HMP Risley

Inspection report

Risley
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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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Overall summary

We accompanied His Majesty's Inspectorate of Prisons (HMIP) on their independent review of progress (IRP) and carried out a focused inspection of healthcare services provided by Greater Manchester Mental Health NHS Foundation Trust (GMMH) at HMP Risley.

At our last joint inspection with HMIP in April 2023, we found that the quality of healthcare provided by GMMH at this location required improvement. We issued a Requirement Notice in relation to Regulation 12, Safe care and treatment and 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 by GMMH were meeting the legal requirements of the relevant regulations. At this inspection, we found that improvements had been made, and the provider was no longer in breach of the regulations.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Our inspection team

The inspection was carried out by one Care Quality Commission inspector supported by an inspector from His Majesty's Inspectorate of Prisons (HMIP).

Before this inspection, we reviewed a range of information provided by the service including the action plan associated with the Requirement Notice.

During the inspection, we looked at a range of records, observed clinical activities and spoke with staff, managers and patients.

Background to HMP Risley

HMP Risley is a Category C resettlement prison operated by His Majesty's Prison Service. The prison is located in Warrington, Cheshire and accommodates up to 1,100 adult male prisoners.

Greater Manchester Mental Health NHS Foundation Trust is the provider of healthcare services at HMP Risley. 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 comprehensive inspection was conducted jointly with HM Inspectorate of Prisons (HMIP) in April 2023 and published on the HMIP website on 24 July 2023. The joint inspection report can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2023/07/Risley-web-2023.pdf

Inspected but not rated

Are services safe?

Assessing and managing risks to patients

At our last inspection, we found that patients with long-term conditions did not have individualised care plans that addressed the risks associated with their conditions. During this inspection, we found improved systems and processes that helped ensure the effective monitoring of long-term conditions.

The service had a clear pathway to support the management of long-term conditions. Managers used a spreadsheet to track patients' progress along the pathway. The service used the NHS Quality Outcomes Framework (QOF) to support their management of long-term conditions. They maintained a chronic disease register and offered appropriate checks and observations in line with NICE clinical guidelines.

Staff identified prisoners with long-term conditions at reception screenings and dealt with any immediate concerns at this time. They set up care plans and booked appointments for further assessments with the appropriate healthcare professionals such as GPs. They made referrals to other services such as mental health and social care. They also booked patients into the chronic conditions clinics that were held daily Monday to Thursdays. These were led by dedicated team of senior nurses who were becoming skilled in the management of long-term conditions.

Patients received regular reviews at these clinics, which included the relevant monitoring checks associated with their conditions such as blood pressure, peak flow, and blood sugar tests. Staff also took the opportunity to make 'every contact count' by conducting health and wellbeing checks, offering vaccinations, and responding to any new heath concerns. The patients we spoke with told us they appreciated the holistic approach the nurses adopted.

We reviewed care records for 10 patients with various long-term conditions. The records were comprehensive and up to date. Patients had personalised care plans that set out their individual needs and risks alongside the standard clinical observations required for their specific condition, for example, regular blood pressure checks for hypertension.

We found the provider had addressed the issues identified at our last inspection and was no longer in breach of the relevant regulations.

Inspected but not rated

Are services well-led?

Management of risk, issues and performance

At our last inspection, the provider did not have a quality assurance process in place for reviewing responses to complaints. At this inspection, we found an improved system for handling complaints and checking the quality of responses.

The service had developed a spreadsheet to log and track all complaints. The primary care manager handled all the complaints received (or the head of healthcare in their absence). The head of healthcare reviewed at least 20% of all complaints each month to check the quality of the responses. They identified any themes from the complaints and discussed them at local governance meetings and staff meetings.

The service received very few formal complaints with most complaints resolved as informal concerns. We reviewed 20 complaints received between October and December 2023 and found they were processed in a timely manner and the responses addressed the concerns raised.

At our last inspection, the provider did not have a system for monitoring the use of their emergency medicines out of hours. At this inspection, we found improvements that helped ensure good management and oversight of emergency medicine stocks.

The provider had developed a new standard operating procedure that listed the medicines available in the out of hours stock cupboard and set out how they should be issued and recorded. Pharmacy staff had responsibility for checking the quantity of stocks three times a week. The staff we spoke with were aware of the new procedure.

At our last inspection, we found that fridge temperatures in one treatment room had been out of range for 3 days but staff had not escalated in line with the provider's policy. At this inspection, we found the provider had developed a new operating procedure to clarify responsibilities and escalation processes that had been shared with all staff. Managers had updated the daily fridge monitoring checklist that staff completed and introduced daily audits completed by senior nurses. We reviewed daily checklists that showed staff kept up with fridge temperature checks and knew what to do if the readings were out of range.

At the last inspection, we found that the provider did not undertake audits of clinical records or patients' care plans. By this inspection, the provider had developed an audit tool to check that care plans were in place and tailored to patients' individual needs. Managers completed weekly audits on a high proportion of care records; they identified any gaps and issues, and ensured action was taken to address them. We reviewed audits completed since June 2023, which showed an increasing level of compliance demonstrating that changes had been embedded into practice.

We found the provider had addressed the issues identified at our last inspection and was no longer in breach of the relevant regulations.