Policy

Health in Justice – Constant Supervision Policy

For Establishment Name

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14th May 2020	Russell Green	

Read and understood at Establishment		
Print Name	**Signed**	**Date**

Contents

1. Introduction

1.1. Constant Supervision is used to monitor and support prisoners at high risk to themselves from self-harming behaviours or suicidal intent. The decision to place someone on a constant supervision can be made by prison discipline staff or healthcare staff. Sometimes the risk arises from mental illness and a constant supervision forms part of the therapeutic management of prisoners during the acute phase of an illness. However constant supervision is often started for prisoners communicating their distress by expressing thoughts and/or acts of self-harm or suicidal tendencies where there is no evidence of mental illness present.

1.2. A constant supervision is a highly intrusive intervention requiring, as the name suggests, a prisoner to be monitored 24 hours a day via a member of staff usually by sitting outside a gated cell. Whilst some people find this a supportive process, for many it is distressing and can be counterproductive in terms of recovery. Equally, for some prisoners it can provide the opportunity to create disruption to the regime and the activities of healthcare. In extreme cases this can involve conditioning and manipulation of both prison and healthcare staff in an attempt to gain greater privileges or a higher level of care.

1.3. It is important that we consider the clinical implications of the use of constant supervision when making decisions to start, continue and stop constant supervision. This involves close partnership working with prison colleagues to ensure a common approach in order to avoid 'splitting' of the team by prisoner behaviours and ensure that risk is managed in a shared and therapeutic way.

1.4. This policy should be read in conjunction with PSI 64/2011 : Management of prisoners at risk of harm to self, to others and from others (Safer Custody)

2. Aims

2.1. This policy describes the process for deciding to start constant supervision, defines who is involved in the decision to continue or stop constant supervision, and who is responsible for the cost of constant supervision.

2.2. In order to make the policy establishment specific there are a number of areas in the policy that must be agreed locally following discussion with the prison operator and commissioners.

2.3. This policy aims to optimise prisoner care whilst recognising the custodial setting in which Healthcare is being delivered and the risks inherent in the population. Safety and appropriateness of decisions for each individual will be key to delivering safe and appropriate care.

3. Assessment for Constant Supervision

3.1. Prisoners may be placed on constant supervision for a variety of reasons but is a response to an acute suicidal crisis, which is a temporary state and risk should remain under regular review.

3.2. Constant supervision may be considered under the following circumstances:

- Serious attempts and/or compelling preparations for suicide e.g. making a ligature, hoarding medication and/or writing a suicide note
- Credible expression of a wish to die
- A recent and serious attempt to take own life e.g. in prison or recently prior to imprisonment

3.3. This list is not exhaustive and each case must be considered individually using a multidisciplinary case management approach.

3.4. Once placed on constant supervision a prisoner will be assessed by a mental health practitioner on the next working day determine whether there is a diagnosable mental illness and/or if further assessment by a psychiatrist is required.

3.5. Constant Supervision must be clearly document on the prisoners SystmOne records clearly identifying the rationale for the use of constant supervision.

3.6. Constant supervision may be used on a flexible basis. For example, a prisoner could be placed on constant supervision overnight and on less frequent observation during the day while involved in activities. This will be dependent on risk assessment and any decision regarding this should be made within the context of the multidisciplinary ACCT review.

3.7. Constant supervision can be initiated by any member of clinical or prison staff. This should then be reviewed at the earliest opportunity by the Daily Operational Manager or the Senior Clinical Lead on site after consultation with each other and the decision documented in the ACCT Plan

3.8. During periods where the Daily Operational Manager and/or the Senior Healthcare Manager/Clinical Lead Nurse are not in the prison (i.e. night state), authority for constant supervision can be given by the Night Operational Manager or Senior Nurse following consultation with each other. The Daily Operational Manager must be informed at the earliest opportunity.

3.9. Where healthcare agree to take responsibility for a period of constant supervision, this may be undertaken by an officer or a healthcare assistant who is trained to understand the role and its expectations, including engaging with the prisoner, documentation, information sharing and contribution to the ACCT review. In these cases, if 24 hour healthcare is not available in the establishment then consideration should be given to transferring the prisoner to another prison with 24 hour healthcare for the period of constant supervision and further assessment.

3.10. Where the prisoner is already under the care of the Mental Health team, the duty mental health worker must be notified at the earliest opportunity in order that they can engage therapeutically and advise of any clinical support needed.

3.11. Where a patient is awaiting transfer to hospital and is on constant observations this should be raised and noted on appropriate escalation calls (refer to Health in Justice – Escalation of issues affecting patient care policy on the Policy Manager)

4. Reviewing prisoners on constant supervision

4.1. Prisoners should be kept under constant supervision for the shortest time possible to manager their acute risks

4.2. All prisoners diagnosed with mental illness will be allocated a named care coordinator from the mental health team who will contribute to the ACCT process in partnership with the prisoner operator.

4.3. Planning to de-escalate the situation and reduce the level of supervision should begin at the first ACCT review

4.4. Healthcare staff involved in ACCT reviews must consult SystmOne records, other staff involved in the care of the prisoner and the ACCT ongoing record prior to the ACCT review.

4.5. Observations by the person undertaking the constant supervision must form part of the review either by them being present in the review or by ensuring the most up to date written record of observations is available for the ACCT review

4.6. The outcome of the ACCT review must be clearly documented on the SystmOne record

4.7. In addition to the ACCT review process, all prisoners on constant supervision should be discussed in the next Multi Professional Complex Case Clinic (MPCCC) to ensure their wellbeing care plan is reviewed and all staff are aware of the risks and plans in place.

4.8. The MPCCC should identify a care coordinator from healthcare who will coordinate the care provided and ensure continuity through the period of constant supervision. This care coordinator will be responsible for updating the ACCT document following an MPCCC discussion to ensure good information sharing with prison colleagues.

4.9. The MPCCC should consider whether it is appropriate to involve family members in ACCT discussions and/or to update family following the discussion. The team should consider the safety and appropriateness of this in partnership with the prison operator

4.10. The decision to stop a clinical constant supervision must be jointly agreed by a clinician actively involved in the prisoners clinical care and

never by the service manager in isolation, even if they have a clinical background

4.11. If a constant supervision is still in place after 72 hours, or if the MPCCC has any concerns about the appropriateness of a constant supervision, the Regional Manager (RM) and the manager of any subcontracted mental health services should be informed. The RM will require sight of the Crisis Plan with plans to mitigate immediate risk, an ongoing Care Plan to aid recovery and details of planned reviews.

4.12. The RM will work with the clinical team and the prison operator to resolve any conflict of opinion and ensure a therapeutic approach to the risk is agreed.

4.13. If a constant supervision continues for longer than 7-10 days, or if the MPCCC has any concerns about the clinical case, then the Regional Medical Director and National Lead Nurse should be informed in order to provide support and advice.

4.14. The PSI states that prisoners on constant supervision should be reviewed by a GP every day. Where this is possible it should be facilitated. However where this is not possible (e.g. weekends and bank holidays) it should be raised as a risk on the risk register and discussed with prison operator and commissioners to reach an agreement regarding mitigating actions.

5. Governance and Quality Assurance

5.1. A database will be kept by healthcare of each constant supervision and the decision following the clinical review as to whether it is clinical or non-clinical. This database will also include:

- Number of prisoners on constant supervision
- Average length of constant supervision
- Total hours of constant supervision

5.2. The data will be reviewed by the HiJ Quality Assurance processes and benchmarked against similar sites to compare practice and identify trends and issues

5.3. In the event that a decision cannot be made locally regarding clinical vs non-clinical constant supervision this will be escalated to the healthcare governor and Practice Plus Group senior management along with mental health subcontractor senior management where applicable

5.4. All parties will work together to agree decisions in an amicable and non-quibble basis

5.5. It is important that accurate records are kept by Healthcare to ensure that the costs incurred for constant supervisions are correct. Heads of Healthcare should inform their finance manager at the end of every month how many hours of constant supervision there have been in the month and how they have been staffed

5.6. Data related to the use of constant supervision within the prison should be a standing agenda item at the quality assurance meeting and/or shared management forum and the parties should work together to consider how to minimise constant supervision and when used that it is in line with PSI 64 and NHSE standards.

6. Funding Responsibility

6.1. **The prisoner's safety is the first priority** and constant supervision should be commenced when the risk is identified. Commencement of constant supervision should never be delayed while a decision regarding funding is made.

6.2. There is variability across our prisons as to who is responsible for the funding and staffing of constant supervision. A high level process for deciding who is responsible for the cost of constant supervision needs to be agreed with prison operator and commissioners and clear to the healthcare provider.

6.3. Where the healthcare provider has responsibility for 'Clinical' constant supervision, the flow chart below (Figure 1) articulates the process for determining whether the reason for a constant supervision is clinical. Decisions to determine clinical constant supervision are taken by the mental health team and may involve both mental health nurses and a psychiatrist.

6.4. Healthcare and prison colleagues will work together to manage the prisoner and their risk, utilising the ACCT process, regardless of whether the reasons for constant supervision are determined to be clinical or non-clinical. Healthcare staff will support therapeutic risk management and support the prisoner and the prison in reducing the level of observations according to need.

6.5. Figure 1 outlines a suggested process for determining whether the healthcare provider or the prison operator are responsible for funding a period of constant supervision

- The decision to start constant supervision is solely made to manage identified risks in an individual prisoner and does not determine who is responsible for funding.

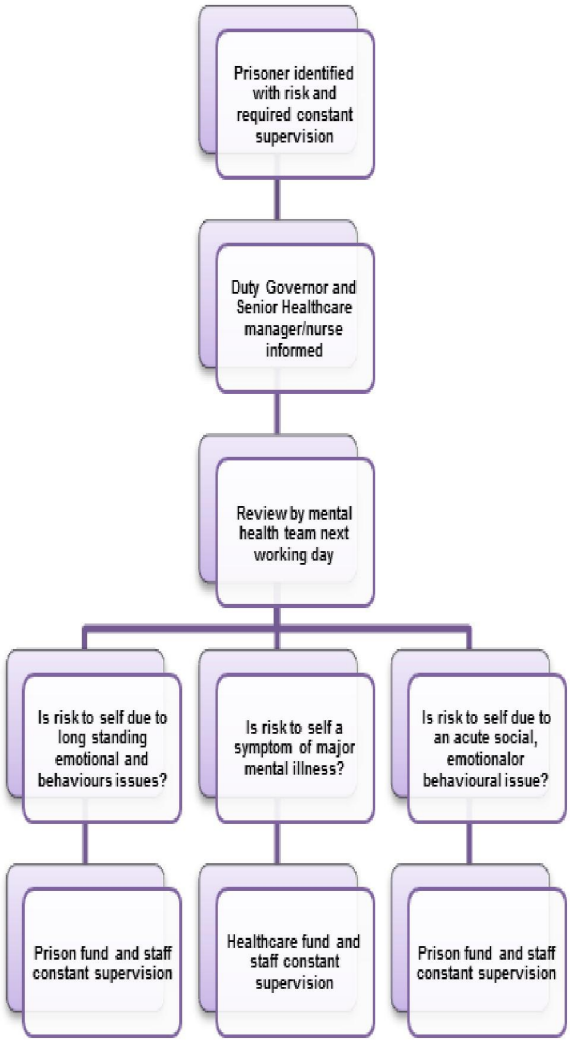
- The location of the constant supervision does not determine who is responsible for funding.

- Definition of longstanding emotional & behavioural issues would include personality disorder, which is problematic, persistent and pervasive; '*An enduring pattern of inner experience and behaviour that deviates from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment.*'

- Definition of a major mental illness would include psychosis and mood disorders such as severe depression or bipolar affective disorder.

- Definition of an acute social, emotional or behavioural issue may include (but not limited to) immigration issues, drug induced mental states in the absence of underlying mental illness, loss of housing, bereavement, family issues, drug seeking behaviours

Figure 1 Process to determine responsibility for funding



7. Responsibility

7.1. The Head of Healthcare/Service Manager (CQC registered manager) is responsible for ensuring this policy is disseminated, understood, signed off and used appropriately.

7.2. The Head of Healthcare/Service Manager will be responsible for monitoring the level of prisoners undergoing constant supervision and

monitor incident reports related to constant supervision. Analysis from this data will be presented at the local, regional and national Quality Assurance meetings along with any relevant action plans for monitoring.

7.3. The head of healthcare should ensure that there is appropriate clinical healthcare attendance or written report at all ACCT reviews and that the prisoner is discussed within the MPCCC.

7.4. The head of healthcare should ensure that any HCA undertaking constant supervision duties fully understands the role and expectations

8. Implementation

8.1. The Head of Healthcare/Service Manager will ensure that documentation relating to any previous healthcare constant supervision policy is removed and replaced with the current version.

8.2. All healthcare staff should be facilitated to attend ACCT training.

8.3. The policy should be discussed in relevant local meetings and be available to all Healthcare Staff.

9. References and Further Reading

9.1. PSI 2011/64 Management of prisoners at risk of harm to self, to others and from others (Safer Custody). https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc

9.2. Prison and Probation Ombudsman. Learning from PPO Investigations: Self Inflicted deaths of prisoners on ACCT. April 2014. http://www.ppo.gov.uk/wp-content/uploads/2014/07/ACCT_thematic_final_web.pdf

9.3 Practice Plus Group Health in Justice Mental Health Pathway (2017).