

Action Plan in response to the PPO Report into the death of Mr Keith Fairbrother 04/06/2022 HMP Wakefield

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Head of Healthcare should ensure that staff carrying out reception health screens:</p> <ul style="list-style-type: none"> • Complete the screening template in full so that all relevant information, such as medication and mobility issues, are recorded. • Refer prisoners to the clinic for long-term conditions where appropriate. • Arrange follow up appointments if necessary, for example, where there is a high blood pressure reading. 	Accepted	<p>Completion of the reception screening template is audited monthly by the Business Manager in line with PPG data performance reporting. Compliance is addressed with individuals through one-to-one sessions.</p> <p>This PPO report has also been shared with all healthcare staff via email and the recommendations discussed in team meetings and clinical supervision sessions.</p> <p>Staff are aware of the requirement to make referrals and arrange follow ups due to these discussions. Auditing and monitoring of this is not possible as there is no report to pull this information. If it is identified that staff have not appropriately referred or arranged follow up, then this will be managed in line with PPG performance policy</p>		Completed 13.02.2023
2	The Head of Healthcare should ensure that all clinical staff are trained and competent in	Accepted	This recommendation is not relevant for all clinical staff. GPs and ANP's have been given one to one training by the PPG Business		Completed 13.02.2023



	managing GP2GP degraded entries to support with continuity of care.		Manager in managing degraded entries. The training took place following receipt of the Clinical review in September 2022 which identified this as an action. The Business Manager oversees completion of this by reviewing GP2GP tasks daily and ensuring they are actioned that same day. Ongoing monitoring of this process has provided assurance that GP2GP degraded entries tasks are not completed promptly		
3	The Head of Healthcare should ensure that care plans are initiated, reviewed and updated for any active medical or mobility issue.	Accepted	Care plan training was delivered to the healthcare team on 7 th December 2022. The training included initiating, reviewing and actioning of care plans. The Clinical leads are accountable for the implementation and management of care plans for their areas of service. Auditing of care plans is part of the monthly 'managers checklist' and compliance issues will be addressed with individuals in their monthly managerial supervision/one to one sessions.		Completed December 2022
4	The Head of Healthcare should ensure that staff carry out a full clinical assessment of a prisoner with chest pain, in line with National Institute for Health and Care Excellence (NICE) guidance CG95 on recent-onset chest pain of suspected cardiac origin.	Accepted	PPG 'Chest pain pathway' was circulated by the Deputy Head of Healthcare to the primary care nurses & inpatient nurses (which includes night staff) in July 2022. This was re-circulated by the Primary Care Clinical Lead via email in November 2022 to capture new starters. The Clinical Leads review the SystmOne records of prisoners who have reported chest pain to ensure the pathway has been followed.		Completed 13/02/2023



5	The Head of Healthcare should ensure that all clinical staff are aware of their responsibilities in managing medical devices and the escalation processes in place when equipment is faulty or not available.	Accepted	The medical device relevant to this report is a sphygmomanometer (to take blood pressure). These devices are readily available in the primary care clinic rooms and could have been accessed. Following this incident, primary care nursing staff have been issued with 'bum bags' which contain monitoring equipment, including a sphygmomanometer. The nursing staff carry these at all times so that observations can be taken without delay		Completed 31.10.2022
6	The Head of Healthcare should review the events that led to the incorrect administration of adrenaline during the emergency response and consider whether additional training is needed.	Accepted	This incident has been discussed at length with the staff involved in individual clinical supervision sessions. In addition, all clinical healthcare staff are mandated to complete rolling annual ILS (immediate life support) training which includes the causes and prevention of cardiorespiratory arrest. Implications for the use of adrenaline is covered in this training		Completed 13/02/2023

