

**Action Plan – Mr Richard Dimmock at HMP Hewell – Self Inflicted on 25/06/2019**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that:</p> <ul style="list-style-type: none"> <li>• Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.</li> <li>• Staff have a clear understanding of their responsibilities and the need to record and share promptly relevant information about possible risk.</li> <li>• Prison, healthcare and mental health team staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least</li> </ul>	Accepted	<p>HMP Hewell continue to work to strengthen the management process surrounding ACCT to ensure that the outcomes for prisoners are improved and that all staff adhere to the appropriate ACCT policy. As part of this process the Head of Healthcare/Head of Safety are working towards increasing the level of quality assurance of ACCT case management. On completion of conducting quality assurance of an ACCT case, the Head of Safety/Head of Healthcare will provide feedback and guidance to case managers responsible for managing prisoners on the ACCT case.</p> <p>In January 2020 additional training was provided for all staff who look after men on ACCT about risks and triggers. This training will continue to be delivered on a monthly basis and will be facilitated alongside Healthcare staff to improve joint working practices.</p> <p>The Head of Safety/Head of Healthcare are currently in the process of introducing a rolling programme of notices to staff using national learning bulletins around the process and how staff should aim to identify risk. These notices will act as an ongoing reminder to staff informing them of their responsibilities when managing prisoners on ACCT.</p> <p>The Head of Safety will also continue to communicate with all staff via emails informing them of Safety themed awareness sessions, meets and greets in the gate, Monthly Safety themed newsletter, staff forums and regular training days.</p> <p>A new scheduling system was introduced in January 2020 to improve the opportunities for prison staff to work closely with healthcare colleagues and particularly with mental health partners to support men on ACCT at case</p>	<p>Head of Safety/Head of Healthcare/Head of Function</p> <p>June 2020</p>

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	<p>the first review and subsequent reviews if the prisoner has serious health concerns.</p> <ul style="list-style-type: none"> <li>• Staff hold multidisciplinary ACCT reviews, with the same case manager and which involve staff who contribute to a prisoner's care.</li> <li>• Case manager's complete caremaps, identifying all the risks, setting specific and meaningful caremap actions, identifying who is responsible for them, reviewing progress at each review and not closing ACCT procedures until all the risks have been addressed.</li> </ul>		<p>reviews. This system allows all staff to work jointly to manage prisoners on ACCT. The Head of Safety/ Head of Healthcare will continue to monitor its effectiveness on a monthly basis and take further action if required.</p> <p>In January 2020 an ACCT review week was conducted by the Head of Safety/Head of Healthcare where all open ACCT cases were reviewed to assess the efficiency of the care being provided in each open ACCT case. After each review discussions were held with each case manager responsible for the case to ensure that they were aware of the risks present and were informed what agencies need to be involved in the ongoing care for that prisoner.</p> <p>Case managers will be identified who require further support and training to improve the quality of caremaps and this will be monitored via the additional quality assurance process on a monthly basis. The Head of Function will conduct spot-checks on 50% of completed caremaps and will provide live feedback and coaching to the case managers and staff concerned.</p> <p>A caremap guidance has been created and has been shared with case managers in February 2020.</p> <p>HMP Hewell has made a request to the Regional Safety team to focus on the importance of completing caremaps accurately during their training and awareness sessions with staff. This process will be reviewed quarterly to ensure consistency in quality. Training sessions are due to take place by June 2020.</p>	

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2	The Governor and Head of Healthcare should ensure that prison and healthcare staff share all information about a prisoner's cell-sharing risk and record it in prison and medical records.	Accepted	<p>In March 2020 The Head of Healthcare will inform all Healthcare staff in reception that they must record the details of the cell-share risk assessment onto the SystemOne Patient Medical Record and that any relevant risk is communicated to prison staff who will document on NOMIS prison record.</p> <p>A single point of contact (SPOC) will be identified with Healthcare to ensure clear lines of communication and individuals accountable for completing these actions will be provided.</p> <p>CSRAs will be reviewed weekly as part of the Safety Intervention Meeting and any changes made during this process will also be communicated by the Safety team to the Healthcare SPOC.</p>	<p>Head of Healthcare/ Head of Safety/Head of Operations</p> <p>March 2020</p>
3	The Head of Healthcare should ensure that in cases where prisoners are admitted with no known GP and then a registered GP becomes identified some time later, healthcare staff should give consideration as to whether their medical history is requested or not.	Accepted	<p>A Notice to Healthcare administration staff will be issued in March 2020 informing them that they must check that the patient's community medical records are requested on arrival at HMP Hewell. Where no GP details are identified the progress is to be clearly documented within the patient's electronic medical records.</p> <p>In May 2020 The Head of Healthcare will review the current process to include; where the community GP has been identified following the point of admission from an external source. Following receipt of a prisoner's medical records, a medical Clinician will assess any risks that have been identified and will clearly document this within the prisoner's electronic medical records.</p>	<p>Head of Healthcare</p> <p>March 2020</p>
4	The Governor and Head of Healthcare should ensure that staff are given clear guidance	Accepted	Guidance from the British Resuscitation Council was issued to all prison staff in January 2020 as a reminder of their roles and responsibilities surrounding Resuscitation.	Head of Safety/Head of Healthcare

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	and understand the circumstances when they should not try to resuscitate prisoners in line with European Resuscitation Council Guidelines.		In December 2019 The Clinical Services Manager provided guidance in line with the European Resuscitation Council Guidelines to all Healthcare staff. A Notice to Staff reinforcing these actions will be issued in March 2020.	March 2020