HMP Rye Hill

Quality Report

Willoughby
Rugby
Warwickshire
CV 23 8SZ
Tel:01788523300
Website:

Date of inspection visit: 30 November 2016
Date of publication: 23/01/2017

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 4 April 2016

- Patients had sufficient space in which to wait when attending healthcare appointments.
- The overall number of nursing staff employed at the service had increased and this meant healthcare services had better capacity to respond to patients' care and treatment needs.
- The staff skill mix now included a range of qualified, skilled and experienced nurses to meet the needs of patients.

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 4 April 2016

- Staff completion of mandatory training had improved since our last inspection. However, some staff needed to complete training in the Mental Capacity Act 2005 in accordance with G4S policy.
- Nurses assigned a lead role in long term conditions had not received specific training to support them to provide effective care and treatment.

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 4 April 2016 .

- We observed that the quality and detail in some care plans had improved, however there was still little documented evidence of patients' involvement in their development or review.
- Some care plans did not reflect the most up to date information in respect of how a patient's care and treatment needs were being met.
- Patients' needs were reviewed at appropriate intervals but this was not always recorded in a way that ensured care plans were updated.

Summary of findings

- In February 2016 we were told that nurses had protected time during their work schedule to complete care plans. However we saw limited evidence during the inspection to support nurses to do this.

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 4 April 2016.

- The provider's action plan in response to our previous inspection indicated that care plan audits would be implemented from February 2016. This had not yet commenced and therefore there was no monitoring or analysis of the quality of care planning.

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 4 April 2016.

- Governance arrangements were not fully embedded and further work on monitoring the quality of care records and staff training needs was required.
- There was a clear leadership structure in place and staff felt supported by management.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Governance systems must fully assess, and monitor the service to ensure it remains effective.

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 and was accompanied by an inspection manager from CQC.

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.

Why we carried out this inspection

On the 30 November 2016 we undertook a focussed inspection under Section 60 of the Health and Social Care Act 2008. The purpose of the inspection was to follow up on requirement notices that we issued following an inspection in February 2016 and to check that the provider was meeting the legal requirements and regulations associated with the Act.

During the focussed inspection, we found the provider G4S Forensic and Medical Services (UK) Limited had made some improvements since our last inspection and they were now meeting the two requirement notices that we previously issued.

However we found the provider, G4S Forensic and Medical Services (UK) was in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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.

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?
- Is it well led?

Are services safe?

Our findings

Overview of safety systems and processes

- Since our last inspection the health care provider in conjunction with the Director for HMP Rye Hill had reviewed patient waiting areas and clinical treatment areas within healthcare. As a consequence of this the patient waiting area had been redesigned, decorated and the overall space had increased.This meant that patients had sufficient space and seats to use whilst waiting in this area. Further building work was in progress to develop two further treatment rooms, which would mean an increase in the frequency and range of treatment clinics offered to patients.

Monitoring risks to patients

- Since our last inspection the provider had undertaken a robust recruitment programme that had led to the appointment of four nurses including three registered general nurses (RGN) and a registered mental health nurse (RMN). In addition to this a regional clinical manager for West Midlands had been appointed. A further three appointment letters had been sent out to other applicants and we were told that more interviews were planned for the coming weeks.The team was carrying a vacancy rate of 1.6 whole time equivalents which was a considerable improvement to what we found in February 2016. Agency staff continued to be used to fill gaps on the staff rota, but the provider had taken measures to identify and ensure that only nurses skilled in working in prisons were used.

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

- Staff completion of mandatory training had improved since our last inspection. The training matrix showed that most staff had completed their required training and where training had lapsed, action had been taken. The matrix contained some gaps but for those staff currently at work these gaps were being addressed. However, one notable area of low completion (45%) was for training in the Mental Capacity Act.
- The training matrix was monitored by a dedicated administrator who provided monthly performance reports against the provider's 85% target, to the clinical lead. Staff were prompted to complete mandatory training, offered specific time to complete it and this was followed up during supervision. Staff we spoke with were clear about their responsibilities for updating their mandatory training.
- The provider had identified a range of 'desirable' training programmes that included sessions on common long term conditions. Sessions had been arranged to enable staff to improve their knowledge in relation to foot care and immunisations. Very few staff had completed additional training in long term conditions prevalent within the prison population, such as asthma and diabetes. Nor had any completed training in dementia. However, nurses had recently been allocated a lead role for particular medical conditions in response to their individual areas of interest. The clinical lead for healthcare told us that they planned to analyse and address the staff group's skill mix once all vacancies had been successfully recruited to.Similarly we found that only three nurses had completed training in care planning.
- The use of agency staff had reduced since our last inspection as permanent posts had been filled. Action had been taken to rationalise the use of agency nurses to ensure their effective use. A senior nurse had begun to monitor agency nurses' clinical practice.

Are services caring?

Our findings

Care planning and involvement in decisions about care and treatment

- We observed that the quality and detail in some care plans had improved and those we saw were personalised. However, whilst care plans were individualised there was still little documented evidence of patients' involvement in their development or review.
- Whilst some care plans included actions to enable health staff to meet patients' needs, this information was sometimes recorded in other care and treatment records. This meant that care plans did not always reflect the most up to date information; for example, how to address any acute exacerbation of a patient's condition.
- Care plans were reviewed at appropriate intervals and where the patient's condition changed.
- In February 2016 we were told that nurses had protected time during their work schedule to complete care plans. However we saw limited evidence during the inspection to support nurses to do this.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- At our last inspection care planning for patients with complex needs or long term conditions was largely absent. Where care plans did exist they lacked detail and clear actions to address the patient's needs. During this inspection we looked at a sample of electronic patient records and tracked individuals' care and treatment. We found that some care plans had been developed promptly in response to patients' diagnosis of a long term condition, or complex needs. However further work was needed to ensure that the development of care planning for patients with complex health care needs was fully embedded.
- The provider's action plan in response to our previous inspection indicated that care plan audits would be implemented from February 2016. This had not yet commenced and therefore there was no monitoring or analysis of the quality of care planning.

Are services well-led?

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

Our findings

Governance arrangements

- The recent appointment of a regional governance and clinical manager and the introduction of monthly clinical quality review meetings in October 2016 meant that there was the opportunity for all aspects of service delivery to be reviewed on a regular basis.However at the time of our inspection this arrangement was not fully embedded and futher work on monitoring the quality of care records and staff training needs was required.
- At our last inspection we were told that care plan audits would be implemented from February 2016. This had not yet commenced and therefore there was no monitoring or analysis of the quality of care planning.

Leadership and culture

- There was a clear leadership structure in place and staff felt supported by management.
- Regular team meetings and a daily handover took place where information about patients, risks and incidents was shared.

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 Governance systems did not fully assess, and monitor the service to ensure that it remained effective. Records relating to the care and treatment of each person using the service did not include an accurate record of all decisions taken in relation to care and treatment and make reference to people who use the service, including consent. Regulation: This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014