Mental Health Observation, including Constant Observation

Good Practice Guidelines for healthcare staff working in prisons

Gateway Reference: 7003
1 Introduction

1.1 This guidance seeks to inform the development of local strategies and procedures for the management of prisoners who require formal observation because of a combination of an assessed mental health problem or a potential mental health problem awaiting assessment and it being in the interests of the safety of the service user to minimise risk.

1.2 The guidance is drawn from evidence based best practice guidelines and existing strategies across both the prison and mental health services, and whilst some of these guidelines were drawn up for acute mental health settings, they would equally apply across custodial services, where there is a duty of care placed on the service.

2 Background

2.1 The Prison Service has a duty of care for all prisoners and staff. The Prison Service Order (PSO) 2700, Suicide and Self-Harm Prevention identifies actions to be considered in developing a care plan for prisoners considered at risk following the opening of a F2052SH or ACCT Plan. Each prisoner on an open F2052SH or ACCT must have their level of supervision specified, to include whether that will be in a single cell or shared accommodation.

2.2 There is a requirement for Area/Operational Managers and the Director of High Security Prisons to validate annually the suicide prevention strategy for each of their establishments. The local suicide and self harm prevention strategy should include references to undertaking constant observation, covering:

- The rotation of observing staff
- Interactivity between observing staff and the prisoner
- When and how the prisoner can participate in normal regime activities

The strategy will also include ensuring prisoners in shared accommodation who have been risk assessed as needing constant company are not left alone.

2.3 The Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision (Department of Health, 2002) outlines the need for observation policies and practices as a therapeutic intervention, a view supported by the UKCC definition of observation as; A two-way relationship, established between a service users and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (UKCC, 2002). The National Confidential Inquiry Report has shown that there is an increased risk when observation policy and practice are not clear or sufficient. Services and clinical teams need effective and sensitive protocols for the practice of supportive observation and positive opportunities for engagement.

2.4 The clinical practice guidelines for the short term management of disturbed/violent behaviour commissioned by NICE (available at www.nice.org.uk/CG025NICEguidenline), explore observation, and its application both in the management of violence and self-harm, since they recognise that the principles and literature available apply to both contexts. This supports the view taken by the UKCC report on the short term management of violence in in-patient settings.

3 Good Practice Guidance

3.1 Policy

3.1.1 Each Prison Health Partnership Board must agree a policy on observation and engagement (reflecting the needs of specialist facilities), that adheres to contemporary NICE terminology and definitions and that fits with the policy of the prison establishment. The risk levels that a service user poses must be reviewed a minimum of twice daily. This policy must include:

- Who can instigate observation
- Who can increase or decrease observation level
- Who must review level of observation
- When reviews must take place
- How service user perspectives will be taken into account
A process through which a review by a full clinical team will take place if observation above a general level continues for more than 1 week.

3.2 Levels of observation

3.2.1 General – Where the location of the patient is known to staff at all times, but the patient need not be kept within sight. Once a shift a nurse should sit down, talk to the patient and assess their mental state.

3.2.2 Intermittent Observation - Where the prisoner is checked at least five times an hour at irregular intervals

3.2.3 Constant Observation - Where the prisoner is observed by a designated member of staff who remains constantly in his or her presence. Constant observation may fall into one of the following categories:

- **Within eyesight** (At all times without exception) – The prisoner should be observed at all times, by day and night and, if deemed necessary any tools or instruments that could be used to harm self or others should be removed
- **Within arms length** (At all times without exception) – Prisoners at the highest level of risk of harming themselves or others (possibly awaiting transfer) may need to be supervised in close proximity. On specified occasions more than one member of staff may be necessary.

(N.B. A chart showing how these levels of observation fit with those required of prison establishments in PSO 2700 is provided at Annex A.)

The remainder of this guidance refers to the higher levels of observation, which is intermittent, within eyesight and within arms length.

3.3 Responsibility for implementing intermittent or constant observation

3.3.1 Where possible decisions about observation should be made jointly by medical, nursing and residential staff. PSO 2700 requires that intermittent and constant observation be authorised by either a doctor or senior nurse (in consultation with the Duty Governor) or the Duty Governor (in consultation with a doctor or senior nurse)

3.3.2 If any member of staff becomes aware that an individual is having suicidal or self harm thoughts, they should instigate the risk management process that pertains to their establishment (i.e. open an ACCT Plan or an F2052SH).

3.3.3 If a member of staff believes there is an imminent risk then they should ensure that the individual is not left alone until an immediate care-plan is agreed. They should inform the senior nurse in charge or a doctor, who will decide whether constant observations should be instigated.

3.3.4 The senior nurse or doctor should inform the Duty Governor.

3.3.5 Where constant observation has been agreed, the prisoner should be referred to the appropriate resource for urgent mental health assessment. PCTs/establishments should agree with their mental health service provider protocols for urgent referrals based upon clinical need.

3.3.6 Where constant observation has been agreed, a review must be carried out within 4 hrs (or immediately prior to unlock the following morning in cases where the prisoner is placed on constant observation during the night). This review should include a registered mental health nurse or doctor, Duty Governor, the Unit Manager (where the individual is located outside the healthcare centre), the prisoner (if at all possible) and other staff as appropriate.

3.4 Carrying out Observation

3.4.1 The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a prisoner’s dignity and privacy whilst maintaining safety for the individual and those around them.

3.4.2 The responsible clinician (in consultation with the care team) should review and stop constant observations as soon as is practically possible.

3.4.3 Decisions about observation levels should be recorded. The reasons for using observation should be clearly specified.

3.4.4 Decisions regarding the specific level of observation implemented, clear directions regarding therapeutic approach, timing of next review, and name/title of person who will be responsible for carrying out review should take into account current mental state, prescribed
medications and their effects, and current assessment of risk. The views of the prisoner should be taken into account as far as possible and clinical records should evidence the team’s attempts to engage with the prisoner and establish capacity for consent.

3.4.5 Observation skills may be used to recognise, prevent and therapeutically manage violence.
3.4.6 Specific observation tasks are ideally undertaken by registered nurses, who may delegate to competent persons while retaining overall responsibility and accountability.
3.4.7 Each staff member responsible for observation should take an active role in engaging positively with the service user by knowing their history, risk factors, early warning signs and likes and dislikes.
3.4.8 An individual staff member should not undertake a continuous period of observation for longer than 2 hours.
3.4.9 The prison GP will be informed of any decisions concerning observation as soon as possible.
3.4.10 Where necessary the Senior Nurse and Duty Governor will review staffing in order to facilitate increased observation levels

3.5 Observation Skills
3.5.1 Staff responsible for carrying out observations must be appropriately briefed about the prisoner, including their history, background, specific risk factors and particular needs. Prison officers undertaking observation duty should be considered to be a part of the care team and information shared accordingly.
3.5.2 They should be familiar with the environment, and of emergency procedures and potential risks in the environment.
3.5.3 Observers must be able to vary their engagement and interactions with the prisoner sensitively according to need and the level of observation.
3.5.4 The person carrying out the observation should be approachable, listen to the service user, and be able convey to the prisoner that they are valued.
3.5.5 Staff should be aware that individuals sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation.

3.6 Prisoner Needs
3.6.1 The prisoner is entitled to information about why they are under observation, the aims of observation and how long it is likely to be maintained. For some service users a written contract stating the roles and expectations of staff and service user might have some therapeutic potential.
3.6.2 The aims and level of observation should where appropriate be communicated, with the service user's approval, to the nearest relative. Where the service user is under 18, the Child Protection Coordinator must be consulted about the appropriateness of informing the parents/carer/next of kin and about whether to make an external referral to Social Services for advice, support or assessment.
3.6.3 Where possible and appropriate, the handover from one observer to another should involve the service user so that they are aware of what is being said about them.

3.7 Training
3.7.1 Staff responsible for carrying out observations should receive on-going training in observation so that they are equipped with the skills and confidence to engage effectively.
3.7.2 Training in observation should be incorporated into induction, Mental Health Awareness and ACCT training programmes.

3.8 Demands on Staff
3.8.1 The Standing Nursing and midwifery advisory committee practice guidance note (1999) produced in response to Addressing acute concerns recognised that observation of a person who is deeply distressed and potentially suicidal is one of the most difficult and demanding tasks to undertake. Observation calls for empathy and engagement combined with a readiness to act. Service Managers should support staff engaging in constant observation by providing the opportunity to debrief, and local policies should include how additional support might best be offered.
3.9 Funding

3.9.1 The resourcing of constant watches, initiated as a result of a clinical need following a clinical assessment, is and will remain the responsibility of the PCT. Provision for which was included in the baseline funding transfer and indirectly in subsequent growth allocations received by PCTs. This applies in respect of clients placed on constant watch in any setting within the prison i.e. Healthcare Centre or on normal location, provided clinical need has been established.

In a small number of cases, local agreements exist such that the establishment has retained the funding for constant watches to date. In these circumstances, it may be necessary to consider further clarification and a more detailed local Service Level Agreement to enable the implementation of this guidance.

3.9.2 Constant watches may also be necessary for security or other non-healthcare purposes, the individual may or may not have been the subject of a clinical assessment. Where the increased observation is not as a result of the clinical assessment, the funding responsibility will remain with the Establishment.
ANNEX A

Chart showing ‘fit’ between Prison Service levels of observation (PSO 2700) and those recommended by National Institute for Clinical Excellence and for NHS in-patient psychiatric settings and emergency departments

<table>
<thead>
<tr>
<th>Level</th>
<th>Prison Service PSO 2700</th>
<th>NHS</th>
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<tbody>
<tr>
<td>Low – once a day</td>
<td>Required. Suitable for prisoners making a good recovery, perhaps prior to closure of ACCT Plan or those at low risk requiring long-term, low level care</td>
<td>Not required. People at this level will not require in-patient psychiatric or emergency care</td>
</tr>
<tr>
<td>General – once a shift; 4 times in 24 hours</td>
<td>Required. Minimum acceptable level for in-patients (SNMAC: ‘Safer and Supportive Observation of Patients at Risk’)</td>
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</tr>
<tr>
<td>Intermittent – irregular 5 times an hour</td>
<td>Required</td>
<td>Required. Minimum acceptable level for in-patients (SNMAC: ‘Safer and Supportive Observation of Patients at Risk’)</td>
</tr>
<tr>
<td>Constant: within sight</td>
<td>Required.</td>
<td>Required. Minimum acceptable level for in-patients (SNMAC: ‘Safer and Supportive Observation of Patients at Risk’)</td>
</tr>
<tr>
<td>Constant: at arms length ie observer in same room as observed</td>
<td>Not required. Almost impossible to achieve in mainstream prison setting. People requiring this level of care are probably in need of admission to an external psychiatric hospital</td>
<td>Required. Where a prisoner/mental health service user requires this level of care they should be considered for urgent referral to external psychiatric hospital.</td>
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