled a range of records.

Background to HMP Chelmsford

HMP & YOI Chelmsford is a local Category B male adult and young offenders' institution. The prison is in the city of Chelmsford, England and accommodates up to 745 adult prisoners and young offenders. The prison is operated by Her Majesty's Prison and Probation Service.

HRCG Medical Services Limited is the health provider at HMP & YOI Chelmsford. The provider 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 August 2021. The joint inspection report can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/11/Chelmsford-web-2021.pdf

Inspected but not rated

Are services safe?

Risks to patients

At this inspection, we found that staff had not completed adequate risk assessments for each patient in relation to their medication or food refusal. We identified two patients on the enhanced care unit (ECU) who were refusing to take their medication, with one also documented as refusing their food. Staff had documented that both patients lacked capacity to make decisions about their medication. Adequate risk assessments had not been completed for either patient. This meant that patients were going without their medication and an adequate assessment of how this impacted on both their physical and mental health.

Appropriate and safe use of medicines

The service used systems and processes to safely prescribe and administer medication for patients across most of the prison. However, systems and processes to administer medicines for patients on the enhanced care unit were not safe.

At our last inspection we found there were delays in the prescribing and supply of some routine medicines, and that staff were not always consistent in how they reported medicine administration. During this inspection we found that there had been improvements in the administration of medicines for patients across the prison with exception of the ECU. There were processes in place to ensure these patients received their medication. New prescriptions and orders were also placed in a timely manner. However, we found that medicines were not always administered for patients on the ECU. In some instances, medications had not been ordered in advance to ensure there were no gaps in the administration of medication. We reviewed medication for all patients on the ECU and found that four patients had not been administered their medication as prescribed. Two patients had several missed doses of essential medication due to delays in new prescriptions starting, medication unavailable, or unable to administer. On occasion, there was no documented reason as to why these patients had not received their medication.

A multi-disciplinary team had not regularly reviewed patients who lacked capacity and refused to consent to take their medication. We identified two patients on the ECU who staff had recorded as lacking capacity. There was no evidence of multi-disciplinary oversight on the impact to the patient's health and well-being for each individual medication, potential for deterioration or what staff could do to better support the patients.

At the last inspection, we found that staff had not always recorded sufficient detail when patients were not administered their prescribed medication. During this inspection we found insufficient improvements. For medication administered to patients in May, June and July 2022, 122 were recorded as 'unable to administer', 127 as 'unavailable', 147 as 'missed', 45 as 'other'. There was no clear detail recorded as to why patients had not received their medication. The lead pharmacist informed us they were aware and planned to take action to address this.

At the last inspection we found that controlled drugs administered to patients had not consistently been signed by a second checker. During this inspection we found that staff had not always complied with the provider's policy to use a second checker for administering controlled drugs.

A record should be made in the controlled register for all schedule 2 controlled drugs which must be signed by the person making the entry and another suitably trained person as a witness. Schedule 3 controlled drugs are not required by law to be recorded in the controlled drug register. HCRG did not have a specific policy for the administration of controlled drugs, so staff followed a controlled drug competence framework. This stated that a secondary signature was required for the

administration of all controlled drugs, and did not distinguish between the different schedules of drugs. We found several examples on C wing and the ECU where a second signatory had not been obtained for schedule 3 controlled drugs in accordance with the provider's own guidance. We discussed this with the head of healthcare who confirmed a prompt review of staff practice and the provider's local guidance would take place.

Staffing

At the last inspection we found there were insufficient pharmacy staff to safely administer medication. During this inspection the registered manager confirmed that the pharmacy team had been reprofiled with support from additional pharmacy technicians to support administering medication on the main wings.

The service had enough pharmacy staff to ensure patients were administered their medication. Managers regularly reviewed and adjusted staffing levels and skill mix, and used bank and agency staff as well as resources from other teams where required. We found that where required second checkers were used and staff from different disciplines worked together to ensure patients were administered their medication as prescribed. The service also used bank and agency staff when required. The ECU did not use members of the pharmacy team to administer medication, and instead medicines were administered by nursing staff.

Inspected but not rated

Are services effective?

Effective needs assessment, care and treatment

Staff had not consistently planned and delivered high quality care in line with best practice and national guidance. During our inspection, we identified two patients on the ECU who refused medication and were recorded as lacking capacity to consent. Staff had not developed adequate care plans to ensure they were supported appropriately.

Nutrition and hydration

Prison staff were responsible for providing patients with food and drink. However, we identified one patient who regularly refused food and drink. Healthcare? staff had documented significant weight loss for this patient and recorded that they were at risk of malnutrition and dehydration but had failed to act on their concerns.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not consistently work together as a team to benefit patients. Staff did not hold regular and effective multidisciplinary (MDT) meetings to discuss patients on the ECU, including some with complex physical and mental health needs. During this focused inspection, we found that staff had not considered patients' best interests when they lacked capacity to make decisions for themselves. Multidisciplinary meetings had taken place for both patients on the ECU. A series of MDTs had taken place in July and August for one patient, the second patient who had complex health needs had been subject to discussion at MDT on 11 August 2022 as well as in April. Meetings held for both patients lacked detail around the impact of not taking their medication. Different options to support the patients with their medication were not considered. This patient was recorded as consistently refusing medication since at least 02 August 2022 and on 12 August 2022 staff had documented in his records that he was refusing all medication due to lack of capacity and potentially causing harm to himself. It was further documented to monitor his capacity and whether he could make decisions for himself, but this had not been undertaken with the multi-disciplinary team. Best interest meetings had not been held for either patient. We discussed this with the head of healthcare who promptly put into place a weekly MDT meeting for all patients on the ECU.

Consent to care and treatment

When staff assessed patients as not having capacity, they did not always make decisions in the best interest of patients or consider the patient's history. During our inspection we identified two patients who regularly refused their medication. Staff had not held best interest meetings to discuss what action could be taken to support these patients. Both patients had complex physical and mental health needs. It was not clear how staff were supporting these patients to identity how their health was being affected by medication refusal, what impact this may have and what they could do to support these patients to ensure they were not disadvantaged compared to patients who had capacity.

Inspected but not rated

Are services caring?

During this focused inspection, we found that staff were kind to patients and treated them with compassion.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Patients we spoke with told us that healthcare staff treated them well and behaved kindly. We also observed positive interactions between staff and patients, both on the wings and with patients on the ECU. One patient told us that the head of healthcare had visited him during a recent hospital admission.

Inspected but not rated

Are services well-led?

Leadership

Leaders had developed positive working relationships within the service. They were visible in the service and approachable for patients and staff. We saw evidence of positive working relationships between the provider and other healthcare services, as well as with prison staff. Representatives from healthcare attended a range of prison meetings and this was reciprocated with an effective lead in the prison promoting healthcare services to patients.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear. Staff told us that managers were supportive and had made lots of positive changes to improve healthcare for patients, including increasing staff numbers. Staff reported that managers always took the time to listen to them and that they felt comfortable discussing any concerns they had. They also told us that managers would step in to help with clinical taks when needed.

Governance arrangements

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not always managed well.

At our last inspection, there was no information available to report how many prisoners had a medicines review within 72 hours of their arrival. During this inspection we found that a report had been developed and that 98% of all prisoners had a medicines review within 72 hours of their arrival.

At our last inspection we found that governance arrangements to ensure the safe management of prescriptions were not adequate. During this inspection we found that prescriptions were stored in a safe and there was a clear log of serial numbers and details of who prescriptions had been allocated to.

At our last inspection we found that there were limited processes in place to ensure staff knew how to accurately complete patient records for administration. During this inspection, we found similar concerns and that some improvements were still being embedded. However, the lead pharmacist was taking steps to ensure staff provided a suitable narrative explanation when patients did not receive their medication. Pharmacy staff on the wings told us that they maintained a list of all patients who missed medication each day and that they chased them up to ensure they received their medication.

Patients who lacked capacity or had complex health needs were not discussed at MDT meetings, and best interest meetings had not been held where appropriate. During our inspection there were 10 patients on the ECU, including some with complex mental and physical health needs. Regular MDTs had not been held to discuss these patients. Staff had recorded that two patients lacked capacity to consent to treatment and were consistently refusing their medication, which meant they were not taking vital prescribed medication. However, best interest meetings had not been held for these patients which placed them at increased risk for their physical and mental wellbeing.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found you had failed to operate effective systems or processes to ensure compliance with the requirements of the regulations as you had failed to ensure there was oversight of the safe care and treatment of service users who missed or refused medication and for service users recorded as lacking capacity there is no evidence that best interests had been considered and there was minimal multidisciplinary oversight or suitable actions taken.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found you had failed to ensure safe care and treatment was provided to all service users. We found that some service users were not administered medication in accordance with their prescription. We also found that some service users' records indicated that they were not administered their medicines and there was not a clear reason documented.