HMP/YOI Exeter

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.

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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 detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in August 2016.

Robust systems were in place to monitor and follow up on patients who failed to attend health appointments.

Medicines were transported around the prison safely.

Appropriate risk assessments were carried out for patients in possession of their own medicine.

Medicine review clinics were held monthly by a pharmacist.

Dental equipment had been maintained and serviced to ensure it was safe to use and fit for purpose.

Are services effective?

We did not inspect the effective domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with HMIP in August 2016.

Patients with long term conditions were well manged. However, more work needed to be done to ensure all patients with such conditions had individualised care plans in place.

Are services caring?

We did not inspect the caring domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with HMIP in August 2016.

Healthcare promotion continued to be under developed. However, Information was available to promote health and wellbeing, but this required further improvement.

Are services responsive to people's needs?

We did not inspect the responsive domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with HMIP in August 2016.

Waiting lists for appointments were well managed and waiting times with the exception of dental appointments were low.

Summary of findings

Additional dental clinics had been held to reduce the time patients had to wait to see the dentist. Secondary health screening took place within 72 hours. Healthcare boxes installed on the wings meant prisoners could make complaints confidentially.	
Are services well-led? We did not inspect the well-led domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in February 2017 as a result of the joint inspection with HMIP in August 2016. A comprehensive audit process was in place that was being adhered to. Staff received good clinical and managerial support and all appropriate checks to ensure staff were suitable for their role had been carried out.	

HMP/YOI Exeter

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was completed by two CQC Health and Justice Inspectors who had access to remote specialist advice if required.

Background to HMP/YOI Exeter

Her Majesty's Prison Exeter is a category B local prison that accepts all adult and young offenders committed to prison by the courts in Devon, Cornwall, Somerset and further afield. Care UK Health & Rehabilitation Services Limited provides a range of healthcare services to prisoners, comparable to those found in the wider community. The location, HMP/YOI Exeter is registered to provide the regulated activities, diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury. CQC and Her Majesty's Inspectorate of Prisons (HMIP) undertake joint inspections under a memorandum of understanding. Further information on this and the joint methodology can be found by accessing the following website: http://www.cqc.org.uk/content/health-and-care-criminal-justice-system. CQC inspected this service with HMIP in August 2016, at that time Dorset Healthcare University NHS Foundation Trust were registered to provide regulated activities. We found evidence that essential standards were not being met and two Requirement Notices were issued in relation to Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report can be found by accessing the following website:https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-exeter/.As of the 1 April 2017 Care UK Health and Rehabilitation Services Limited were registered to provide regulated activities.

Why we carried out this inspection

On the 31 October and 1 November 2017 we undertook an announced focused inspection 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 Health and Social Care Act 2008 and specifically whether the significant improvements as identified in the requirement notices issued to Dorset Healthcare University NHS Foundation Trust, as a result of the inspection in August 2016, had been made.

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. During the inspection we spoke with staff and patients who used the service, observed practice and reviewed a range of documents.

Evidence reviewed included:

- An updated action plan from Care UK for HMP/YOI Exeter.
- An updated action plan from the dental provider (Time for Teeth) for HMP/YOI Exeter.

Are services safe?

Our findings

At our previous inspection in August 2016, we found concerns related to poor monitoring of patients' failure to attend health care appointments, medicines management and clinical equipment within the dental suite.

These included:

- There were no systems in place to monitor failure to attend health appointments or those who failed to attend to receive their prescribed medicines. This meant staff could not be certain that patients' needs were being met.
- Medicine fridges not being suitably monitored to protect the integrity of stored medicines.
- Unsafe practice in the transportation of medicines.
- Lack of a comprehensive risk assessment process in place for patients to have medicines in their possession.
- No processes in place to provide staff with up to date information to support the safe and proper use of medicines.
- There was no system in place to ensure timely reviews of patients' medicines.
- No current documents to provide assurance of the safety of dental x-ray equipment and procedures. There was no evidence that legionella checks had been completed within the dental suite.
- Maintenance logs were not all up to date to help ensure dental equipment was fit for purpose and safe to use.

When we carried out our focused follow up inspection we found a number of changes had been made to address the concerns and significantly improve the service.

The clinical lead nurse was responsible for monitoring patients who did not attend their planned appointments. Patients were spoken with where possible to ascertain the reasons for their failure to attend and if appropriate were re-booked into the next available clinic. Pharmacy technicians ran clinics to follow up on patients face to face who had failed to attend to receive their medicine for 3 consecutive days.

There was a system in place to monitor the temperatures that medicines were stored at which required staff to make a daily check of room and fridge temperatures. The temperatures recorded indicated that medicines were being stored appropriately. However, staff had not always remembered to complete the form meaning that there were some days when the storage temperatures were unknown. The team leader carried out a monthly audit of these forms and we saw that they had already taken action to address this issue with staff.

The provider had acquired secure boxes which were used for the transportation of medicines across the prison. Staff told us they would only transport medicines around the prison when prisoners were in their cell. If this was not possible, staff would request an escort from a prison officer.

The records we checked confirmed that a risk assessment had been carried out prior to people being able to keep a supply of their medicines 'in possession' (where a prisoner is able to keep an agreed supply of their medicines in their cell). The risk assessments were also reviewed periodically or when any concerns were raised.

Staff told us that they received updates as required regarding any drug safety alerts and product recalls, either from the registered manager or from Care UK.

A pharmacist held monthly medicines review clinics to help ensure patients' medicines were routinely reviewed.

There had been a change of dental provider since the last inspection. The new provider, Time for Teeth, had put into place a radiation protection file which clearly identified who the radiation protection advisor was. The file also contained a clear set of local rules for the use of x-ray equipment as well as an inventory of all equipment kept on site.

There was a clear audit trail for the maintenance and servicing of all equipment that the provider was responsible for. In addition, they worked closely with the prison works department to ensure items belonging to the prison were serviced as required, such as the dental chair. A legionella risk assessment had been carried out and a sample of water had been taken from the building which housed the dental suite. The testing of this sample confirmed that no legionella was present in the water at the time of testing.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in August 2016, we found concerns related to the care of patients with long term conditions, care records were inadequate and staff were not supported.

These included:

- Lack of monitoring in place to help ensure regular reviews and checks were carried out for patients with long term conditions.
- The quality of patients' records was inadequate, care plans were not individualised and were insufficiently detailed or routinely reviewed.

When we carried out our focused follow up inspection we found a number of changes had been made to address the concerns and significantly improve the service.

People with long term conditions were well manged through the GP with support from the nursing team. Specific long term conditions clinics were run dependent on the need of the current population. We saw written evidence and a structured staff training programme that showed there was a developing system in place, to train staff to hold specialist leads roles in identified common long term conditions. This would further improve the service offered to patients.

Care records were of an appropriate standard and were being monitored to help ensure consistency, quality and accuracy. However, more needed to be done to ensure patients with long term conditions had individualised care plans that reflected how their needs could be met, as currently not all patients had this. Well-developed plans were in place to address this which had started to be implemented.

Are services caring?

Our findings

At our previous inspection in August 2016, we found concerns related to a lack of health care promotion.

This included:

- No effective arrangements to promote prisoners health and wellbeing.
- Lack of access to translated healthcare materials.

When we carried out our focused follow up inspection we found a number of changes had been made to address the concerns and significantly improve the service.

Two people had been identified to lead in healthcare promotion within the prison. Healthcare promotional information was available and on request this could be translated. However, this was in its infancy and more work was needed to be done to further develop this area in order to promote health and wellbeing as a whole prison approach.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection in August 2016, we found concerns related to poor access to routine dental appointments, a lack of monitoring of patients who failed to attend arranged appointments and the management of complaints.

These included:

- No monitoring in place for clinic waiting lists; patients had reported poor access to healthcare professionals and secondary screening was not always timely.
- No established triage system in place to prioritise appointments.
- A complicated application process which led to confusion amongst prisoners and application boxes were not fit for purpose.
- Patients waited too long for dental assessment and treatment.
- No system in place to follow up on or monitor failure to attend appointments.
- No system in place to ensure complaints could be made confidentially.
- Complaints were not responded to in a timely manner.

When we carried out our focused follow up inspection we found a number of changes had been made to address the concerns and significantly improve the service.

Care UK had an effective system in place for managing and monitoring waiting lists, waiting times were low. Access to healthcare professionals was good and secondary health screening took place within 72 hours.

Senior nurses triaged all applications for healthcare appointments and prioritised them based on clinical judgement of need. The application process had been simplified with one universal application form in use to prevent confusion amongst prisoners. All application boxes were firmly in place and fit for purpose.

The dental provider had implemented additional clinics in order to reduce waiting times. There were 77 people on the dental waiting list. Due to the high level of need for dental treatment, new patients waited longer to be seen. This was because patients currently undergoing a course of treatment took priority when appointments were booked. However, most people waited less than six weeks for a routine appointment. The dental provider and healthcare provider were looking into the possibility of reserving one clinic per week for new patients only.

On average, 19% of patients did not attend (DNA) for their dental appointment. The majority of failed appointments were people who resided in one wing of the prison who experienced difficulty in getting to the dental suite. The healthcare provider had worked with the prison to have a prison officer allocated each weekday for the purpose of escorting people to their appointments. It was anticipated that this would address the issue and result in greatly reduced DNA rates and therefore reduced waiting times. However, this development had not been communicated to the dental staff, which resulted in frustration amongst dental staff. In addition, dental staff were not invited to staff meetings, meaning they felt distanced from the wider healthcare team.

Healthcare boxes had been installed on each wing so that prisoners were able to make complaints confidentially. Care UK had implemented a separate healthcare complaint form and these were available for prisoners to use. However, most prisoners despite having the choice to make complaints confidentially still continued to use the prison complaints form. Staff were exploring reasons for this and raising awareness of the importance in maintaining confidentiality.

Complaints were responded to in a timely manner and prisoners who had made complaints were seen to face to face to help resolve their concerns. Robust systems for managing and monitoring complaints had been put in place. A written outcome of the resolution had been clearly recorded; however this could be more detailed to highlight how the agreed resolution was reached. Information on how a prisoner can escalate their complaint if they felt the outcome had not been satisfactory was displayed, yet more could have been done to raise awareness of this process.

Are services well-led?

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

Our findings

At our previous inspection in August 2016, we found concerns related to a lack of audits taking place to help ensure the service's quality and effectiveness.

These included:

- There was only one audit in place which was not appropriate.
- There was no monitoring in place to ensure staff appraisals, supervision and Disclosure and Barring Service (DBS) checks had been completed. DBS checks are completed to help ensure staff are suitable to work with vulnerable groups of people.

When we carried out our focused follow up inspection we found a number of changes had been made to address the concerns and significantly improve the service.

Care UK had a comprehensive audit process in place. This had been embedded in practice. Actions had been taken following audits to change processes, enhance service delivery and improve quality and outcomes for patients.

There was a robust system in place to help ensure staff supervision and appraisals took place in accordance with Care UK's policy. Staff told us they felt well supported. Staff had current DBS certificates and there was good oversight and management of this process.