HMP Rochester

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?

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018. At the time, we found that:

- The planning and delivery of care was not based on risk assessments to balance the needs of people using the service.
- Staff did not follow procedures to manage medicines safely when transporting them around the prison.

On inspection on November 8, 2018, we found that the provider had addressed all the issues of concern we had identified in the Requirement Notice, and was now compliant with the requirements of the Health and Social Care Act 2008 in relation to the safe key question.

- Emergency GP slots for urgent appointments had been introduced and were being used appropriately to ensure that patients with acute need were prioritised.
- Medicines were now transported when prisoners were not moving around the site, by two staff members, in a sealed case.

Are services effective?

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018, which did not relate to the effective key question.

Are services caring?

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018, which did not relate to the caring key question.

Are services responsive to people's needs?

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018, which did not relate to the responsive key question.

Are services well-led?

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018, which did not relate to the well-led key question.

Key findings

Areas for improvement

Action the service SHOULD take to improve

We found that the provider should undertake the following improvements:

- The provider should devise care plans for all patients with long term conditions to ensure that these are monitored and reviewed appropriately.

The provider should ensure that all relevant staff members have read and signed the standard operating procedure regarding the safe transporting of medicines within the prison.

HMP Rochester

Detailed findings

Our inspection team

Our inspection team was led by:

Two CQC health and justice inspectors visited HMP Rochester on November 8, 2018, to inspect health services related to concerns identified in the Requirement Notice issued on March 15, 2018.

We do not currently rate services provided in prisons.

Background to HMP Rochester

HMP Rochester is a category C training and resettlement prison holding up to 744 adult and young adult male prisoners. The prison is located on the outskirts of Rochester in Kent and is operated by Her Majesty's Prison and Probation Service (HMPPS).

Oxleas NHS Foundation Trust (Oxleas) is commissioned by NHS England to provide primary and mental healthcare at the prison. Oxleas is registered with CQC to provide the regulated activities of Treatment of disease, disorder, or injury, Diagnostic and screening procedures, and Personal care at HMP Rochester.

Why we carried out this inspection

We undertook a joint inspection of HMP Rochester with Her Majesty's Inspectorate of Prisons (HMIP) between October 30 and November 3, 2017. During this inspection, we determined if the registered provider, Oxleas, was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008, and that men at the prison were receiving safe care and treatment. We found Oxleas to be in breach of Regulation 12 (Safe care and treatment), and issued a Requirement Notice on publication of the joint inspection report on March 15, 2018.

We returned to HMP Rochester on November 8, 2018, to undertake a focussed inspection to determine if Oxleas had taken the action required to address the concerns identified in the Requirement Notice.

How we carried out this inspection

Before this inspection we reviewed a range of information we held about the service, including action plans and associated documentary evidence of the trust's response to the Requirement Notice issued in March 2018. During the inspection, we reviewed information which we asked the provider to share with us, spoke to healthcare staff and men who used the service, sampled a range of records and observed practice.

Are services safe?

Our findings

Safe track record

When we inspected HMP Rochester in October and November 2017, we found that the planning and delivery of care was not based on risk assessments to balance the needs of people using the service:

- Prisoners waited up to 3 weeks to see a GP for a routine appointment.
- There was not an effective system in place to ensure that appointments were prioritised appropriately.

During the focused inspection in November 2018, we found that the provider had made improvements to appropriately prioritise patients' access to GPs.

- Twelve daily appointment slots had been introduced to allow urgent cases to be seen by GPs within 24 hours.
- On the day of inspection, November 8, 2018, we saw that appointments were available that day and on the following morning for urgent cases.
- The next available slot for non-urgent appointments was November 27. We were satisfied that these routine slots were being used appropriately, and that patients with acute need would be seen much sooner than this.
- Patients' needs for appointments were effectively assessed via the prison's "special sick" application process for men who felt ill, and via nurse triage clinics.
- The healthcare team did not use care plans to manage patients with long-term conditions, which could increase the risk of patients not receiving appropriate reviews or monitoring of their long term condition.

Medicines management

During the 2017 inspection we observed that staff did not follow procedures to manage medicines safely when transporting them around the prison:

- We observed staff transporting medicines insecurely to other areas of the prison without using the appropriate safety equipment.

During the focused inspection in November 2018, we found that the provider had improved procedures to manage the safe transportation of medicines:

- Two nursing staff now transported medicines and any related paperwork around the prison in a sealed case. Movement of medicines was authorised by the senior nurse on duty. Staff also communicated their movements to prison staff and transported medicines when prisoners were not moving around the site to further ensure security.
- The provider had introduced a standard operating procedure in January 2018 to support staff in transporting medicines safely within the prison. Staff we spoke to during this focused inspection told us they had read and understood the policy, although the master copy had not been signed by all relevant staff members.

Are services effective?

(for example, treatment is effective)

Our findings

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018.

Are services caring?

Our findings

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018.

Are services well-led?

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

Our findings

This report focusses only on concerns mentioned in the Requirement Notice we issued on March 15, 2018.