

Action Plan in response to the PPO Report into the death of Mr Kevin William on 07/03/2021 at HMP Wayland

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should ensure that referrals are made at reception screening to the long-term conditions clinic for the onward monitoring of pre-existing health conditions.	Accepted	<p>Patients who have long term conditions are referred to long term conditions clinic, this is to ensure patient have a patient centred/individualised care plan.</p> <p>The national Arden's templates are used to capture patient assessment and support escalation. There are quarterly long term conditions audits in place to monitor quality.</p>	Head of Healthcare	Completed
2	<p>The Head of Healthcare should:</p> <ul style="list-style-type: none"> ensure that record keeping is in accordance with the NMC Code (2018) which stipulates that records should be always clear and accurate; and 	Accepted	Staff have been reminded to write down interventions timely in consistence with record keeping standards, following code of conduct guidelines. This has been discussed at handover and at patient safety incident review meeting as part of learning and reflection following serious incident. This is also further discussed with the team at local quality	Head of Healthcare	Complete



	<ul style="list-style-type: none"> ensure that the information recorded is adequately detailed to capture a significant event that has occurred, including the emergency response and subsequent admission to hospital. 		<p>assurance meeting to raise awareness to all staff.</p> <p>Record Keeping training has been developed on the National Learning Management System (LMS). Staff will be allocated the time to complete and discuss as part of their clinical supervision.</p>		30.03.2022
3	The Head of Healthcare should share this report with all the staff named in it.	Accepted	The report will be shared with the wider team and key themes and lessons learned will be reviewed at the Patient Safety Incident Review Group Meetings (PSIRG) which feed into the regional PSIRG meetings and at the local quality assurance meeting.	Head of Healthcare	30.03.2022

