Bracton Centre Medium Secure Unit

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	Not inspected
Are services safe?	**Inspected but not rated**
Are services responsive to people's needs?	**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 Oxleas NHS Foundation Trust at HMP Rochester between 20 and 22 September 2022.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in October 2021, we found that the quality of healthcare provided by Oxleas NHS Foundation 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 were meeting the legal requirements of the Requirement Notice that we issued in February 2022 and 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 Regulation 17, Good Governance.

We do not currently rate services provided in prisons.

At this inspection we found:

- Managers did not maintain accurate records of staff training in relation to incident reporting and medicines management.
- Staff did not consistently report all incidents and shared learning following incidents was limited.
- Complaints were high and the service did not always investigate and respond to complaints in a timely manner.
- Managers did not analyse data sufficiently to identify patient safety concerns, gaps in service provision and opportunities for service improvement.

However;

- Governance within the dental service had improved through effective infection prevention and control management and timely completion of repairs within the dental suite.

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

- Clinical governance systems and process must operate effectively at team level to identify issues relating to incidents, complaints and service improvements.

Our inspection team

Our inspection team was led by a CQC inspector with support from 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, policies and procedures and management information.

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

Background to Bracton Centre Medium Secure Unit

Background to HMP Rochester

HMP & YOI Rochester is a category C training and resettlement prison for adult men and young offenders in Kent and accommodates up to 695 adult prisoners and young offenders. The prison is operated by His Majesty's Prison and Probation Service.

Oxleas NHS foundation Trust is the health provider at HMP & YOI Rochester. 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 October 2021. The joint inspection report can be found at: Report on an unannounced inspection of HMP & YOI Rochester by HM Chief Inspector of Prisons 4 and 11-15 October 2021 (justiceinspectorates.gov.uk)

Inspected but not rated

Are services safe?

Maintenance, cleanliness and infection control

The dental suite was clean, well maintained and fit for purpose.

At our last inspection we found the room adjacent to the dental suite did not comply with current infection, prevention and control (IPC) requirements. The floor had come away from the skirting, there was dust on top of the steriliser, and an extension lead resting next to the sink. Furthermore, a daily IPC checklist had not always been signed on the two days the dental clinic had taken place. Governance processes did not monitor compliance with the checklist completion. The flooring had not been reported for repair.

At this inspection we found effective IPC management and all the required repairs had been completed within the dental suite. Staff completed the daily dental checklist.

The trust also completed its annual IPC audit of the dental suite in March 2022 and achieved a 96% compliance rate. Staff completed the required actions; however, the action plan was not updated.

Staff Training

Staff received appropriate training, but accurate records of attendance were not maintained.

Since our last inspection staff had completed additional training in incident reporting and medicines management. However, at this inspection we found that records of all those in attendance at the training sessions were not available and managers could not confirm who had completed this training.

Reporting incidents and learning from when things go wrong

Staff did not always recognise incidents or report them appropriately. Managers investigated incidents but did not routinely share lessons learned with the whole team. Service improvement to patient care was limited.

At our last inspection we found that not all incidents were being reported and not all staff were able to identify learning or service improvements introduced following the reporting of an incident.

At this inspection we found that staff had received training in how to report incidents, including bank and agency staff and incident reporting had increased but remained inconsistent. We found several examples of incidents that staff had not reported. For example, one patient repeatedly did not attend the emergency department over the course of one week as the prison could not facilitate the escort and we identified four patients who did not receive medication on consecutive days as their medicines were not available. Staff did not always report incidents of verbal abuse and aggression from patients to healthcare staff.

Managers investigated incidents; however, feedback to staff following investigation was poor. Managers and staff we spoke with told us there was a richness to their discussions in staff meetings. However, meeting minutes for staff, manager and clinical governance meetings were vague and did not include detail of incidents discussed or outcomes from investigations. Managers did not provide any supplementary data analysis reports of incidents for staff to aid discussion at meetings.

Inspected but not rated

Are services safe?

At this inspection we found some examples of shared learning, for example the introduction of a best practice forum for staff across the Kent prison cluster. However, any specific learning from incidents at HMP Rochester were not shared comprehensively. A regional bulletin was available within the Kent prison cluster, however information relating to HMP Rochester did not feature in this. This would have mitigated some of the poor recording in meeting minutes and help reduce repeated incidents and future risks.

At our last inspection we found there were occasions when the health care team was not informed a patient had not been escorted to an external hospital appointment and these were not reported as an incident.

At this inspection we found some examples of service improvements to patient care following incidents. For example, staff introduced a comprehensive tracking and reporting mechanism to inform cancellations and those not attending for external hospital appointments, enabling staff to have oversight of any potential clinical risk. The pharmacy team had implemented a near miss log that identified potential risks that were then discussed within the team.

Inspected but not rated

Are services responsive to people's needs?

Listening to and learning from concerns and complaints

Patients had access to a dedicated healthcare complaints system and a separate prison complaints process. The service did not always investigate and respond to complaints in a timely manner.

At this inspection we found managers had introduced a new system for recording and responding to complaints. However, administration staffing levels were impacting on the efficiency of this, as complaints were not uploaded into the system daily. Complaint numbers were high, due to the repeated number of submissions created by an initial lack of response from the provider. There were delays with the prison sharing healthcare complaints they had received; this meant complaints were not logged or responded to within the expected timeframes.

We reviewed complaints data received from the provider between March 2022 and August 2022. A total of 306 complaints were received; of these 95 related to medicines, 80 to waiting times, 69 to treatment, 21 to dental and 21 other. Many complaints were not responded to and those that were, were poorly written and did not always address the nature of the complaint.

There was minimal quality assurance of the complaints process, although managers had started to review complaints data more closely to inform learning and service development.

Inspected but not rated

Are services well-led?

Good Governance

Governance processes did not operate effectively at team level and were not sufficiently optimised to identify issues relating to incidents, complaints and service improvements.

The service had an established framework of regular meetings; however, minutes of meetings were not always available to staff and the quality of meeting minutes was poor. The head of healthcare chaired a regular meeting with team managers for primary care, mental health and substance misuse; but minutes were not taken during these meetings. This meant the flow of information between managers and staff was predominantly verbal during staff meetings and clinical handovers.

Managers did not maintain accurate records of staff training in relation to incident reporting and medicines management. Staff did not update IPC audit action plans following audit activity in March 2022.

The service now had a governance and quality manager in post, and we identified some early signs of improvement in using the available governance processes but progress was slow. However, the inconsistency in reporting incidents, high numbers of complaints and minimal analysis of themes and trends, limited how managers identified patient safety concerns, gaps in service provision and opportunities for service improvement. Managers did not have any service specific action plans or overarching service improvement plan in place.

Governance within the dental service had improved through effective IPC management and timely completion of repairs within the dental suite.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes in place were not effective in assessing, monitoring and improving the quality and safety of the services being provided. In particular: • An established framework of regular meetings was in place, however; the minutes of these meetings were not always available to staff and the quality of recording was poor. • Managers did not maintain accurate records of staff training. • Staff did not consistently report all incidents and shared learning following incidents was limited. • Complaints were high and the service did not always investigate and respond to complaints in a timely manner. • Managers did not analyse data sufficiently to identify patient safety concerns, gaps in service provision and opportunities for service improvement. Systems or processes in place were ineffective in assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • Medicines were not available for some patients to collect for three consecutive days.