Supporting Nursing Staff Caring for Patients From Places of Detention
The RCN Nursing in Criminal Justice Forum committee would like to thank all those who contributed to this guidance and to acknowledge the invaluable feedback provided by delegates attending RCN Congress 2016.

Acknowledgements
This guidance was prepared by:

- RCN Nursing in Criminal Justice Services Forum
- RCN Forensic Nursing Forum
- Ann Norman, RCN Professional Lead for Criminal Justice and Learning Disabilities Nursing

Description
There are an increasing number of people within the criminal justice setting who have multiple and complex health care needs. From time-to-time these people require attention in NHS settings outside of prison/police custody. This guidance is aimed at nursing staff working in NHS settings and gives further support and advice to provide optimum care to this group of patients.

This publication is due for review in February 2019. To provide feedback on its contents or on your experience of using the publication, please email publications.feedback@rcn.org.uk
Contents

Introduction 4

1 Caring for patients from secure settings 5

2 Attitudes, values and perceptions 9

3 Treatment and care 10

4 Discharge 14

5 Professional reflection 15

References and resources 17
Introduction

The RCN Nursing in Criminal Justice Services Forum, in partnership with the RCN Forensic Nursing Forum, has produced this guidance to support nursing staff working in acute and other hospital settings caring for those from detained settings. It will also be helpful to allied health care professionals and service providers.

Context

Detained individuals come from a number of secure settings including prison, courts, police services, immigration centres, mental health and learning disability units. While primary health care services may be available in some of these environments, there will be occasions where treatment outside a secure setting is necessary.

As a result, detained individuals will receive health care in a wide range of acute and community health settings acute hospital outpatient services, hospital wards, emergency departments and hospices. They are entitled to the same standards of care afforded to the general public.

Ensuring the safe custody of these patients outside of the secure setting is often the responsibility of prison officers, police officers or escorting hospital staff (including nursing staff). Health care staff caring for such patients may encounter both practical and professional challenges arising from competing priorities; the requirement to deliver ethical health care provision and the need for security.

This guidance highlights the importance of effective communication and the need for understanding of the professional roles and responsibilities of both security staff and nurses. This can be promoted via shared protocols between local prisons and NHS trusts, for example, shared care plans, and effective communication between nursing leaders in custodial organisations and external health services.

Who this guidance is for?

This guidance document has been developed to support nurses and allied health care professionals working outside of secure detention settings to care for those who are detained.
1 Caring for patients from secure settings

1.1 Professional behaviours and approaches

Health care professionals may have concerns that caring for patients from secure settings will be challenging. It is important to recognise that not all detained patients will be dangerous or violent.

Many will be anxious about their treatment or may feel a sense of embarrassment at being seen in public handcuffed to escorting staff. Others may feel stressed or frightened when attending external hospital appointments, as do many members of the public.

Nursing staff should always recognise the importance of compassion and the need to adopt a non-judgemental attitude and professional demeanour when caring for patients from detained settings.

Senior nurses should ensure they liaise with the health care lead at the secure setting to discuss any concerns or clinical issues. For example, individuals from a prison setting may have drug and/or alcohol related issues that could impact on their care plan.

Care should be taken to ensure the appropriate and safe prescribing and administration of medication. The Royal College of General Practitioners (RCGP) has produced specific guidance for nurse prescribers and GPs working in offender health which will be of use to all prescribers working with detained patients, and its Safer Prescribing in Prisons (2011) guidance is available online at www.rcgp.org.uk

1.2 Communication

Secure settings can be stressful and complex environments in which communication can prove more difficult due to the multitude of stakeholders involved, many of whom have different interests and objectives.

It is therefore crucial that there is good contact and communication between sending and receiving health care teams to avoid miscommunication and/or conflict.

Nursing staff caring for people in detention outside of the secure setting should feel able to communicate with escorting staff to discuss or even challenge any practices they feel are inappropriate.
For example, it may feel unsuitable for the patient to be handcuffed. However, via effective communication with escorting staff, the decision making processes underpinning the use of restraint in public will be more fully understood. Gaining this understanding of the rationale for using handcuffs can help nursing staff manage any emotional conflict they may experience.

Another area that may result in the need to discuss plans with security staff is the prescription of medication that is unavailable in a prison or police setting, or where its use is controversial, for example, opioid analgesia which is highly tradable.

It is important that discussions about security issues – or prescribing concerns – should initially take place out of earshot of the detained patient or any member of the public.

See also Section 3.4, Section 3.7, Section 3.8 and Section 4.1.

### 1.3 Prison and prisoner categories

There are four main security categories for prisons and prisoners:

- **Category A**: prisons holding individuals whose escape would be highly dangerous to the public or national security and therefore require conditions of maximum security.

- **Category B**: prisons holding individuals who do not require maximum security, but for whom escape would still pose a large risk to members of the public.

- **Category C**: prisons holding individuals who cannot be trusted in open conditions, but are unlikely to try to escape.

- **Category D**: prisons holding individuals who can be reasonably trusted not to escape and are given the privilege of open conditions.

### 1.4 Secure hospital categories

Similarly, secure hospitals are divided into high, medium and low secure services. Patients are placed, depending on the nature and degree of their mental disorder and associated risks. Often these patients are subject to ‘restriction orders’, overseen by the Ministry of Justice, which may stipulate that any leave outside the secure setting involves the use of handcuffs or the patient being in constant sight of escorting staff.
1.5  Record keeping and information sharing

Detained patients will return to secure settings where there are health care professionals caring for them, but not necessarily 24-hours a day. As a minimum, and in accordance with the NMC Code (2015), it is important that any medical information relevant to the patient is shared as soon as possible with the secure setting health care team to ensure appropriate arrangements are made for their return to detention. This is particularly important in instances where the patient is returning with medication.

It is important for continuity of care and patient safety that members of the multi-disciplinary team (nurses, allied health personnel, or medical staff) responsible for delivering health care interventions for individuals in detention establishments receive discharge communications in a prompt and appropriate manner. The importance of effective record keeping and information sharing with the secure setting multi-disciplinary team cannot be underestimated.

See also Section 4.2.

1.6  Security measures

A key principle underpinning the delivery of health care services is that detained individuals should be managed in the least restrictive environment possible to facilitate their safe recovery. Least restrictive refers to the minimum level of physical, procedural and relational measures necessary to provide a safe and recovery-focused environment. The following defines these areas of security:

- physical security relates to the use of restraints when escorting patients (for example, handcuffs)
- procedural security relates to the policies and procedures underpinning security (for example, search practices, techniques for dealing with aggression or violence, reporting)
- relational security relates to a sound knowledge and understanding of the patient and their environment in order to provide a base on which high quality care and treatment can be delivered. Further information on relational security can be found in the See, Think, Act guidance published by the Royal College of Psychiatrists (2015).
Role of escorting/security staff

The role of escorting/security staff is to ensure continued safe detention of the patient. If escorting staff believe a patient is showing signs of aggressive or dangerous behaviour, they will respond accordingly. It is important to remember that escorting/security staff will have conducted security risk assessments and will therefore manage any identified risks appropriately.

It is usual for the patient to be handcuffed to a member of the escorting/security staff. This is done using either handcuffs, which are applied to both wrists of the patient and linked by means of a short chain to a single handcuff attached to the arm of the escorting staff member; or via a chain which will be attached to one wrist on the patient and one wrist of the escorting staff member.

Handcuffing decisions are made by the secure setting. If a request is made to remove the handcuffs (except in the case of an emergency), then permission will have to be sought by the escorting staff from their senior management team.

People detained in police custody may be cuffed and will have two officers, one on either side at all times, except during clinical examinations.

Health care staff escorting a patient from a secure setting will also be responsible for supporting the patient and sharing clinical information as is required and appropriate.

See also Section 3.10 and Section 3.11.

1.7 Suicide and self-harm

Suicide and self-harm is more prevalent in those detained in prison and police custody than in the wider community. Consequently, health care professionals may be required to offer clinical care to detainees who have made serious self-harm attempts. A further contributing factor in the early stages of detention is the level of alcohol or substance intoxication resulting from either deliberate or accidental overdose.

The management of those at risk of suicide and self-harm requires a concerted, joined-up and holistic approach. In 2014 the Department of Health (England) facilitated a consensus statement on confidentiality entitled Information Sharing and Suicide Prevention: Consensus Statement which sets out guidelines relating to information sharing and disclosure.

See also Section 3.9.
2 Attitudes, values and perceptions

2.1 Equivalence
Caring for people in detention can be challenging on a number of levels. The concepts of parity of care and equivalence in accordance with the NMC Code are brought to the fore with this patient group, as they are entitled to the same level of care as anyone else.

Some people can find this difficult to understand and may have strong opinions regarding the provision of care to those they feel are somehow less deserving. Whilst equivalence of care is the primary aim there is a growing concern that people in places of detention are under-served in relation to their high unmet and complex needs.

2.2 Risk of manipulation
Individuals in detention may sometimes enact illness for secondary gain. Whilst nursing staff are used to working within a trusting nurse/patient relationship, the relationship with a person in detention should be viewed with more caution.

We should consider that individuals may try to manipulate health care professionals for a variety of reasons, including obtaining ‘tradeable’ medication or unauthorised articles (such as glass, mobile phones, tobacco, chewing gum) or making contact with friends/family outside of detention procedures.

Nursing staff must be acutely aware of the need for professional boundaries with detained individuals and the potential for manipulation.

2.3 Terminology and jargon
It is important to communicate clearly, using terms that the patient understands. Use plain English, only use agreed and defined abbreviations, and clarify anything the patient appears unclear about.

If escorting staff or patients use jargon that you do not understand, ask for an explanation.
2.4 Violence and aggression

There can be a risk of violence and aggression with any patient, but some nursing staff report feeling anxious or concerned about potential exposure to aggression and/or violence when caring for patients from secure settings.

It is important to recognise that robust risk assessments will have been carried out by the secure setting management team prior to the transfer of the patient, and plenty of measures will have been put in place to minimise any risk of escape or violence.

Health care professionals should be reassured that risks to self, colleagues and the wider public will have been considered and addressed. This may manifest in an increased number of escorting staff, requests from security staff to accompany the patient at all times, and the use of mechanical restraints. Whilst these actions may appear excessive, they will be proportionate.

In 2014, the Department of Health produced guidance for health and care services in relation to the management of difficult patient behaviour: Positive and Proactive Care: Reducing the Need for Restrictive Interventions.

3 Treatment and care

3.1 Accident and emergency

Caring for detained people in emergency departments can provide an additional set of challenges. Handcuffs are generally only removed when the presenting patient is unconscious, anaesthetised or being resuscitated. In the case of resuscitation, escorting staff MUST be asked to remove the handcuffs before a defibrillator is used.

The presence of a handcuffed individual may cause alarm to other patients, and staff may feel uncomfortable treating or working with these patients. They may also feel uncomfortable about security staff and police officers being present or view the use of restraints as an obstruction to treatment. However, these concerns must be balanced against the need to keep the patient in custody and ensure the safety of hospital staff and the wider public.
3.2 Assessment and admission

Patients admitted or assessed from a secure setting should be treated no differently from any other patient. These individuals may be anxious or nervous and there are likely to be escorting staff present during the consultation, so it is important to be discrete and respect patient dignity.

The patient and escorting staff from prisons will be visited by senior management at least once every 24 hours and will record all interactions and activity by the patient with health care staff and themselves. This is known as the bed-watch log.

Staff escorting a patient from a secure hospital should liaise with the in-patient staff in order to ensure that effective management and monitoring takes place. It is often helpful if ward managers can communicate directly to establish arrangements.

3.4 Communication protocols

Information should NOT be given to enquirers by telephone, particularly any dates and times of appointments. Any requests for information or messages for the patient should be referred back to the secure establishment or reported to the escorting staff. If requests for information are alleged to have come from the sending secure establishment, it is essential that callers are asked for their name, telephone number (including extension) and are called back.

Security risks should be discussed with senior managers and the security team at the hospital. This will include agreeing the actions to be taken in the event of an incident or issue of concern.

If a patient is likely to be in for a protracted period of time, then it is best practice to agree a security password for the health care team to use when liaising with the ward to maintain patient confidentiality. The health care team are likely to phone the ward on a daily basis or more frequently if required, for an update.

Appointments should not be sent directly to the patient or to the patient’s home address, but rather directed to the managing health care team at the sending establishment, who will then liaise with the security department to make the necessary arrangements for the appointment. Failure to follow this process may well result in appointments having to be changed.

Nurses should not disclose a patient’s presence in hospital; this includes on social media platforms.

See also Section 3.7, Section 3.8 and Section 4.1.
3.5 Risk management visits
Prior to some admissions, security managers may visit the hospital or department to identify and assess any potential risks and what actions should be put in place to minimise these. These visits should be co-ordinated with hospital managers and it is important that staff co-operate with their employer in these assessments.

Escorting staff will advise nurses what the detained patient is allowed to do and not do from a security perspective.

See also Section 3.10.

3.6 Imaging
Hospitals will have their own policies to follow and additional consideration for any accompanying security staff will need to be acknowledged.

3.7 Maintaining family ties
Detained patients are not normally allowed to make or receive telephone calls. Any such requests must be made to the escorting staff.

Patients may receive visits during scheduled visiting times, but only after permission has been obtained from the secure establishment. The escorting staff will be notified of any visits, including who is visiting and when. Any items brought in by visitors must be given to the escort staff and not handed directly to the patient.

3.8 Medication
Prescribed medication can be misused in secure environments and detained individuals may seek medication for its psychotropic effect or tradable value, rather than for its therapeutic or licensed use.

The diversion of prescribed medication to the illicit economy poses a risk to the wider safety and security of the community. Those risks may come in the form of gang and group behaviours that are not conducive to safety; bullying and coercion, and subsequent self-harming behaviours.

It is important that there is effective communication with the sending establishment to get an understanding of what can be safely prescribed and those medications which pose a potential risk.
3.9  **Mental capacity advocates**  
Individuals that lack capacity to make decisions for themselves must be referred to the Independent Mental Capacity Advocate (IMCA) service, in accordance with local policies and procedures. There is a wide range of guidance and support available. Legislation in the four UK countries differs in relation to assessing capacity and in the provision of support.

In England and Wales: www.gov.uk/government/uploads
In Scotland: www.gov.scot
In Northern Ireland: www.legislation.gov.uk

See also Section 1.8.

3.10  **Midwifery**  
The National Offender Management Service’s external prisoner movement protocol (2015) stipulates that pregnant women are not handcuffed after arrival at a hospital or clinic, and that women in active labour should not be handcuffed either en route to, or while in, hospital. Restraints are to be carried, but not applied, unless the woman’s behaviour is refractory or there are indications that she may attempt to escape.

Escort staff should be absolutely clear about the security requirements of escorting pregnant women, women in labour and women who have recently given birth.

Ante-natal and post-natal care should include specific provisions for substance misuse and a history of alcohol misuse.

Women may have to terminate pregnancies while in detention and this can be a very traumatic and difficult experience for the woman and staff.

3.11  **Operating suites**  
Escort staff will accompany a patient to and into the anaesthetic room and remain with the patient until they are anaesthetised. Escort staff will then wait in a suitable area within the theatre complex.

If local anaesthetics are administered, escort staff will accompany the patient into theatre or remain in the post anaesthetic room to allow for observation. The point at which handcuffs are removed will be agreed between the escort staff and the anaesthetist.

Escort staff will be in attendance in recovery and the recovery team should advise the escort staff when it is safe to reapply the handcuffs.
### 3.12 Prisoner deaths and fatal accident inquiries

All cases of death will be treated as a ‘death in custody’ and will be subject to a full investigation by the Prisons and Probation Ombudsman (PPO) or secure hospital and subsequent coroner’s inquest. In Scotland, it is a mandatory Fatal Accident Inquiry and held in the High Court but the principle is the same.

This will require full co-operation from all staff involved and it is therefore essential that appropriate documentation is made in the patient’s record at the time of the event. Further information into the role and responsibilities of the PPO can be found at www.ppo.gov.uk

In Northern Ireland referrals are made to the Prisoner Ombudsman www.niprisonerombudsman.gov.uk Deaths within police settings are referred to the Independent Police Complaints Commission (www.ipcc.gov.uk). Unless safety prevails, staff should not touch any equipment until advised to do so by the police. Some patient documentation may be made available at times for the police, in accordance with the employer’s policy and procedure. Registered nurses must also adhere to the NMC Code. There is also information sharing guidance in Section 1.5. All communication will be dealt with by family liaison officers from the establishment.

### 4 Discharge

#### 4.1 Communication

It is essential that there is effective and timely communication between the hospital and receiving establishment. Any immediate advice and instructions should be sent to the secure setting in a sealed envelope with the escorting officers and, where possible, telephoned through ahead of the discharge.

Discharge medication and follow up appointments should be given to the escorting staff and not directly to the detained patient. Wherever possible this should include a discharge summary.

#### 4.2 Discharge planning

The registered nurse responsible for the patient is accountable for co-ordinating the discharge plan for their patient. This will include assessing their continuing health and social care needs to ensure a coherent and co-ordinated continuing care
pathway. A multi-disciplinary and multi-agency approach with staff from the secure setting is essential. Prior to discharge it is important to contact the sending establishment to establish what facilities and services are available; some will have 24-hour health care with enhanced care beds, but others will have limited health care arrangements.

It is important that the patient being discharged from hospital to police custody is deemed fit for discharge, just as if they were going ‘home’. Most health care teams supporting police custody environments do not have direct access to patients and therefore cannot undertake frequent observations, such as neurological observations.

While escorting staff are a valuable source of information, it is important to double check with the receiving facility to determine exactly what services are available. This also provides an opportunity to discuss discharge arrangements and continuing care.

### 4.3 End of life care

The challenges associated with providing end of life and palliative care in prisons is unique. Some people will wish to return to the secure setting to die surrounded by those they know and in an environment they are familiar with.

It is essential that these patients are afforded comparable care to the wider community and therefore arrangements should be made with the local palliative/ end of life care team to support them on discharge.

Further information and guidance can be found in the NHS Improving Quality 2014 guidance: *The Route to Success in End of Life care – Achieving Quality in Prisons and for Prisoners.*

### 5 Professional reflection

#### 5.1 Reflection and reflective discussion

Caring for people who are in detention can be stressful, as the competing priorities of security and health care can often cause friction.

In addition to managing these challenges, nursing staff need to acknowledge how their own personal feelings about caring for someone from detention may affect the care they provide. This is particularly the case when caring for a high profile patient.
who has been convicted for very serious offences. This is a natural human response that, with the right support, can be managed effectively to enable the provision of compassionate, caring treatment.

Nursing staff need to be reflective in their approach to caring for this challenging patient group and be mindful of their feelings and how both they, and the care they are providing, may be affected. Seeking support from more senior, experienced members of staff is encouraged as is contact with senior nurses from the prison or police detention services where necessary.

Caring for detained patients offers a valuable source of learning and reflection that nurses can use for their revalidation process. Learning with, and from, prison and police staff about promoting effective care for people in detention provides a useful opportunity to reflect on how nurses enact the NMC Code to provide safe, compassionate and effective nursing care for some of society’s most vulnerable members.

Nursing caring for detained patients in other health care environments can have feelings of being manipulated. It is important that during any reflection or supervision, nurses and other health care professionals are able to express, discuss and manage their feelings.

5.2 Professional boundaries

The NMC Code clearly sets out the appropriate professional and social boundaries that should be observed and maintained at all times. Nursing staff in traditional settings must remain alert to their own vulnerabilities, as some detained patients may attempt to manipulate or take advantage of their authentic and caring perspective.
References and resources


Department of Health (2014) *Positive and Proactive Care: reducing the need for restrictive interventions*, London: DH.

Department of Health (2016) *Care and support statutory guidance*, London: DH.


Notes
The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

February 2017
Review date: February 2019

RCN Online
www.rcn.org.uk

RCN Direct
www.rcn.org.uk/direct
0345 772 6100

Published by the Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333

www.facebook.com/royalcollegeofnursing
www.twitter.com/thercn
www.youtube.com/rcnonline

Publication code: 005 856

ISBN: 978-1-910672-80-8