HMP Rye Hill

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.

Summary 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 mentioned in the Requirement Notices issued on 18 August 2015.

Are services effective?
We did not inspect the effective domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 18 August 2015. **We found that not all the required improvements had been made.**

Are services caring?
We did not inspect the caring domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 18 August 2015. **We found that not all the required improvements had been made.**

Are services responsive to people's needs?
We did not inspect the responsive domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 18 August 2015. **We found that all the required improvements had been made.**

Are services well-led?
We did not inspect the well led domain at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 18 August 2015.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Patients with long term conditions, mental health conditions and other significant health issues must have a plan of care that details how their care needs are to be met.
- Care plans must be person-centred and patients must be involved and consulted about their care.
- The staff skill mix must be reviewed to ensure that suitably skilled staff are employed to meet the needs patients.
- Staff must undertake relevant training to support them in their role

You can see full details of the regulations not being met at the end of this report.

Action the service SHOULD take to improve

- Review the current healthcare facilities to ensure that sufficient space, including the waiting area and treatment rooms are available to meet their needs of the patients.

HMP Rye Hill

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC health and justice inspector , accompanied by a HMI Prisons healthcare inspector.

Background to HMP Rye Hill

HMP Rye Hill is a category B training prison, acting as a national resource for sentenced male adults who have been convicted of a current or previous sex offence(s). G4S Forensic and Medical Services (UK) Limited provides a range of healthcare services to prisoners, comparable to those found in the wider community.

In August 2015 we undertook a joint inspection of health Services at HMP Rye Hill with Her Majesty's Inspectorate of Prisons under a memorandum of understanding agreement. We found the provider was in breach of regulations and we issued four Requirement Notices.

During the focussed inspection, we found the provider, G4S Forensic and Medical Services (UK) Limited had made some improvements since the last joint inspection and they were meeting two of the four regulations which they had previously breached.

The provider remains in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person-centred Care and Regulation 18 staffing.

Our findings were:

- The arrangements for the safe and effective management of medicines had significantly improved, promoting better outcomes for patients
- The provider had reviewed its complaints process and now operated an effective and accessible system for handling complaints and concerns.
- Sufficient numbers of staff were employed.

To get to the heart of patients' experiences of care and treatment, we asked the following questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Why we carried out this inspection

This was a follow up focus inspection under of the service under Section 60 of the Health and Social Care Act 2008, to check that the provider was meeting the legal requirements and regulations associated with the act.

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a range of information which we reviewed as part of the inspection. During the inspection we spoke with staff and patients who used the service and security staff.

Are services safe?

Our findings

Overview of safety systems and processes

- The provider had reviewed the arrangements for medicines management and made improvements, including increasing the input from a pharmacist to ensure that improved systems were implemented and monitored.
- Medication administration had improved but there were still instances of administration charts being either signed too early (before administration) or too late (not immediately after administration).We spoke with the clinical lead about what we saw, and they reassured us that they would speak with staff and remind them to follow the correct procedure.
- Previously we reported that medicines were administered on the wing in full view of other prisoners and this compromised patient's dignity and confidentiality. Where medication was taken to a patient in their cell, nurses were accompanied by a dedicated officer.
- Previously we reported that nurses spent a considerable amount of their core working day administering medicines. During this inspection staff told us that changes made around medicines administration had reduced the time they spent administering medicines. However medicine administration still took a significant amount of time, which meant the number of appointments offered at morning clinics was reduced.
- A small number of prisoners had moved to 'In-Possession' medicines, this meant that following a risk assessment prisoners were allowed to hold and manage their own medication in line with community practices. GP's had reviewed prescribing practices in an attempt to reduce the overall number of medicines administered throughout the day. This meant that the time taken to administer medication was reduced thus freeing nurses time.
- Controlled drugs were managed appropriately and were now given at more equal and regular intervals. Patients we spoke with at this inspection reported that access to their controlled medicines had improved.
- Security of medicines had improved, including treatment room doors being locked and medication trolleys in treatment rooms were securely tethered to the wall. Medication was transported across the prison in hard bodied, locked, medication suitcases.
- Previously we reported that nurses were interrupted during medication administration rounds to attend non-emergency incidents. During the focussed inspection we did not observe this happen, however staff reported that there was still the potential for this to happen as there were only two permanent nurses employed. To assist this G4S had arranged for both bank and agency staff to have key and radio training so they could act as response nurses, which meant that nurses giving out medicines would not be disturbed.
- We found that night time medication was given out at an appropriate time but continued to be administered through a fire door aperture in the cell door which meant the communication and observation of medicines was restricted. The provider told us 'Medication continues to be administered via the inundation points as the prison need to complete a risk assessment for opening cell doors at night.' We were told that the prison had no plans to change this arrangement due to security issues across and within the prison. However in response to this the provider had taken action to reduce the number of patients on nighttime medication and at the time of our inspection this had been reduced to seven patients.
- Healthcare facilities remained the same, the size of the waiting area was inadequate to accommodate the number of patients who waited. There was insufficient seating for patients, which meant that many had to stand and patients could wait in this area for up to two hours. On the day our inspection we observed a group of patients being turned away by a prison officer as the waiting area was over-crowded.

Monitoring risks to patients

- The provider continued to experience difficulties around the retention and recruitment of staff since the re-role of the prison.
- The primary health care team had two nursing vacancies, including a vacancy for a night nurse and another RGN nurse was due to leave the team before the end of February 2016. The team used regular bank

Are services safe?

and agency nurses to fill the gaps on the staff rota. Despite a reliance on the use of bank staff and agency staff the primary healthcare team was fully staffed at the time of our inspection. However we had some concerns about the skill mix of the present staff group and their ability to meet the differing needs of patients.

- Arrangements were in place for planning and monitoring the number of staff needed to meet patients' needs with vacancies reported weekly to the provider.
- Since our last inspection a new clinical lead had been appointed on the 4 of January 2016.
- A registered mental health nurse had been appointed as lead of primary mental health team. We found that since this appointment patients had quicker access to primary mental health services.
- The identification of a clinical lead for older prisoners had improved care services provided to this prisoner group.
- Nurses now had protected time during their work schedule to complete care plans. This was a recent initiative and its full impact had yet to be assessed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

- Previously we found that healthcare staff had not updated their mandatory training such as infection control, safeguarding adults and child protection. We reported that this compromised patient safety. During this focussed inspection we found that some staff had still not completed mandatory training.
- Since their appointment in January 2016 the clinical lead had prioritised training for staff, including mandatory training.
- The skills mix of the staff team did not fully meet the needs of patients. During this focused inspection we found that not all staff had the skills to deliver effective care and treatment. The majority of staff had not completed training specific to the needs of patients, for example, training in diabetes and asthma care.
- We saw that a number of bank and agency staff required to provide general nursing care were qualified in mental health nursing and were not skilled in providing other care, for example, diabetes clinics and asthma clinics.

Are services caring?

Our findings

Care planning and involvement in decisions about care and treatment

- Care plans were of a poor quality and lacked personalisation and patient involvement.
- Care plans were often composed of a list of generic instructions. There was no detail on how a nurse or a healthcare assistant would meet a patient's individual needs.
- Care plans were not reviewed on a regular basis; where a review had taken place we observed that patients had not been consulted. Many had been an administrative review rather than involving and consulting with the patient. Where reviews had taken place the outcome of the review was not consistently recorded.
- The clinical lead told us that there were plans to formally review care plans from February 2016.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The patient population at HMP Rye Hill included a high proportion of older patients and patients with complex health care needs. Older patients' assessments had been introduced. We found a range of healthcare clinics were in place to meet the needs of older patients', these included GP and diabetes clinics and a weekly older patients clinic was held and a drop in session was held on a wing that was frequented by older prisoners. Aortic abdominal aneurysm screening was due to commence in February 2016.
- Care planning for patients with complex health needs and lifelong conditions remained insufficient and underdeveloped. Since the appointment of a clinical lead in January 2016 the development of care plans had been actively promoted. However further work was needed to ensure that patients with complex health needs, including mental health problems and lifelong conditions, had a plan of care which instructed staff how their care needs were to be met.
- Patients with primary mental health needs were seen in a timely manner and primarymental health clinics were held daily.
- Patients no longer had to wait a long time to access healthcare clinics, for example, blood borne virus clinics, and primary mental health services.
- There had been no increase in the number of daily escorts to external appointments made available to prisoners. At the time of this inspection we were not made aware of any patients whose health had been adversely affected because of arrangements around accessing external appointments.
- The nursing director monitored hospital appointment waiting lists; any that were cancelled were reported as part of the incident reporting system. The provider had looked into the possibility of a number of external clinics taking place within healthcare and was considering alternative provision of specialist clinics within the prison to reduce the need for external appointments.

Listening and learning from concerns and complaints

- The service had an effective system in place for handling complaints and concerns.
- There was a designated responsible person who managed all healthcare complaints, including arranging investigations, sending out holding letters to the complainant, assigning the complaint investigation to the most appropriate person and ensuring that responses were appropriate and timely.
- We saw that information was available to help patients understand the complaints system; although there was some confusion about the accessibility of the new easy read complaints forms on some wings and the availability of 'medical inconfidence' envelopes for patients who wished to make a complaint in confidence. This information could be better advertised across wings. However when we reviewed complaints that had been received in the last five months, we saw that the new easy read complaints forms were being used by patients.
- Previously we found that patients did not always receive appropriate responses to their complaints, or that proportionate action had not always been taken in response to their complaints. Responses to complaints were of variable quality, did not address all the issued raised, or provide satisfactory resolution and where appropriate did not include an apology. The provider had reviewed the complaints process and all responses to patients
- We found that patients' complaints were no longer scanned on to their clinical records. The provider had amended the complaints policy to ensure that complaints were handled in a confidential manner and stored separately.

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. We inspected only those aspects mentioned in the Requirement Notices issued on 18 August 2015.

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 9 HSCA (RA) Regulations 2014 Person-centred care Care plans lacked personalisation and patient involvement. Care plans were not reviewed on a regular basis and patients had not been consulted. Care plans were of a poor quality and were not person-centred. There was no detail on how a nurse or a healthcare assistant would meet a patient's particular needs. Patients were not consulted or involved when drawing up their care plan. Regulation: This was a breach of regulation 9(3)(a)(b)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Pperson centred care.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not completed mandatory training. Staff did not always have the skills to deliver effective care and treatment and the majority of staff had not completed training specific to the needs of patients. The skills mix of the staff team did not always meet the needs of patients. Regulation: This was a breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing