

**Action Plan – Mr Brian Lucking at HMP Bure– Natural Causes on 21/01/2020**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/ Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>
1	The Head of Healthcare should review the need for formal assessments of mental capacity for prisoners who fail to comply with treatment that is in their best interests.	Accepted	<p>All staff are able to complete a mental health capacity assessment. The Head of Healthcare will review the process with the Regional Mental Health lead to discuss how to embed into practice.</p> <p>Once the process is agreed this will be shared amongst the team. The new mental health lead will lead on this with completion aimed for mid-August 2020</p> <p>The Local Operating Procedure for omitted doses will be reviewed in mid-August 2020 and updated to reflect consideration for those who do not have capacity to consent and/or do not attend for critical medications including mental health medications.</p>	<p>August to September 2020</p> <p>Head of Healthcare</p>
2	The Head of Healthcare should ensure that staff make full and accurate notes in a prisoner's medical record following involvement in their care.	Accepted	<p>The importance of contemporaneous record keeping is to be discussed at the next local quality assurance and improvement meeting with all staff on the 10th July. Minutes will be disseminated amongst the team.</p> <p>The importance of record keeping has been re-iterated within the clinical team handover to ensure all staff are aware of their responsibility.</p> <p>The NMC Code of Conduct Guidelines will be shared with all staff and they will be advised of the importance of accurate and clear record keeping.</p> <p>The Record Keeping Audit (as an element of the PROTECT Audit) will be audited by the 27th June as part of the Health In Justice Audit Schedule. The results will be shared within the Quality Assurance and Improvement Meeting on the 10th July.</p>	<p>July 2020</p> <p>Head of Healthcare</p>

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3	The Governor should remind staff of the need to make accurate and timely notes in the prisoner's NOMIS record following involvement in an incident.	Accepted	<p>Information For Colleagues (IFC) 124/2020 NOMIS Case Notes was published on 26/05/2020. This clarifies to staff the importance of recording case notes on NOMIS and gives a list of examples incidents where a case note would be appropriate. It also stresses the importance of ensuring case notes are specific to the resident in question and clearly evidence knowledge and understanding of the resident in question. In order to test that staff were aware of this the existing keyworker Quality Assurance was increased to include entries related to incidents and significant events. The content of IFC 124/2020 was added to our daily briefing points so that managers covered this on a daily basis to embed the requirement amongst their staff.</p> <p>Within the Residential and Safer Custody functions, Managers from Band 4 and above undertake Quality Assurance to ensure case notes are being completed by staff and that they are of the content and quality required. Quality assurance of case note entries by keyworkers was an embedded process, since the passing of Mr Lucking this Quality Assurance has been expanded to include entries related to incidents and significant events.</p>	<p>Complete</p> <p>Governor</p>