HMP Belmarsh and HMP Thameside (healthcare)

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 summary

We carried out an announced focused inspection of healthcare services provided by Oxleas NHS Foundation Trust at HMP Thameside on 1 and 2 May 2019.

Following our last focused inspection in August 2018, we found that the quality of healthcare provided by the trust at this location required improvement. We issued a Requirement Notice in relation to 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 by the trust were meeting the legal requirements of the Requirement Notices that we issued in December 2018 and to find out if patients were receiving safe care and treatment. At this inspection we found that improvements had been made and the provider was not found to be in breach of the regulations.

We do not currently rate services provided in prisons.

At this inspection we found that:

- Systems for monitoring storage temperatures of medicines were now effective.
- Systems for checking items stored in the main emergency bags were now effective, although some out of date items were found in the small grab bags.
- Oversight and management of patients with long-term health conditions had mostly improved, including the development of care planning.
- Oversight and management of tasks on the SystmOne electronic clinical recording system had improved.

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

- The provider should ensure that patients with diagnosed long-term health conditions such as epilepsy and diabetes have a personalised care plan in place.
- The provider should implement a system to routinely check items in the small grab bags.

Our inspection team

Our inspection was completed by two CQC health and justice inspectors.

Before this focused inspection we reviewed a range of information that we held about the service, including action plans we had received from the provider in response to the Requirement Notices issued in December 2018.

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

Background to HMP Belmarsh and HMP Thameside (healthcare)

HMP Thameside is a local category B prison in South East London that holds up to 1,232 convicted and remanded men. The prison is operated by Serco and is situated next to HMP Belmarsh and HMP Isis.

Oxleas NHS Foundation Trust is the health provider at HMP Thameside. The trust is registered to provide the following regulated activities at the location: Treatment of disease, disorder or injury, Diagnostic and screening procedures, and Personal care.

Our last joint inspection was in August 2018. During this inspection, we found evidence that fundamental standards were not being met and issued a Requirement Notice in December 2018 in relation to Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The inspection report can be found at: https://www.cqc.org.uk/location/RPGHR

Are services safe?

Medicines management

At our last inspection, we found that systems for monitoring storage temperatures of medicines were not always effective in ensuring their suitability for use. Staff did not consistently monitor room and fridge temperatures and did not always appropriately escalate concerns for review by the pharmacy team. Some medication had been disposed of by staff because of unsafe storage.

During this focused inspection, we found that systems for monitoring storage temperatures of medicines were now effective and embedded into practice:

- Staff now recorded fridge and room temperatures consistently on standardised forms in treatment rooms across the prison. Records we reviewed from January to April 2019 showed evidence of routine daily recordings.
- Staff were required to report fridge and room temperature readings to managers at a daily healthcare handover meeting.
- Staff we spoke with knew how to report and escalate concerns when temperatures were out of range.
- The provider had implemented a standard operating procedure to support staff with the safe management and storage of medication.
- The pharmacy team conducted unannounced spot-checks and monthly audits of temperature recordings to ensure compliance.
- The provider had worked with the prison to improve the environment for storing medicines safely by replacing faulty fridges, and by installing five air cooling units in treatment rooms.

Safety systems and processes

At our last inspection, we found that the systems for checking items stored in emergency bags were not fully effective. Staff did not complete, or record emergency bag checks consistently, and we found emergency medicines that had expired. There was no effective system in place to monitor whether emergency bag checks were being completed.

During this focused inspection, we found that the systems for recording and monitoring the contents of emergency bags had improved:

- Staff now completed and recorded emergency bag checks consistently across the prison. Records we reviewed from December 2018 to March 2019 showed evidence of routine checks, including a full weekly content check. Emergency response bags that we opened contained all documented equipment and emergency medicines were in date.
- The provider had consulted with the GP and introduced a standardised form to record emergency bag contents. This was present in all emergency bags that we reviewed across the prison.
- Staff were required to confirm emergency bag checks to managers at a daily healthcare handover meeting.
- The primary care lead nurse conducted a bi-monthly audit and intermittent spot checks to monitor compliance with emergency bag checks. Findings from the audit were reviewed at monthly management meetings, and themes for improvement shared with staff.
- Small emergency grab bags located in the treatment rooms, which nurses used for non-critical treatment including minor injuries, contained some out of date items including saline solution and dressings. The provider told us they planned to introduce a checklist to regularly monitor the contents of these bags, although we were unable to test the effectiveness of this.

Are services effective?

Coordinating care and treatment

At our last inspection, we found that the management of patients with long-term health conditions was underdeveloped and not systematic. Many patients requiring treatment for long-term health conditions and wound care did not have individualised care plans in place to inform their on-going care, and were not sufficiently monitored to ensure the care and treatment they received met their needs.

During this focused inspection, we found that oversight and management of patients with long-term health conditions was improving, including the development of care planning:

- A lead nurse monitored long-term health conditions weekly through the national Quality and Outcomes Framework (QOF, a framework originating in GP practices to monitor the management of patients with long-term conditions) and conducted daily reviews of newly-arrived prisoners to identify need.
- The lead nurse ran three dedicated clinics each week to review men with long-term health conditions. Although patients could not always attend scheduled appointments owing to prison access issues, the nurse followed these patients up by telephone.
- Training was starting for primary care staff on long-term health condition management and care planning. Progress was limited at the time of our inspection and this needed further development to support the lead nurse in managing patients.
- Out of 10 diabetic patients we reviewed, eight had care plans in place. These care plans were personalised and evidenced discussion with the patient about their preferences. This was an improvement on our previous inspection findings.
- Out of 30 patients that we reviewed who were recorded as having epilepsy, only seven had a formal diagnosis indicated in their clinical record and only two had a current care plan. This indicated that further work was required to maintain an accurate register of patients with long-term health conditions. However, all seven patients were either on the waiting list for, or booked into, the long-term health condition clinic for a review.
- Patients requiring wound care now had care plans in place based on a trust-wide template to encourage consistent recording, and we saw evidence of effective treatment in the care records we reviewed.
- The provider had recently introduced monthly audits to monitor and improve the quality of care plans for long-term health conditions.

Are services caring?

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

Are services responsive to people's needs?

Timely access to care and treatment

At our last inspection, we found that the number of outstanding tasks (prompts for staff to take

action regarding a patient) on SystmOne had increased significantly, including some urgent requests which were not dealt with promptly. This increased the risk that patients' immediate health needs may not be met.

During this focused inspection, we found that management of tasks on the SystmOne electronic clinical recording system had improved:

- The total number of overdue tasks on SystmOne had reduced significantly since our last inspection, from 855 to 196. At least 52 overdue tasks were historic and required cleansing. The provider was unable to cleanse these tasks and had escalated this to the system owner.
- Tasks were generally actioned quickly; the majority of outstanding tasks had been added less than four days prior to our inspection, and there were no urgent tasks over two days old.
- The primary care lead nurse periodically reviewed and allocated tasks across the team to action, and task numbers were reviewed daily at the healthcare handover meeting.

Are services well-led?

Governance arrangements

At our last inspection, we found that there was a lack of positive action being taken to address concerns around overdue tasks on SystmOne, the management of long-term health conditions, monitoring medicines storage and emergency bags. We were not assured that governance

systems sufficient to assess, monitor and improve the quality and safety of the service.

During this focused inspection, we found that the provider had acted to improve governance of the service:

- Service managers now periodically reviewed overdue tasks on SystmOne. The provider produced a weekly dashboard including details of outstanding tasks which was used to monitor performance and inform staff action to address any concerns.
- We found evidence that managers had improved oversight of medicines storage and emergency bags by introducing standardised recording, regular audits and increased oversight at daily meetings.
- The provider had started to develop staff to better manage long-term health conditions and audit care plans to monitor quality, although this required further development to ensure care met patients' needs.