HMP Belmarsh and HMP Thameside (healthcare)

Inspection report

Western Way
Thamesmead
London
SE28 0EB
Tel: 02083314400

Date of inspection visit: 09, 12, 15 and 19 May 2023
Date of publication: 06/06/2023

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**

Overall summary

We carried out an announced focused inspection of healthcare services provided by Oxleas NHS Foundation Trust, remotely on 09,12,16 and 17 May 2023.

Following our joint inspection with HM Inspectorate of Prisons (HMIP) in November 2021 we found that the quality of healthcare provided by Oxleas NHS Foundation Trust at HMP Thameside required improvement. We issued a Requirement Notice in relation to Regulation 12, Safe Care and Treatment and Regulation 16, Complaints, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In December 2022 we followed up the concerns reported in the requirement notice and found that they had not been met. We reissued the requirement notices.

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 2021 and subsequently in December 2022 and to find out if patients were receiving safe care and treatment. At this inspection we found that improvements had been made and that concerns had either been fully addressed or significant improvement had been made.

We do not currently rate services provided in prisons.

At this inspection we found:

- Systems and processes to administer medicines for patients had improved. Patients who had missed doses of medicines were followed up and either subsequently received their prescribed medication or there was adequate justification why they were missed. We found the systems for managing medicines reconciliation had improved, although due to staffing shortages this did not happen consistently. Quality control checks for the blood glucose monitor were completed regularly, although when results were out of range, staff did not escalate this issue.
- Complaints were responded to consistently. Staff had responded to the complaints in full or ensured that concerns raised were investigated and acted on. Staff informed the patient how to escalate concerns if they remained dissatisfied with the response. However, we noted that there was no process in place to respond to complainants who had been transferred or released.

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

- The provider should ensure that medicines reconciliation checks are undertaken for all patients in a timely manner and that when blood glucose quality control check results are out of range, this is escalated in line with policy.
- The provider should ensure there is a process in place to respond to complainants who have been released or transferred.

Our inspection team

Our inspection team was led by a CQC inspector with support from one CQC pharmacist inspector.

This inspection was carried out remotely. During this inspection we reviewed a range of information provided by the service including the requirement notice action plan, meeting minutes, policies, management information, complaint responses as well as medicines records for some patients.

Background to HMP Belmarsh and HMP Thameside (healthcare)

HMP Thameside is a local/reception category B establishment. The prison is located within Thamesmead, Greenwich, England and accommodates up to 1232 male adult prisoners. The prison is privately run by Serco.

Oxleas NHS Foundation Trust is the healthcare provider at HMP Thameside. 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 November 2021. The joint inspection report can be found at:

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

Inspected but not rated

Are services safe?

Appropriate and safe use of medicines

At the last inspection, we found that systems for managing repeat prescriptions were not effective. At this inspection, we did not see any missed doses because of poor management of repeat prescriptions. A training programme was being delivered to staff which ensured staff were aware of the policies and measures to follow to minimise the risk of missed doses.

At the last inspection, the provider was aware that systems for managing medicines reconciliation (the process of accurately listing a prisoner's medicines they were taking at home and comparing it to what is currently prescribed) were not effective. The key performance indicator for this area was not being met. An action plan was implemented to drive improvement in this area, which included recruiting more pharmacy staff who would be dedicated to completing medicines reconciliation. At this inspection, we saw that the completion of medicines reconciliation continued to be an issue. Out of 15 medical records that we reviewed, 7 prisoners had a medicines reconciliation recorded, and 8 prisoners did not. The provider told us that pharmacy staffing shortages were continuing to impact on the completion of medicines reconciliation. The provider had oversight of this and was in the process of trying to recruit more pharmacy staff who would be able to assist in this area.

At the last inspection, we identified that whilst some emergency equipment bags were safely stored in the healthcare dispensing offices, one bag was stored in a communal area and therefore easily accessible to officers and prisoners. This meant they could access medicines and sharp implements. At this inspection, we were told that the emergency bag had been relocated to a locked area where temperatures were monitored. Prison staff would have to contact healthcare staff to access the emergency bag if required. The resuscitation officer for the organisation was involved in the decision making and had considered the minimal number of incidents that had required the use of the emergency bag.

At the last inspection, we found that equipment to monitor blood sugar levels was not being managed appropriately. This meant that the provider could not be assured that blood glucose readings were accurate. At this inspection, we saw some improvement in this area in that the provider had implemented regular blood glucose quality control checks as part of the emergency checklist. The blood glucose quality control checks were satisfactory. However, when the monitors were tested, results were out of range, staff did not always escalate the issue appropriately. This meant that there was no assurance that ketone readings from the blood glucose monitor were accurate.

Inspected but not rated

Are services responsive to people's needs?

Complaints

The system in place to receive and respond to complaints was effective. At the last inspection we found that complaints were not always investigated or responded to appropriately and that patients who made a complaint were not always informed of how to escalate their concerns if they were dissatisfied with the response. We also identified that some patient complaints had been logged as queries.

During this inspection we found that staff involved in responding to complaints had received additional training. Managers also undertook regular audits of the complaints and responses. There was a total of 91 complaints and queries had been logged in March, April and May 2023 up to the first day of inspection. We found that staff logged the complaint or query appropriately and that complaint responses were much improved and responded to promptly. The complainants were informed of how to escalate their concerns in all cases.

The provider had drafted new procedures locally and for the prison healthcare group as a whole, these were rolled out in January 2023. We found that complaints guidance was adequate, although there was no process in place to respond to complainants who had been released or transferred.

There was oversight of complaints at the monthly Clinical Governance meetings.