HMP Bullingdon

Quality 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.

Key findings of this inspection

Detailed findings from this inspection

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We did not inspect the safe domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in September 2017 as a result of the joint inspection with HMIP in April and May 2017.

At this focused inspection, we found that medicines management had improved significantly. The provider had implemented an effective process for recording fridge and room temperatures, with much improved monitoring and governance processes in place.

Are services effective?

We did not inspect the effective domain at this inspection.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in September 2017 as a result of the joint inspection with HMIP in April and May 2017.

At this focused inspection, we found that the provider had taken adequate action to address concerns around the complaints process, including improvements to confidentiality, recording and timeliness of responses. The provider had started to analyse complaints trends and themes, and used this information to inform service improvement, although further work was required to communicate lessons learnt from complaints to all staff.

Are services well-led?

We did not inspect the well-led domain at this inspection.

HMP Bullingdon

Detailed findings

Our inspection team

Our inspection team was led by:

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

We do not currently rate services provided in prisons.

Background to HMP Bullingdon

HMP Bullingdon is a local prison holding both remanded and sentenced prisoners, and also accommodates young adults between the ages of 18 to 21. HMP Bullingdon serves the courts of Oxfordshire, Berkshire and Wiltshire and surrounding areas, and supports magistrates courts within the Thames Valley. It also acts as a resettlement prison for prisoners from Hampshire.

Care UK Health & Rehabilitation Services Limited (Care UK) provides primary healthcare services at HMP Bullingdon. The location is registered to provide the regulated activities: Treatment of disease, disorder or injury, and diagnostic and screening procedures.

Why we carried out this inspection

CQC inspected this location with HMIP between 24 April and 11 May 2017. We found evidence that fundamental standards were not being met and issued Requirement Notices in relation to Regulation 16, Receiving and acting on complaints, and Regulation 17, Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The joint report published following the 2017 inspection can be found by accessing the following website: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/09/Bullingdon-Web-2017.pdf

We subsequently asked Care UK to make improvements regarding these breaches. We checked these areas during this focused inspection and found that the provider had addressed the previous regulatory breaches identified.

How we carried out this inspection

During this focused inspection, we spoke with service managers and staff from Care UK, and patients. We also checked clinical areas in the healthcare unit and prison, and reviewed a range of documents and records relating to clinical practice, complaints management, and governance.

Are services safe?

Our findings

Medicines Management

At our previous inspection with HMIP in April and May 2017, we found that Care UK did not have adequate systems and processes in place to ensure safe management of medicines.

The concerns included:

- Medicines fridge and room temperatures in wing treatment rooms were not being checked consistently.
- When temperatures were out of range, there was no process in place to escalate concerns and ensure that the efficacy of medicines had not been compromised.

At this focused inspection, we found that the management of medicines had improved significantly.

The provider had implemented an effective process for recording fridge and room temperatures using the SystmOne electronic clinical record. Staff were now required to record temperatures daily on SystmOne, and report the readings back to the wider team at a daily staff handover meeting. Regular audits of SystmOne were undertaken to ensure that temperatures were being checked and recorded consistently. Audit results showed that compliance was improving. Managers wrote to staff who failed to record temperatures to remind them of their responsibilities, following this up through the formal supervision process where necessary.

Staff had access to a clear local operating policy which set out the process for maintaining fridge temperatures and how to escalate concerns to the pharmacy for advice. The provider had also produced a quick reference guide to support staff, which was displayed clearly in each treatment room. Staff responsible for managing medicines had recently undertaken training on safe storage of medicines requiring refrigeration.

Pharmacy technicians now had more involvement in the daily management and supervision of medicines administration, which provided nursing staff with an additional level of support. During the inspection, we observed safe administration of medication by healthcare staff. We saw some poor management and monitoring of treatment rooms, for example a nurse leaving packets of prescription drugs on the work surface in an unattended locked treatment room. The provider took prompt action to address the concerns during the inspection.

Are services effective?

(for example, treatment is effective)

Our findings

We did not inspect the effective domain at this inspection.

Are services caring?

Our findings

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Listening and learning from concerns and complaints

At our previous inspection, we found that the provider did not operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. The provider also failed to effectively act on feedback from service users.

The concerns included:

- The complaints system was not effectively promoted. Some complaints were sent through the prison's complaints system, resulting in delays and confidentiality issues.
- Complaints were not acknowledged, or responded to promptly.
- There was no quality assurance of complaint responses.
- There was no evidence of identifying and addressing trends or themes, or that lessons learnt informed service improvement.

At this focused inspection, we found that the provider had taken action to adequately address these concerns.

The complaints process was well advertised on healthcare notice boards across the prison wings, and in the healthcare unit. Prisoners we spoke to understood how to complain, and there was an adequate supply of the provider's complaints forms on each prison wing. The provider employed a porter to collect completed complaints forms and restock blank forms daily. The provider also sent a representative to the prison's daily senior management team meeting to collect any complaints forms that were sent to the prison in error. This ensured that confidentiality was maintained as far as possible.

The provider recorded all complaints received on Datix, an electronic incident reporting tool, which helped them to manage and monitor the progress of on-going complaints more effectively. All prisoners who complained now received an acknowledgement letter explaining what would happen next. The number of overdue complaint responses had reduced significantly since our previous inspection. Three complaints that were outside the provider's response target time of 28 days were being managed proactively.

The head of healthcare reviewed all complaints responses to ensure quality and consistency, and the provider was planning to introduce a regular quality meeting to provide further oversight. All staff responsible for responding to complaints were scheduled to undertake complaints handling training in September 2018. Complaint responses that we reviewed adequately addressed the concerns raised, and included details of how a complainant could escalate their complaint if they remained dissatisfied with the response.

The provider had started to regularly analyse complaints trends and themes, and used this information to inform service improvement. For example, pharmacy technicians were assigned to assist with medicines administration following a rise in complaints around medicines management. This change was followed by a reduction in complaints in this area. Lessons learnt from complaints were not routinely shared with the whole team, and the provider was developing plans to introduce a regular email communication to improve information sharing.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

We did not inspect the well-led domain at this inspection.