Shropshire Community Health NHS
NHS Trust

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3		

HMP/YOI Stoke Heath
unlocking potential securing the future

HMP/YOI STOKE HEATH

CONSTANT OBSERVATION POLICY

September 2021

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1. INTRODUCTION

There are prisoners who present a serious risk to themselves due to their reaction to a situation over which the individual concerned has little or no control; this applies to non-clinical constant observation. Additionally, there are prisoners who present a risk to themselves through psychotic or paranoid behaviour, being actively suicidal and/or carrying out severe acts of self-harm due to diagnosed mental illness or disorder; this applies to a clinical constant observation.

2. PURPOSE

This policy intends to provide both prison and NHS staff working within HMP/YOI Stoke Heath with guidance for defining whether the prisoner requires the implementation of a clinical or non-clinical intervention, namely constant observation, that potentially restrict a patient's autonomy and freedom of movement thus reducing the risk of suicide or self harm within a prison setting. The overall purpose of the policy is to:-

a) Protect prisoners who are at risk of harming themselves or others
b) Provide a safe environment for prisoners, either for reasons of mental illness or due to their current circumstances influencing their behaviour.
c) Provide a safe working environment for staff whose duties involve direct contact with prisoners

3. Definitions

ACCT: Assessment, Care in Custody and Teamwork is the care planning process for prisoners identified as being at risk of suicide or self-harm

MCA: Mental Capacity Assessment

TAG: Threshold Assessment Grid

PSI 64/11: Safer custody document

4. Roles and Responsibilities

Prison and NHS staff working within HMP/YOI Stoke Heath must be aware of this guidance for defining whether the prisoner requires the implementation of a clinical or non-clinical intervention, namely constant observation, that potentially restrict a patient's autonomy and freedom of movement.

5 Duties and Procedure for Constant Observation

5.1 Principles of Clinical Constant Observation

In order to place a patient on clinical constant observation, an assessment must have taken place which will include their mental health state and risk factors involved. There will be a direct correlation between risks identified, the risk management initiated and observation level indicated; clinical constant observation must only be

initiated by a nurse or doctor where a mental health assessment has identified that a mental illness is influencing the individual's thoughts of suicide. An example may be that the individual complains of hearing voices instructing him to take his own life.

Clinical constant observation is an intervention designed to provide intensive support to a patient who is assessed as being at risk due to diagnosed mental illness or disorder. It is an activity whereby medical and nursing staff will observe and engage with the patient more closely to ensure their safety and to conduct effective therapeutic engagement. A clinical need for this intervention must be established.

Clinical constant observation needs to balance therapeutic considerations with safety factors, which result in restricting the patients' autonomy, personal freedom and privacy and dignity, in order to maintain patient safety. Therefore, it should be used for the minimum length of time appropriate to the patient. An urgent secondary mental health opinion should be sought if the Threshold Assessment Grid (TAG) assessment identifies a clinical constant observation is required, and arrangements for the patient to be transferred to a prison in-patient unit should be considered if the patient has not yet been accepted.

An individual care plan is required to be formulated in conjunction with the Assessment, Care in Custody and Teamwork (ACCT) documentation. The healthcare professional undertaking the clinical constant observation must be given information regarding the patient and be aware of the emergency procedures within the healthcare centre. He/she must be made aware of the prison's radio procedure and the code words/process to raise an alarm or call for assistance. A period of clinical constant observation by a member of staff **should not exceed 2 consecutive hours.**

5.2 Principles of Non-clinical constant observation

Once an individual has been identified as suicidal/at risk of serious self-harm, an ACCT document will be opened and an initial review held by a multi-disciplinary team with all the findings being documented.
Constant observation for non-clinical reasons could be initiated as a response to the risk of suicide/self-harm increasing due to situations over which the individual has little or no control and for which coping skills are poor. Examples of these situations include the death of a loved one, the ending of a relationship, frustrated needs and wants, or a desire for a transfer to another prison, wing, or out of segregated conditions. The least intrusive level of observation which maximises prisoner safety should always be adopted, so that due sensitivity is given to the individual's dignity and privacy.

The prisoner will be referred to the primary care team in the first instance so that an urgent mental health assessment can be carried out as quickly as possible, and at the most within 24 hours. The health professional conducting the assessment will determine whether or not there is a clinical need for constant observation.

Non-clinical constant observation will be initiated by the Duty Governor only, although the Night Orderly Officer may instigate it when he/she is in charge of the prison; the Duty Governor must be informed by telephone at the earliest opportunity. The individual at risk will be managed via the ACCT document and will remain the responsibility of the prison, who will arrange for discipline staff to provide the required cover.

The Orderly Officer will ensure that the 'constant watch' documentation is updated on the prison's computer system (Z: drive) at the commencement of a period of constant observation. He/she must also ensure that suitable arrangements have been made for to provide staff for the constant observation and include adequate rest breaks.

5.3 Summary of principles of clinical / non-clinical constant observation.

A non-clinical constant observation would be determined when the feelings of suicide are as a reaction to a situation over which the individual concerned has little or no control.

A clinical constant observation would be determined after a mental health assessment identified that a mental illness influenced the individual's thoughts of suicide.

5.4 Privacy and Dignity

Maintaining privacy and dignity is one of the most challenging aspects for staff undertaking a constant observation. Therefore the level of risk of harm occurring to the individual will need to be considered against the effects this intrusive activity may have upon them.

5.5 Record keeping for Clinical Constant Observations

An entry must be made in the patient's clinical records following the mental health assessment and the decision to implement a constant observation. This should detail:-

- Current mental state
- Nature of risk, psychosis, depression, other mental illness
- Severity of risk - e.g. actively suicidal, making note of any direct expressions/plans/history prior to reception
- Review date of the constant observation
- Individuals involved in the assessment/discussions and decision making

The observer is required to make an entry in the patient's ACCT document at the beginning and end of a period of observation to formally accept/handover the responsibility for the activity of observation. The observer is required to make a substantial entry in the ACCT document and the care plan at the end of the period of observation detailing:-

- Mood
- Mental state
- Behaviour
- Significant events occurring during the observation period
- Specific therapeutic activity that may have occurred

Written entries at intervals of not less than thirty minutes are also required in the ongoing ACCT observation sheets and any significant events must also be documented without delay.

Clinical constant observation tasks are ideally undertaken by registered nurses, who may delegate to competent persons while retaining overall responsibility and accountability.

No period of observation by a member of health staff should be longer than 2 hours, except in very exceptional circumstances, and the healthcare professional should have a break from observations of at least ½ hour at the end of each observation; the breaks will be discussed at the beginning of the shift.

All clinical staff will be trained in ACCT awareness and constant observations during induction.

5.6 Factors that may indicate the need for clinical constant observation

Nursing and medical staff should note that constant observations should continue even where a person lacks a capacity to consent and where it is in the persons best interest (capacity and best interest are defines in the Mental Capacity Act 2005 (MCA) and the MCA code of practice).

Where the person does have capacity to consent but withholds it, nursing staff have a duty of care to the person and should continue to initiate the constant observation, if the nurse considers it clinically appropriate. The extent of the risk may be indicated by one or more of the following.

- History of previous mental disorder or self harm/suicide attempts.
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the patient believes that other people pose a threat
- Specific plan or intentions to harm themselves
- Past and present problems with drugs and alcohol
- Poor adherence to medication programmes
- Recent life events.
- Marked changes in behaviour or medication
- Known risk indicators

All patients requiring clinical constant observation must be discussed with the mental health `In-reach' team, as a matter of urgency. A TAG assessment form will be completed by a primary mental health nurse which will be used as part of the referral document to the `In-reach' service should this be required.

5.7 Reducing clinical constant observation to intermittent

The decision to reduce the level of nursing observation will be by a risk assessment undertaken by nursing staff who have completed the ACCT foundation training and the following should be considered:

- Review of recent patterns of behaviour
- Patient's current state of mind
- Seriousness of intent or acts of self-harm
- Expression of thoughts to harm self or others
- Significant events that have occurred during the period of constant
- Observation
- Known triggers
- Medication concordance

- Review of ACCT documentation and care plans

The rationale for the decision to reduce the watch will be recorded in the patient's clinical records and ACCT document. Constant observation status should be reviewed jointly between nursing staff, doctor or psychiatrist and operational staff as a minimum, as well as any significant additional staff.

5.8 Management of individuals undergoing non-clinical constant observation

The individual will have a comprehensive risk assessment and care plan completed by the ACCT case manager as soon as possible after the initiation of constant observation. This assessment should consider:-

- Suitable location to carry out constant observation, locations include cells on B and D wings and the healthcare centre. Special consideration will need to be given to the location of those prisoners who require constant observation **and** are subject to 'E List' restrictions, **and/or** are potential category A prisoners. In these circumstances advice should be sought from the Governor and guidance from the local security strategy.
- Suitable activity/work participation
- In-possession property
- Possible engagement in exercise/PE
- Visits arrangements
- General movement- it is important to note the observer can engage the prisoner in activities such as a walk or visit to the library, subject to an appropriate risk assessment
- Religious worship
- Any other areas of concern, including the safety of staff.

The following information relates to the staffing of constant watches and facilitating a regime for prisoners in crisis on B & D wings.

- Showers and phone calls will be facilitated on the wing by the constant watch officer
- Meal choices will be given to the wing staff and confirmed with the kitchen
- Meals will be delivered by a red band to the constant watch officer
- Breaks will be facilitated by the B or D wing staff, according to location and the constant watch officer will take over the relieving officer's duties during this break. The minimum break requirement is 15 minutes every 2 hours.
- Prisoners will be entitled to a maximum of three cigarettes per day; they will be taken to the healthcare exercise yard and this will be their access to fresh air. This will be facilitated by the constant watch officer, ideally one during the morning, one lunch time and one late afternoon.
- Prisoners who do not smoke will be given be given 30 minutes exercise on the relevant wing yard.

A member of staff should not conduct constant observation without a break every 2 hours, except in exceptional circumstances; the Orderly Officer will make arrangements to facilitate breaks.

The officer supervising the prisoner will be mindful of any 'officer unlock' instructions applied when organising the prisoner's daily activities and plans. The prisoner must remain in sight of staff at all times and supervision should be interactive, subject to an individual risk assessment.

Staff responsible for carrying out observations must be appropriately briefed about the individual, including their history, background, specific risk factors and particular needs. In all cases staff must be familiar with the content of the ACCT documents, including the care plan, the environment and the emergency procedures and potential environmental risks.

The prisoner is entitled to information about why he is under observation, its aims and how long it is likely to be maintained. The handover from one observer to another should be conducted with the prisoner being observed, where possible and appropriate. Staff should be aware that observation can be intensive and proactive and that it can lead to feelings of isolation and even dehumanisation.

PSI 64/11– safer custody states: “For the first 72 hours, a multi-disciplinary case management review must be held daily. The review must be chaired by a competent manager who has the appropriate authority to make decisions. The daily operational manger or residential manager and a member of the nursing staff (or senior clinical manager) must be in attendance, as well as any other relevant staff. Given the acute crisis that the prisoner will be experiencing continuity of membership of the review team will be an important consideration in order to reduce the prisoner’s distress. If a prisoner remains on constant supervision for longer than 72 hours, the case management review team will decide upon the regularity of future reviews and record this in the ACCT document. If a prisoner’s behaviour is particularly challenging, or is subject to constant supervision for 8 days or more, they will be managed with the additional input of an enhanced case review”.

Further guidance on additional interventions that may be implemented as measures of last resort in a non-clinical constant observation can be sought within the PSI 64/11 – safer custody document. These include guidance on the use of alternative clothing and the use of in-cell CCTV.

5.9 Accessing staff for constant observation

5.9.1 Clinical Constant Observation

Once a clinical constant observation has been agreed by the nursing staff, the primary care nurse in charge will need to be informed. S/he will identify and instruct on-duty nursing staff to conduct constant observation where possible. In case of difficulty in covering the watch s/he will contact the Orderly Officer and negotiate with the prison for assistance in the staffing requirements of the observation. The Clinical Nurse Manager/ nurse in charge will also contact nursing agencies for cover if unable to access appropriate in-house staff for the initial period of observation. Clinical constant watches should be notified and discussed with the Head of Healthcare and Duty Governor at the point of commencement. This should not delay the constant watch beginning.

Nursing cover will fall where possible to the nursing staff that are already working the shift but any increase in the nursing complement to accommodate the observations during the core hours Mon-Fri must be agreed by the nurse in charge. Agency nurses /temporary staffing will only be used when there is insufficient coverage and only for the period of time required before they can be relieved by regular nursing staff. All staff will be trained in ACCT procedures and healthcare staff will be trained in constant observations during staff induction; agency staff will receive the same levels of training. It should be noted that healthcare staff do not have cell keys and as such do not have direct access. This should be considered in all cases.

The nurse in charge during night state will discuss with the healthcare assistant the plan, when they have completed their medication round, will discuss the plan to continue the constant observation throughout the night shift with the Health Care Assistant, and arrange rest periods as per this policy.

5.9.2 Non Clinical Constant Observation

The business hub, in conjunction with the Orderly Officer, will make arrangements for adequate staffing cover and rest breaks in the case of a non-clinical constant observation.

6. Additional Implementation Guidance.

In all cases where a constant observation is required, staff will require appropriate access to the cell. This will require the nurse in charge during the night state to collect a designated key pouch, which includes the key for the gated cells. In the case of officers assisting with clinical constant observation, the nurse responsible for the observation will brief the officer prior to commencement, and maintain regular contact to review the patient.

In all cases, prisoners must be searched, and the area searched, prior to facilitating showers. This is to further reduce the risk of self-inflicted injury whilst in the shower areas. Constant observation must be maintained during showers.

7. Dissemination and Implementation

Need to add an additional required paragraph here covering how the policy is to be disseminated and implemented- ie how is it shared and what if any training requirement are there and how with they be met?

7. Monitoring Compliance

Compliance with this policy will be monitored by the Head of Healthcare and the Head of Safer Prisons within HMP/YOI Stoke Heath and by clinical audit by the Clinical Lead for Shropshire Prison Healthcare. The Prison and Healthcare collect detailed information regarding Constant Observations.

8. Consultation List

J. Huntington	Governor, HMPYOI Stoke Heath
Dr. P. Staite	Lead Prison GP
H. Newton	Head of Healthcare, HMPYOI Stoke Heath
S. Bradley	Head of Safer Prisons, HMPYOI Stoke Heath
W. Sweeney	Clinical Nurse Manager, HMPYOI Stoke Heath
A. Chambers	Team Leader, Prison In-reach service
Liz Watkins	Head of IPC

9. References

Mental Health Observation including Constant Observation Good Practice Guidelines for healthcare staff working in prisons Gateway (2006) References

HMP PSO 2700 Suicide Prevention and Self Harm Management.

Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice, London

National Confidential Enquiry – Safer Prisons Report 2003, London HMSO

Offender Health NHS West Midlands – constant supervision good practice guidelines.

Reducing Enhanced Observations on a Mental Health Ward (2019) Roberts and Murry, North Staffordshire Combined NHS Trust

PSI 64/11 Safer Custody

www.offenderhealth.org.uk

10. Associated Documents

SCHT Consent to Examination and Treatment Policy