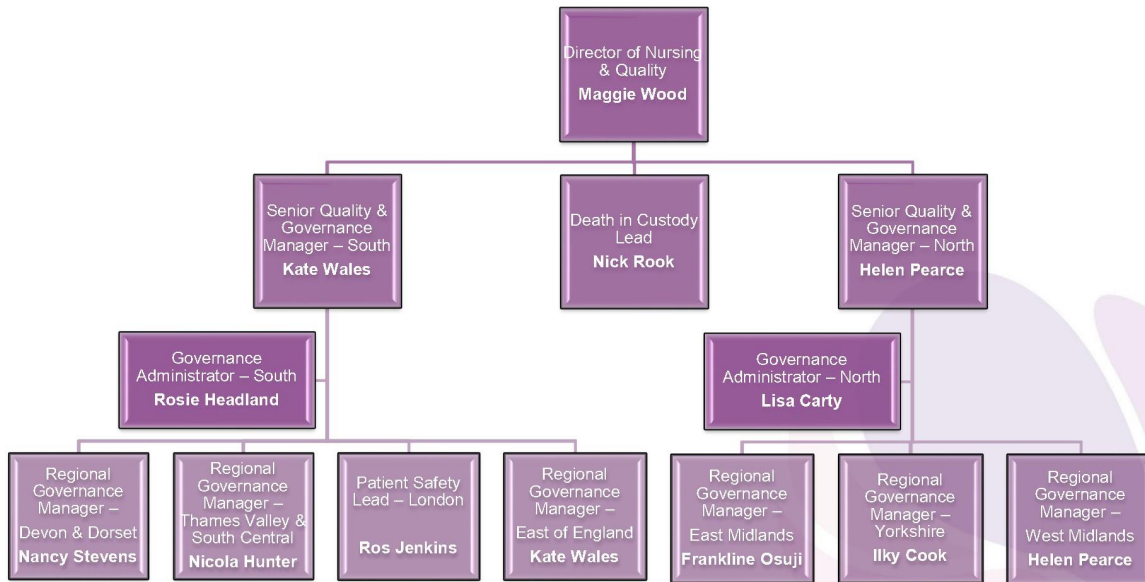




Governance – The Team





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Practice
Plus
Group

PROTECT - 7 key learning themes

P

Patient screening

Assessing every new patient thoroughly

R

Record keeping

Get it all down

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Ongoing medication

Safely prescribing to new patients

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Take ACCTion

Proactively involved with ACCT

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Emergency preparation

Ready for action

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Continuity of information

Getting a bigger picture

T

Tackle abnormalities

Don't miss the early natural death warning signs, head them off

At Practice Plus Group, we're dedicated to ensuring the highest levels of patient safety at all times. As a team, we uphold certain standards every day, which help us to protect patients and ensure their safety.

Patient screening – Assessing every new patient thoroughly

The first screening appointment with a new patient, means more than just asking a few questions and ticking a box. It's your first opportunity to assess and understand the needs and risks that the patient may be presenting with.

Suicide risk assessments need to be delivered with consideration, as well as a run through of screening questions and clinical assessment. Those identified as 'at risk of suicide' need to be placed on an ACCT, and referred for mental health assessment by the reception nurse.

All patients identified as being newly charged with or convicted of murder, should be referred automatically for a mental health assessment.

The second screening session should be a thorough assessment to undertake an in-depth review of the patient's needs, understand their health and wellbeing goals, and to develop a comprehensive care plan, including making relevant referrals.



Record keeping – Get it all down

Full record keeping needs to be standard and consistent with every patient encounter documented at the time, or as soon as practical. If notes are backdated, this needs to be clearly detailed with the reasons for backdated entry.

Notes must always be made under your personal log in, so as to clearly identify the author. Notes should contain a full account of the information discussed with the patient, any examination findings or observations, along with a plan for further care and safety netting advice.

Notes relating to resuscitation should be made by each member of the resuscitation team as soon as possible after the event of resuscitation.

Ongoing medication – Safely prescribing to new patients

It's important to check community prescribing when a new patient arrives at the prison, but it's equally important to continue a patient's medication – providing it is safe to do so – while waiting for confirmation on prescriptions.

This is because some patients who have a break in their medication regimes can be at a higher risk of suicide.

Prescriptions must then be reviewed when information is received into the prison from community health services or hospitals.

Patients who do not attend for medication should be followed up appropriately, in accordance with the local operating policy.

Take ACCTion – Proactively involved with ACCT

Patients need to be placed on the care planning system, ACCT (Assessment, Care in Custody and Teamwork) as soon as a risk of self-harm or suicide is identified.

It is important for healthcare members to be proactively taking part and attending ACCT reviews. An agreed process in place, to maximise healthcare's attendance, can be found in the local operating policy.

S1 notes and ACCT documentation should be read before a review to effectively contribute to the proceedings.

It is important to document an ACCT review on S1 using the ACCT template.

Healthcare attendees should be trained in ACCT processes. Speak to your manager about ACCT process training.

Emergency response – Right training, right equipment, right codes

All services need to be ready for an emergency and compliant with the emergency care Standard Operating Procedure. Regular checks of all emergency equipment should be carried out, and Immediate Life Support (ILS) training for all colleagues should be up to date.

If you know yours isn't, or feel you could do with a refresher course in ILS, speak to your manager about extra training.

All healthcare team members should be aware of the process in place, set out in the local operating policy, for the management of an emergency. The process – agreed with the prison – identifies the use of emergency codes and calling of ambulances.

Continuity of information – Getting the bigger picture

During the first screening of a new patient, it's essential that the patient's information is gathered ready for the clinician's review, including previous SystemOne records, communications from court teams and the Prisoner Escort Record (PER).

Having a patient's full information, including previous medical history and risks, allows for a bigger picture and can better inform for good decision making.

You should follow the local operating policy for requesting medical records from the community.

Information, particularly that relating to risks, must be shared freely between the healthcare teams and with the prison, using the ACCT process where appropriate.



Tackle abnormalities – Don't miss the early signs of illness or deterioration

Any observations should be recorded using READ codes where possible. Any abnormal observations or results need to be documented along with a plan for following up.

This may include repeating the observation or referring the patient to an appropriate clinician such as a GP for further assessment.

If a patient is ill, consideration should be given to using a national early warning score (NEWS) chart to monitor observations.

Missing, or not acting on, something such as high blood pressure in a patient could result in a heart attack later on.

But if noticed, assessed and followed up, early warning signs of illness or deterioration can be tackled.





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[View the PROTECT video](#)

DATIX REPORTING

- Risk Assessment Tool
- Remote access to PPG intranet
- Three levels user, reviewer, approver
- Require LMS Training Modules.
- Incidents, Feedback (Complaints) and Risk Register.

Please remember when reporting an incident there needs to be some context to the report as the person reading it wasn't there when the incident occurred – they need all the details.

Those who receive Datix notifications, only see the description and immediate action taken. For this reason, it is so important to ensure staff are aware of appropriate incident reporting and an appropriate level of detail to eradicate immediate queries being raised due to lack of information and immediate actions taken that provides assurance.

People who see your Datix includes, but not limited to:

- Ross Dowsett, Luke Wells
- Medical Team: Sarah Bromley, Iain Brew, Maggie Wood, Russell Green
- Performance: Gayle Francis
- Meds Management: Mark Langridge
- Primary Care: Marjorie Gillespie

Datix is not a tool for staff to have a good old moan about the environment, lack of staffing, etc., unless it does have a direct impact on service delivery and patient safety.

Datix reports come in all different formats. Some are very detailed, some are very brief, some are just about right.

Some are just a complete and utter moan about being short staffed, untidy working areas, etc., but not relating to an actual incident occurring.

For staff 'gripes' there should be other mechanisms for them to be logged.

What? So what? Now what?

Staff reporting an incident on Datix, need to be mindful of who is going to be seeing the information they are providing, and that these individuals will make an informed decision based on the information provided as to how confident they feel the incident is being managed.

This audience needs to be made aware of:

- What are the details of the incident?
- So what has been done to ensure appropriate actions have been taken, providing assurance of patient/staff safety?
- Now what is going to happen that will ensure the audience that patient and/or staff safety in the future, and similar incidents will not occur?

When writing a datix, there needs to be a level of detail that is recorded that gives those who see these reports, a clear understanding of what the issue is, what level of harm has been caused, is the patient and are the staff safe/ok and what immediate actions have been taken to ensure the audience feel assured; that this incident can wait for you to do your investigation.



Incident or Serious Incident?

Patient suffers from poorly controlled epilepsy. I was asked to re-prescribe his medications and noticed that we had recently received advice from his neurologist about an increasing dose of levetiracetam. Using the SystmOne prescribing variable dose prescribing option I wrote up complicated and gradually increasing dose of this drug as advised. It involved 2 different strengths of the drug with a final dose of 1500mg bd. The increasing dose regime was written up absolutely correctly and fully complied with as it was NIP with each dose dispensed by a nurse. However, I made a mistake in that I wrote up the final dose as "750mg tablets, 1 tab twice daily" whereas it should have been 2 tabs twice daily. Subsequent to this unintended dose reduction he had 4 seizures on 20/10, 24/10, 26/10 and 29/10 one of which resulted in him suffering a shoulder dislocation and needing A+E treatment. Patient is known to have recurrent dislocations and awaiting surgery to try to address this so the dislocation is not an unusual event for him.

Causative factors include:

- 1 - number of tasks - that day I addressed 67 varying tasks (mainly prescribing), 65 blood results (and 95 the day before due to a dump of old results related to an IT issue with the hospital) and a large amount of other work
- 2 - my relative inexperience with SystmOne and especially the Secure Environment prescribing module, it has taken at least 2 months to feel on top of it
- 3 - 'busy' screen layout on SystmOne, small screens result in limited view of prescribing information

I first became aware of the frequent seizures on 30/10. I studied the medication chart and noticed my error. I took immediate steps to rectify this by writing up a new increasing dose regime to get back to the full dose of 1500mg bd. I have sent myself a task to ensure the correct dose is achieved and am sure it will be fine from now on.

This is the type of Datix we can receive along with another 5, 10 or more datix reports within a very short space of time.

Have a quick read and share your initial thoughts

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The fact that this patient had 4 seizures due to the reduced medication could, potentially make this a serious incident. A 72 hour call would need to be held to discuss and investigate further to clarify the level of investigation required.

This incident has actually been missed – bare in mind how many people have seen this! No-one has picked up that this is an SI.

Incident or Serious Incident?

Patient has been waiting for a hospital bed on Ashcombe Ward at Langdon hospital for a period of 2 weeks now.

Liaised with Dr Upadyhe who confirms that Mr Gale is on the bed waiting list.

Not sufficient detail

Also names included which shouldn't be recorded

Incident or Serious Incident?

Patient is currently a 3 Officer unlock due to unpredictable behaviour. Patient is on a Discipline constant watch and began to harm himself, the Officer observing did not wait for other Discipline Staff to go in to the room and unlocked and entered and stopped the patient himself to stop Patient from hurting himself.

Officers arrived afterwards.

Discussed with Officer the dangers to himself and others that he had caused by opening up the room when the gentleman is a 3 Officer unlock.

Although nobody was hurt on this occasion, if a management is in place (which it was) and instructed to be a 3 Officer unlock this has been done for a reason and this is to protect not only the patient but fellow patients and nursing staff too.

Prison incident



SAFEGUARDING

What are the types of Safeguarding concerns we may see?

- Physical abuse
- Sexual exploitation
- Sexual abuse
- Neglect and acts of omission
- Self neglect
- Organisational abuse
- Domestic abuse
- Emotional and psychological abuse
- Female genital mutilation
- Discrimination and extremist views
- Modern slavery

Who do we refer too?

All prisons and IRC's should have a nominated Safeguarding Lead working for the prison provider. For people in the prison system you need to complete the referral template in the HIJ Supplementary Safeguarding Policy and pass this over to the Prison/Detention Safeguarding Lead on site.

Who's responsibility is Safeguarding in Prison/IRC's?

Everyone's

All staff working in establishments have a responsibility to understand what safeguarding means and report any concerns. The Governors/Directors have the ultimate responsibility over safeguarding prisoners / detainees who are unable to protect themselves from abuse or neglect as a result of having care and support needs.

What training do staff need?

- Admin (Non patient facing) — Level 1 Safeguarding
- Admin (Patient Facing staff) - Level 2 Safeguarding
- All Clinical staff — Level 3
- Safeguarding Leads and CQC Registered Managers — Level 4



SAFEGUARDING

What training does the Safeguarding Lead require?

All Safeguarding Leads should be trained to Level 4.

Safeguarding Leads should also complete Safeguarding Supervision training.

All course information can be found on the Training List spreadsheet found on the My Practice Plus Health in Justice Training Page

Where do I find the Safeguarding Policy?

Visit My Practice Plus Health in Justice Safeguarding. Here you will find:

- ☐ Health in Justice - Safeguarding policy for Healthcare within prisons
- ☐ Safeguarding Assurance Framework
- ☐ Section 11 Questionnaire



AUDITS



RISKS

3 Phases:

Concerns – Face to Face discussion

Stage 1 – Managed on site

Stage 2 – Investigated independently of site

Ombudsman

MEETING STRUCTURES

Local and Regional meetings:

- Quality Assurance & Improvement
- Patient Safety Incident Review Group
- Medicines Management
- Regional Quality Review Meetings

National meetings:

- Quality Assurance & Improvement
- Clinical Effectiveness