HMP Ranby

Quality Report

Straight Mile
Ranby
Retford
Nottinghamshire
DN22 8EU
Tel:
Website:

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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.

Contents

Overall summary

On 5 and 6 July 2016 we undertook a focused inspection. At this inspection we found that the provider had taken some action to satisfy the recommendations made by HMI Prisons following their September 2015 inspection and the subsequent recommendations of HM Coroner in March 2016.

Our key findings were:

- We found that most of the necessary improvements to the safety, effectiveness and responsiveness of the service had been made.

Summary of findings

- The systems for obtaining and learning from feedback from patients were robust.
- Some improvements were incomplete but there were robust plans to ensure service development was achieved.
- Further work was required to improve the safety and effectiveness of medicines management.

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 the areas for improvement from the Her Majesty's Inspectorate of Prisons (HMIP) report published in February 2016 and in a prevention of further deaths report to CQC from HM Coroner in March 2016. We found that most of the necessary improvements had been made. However further work was required to improve the safety and effectiveness of medicines management.

Are services effective?
We did not inspect the effective domain in full at this inspection. We inspected only the areas for improvement from the HMIP report published in February 2016 and in a prevention of further deaths report to CQC from HM Coroner in March 2016. We found that the necessary improvements had been made.

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 the areas for improvement from the HMIP report published in February 2016. We found that the necessary improvements had been made.

Are services well-led?
We did not inspect the well-led domain in full at this inspection. We inspected only the areas for improvement from the HMIP report published in February 2016. We found that the necessary improvements had been made.

Summary of findings

Areas for improvement

Action the service MUST take to improve

The risks associated with the proper and safe management of medicines were not identified or mitigated effectively. We have asked the provider to make improvements in this regard.

Action the service SHOULD take to improve

- Policies and procedures for medicines management require review without further delay to ensure the safety and effectiveness of medicines.
- All healthcare staff should complete mental health awareness training to enable them to more effectively identify patients' needs.

HMP Ranby

Detailed findings

Our inspection team

Our inspection team was led by:

This focused inspection was led by a CQC health and justice inspector, who was supported by a second CQC health and justice inspector.

Background to HMP Ranby

HMP Ranby is a very busy category C prison that holds up to 1038 adult men. In May 2016 it became one of six early adopter sites for autonomy where the executive governor is able to make business and financial decisions separately to the wider prison estate.

Nottinghamshire Healthcare NHS Foundation Trust provides primary physical and mental healthcare, secondary mental healthcare and substance misuse services to men detained at the prison. The location, HMP Ranby, is registered to provide the regulated activities, diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.

Why we carried out this inspection

We carried out this focused inspection to follow up on recommended areas for improvement identified by HMI Prisons during their announced inspection in September 2015. The HMIP inspection report can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/?post_type=inspection&prison-inspection-type=pris

We also inspected in direct response to concerns raised by HM Coroner following at death at HMP Ranby in 2015.

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the NHS commissioner and registered provider to share with us other information, which we reviewed as part of the inspection.

We were on site for one and a half days and during the inspection we looked at provider documents and patient records, spoke with healthcare staff, prison staff and patients.

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 responsive to people's needs?
- Is it well-led?

Are services safe?

Our findings

Safe track record

- In September 2015 HMI Prisons found that health services were 'under significant pressure from the prevalence of novel psychoactive substances (NPS) related incidents.' At this focused inspection staff told us that the severity of such incidents had significantly reduced over recent months and was therefore not impacting on the services being offered to patients. However, demand for mental health services for prisoners using NPS had increased and the mental health and substance misuse teams were working jointly to manage this risk. A designated nurse was leading on dual (mental health and substance misuse) diagnosis. We did not observe any NPS-related incidents during our inspection but records demonstrated that such patients were effectively managed.

Learning and improvement from safety incidents

- A system had been recently introduced to enable the recording of near miss incidents involving medicines and staff we spoke with were aware of the new process. A monthly analysis was planned to identify trends and address any apparent risks. We were unable to confirm the effectiveness of these very new arrangements.
- Staff were able to describe their role in reporting and managing incidents. Guidance about incident management and medicines errors had been circulated to all staff within the provider's learning lessons bulletin, reminding them of their responsibilities.

Reliable safety systems and processes including safeguarding

- Health staff and particularly the mental health team were actively engaged with safeguarding meetings and the Assessment, Care in Custody and Teamwork (ACCT) process intended to provide support to vulnerable prisoners. Effective systems ensured that healthcare staff were aware of those prisoners on ACCT. Staff's involvement had increased in frequency and consistency over recent months as vacancies were filled and capacity increased. Prison staff were complimentary about healthcare staff's contribution and the quality of their records. Health staff also routinely attended other key reviews, such as for those prisoners in segregation, or subject to constant observation by prison staff. Information from these reviews clearly influenced care planning and records provided good evidence of clinical input to multi-disciplinary reviews.

Medicines management

- Improvements had been made to the safety of how medicines were managed, particularly following the introduction of electronic prescribing and administration. This supported accurate monthly prescribing audits and stock reconciliation processes. We saw that action had been taken as a result of audits.
- Some policies and standard operating procedures were out of date. However, this was being addressed and specific policies were being prioritised, but some key policies, including the policy for in possession medicines, had been overdue for review since November 2015. We found that staff were aware of which policies they should be adhering too, however, the provider could not be sure that staff had access to up to date guidance.
  In possession risk assessments were being completed, where needed, and formed part of the reception screening process. Effective systems were in place to ensure that these were being reviewed and to monitor patients' compliance with their medicines held in possession. An analysis had been completed to identify the in possession medicines at greatest risk of abuse.
- Despite an agreed joint prison and trust operational procedure for the administration of medicines we observed a lack of privacy and confidentiality treatment hatches because there was inadequate supervision by prison staff to support safe administration. In the absence of a supervising officer, there was a lack of clarity about health care staff's responsibilities for routine checking that medicines had been swallowed. This combination meant there was an increased risk of patients concealing and diverting their medication. The provider had raised this as a concern and the lack of discipline supervision had been added to their risk register to ensure on-going consideration.

Are services safe?

- The treatment hatches on house block one did not promote safe administration. Whilst we observed staff managing medicines administration well, two queues of patients waiting and the background noise level increased the risk of errors being made.
- Medication administration times were constrained by the prison regime and complicated by recent changes to this regime. However, we found that within these constraints medication was not being given at optimum therapeutic dose intervals, which may have compromised the desired effect of the medication. Medication prescribed to promote sleep was routinely administered as early as 2.45pm.Further changes to the prison regime were planned, which were expected to support more timely medicines administration; however they were not in place at the time of the inspection.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- HM Coroner's report of March 2016 identified concerns about the quality of health screening during prisoners' reception to the prison, particularly in relation to those with mental health needs. The provider had taken effective steps to improve the consistency and quality of the initial health screen by ensuring nurses were aware of their responsibilities for obtaining a full medical history. Systems had been established to support routine checking of previous patient records and obtaining information from external sources as necessary. Assessments were completed in a timely way and were of good quality. Records showed that referrals to the primary mental health team were made and responded to promptly.

Management, monitoring and improving outcomes for people

- An effective system ensured that medication reviews were being undertaken, supported by dedicated appointment slots. Following a change to the sub-contracted GP service improved consistency of GP attendance was helping to reduce a backlog of planned medication reviews. Further work was in progress to ensure that GP prescribing was consistent with national guidance; however this was at an early stage. We found that one person had been waiting for ten weeks for a GP review but had been seen twice in the interim by a prescribing nurse.
- People who failed to attend for their medication were being regularly monitored by a nominated pharmacy technician. Relevant action was taken to determine the reasons for non-attendance and promote concordance with their prescribed treatment. There were plans in place for daily monitoring once all staffing vacancies were filled.
- The patient records system was managed effectively to ensure that patients' needs were clearly documented and met. Care planning was well developed and caseloads and registers were well managed, in line with national frameworks to support timely review of care and treatment. The 24 patients with complex needs were easily identifiable and their needs were regularly reviewed. Recall systems ensured that those people with long term conditions, or subject to regular screening, were reviewed promptly.
- Clear mental health pathways were in place, based on a multi-disciplinary stepped care model, and regularly monitored. A weekly 'allocations' meeting of mental health teams reviewed all new referrals and those patients giving cause for concern. This ensured that caseloads were proactively managed and individual needs were met.

Effective staffing

- With support from commissioners, the provider had increased the number of staff employed within the service and enriched the skill-mix of the healthcare team. Recruitment was on-going and some posts already filled.
- Mental health nurses were available seven days a week, which was an extension on the previous service. A duty worker system had been introduced to support the mental health teams to respond to patients in crisis, contribute to prison management plans and to attend review meetings.
- Once all vacancies were recruited to the mental health team was expected to include staff who would specialise in psychological therapies, intellectual disability and dual diagnosis (mental health and substance misuse).
- Staff training to ensure that patients' needs were met was planned or in place. All nurses had received triage training. Whilst some staff had completed mental health awareness training in November 2015, the provider was unable to identify those who still required it. However, a further training session was booked for September 2016. Training had also been arranged for four staff to enable them to support prisoners who expressed a wish to give up smoking and reduce the current waiting time of nine weeks. Other staff had received training in foot triage, sexual health and NHS screening to enable them to deliver clinics.

Are services effective?

(for example, treatment is effective)

- Staff had regular access to both managerial and clinical supervisors, according to their role. In addition there were several opportunities for informal supervision, such as the mental health team's 'allocations' meeting where individual patients were discussed.
- All staff that we spoke with had an understanding of how to raise any concerns they may have about colleagues' behaviour or practice. They stated that they felt well supported in their roles and felt that should they raise any concerns they would be listened to.In September 2015 guidance about 'whistleblowing' had been circulated to staff within the provider's learning lessons bulletin.

Working with colleagues and other services

- Healthcare provision had been challenged over recent months due to a series of changes in senior prison managers and prison regimes. However, engagement with the prison was universally positive with staff at all levels making unsolicited comments about their positive relationship with the prison and mutual support. Communication systems were effective and ensured that health staff were aware of those prisoners who presented a risk, or had particular needs.Multidisciplinary working was effective in addressing individual risk and need.
- A specialist out of hours GP service had been commissioned, partly in response to a recommendation from HMI Prisons. Prison and health staff were aware of how to contact the provider that offered telephone advice and remote prescribing. Both groups felt well supported by this service and communication with out of hours GPs worked well as they had access to the patient record system. In April 2016, of the 12 calls to this service, 10 were managed successfully within the prison. The remainder were transferred out to hospital to receive acute care and treatment. Regular reporting on contact with the out of hours service enabled the trust to effectively monitor themes and inform improvements to their service.

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

Access to the service

- On arrival at HMP Ranby prisoners were provided with a comprehensive pack of information about health services, including common emotional and mental health conditions. This signposted them to the available services to which they could self-refer.
- During our inspection we received mixed feedback from patients about how long they had to wait for appointments. However, records showed that waiting times were short and comparable to, or shorter than, waits to access services in the wider community. The exceptions were the extended time that patients were waiting for smoking cessation support (9 weeks) and to see the physiotherapist (10 weeks). However, these backlogs were being addressed and NHS commissioners were actively monitoring waiting times.
- New arrangements for confirming patients' booked appointments and for monitoring and following up patients who failed to attend, were supporting prompt access and promoting better outcomes for patients. Weekly drop-in sessions were provided on some house blocks to enable prisoners to raise queries with a nurse.
- Effective triage arrangements helped to manage requests for appointments with GPs, podiatrist and physiotherapist. Appropriately trained staff undertook preliminary assessments to ensure that individual needs were met quickly and appropriately. Non-medical prescribers supported patients to access the medicines they required promptly.

Listening and learning from concerns and complaints

- An independent service level review of complaints management was completed in March 2016. Prisoners had access to a healthcare-specific 'How can we help you?' form and effective systems were in place to manage and respond to patients' concerns and complaints. Staff were supported to provide appropriate responses to complaints by referring to guidance and relevant staff had completed complaints investigation training. A complaint log was proactively monitored and response times and the quality of responses were audited to ensure that complaints were resolved to prisoners' satisfaction. Themes were discussed at management and governance meetings. There was evidence of improvements made in response to recurrent themes. For example, improved consistency of GPs' approach to patients.

Are services well-led?

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

Our findings

Provider seeks and acts on feedback from its patients, the public and staff

- We observed effective engagement with patients through a range of mechanisms. Healthcare representatives provided feedback from their peers and also communicated information about health services to increase awareness. A programme of forums, led by the matrons, provided prisoners with opportunities to raise queries and provide feedback to health staff. We saw examples of improvements made in response to prisoner feedback and of communications to prisoners about service quality. For example, published information about the number of appointments that were not attended and the length of waiting lists. Matrons also 'walked the floor' each month to engage with prisoners about their healthcare experiences.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not ensured that care and treatment was provided in a safe way for service users. Service users were not protected against the risks of receiving inappropriate treatment, associated with the proper and safe management of medicines. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The risks associated with the proper and safe management of medicines were not identified or mitigated effectively. Limited medicines administration times encouraged the inappropriate use of medicines. Medication was not being given at optimum therapeutic dose intervals which may have compromised the desired effect of the medication such as sub therapeutic anti-microbial levels or inadequate pain relief. Examples we found included: • Longtec 30mg modified release tablets, which was prescribed to be administered at 8am and 4pm had been given at 10.55am and 2.51 pm • Dihydrocodine 120mg prescribed to be administered at 8am and 4pm had been given at 9.52am and 2.44pm. • Dihydrocodine 60mg prescribed to be administered at 8am and 4pm had been given at 11.19am and 1.45pm. • Medicines prescribed to assist with sleeping had been administered as early as 2.45pm.