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 well-led?	**Inspected but not rated**

Overall summary

We carried out an announced focused follow up inspection of healthcare services provided by HCRG Medical Services Limited at HMP Chelmsford on 24 October 2022.

Following our last focused inspection on the 15 - 17 August 2022, where we found that the quality of healthcare provided by HCRG Medical Services Limited at this location required improvement. We issued *a* Warning 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 Warning Notices that we issued in August 2022 and to find out if patients were receiving safe care and treatment. At this inspection we found that significant improvements had been made and the provider was now complying with all regulations.

We do not currently rate services provided in prisons.

At this inspection we found:

- Staff had assessed risks to patients and developed risk assessments in line with patient care plans.
- Medicines administration was managed well for all patients across the prison and on the enhanced care unit (ECU).
- All patients had been administered medicines in accordance with their prescription.
- Multidisciplinary meetings for patients on the enhanced care unit (ECU) were held regularly and staff had held best interest meetings for patients who lacked capacity to make decisions for themselves.
- Leaders had continued to develop positive working relationships within the service and the wider prison.

Our inspection team

Our inspection team was led by a CQC health and justice inspector with support from another health and justice inspector and a Mental Health Act inspector supporting remotely.

Before this inspection we reviewed a range of information provided by the service including the warning notice and the provider's action plan, meeting minutes, medication policies, management information and audits.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff 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 located in the city of Chelmsford, England and accommodates up to 745 adult prisoners and young offenders. The prison is operated by HM 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 HM Inspectorate of Prisons was in August 2022. The joint inspection report can be found at:

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

The last CQC inspection report can be found at:

https://www.cqc.org.uk/location/1-10054240305

Inspected but not rated

Are services safe?

Risks to patients

At our last inspection staff had not completed adequate risk assessments for two patients on the enhanced care unit. The enhanced care unit (ECU) is a 12 bed unit run by the prison with arrangements for healthcare staff to administer medication to patients in accordance with their prescription. Staff had documented that two patients lacked capacity in relation to making decisions about their medicines and /or food refusal but did not review or risk assess how this impacted on their physical health. Staff did not regularly review the effects on patients who lacked capacity and refused to consent to treatment.

At this inspection we saw there was a proactive approach to anticipating and managing risks to people who use the service. There was a standard operating procedure in place for 'refusal of treatment' which staff followed. We reviewed a patient record where a patient lacked capacity and regularly refused to take their medication. Staff had completed a risk assessment which outlined the risks identified to this patient by not taking their medicines and how they could reduce those risks. We saw that the provider had considered arranging a best interest decision meeting where possible and had involved a family member so that the patient's care and treatment could be planned with the patient's wishes and preferences in mind. We found staff had documented how the patient would be monitored and supported. We saw clear explanations as to why a patient had lost weight and records where staff had monitored the patient's weight, nutrition and hydration to assist with reviewing the ongoing effects from the patient refusing treatment.

We reviewed partnership board meeting minutes which showed staff reported all safeguarding issues from patients situated in the ECU to commissioners. Managers also discussed patient care with prison staff so that they could assist with monitoring the patient. We saw examples where the provider sought relevant historical information about a patient from other professionals in the community hospital.

At the time of inspection there were two patients on the ECU who had been assessed as having capacity but refused to take their medication. We saw staff had identified the risks of this and explained these to the patients as well as developing care plans for treating any long-term conditions and health needs. The new standard operating procedure set out patients' right to refuse treatment and offered guidance to staff as to how they could still support and encourage the patient to engage in treatment.

Appropriate and safe use of medicines

At our last inspection we found systems and processes to administer medicines for patients on the enhanced care unit were not safe. There were delays in the prescribing and/or the supply of some routine medicines, staff were not always consistent in how they reported medicine administration.

At this inspection we identified staff in the pharmacy met good practice and standards in line with national guidance. Managers had developed guidance for staff for the administration of medicines across the site including the ECU. There was now a pharmacy technician responsible for each location in the prison.

We found that the nursing staff were able to administer medicines for those patients on the enhanced care unit as patient medicines were stored there and checked daily. We reviewed medicine administration for all the patients in the ECU and found that they all had been given or offered medicines in line with their prescription.

Pharmacy technicians followed a new Standard Operating Procedure for recording medicine administration. There were six indicators for staff to use which showed why patients had or had not been given their medicines. We saw where staff had selected a reason as to why a patient had missed medication and then recorded an entry in the patient notes to

Inspected but not rated

Are services safe?

describe the reasons in more detail, such as, 'patient went to the gym' or 'the patient refused to take their medicines as they did not like the side effects'. We reviewed the monthly numbers of patients missing their medicines and saw improvements had been made, such as the reduction of staff using 'other' as a reason why patients did not receive medicine. The pharmacy manager was able to audit all reasons which allowed them to address any further learning staff needed and explore in more detail about why patients had refused, were unavailable, or unable to have their medication.

Managers ran a report on the pharmacy system every week in advance to identify all patient prescriptions that were due to run out within 7 days. Technicians responsible for each wing and the ECU, reviewed the prescriptions daily, to re-issue or task the GP or substance misuse prescriber to ensure patients' prescriptions were not missed. This was now completed for all patients across the prison which showed a responsive and whole staff approach to ensuring safe management of medicines. The outcome from the medicines reconciliation provided advice to the prescriber for each medicine about whether the medicine need had been validated and whether there were any discrepancies or omissions with the initial prescription. We reviewed medicine management meeting minutes where staff discussed all figures of the missed medicines and those not administered.

Inspected but not rated

Are services effective?

Effective needs assessment, care and treatment

At the last inspection staff had not consistently planned and delivered high quality care according to best practice and national guidance. We identified two patients on the enhanced care unit (ECU) who refused their medicine's and were recorded as lacking capacity to consent. Staff had not developed adequate care plans to ensure they could be supported appropriately.

At this inspection we saw care plans were in place for all patients on the ECU Care plans were developed for long-term conditions, mental health, substance misuse and capacity or compliance to medicine. We saw examples where a patient had initially refused to take their medication, but after staff made several attempts to educate the patient, the patient had decided to engage in treatment.

Nutrition and hydration

At the last inspection we identified one patient who regularly refused food and drink. Staff had documented significant weight loss for this patient and recorded that the patient was at risk of malnutrition and dehydration but had failed to act on their concerns.

At this inspection we saw staff had developed a care and treatment plan to monitor the patient's weight, nutrition and hydration. There was an explanation as to why the patient had lost weight, due to a hospital procedure and how they could try to monitor food and fluid intake. We saw in multidisciplinary meeting minutes where healthcare team and the prison staff were working to together to help monitor one patient's food and fluid intake.

Multidisciplinary working

At the last inspection we identified staff did not hold regular and effective multidisciplinary (MDT) meetings to discuss patients on the ECU, most of whom had complex physical and mental health needs.

At this inspection we now found that managers had put in place weekly MDT meetings for patients on the ECUs. Staff discussed any action points from the last meeting, each patient's healthcare needs including their physical and mental health. We saw where staff had noted if patients had or had not taken their medicines and where they lacked capacity, the actions taken to secure a place for the patient in hospital.

These meetings were attended by heads of healthcare, the healthcare prison governor, a GP, pharmacy staff, nursing staff and mental health staff. We could see where the healthcare provider had discussed patients with other agencies such as the local council or mental health hospital.

Consent to care and treatment

During the last inspection where staff assessed patients as not having capacity, we found that they did not make decisions in the best interest of patients or consider the patient's history.

Since the last inspection the provider had put in place multi-disciplinary oversight for all complex patients at HMP Chelmsford. There was a weekly MDT review meeting commissioned by the prison and attended by safer custody, a governor and custodial manager grades alongside healthcare to discuss any complex cases within the prison. This gave staff that knew patients well, an opportunity to share their views.

Inspected but not rated

Are services effective?

The mental health team held an MDT every Wednesday to discuss cases on the mental health case load and included patients who may need a capacity assessment. There was also an MDT for patients on the ECU here consideration of the 2005 Mental Health Capacity Act and best interests were mandatory agenda items. We saw for one patient healthcare had involved a family member of a patient who lacked capacity and refused treatment. The family member was able to provide staff with some insight and act as an advocate for this patient.

Inspected but not rated

Are services well-led?

Leadership

Leaders had continued to develop positive working relationships within the service and the wider prison. Managers were visible in the service and approachable for patients and staff. We saw evidence of positive working relationships between the different healthcare services as well as with the prison.

Within team meetings, managers discussed and explored the overall progress of staff following the new standard operational procedure for recording medicine administration. Advice and training were provided for staff within supervision records on the use of the new recording system. Managers also shared figures within the medicine management meetings to show staff progress. This demonstrated evidence of shared learning, between members of the team and with other healthcare professionals and commissioners where appropriate.

Pharmacy staff we spoke with were engaged, enthusiastic and knowledgeable about the operation of the pharmacy. They told us that they were happier to be administering medicines on a designated wing, as this allowed them to develop a relationship with the patients on the wing and offered continuity. Staff we spoke with said they felt led by management and although there were a lot of changes, they were proud that they had achieved a new way of working by working as a team.

Governance arrangements

At our last inspection we found that there were limited processes in place to ensure staff knew how to accurately complete patient records for medicine administration.

During this inspection we found there was significant improvement. The lead pharmacist had implemented a new system where staff followed steps to ensure they provided good explanations to show why patients did not receive their medicines. Staff on the wings maintained a list of all patients who missed medicines each day so that they could find them and ensure they received their medicines. The pharmacy technicians also noted an entry in each patient record which offered more details around why a patient had not had their medicines. Managers had also arranged for staff to check daily with the prisoner movement system as to which prisoners had moved location. Managers then tasked the appropriate technician and nursing team to ensure that prisoners medicines could be transported to where the prisoner was located. We saw examples of this within patient records where the patient had moved location and received medication as soon as clinically possible.

The provider had in place a list of all critical medicines that patients should not miss, there was clear guidance in place for staff to follow if a patient had missed their medicines. This helped staff to understand the importance of making sure they checked up on any patients that had missed any critical medicine and to inform the GP when needed. We saw there was a reduction in the amount of medicine entries labelled as 'missed', from 147 at our last inspection as 'missed', to 10 where a medicine was 'not available' and 24 where the dose was 'clinically omitted'. Managers audited these monthly figures in order to improve standards.

Managers had developed a 'complex men MDT action plan', where any ongoing actions such as; referring patients to memory clinics, moving a patient with disability needs, following up on progress of mental health transfers, investigating any confirmed diagnosis and arranging best interest decision meetings were recorded. Managers monitored any action dates and outcomes as part of ensuring patients' needs were being met and there was evidence of overall responsibility.