HMP/YOI Exeter

Inspection 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.

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 carried out an announced focused inspection of healthcare services provided by Practice Plus Group Health and Rehabilitation Services Limited (PPG) at HMP/YOI Exeter on 25 and 26 February 2021, in response to information of concern we received about the safety and staffing of the service. Some concerns received were outside of our scope and have been shared with relevant partners.

We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering how we carried out this inspection and took steps to minimise infection risks due to the coronavirus pandemic.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in May 2018 we found that the quality of health services had improved and were mostly good. We did not take any regulatory action against the provider.

The purpose of this focused inspection was to determine if the provider was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment.

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.

At this inspection we found:

- The provider had managed to maintain minimum safe staffing levels, although staff had experienced significant pressures and additional workloads during a recent COVID-19 outbreak.
- Staff followed safe processes when delivering wound care.
- There were appropriate systems in place to monitor and support isolating patients.
- Staff used appropriate personal protective equipment (PPE) to reduce infection risks when treating isolating and clinically vulnerable patients.
- Several staff had recently engaged in secondary dispensing, or 'potting up', of medicines, which was unsafe and illegal.
- Medicines were transported around the prison safely.
- Systems to monitor supervision needed to improve. Staff had mixed views about communication and support from managers, and some primary care staff did not receive regular managerial supervision.
- There were appropriate arrangements in place to manage individual risks to staff.
- There was some good engagement between healthcare staff and patients.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Systems to ensure that medicines are administered safely and in line with legal requirements must be fully embedded in practice.
- Systems to monitor and record the provision of staff supervision must be effective.

The areas where the provider **should** make improvements are:

- The provider should communicate clearly with staff around issues and concerns, including staffing levels and the outcome of concerns raised with managers.
- The provider should consider how to increase capacity for transporting medicines around the prison securely.

Our inspection team

Our inspection team was led by a CQC health and justice inspector supported by a second CQC health and justice inspector.

Before this inspection we reviewed a range of information that we held about the service including information from recent engagement with the provider. We also spoke with NHS England and Improvement (NHSEI) commissioners and requested their feedback before the inspection.

During the inspection, we spoke with and received feedback from over 20 healthcare staff of various grades and roles. We also spoke to prison staff, people who used the service, and sampled a range of records.

We asked the provider to share a range of evidence with us. Documents we reviewed included:

- Governance and management meeting minutes
- Contract and performance management report
- Audit outcomes
- Medicines management and administration policies
- Infection prevention and control guidance
- Datix incident reports
- Email correspondence between the provider and staff
- Staffing and supervision policies
- Staffing rotas
- Supervision records
- A management action plan relating to concerns raised about the service

Background to HMP/YOI Exeter

HMP/YOI Exeter is a category B local and resettlement men's prison in Exeter in the county of Devon, England. It holds men sentenced by the courts in Devon, Cornwall, Dorset and Somerset. There are also prisoners from other areas who have been transferred from other prisons. The prison is operated by Her Majesty's Prison and Probation Service.

PPG provides physical, social and clinical substance misuse services at HMP/YOI Exeter and is registered with CQC to provide the following regulated activities at this location: Treatment of disease, disorder or injury, and Diagnostic and screening procedures.

Our last inspection of HMP/YOI Exeter was a joint inspection with HMIP in May 2018. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/10/Exeter-Web-2018.pdf

Inspected but not rated

Are services safe?

How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?

Before the inspection, we received concerns that healthcare staff sometimes delivered wound care in the cells of patients isolation from COVID-19 and did not have time to adequately clean the treatment room when delivering care on the healthcare unit, which presented contamination risks. During our inspection, we found that staff followed safe processes when delivering wound care.

- Managers told us that all wound care was delivered in the clinic room on the healthcare unit, unless it was unsafe to move a patient in an emergency, and that the prison regime supported moving isolating patients to the healthcare unit for treatment if necessary. Staff told us that they would not deliver wound care in a patient's cell, apart from delivering supplies such as new bandages.
- We reviewed the care records of several patients who were receiving wound care. These showed that treatment took place in the clinic room and was delivered in line with an agreed care plan.
- Staff recorded on two occasions that they were unable to access a patient who required wound care because of time constraints but provided limited detail and no risk assessment in the clinical record. We asked managers to review this case. In a separate case, a nurse completed a Datix incident report when they were unable to access a patient due to the prison regime.
- The provider had doubled the time allocated for wound care treatment appointments from 10 to 20 minutes per patient, to allow staff adequate time to clean the clinic room between patients.
- The clinic room on the healthcare unit was visibly clean. A cleaning rota showed that the room was cleaned frequently.

Before the inspection, we received concerns that patients isolating due to COVID-19 could not access non-urgent medical attention. We found that appropriate systems were in place to monitor and support isolating patients.

- Isolating patients could not access electronic terminals on the prison wings to submit a healthcare application, so requested support by using the bell in their cell to alert a prison officer. Staff told us that prison staff were generally responsive to patients' healthcare needs and alerted them quickly if a patient requested healthcare support. Prison officers also checked isolating patients' welfare three times per day.
- The provider had a policy in place which set out the requirements for staff to review isolating patients based on their presentation and risk.
- We reviewed the care records of several patients who were isolating. These showed that staff had completed daily checks of all patients, including those who were asymptomatic. This went beyond the requirements of the policy. Patients who were clinically vulnerable received regular clinical observations using NEWS2 (a tool for detection and response to clinical deterioration in adult patients), in line with the policy.
- Managers told us that during a recent outbreak of COVID-19, staff had stopped reviewing lower risk and asymptomatic patients daily, in line with the provider's policy, due to time constraints.
- The practice manager maintained an up-to-date monitoring list of isolating patients. These patients were managed through a well-attended daily meeting between healthcare and prison staff. Isolating patients were also discussed at daily lunchtime healthcare and shift handover meetings.
- The GP told us that they offered telephone consultations to isolating patients and could still see patients who required an emergency appointment in person.

Before the inspection, we received concerns that arrangements for managing PPE while treating isolating patients created infection risks. During our inspection, we observed safe management of PPE when staff were treating patients.

- We observed staff who were administering medicines and the supporting prison officers using appropriate PPE while engaging with isolating patients. Staff treating isolating patients told us they had good access to appropriate PPE.

Inspected but not rated

Are services safe?

- During medicines administration rounds, we observed staff donning and doffing PPE safely, regularly cleaning their hands, and disposing of used PPE in a clearly marked clinical waste bag. Staff also disposed of waste safely at the end of administration rounds.
- Some staff raised concerns that canvas bags used to transport PPE supplies could not be cleaned, increasing contamination risks. The provider had addressed this in a recent action plan in response to staff concerns and was ordering replacement wipeable bags.
- The primary care lead, who had an infection control specialism, had provided training and support to healthcare and prison staff around using PPE and managing infection control during the pandemic.
- A recent infection control audit showed good staff compliance with infection control procedures during clinical practice.

Before the inspection, we received concerns that staff treated both patients isolating due to COVID-19 and clinically vulnerable patients during a single shift, increasing contamination risks. During our inspection, we found that there were appropriate measures in place to reduce these risks.

- Staff who were working on the wing with more clinically vulnerable patients during our inspection told us that they would only work with patients on that wing during their shift to avoid contamination risks. Some staff told us they did treat vulnerable and isolating patients in the same day. However, we observed several medicines administration rounds and other staff interactions with isolating prisoners during our inspection where staff always used appropriate PPE and displayed good hygiene practices, which significantly reduced any contamination risks.

Before the inspection, we received concerns that primary care staffing levels were insufficient to deal with large numbers of patients isolating due to COVID-19, creating risks around safe care and treatment. During our inspection, we found that the provider had managed to maintain safe staffing levels, although staff had experienced significant pressures and additional workloads during a recent COVID-19 outbreak.

- The staff team had been impacted by a recent COVID-19 outbreak, with high levels of staff sickness and several staff having to shield or isolate at home. Healthcare services had been reduced to urgent care only during the outbreak.
- Some staff felt that staffing levels were insufficient to provide a safe service, giving examples of recent medicines rounds being delayed and a lack of time to complete clinical records. While this carried potential risks, we did not find any examples of adverse clinical outcomes for patients.
- Staff rotas we reviewed showed that the provider had maintained at least the minimum planned safe staffing levels, as set out in its local policy, during January and February 2021.
- Several staff told us that they had worked additional hours and longer shifts to ensure safe staffing levels during the recent outbreak. Some felt under pressure from managers to work longer hours to ensure that key tasks such as medicines administration, which was sometimes taking much longer than planned, were delivered safely.
- Managers told us that staff were offered additional shifts to cover gaps in the service but were never forced to work additional hours and were encouraged to take breaks if working extended hours. We observed managers highlighting this during a lunchtime meeting.
- Managers told us that staff had worked additional shifts to support recent mass testing of prisoners and gave examples of how they had provided good formal and informal support to staff during this period.
- Bank staff had worked additional shifts to support the service during the recent outbreak. Substance misuse and mental health staff had also covered some recent gaps in primary care staffing where appropriate to do so. Managers and staff were complimentary about the quality of support provided by colleagues from these teams.
- The provider had taken some steps to make workloads more manageable for staff. The GP was completing a medicines review for the wing which housed clinically vulnerable patients, which several staff referred to as particularly time consuming, to reduce numbers where appropriate. Managers were reviewing shift patterns to provide more support for administering evening medicines and were working with the prison to ensure there was greater support for staff administering medicines.

Inspected but not rated

Are services safe?

- Most staff told us they felt well supported by their colleagues and that peer support had been helpful when the service was extremely busy.
- Some staff raised concerns that staffing levels at night were unsafe and felt that arrangements for night staffing had not been communicated clearly by managers. Staff rotas showed that the provider had maintained planned safe staffing levels at night, in line with its local policy, and had recently increased staffing overnight with an extra health care assistant providing support.
- Managers told us that recruitment was on-going with a full-time nurse and healthcare assistant recently employed, however recruitment in the region, including finding suitable agency staff was an on-going challenge. NHSEI had also agreed to provide some short-term funding to help the service with staffing.

Before the inspection, we received some concerns about the prison regime which were outside of our scope and have been shared with relevant partners. During the inspection, no prisoners raised any concerns about their welfare, although our contact was limited due to COVID-19 restrictions. Healthcare staff training levels in safeguarding were good, and staff were aware of how to raise concerns about patients' welfare.

Appropriate and safe use of medicines

Before the inspection, we received concerns that staff were engaging in secondary dispensing, or 'potting up', of medicines (an illegal process where medicines are removed from the original dispensed or stock container and put into medicine pots before the time of administration). We found that this had happened on several occasions during February 2021.

- Several staff told us that they had engaged in, or were aware of secondary dispensing of medicines during February 2021 while administering medicines to isolating patients across the prison. Staff explained that this was due to pressures caused by a COVID-19 outbreak, resulting in a significant increase in the number of patients isolating who required supervised medicines at their cell door. Staff felt that this was the safest way to administer medicines while reducing delays and the associated risks to patients.
- The provider's medicines administration polices set out the risks associated with secondary dispensing and clearly stated that this was unacceptable practice.
- Some staff had raised concerns about secondary dispensing with managers locally but didn't report this through the Datix incident reporting system. Most staff appeared to be aware of the risks associated with secondary dispensing, but we did not see evidence of staff recording the rationale for their actions or a risk assessment in patient care records.
- We did not find any evidence of adverse outcomes related to secondary dispensing, such as medicines being misplaced or patients receiving incorrect medicines.
- The provider had taken some steps to address the risks and reduce pressures on staff. This included the GP prescribing smaller quantities of medicines, reducing the volume of medicines staff transported around the prison. The provider was also looking at alternative ways of transporting medicines around the prison to increase storage capacity.
- Managers told us that after becoming aware of secondary dispensing, they had increased monitoring of medicines administration and raised concerns with individual staff as this practice was unacceptable. They had also consulted with the provider's pharmacy lead to review the medicines administration process.
- Secondary dispensing did not appear to be routine practice and had occurred in response to a recent COVID-19 outbreak. However, while staff were aware of the risks associated with this practice, they did not adequately risk assess or document their decisions. We were not assured that a safe medicines administration process was fully embedded in practice and that staff would not revert to secondary dispensing in similar circumstances. Further work is required by the provider to support staff to administer medicines safely and legally.

Inspected but not rated

Are services safe?

Before the inspection, we received concerns that medicines, including controlled drugs, were moved through the prison in a way which presented risks around diversion and staff safety. We observed safe movement of medicines around the prison during our inspection.

- The provider had a policy in place which set out a process for safely administering medicines to isolating patients at their cell door.
- Staff transported medicines around the prison in small green carry bags which were secured with a padlock. Staff also used a lockable trolley to transport medicines, although this could not be used on upstairs landings.
- Staff administering medicines to patients at their cell door were always supported by one prison officer who opened cell doors, as per the provider's policy.
- We observed prisoners out of their cells walking close to staff who were administering medicines to patients. Prison officers diverted the prisoners away at healthcare staff's request so they could continue to administer medicines safely.
- Managers and staff told us that the prison regime generally supported the safe movement and administration of medicines. They gave a recent example when prisoners were out of their cells while staff were administering controlled drugs. This was raised with prison managers, who ensured the next day that prisoners remained in their cells until staff had completed administering controlled drugs.
- Most staff felt well supported by prison officers while administering medicines, although some reported feeling unsafe administering medicines while prisoners were out of their cells and felt that the bags used to transport medicines were unsafe. Managers were considering alternative transportation which was more secure and had more capacity.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

Before the inspection, we received concerns that managers did not communicate effectively with staff, particularly when staff had raised concerns. During the inspection, staff gave mixed feedback around communication from managers.

- Several staff raised concerns that managers did not respond to tell them what was being done as a result of staff raising concerns.. Some staff said that they did not feel confident reporting incidents via the Datix incident reporting system as they were not assured their concerns would be addressed.
- We reviewed incidents reported on the Datix incident reporting system in January and February 2021. Most reported incidents had been addressed with evidence of appropriate actions taken and lessons learned identified, although some investigations were outstanding which meant that learning had not yet been identified and shared with staff.
- Full team meetings had been limited due to COVID-19, although we observed managers sharing important messages and providing updates to staff during lunchtime and handover meetings.

Governance arrangements

We reviewed staff supervision arrangements and found that the provision of supervision was inconsistent, particularly for some primary care staff who had not accessed regular managerial supervision in the last 12 months.

- Staff gave mixed feedback around the support that they received from managers and access to supervision. While some staff told us that they met regularly with their managers, others said they had not received regular managerial supervision over the last year.
- The provider's performance and development policy did not set out the required frequency for managerial supervision. Managers told us that they expected managerial supervision to take place monthly, although pressures associated with the COVID-19 pandemic had impacted on this recently.
- The provider's supervision record was inconsistent and did not contain details of all completed managerial supervision. Managers confirmed that a particular staffing group had not received regular managerial supervision due to line management changes. This was a missed opportunity to communicate with and support these staff.
- The provider's supervision record showed little evidence of clinical supervision. Managers told us that clinical supervision was being developed and was usually provided in staff meetings. Most staff we spoke to told us they felt supported clinically, with several mentioning good support from the primary care lead, good peer support and sharing learning amongst colleagues.
- The provider's supervision record showed no evidence of recent appraisals taking place. Managers confirmed that appraisals would be completed once they had received PPG's corporate objectives for the year.
- Following our inspection, the provider shared an updated managerial supervision record which provided an accurate record of completed supervision and would help managers to monitor and plan supervision more effectively.

Managing risks, issues and performance

Before the inspection, we received concerns that some staff had not received an individual risk assessment for working during the COVID-19 pandemic. We found that there were appropriate arrangements in place to manage individual risks to staff:

- The provider contacted all staff by email in June 2020 with details of a COVID-19 personal risk assessment tool and related instructions. Managers re-issued the guidance to healthcare staff at HMP/YOI Exeter shortly afterwards. Several staff told us they had completed a personal risk assessment.
- The provider re-issued personal risk assessment guidance to all staff in November 2020.
- Managers told us that new staff were given details of how to complete a personal risk assessment.

Inspected but not rated

Are services well-led?

- Managers told us that the decision to complete a personal risk assessment sat with individual staff due to medical confidentiality, but that they would support staff to complete the assessment where necessary.

Engagement with patients, the public, staff and external partners

Before the inspection, we received concerns that information relating to a COVID-19 outbreak had not been communicated effectively to patients. During the inspection, we saw some evidence of good engagement between healthcare staff and patients.

- Staff provided regular, documented support to patients isolating due to COVID-19, which until recently had often gone beyond the requirements of the provider's policy.
- Staff said that patients had become frustrated in recent weeks when medicines administration rounds had taken longer than planned due to the increased number of isolating patients.
- During our inspection, a medicines administration round was delayed due to computer system failure. The provider printed off letters to give to patients who were receiving supervised medicines to explain the reasons for the delay.
- During medicines administration, we observed a patient become agitated about the care they were receiving and delays to the medicines round. Staff treating the patient communicated clearly and respectfully with the patient to quickly resolve the situation.
- Managers told us that prisoners had received regular updates about changes to healthcare services via announcements over the prison's loudspeaker system during the pandemic. However, this system was broken at the time of our inspection.

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
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The systems and processes designed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk were not used effectively. In particular:** • A system to ensure that medicines are administered safely and in line with legal requirements was not fully embedded in practice. **The provider did not maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. In particular:** • Systems to monitor and record the provision of staff supervision were not effective.