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Oxleas NHS Foundation Trust

GREENWICH PRISONS INPATIENTS UNITS OPERATIONAL POLICY

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In consultation with:	Greenwich CCG, Oxleas NHS Foundation Trust and the Greenwich Prisons
To be read in conjunction with:	Mental Health Act 1983, amended 2007 Mental Health Act Code of Practice NICE Guidelines for Mental Health, Department Health Guidelines on Prison Health Services The Bradley Review Data Protection Act 1998 Freedom of Information Act 2000 Forensic directorate of Oxleas NHS Foundation Trust Clinical Governance Greenwich Prisons Inpatients Unit Observation Polic
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Summary:

Given the high levels of physical and psychiatric morbidities and the associated drugs and alcohols problems in remand prisons, it is vitally important that there are inpatients health facilities to help manage prisoners with acute healthcare needs.

The remand prisons in the Greenwich Cluster Prisons (HMPs Belmarsh and Thameside) both have healthcare inpatients units and this policy is intended to provide guidance to support the delivery of excellent clinical services in these Inpatients units.

VERSION CONTROL

Document Location

Oxleas NHS Foundation Trust Intranet	*See under* Policy and Document Library

Change History

Version	Owner	Changed By	Change Summary	Date
Version 1	Dr Rachel Daly			

Responsibility for distribution of this document

Service Managers, Operational Managers, IPU Clinical Leads.

Contents:

Introduction

The Inpatients Unit is for the care of those men who have been identified as having: acute mental health issues (including acute emotional crisis), chronic physical illnesses or withdrawal symptoms from illicit drugs and alcohol as well as those needing mental health assessment for diagnostic clarity. Prisoners who present with high suicide risk can also be admitted to the healthcare Inpatients Unit as part of their safe management.

Mental health admission is aimed at assisting service users through their crisis and preparing them for return to the house block or to an external mental health hospital. Service users with acute or long term physical health conditions or those experiencing severe withdrawal symptoms from substance misuse may be admitted to the inpatient unit for a short-term period of close observation and interventions by healthcare staff in preparation for return to the house blocks.

Where clinically indicated, patients with physical health problems who had returned from hospital after a clinical procedure/investigation can also be admitted to the unit for a period of convalescence after discharge from outside hospitals.

Prisoners with terminal illnesses who are on End of Life Care will also be admitted to the healthcare inpatients unit and their care will be based on the Palliative/End of Life Care Policy. (please see appendix 1)

Our experience has shown that occasionally, the prison management team would locate a prisoner without any acute healthcare needs in the healthcare inpatients unit for operational or security reasons. Those prisoners will be described as “lodgers in healthcare” and will not be managed by this policy. Instead, they will be managed by the prison regime of the location where the prisoner would have been located had they not been placed in the healthcare inpatients unit.

1. Aims, Objectives and Purpose

Oxleas NHS Foundation Trust in conjunction with the Greenwich prisons have the ultimate responsibility to ensure that the prisoners with acute mental illnesses, drugs and alcohol dependence and chronic debilitating medical conditions are cared for in the most appropriate setting within the prison. The prison healthcare inpatient unit is currently the designated unit for this purpose.

Offender health and providing healthcare services in prison environments are complex and demanding undertakings (Appleby, 2010). It is our philosophy that as far as reasonably practicable, and within the constraints of prison environments, we would deliver a healthcare service similar to what is available in the wider community to prisoners at the Greenwich Prisons irrespective of their index offence, race, disability, sexual orientation or religious orientation.

The aim of this policy is to ensure that systems are in place to guide and support healthcare staff to deliver appropriate care and maintain the best clinical practice in the healthcare Inpatients Unit.

The purpose of the inpatient department is to provide a safe area where men with healthcare needs are assessed and treated. The level of support offered to these men will be higher than that which is available on the house blocks. We aim to provide, where possible, a therapeutic milieu that is focused holistically on each individual's healthcare needs.

Each service user will have a named nurse and personal officer who will be responsible for their care whilst they are in the Inpatients Unit. The named nurse is responsible for assessing, planning, implementing and evaluating the care plan for the service user. The care plan should incorporate the input and views of the multi-disciplinary team following the weekly multi-disciplinary team ward round/meeting.

Other named workers for the service user should also be actively involved in reviewing the patient's care on weekly basis. Ideally, the named nurse will have a planned engagement with the service user at least twice a week or as per the frequency determined by the care plan (with the named officer being present weekly), where the service user can discuss any issues concerning them.

Any amendments to the care plan will be implemented following the service user's engagement. Documented evidence of these engagements will be recorded in the clinical record and the care plan documentation. The care plan must include the appropriate interventions used for that service user including their attendance at Chapel, the Gym, and Education etc.

On each, shift a nominated nurse or healthcare assistant will be identified as the allocated nurse for that service user. This healthcare professional is responsible for implementing the care plan and assessing the service user for that shift. They must refer to the care plan and document evidence of their interventions and interactions in the Clinical Record (System1). They must introduce themselves to the service user at the beginning of the shift to inform them that they are the named nurse for the shift.

Whilst mental health service users are receiving care in the inpatient department, a Consultant Psychiatrist will be the Responsible Clinician. As part of empowering the service users and incorporating NHS standards, there will be a ward round every Tuesday where the care of the service user will be discussed. When appropriate, the service user will be invited to attend the ward round to discuss their care with the team.

General Practitioners will be the Responsible Clinicians for service users who are physically ill or presenting with substance misuse concerns. Surgeries are held on Mondays and Wednesdays. Inpatient staff can call on the duty General Practitioner, Addaction substance misuse nurses or primary care team nurses daily depending on presenting concerns or for advice and guidance. The substance misuse services Consultant will also review patients as and when required.

A ward round is held every week which is a Multi-Disciplinary Team attended by: Consultant Psychiatrist, Associate Specialist, Registrar, a nurse from inpatients, members of the Inreach Team, Complex Case Team, Addiction Services and Leaving Prison Services i.e. Nacro or Probation, whichever is appropriate. The officers also have a very active role in the ward round: planning the ward round, implementing the

ward round actions and endeavouring and enabling prisoners to be part of the ward round.

2. Referral System

Referrals to the Inpatient Department are normally via healthcare professionals following an assessment and identification of the service user's needs. Service users may be referred from all areas including reception, the first night centre, house blocks and the Segregation Unit

All other prison staff should in the first instance, if possible, speak to house block, reception or first night centre nurses or to the inreach team to discuss their concerns about prisoner they want admitted to the healthcare inpatients unit. It is expected that the referral system may differ, depending on where the service user is being referred from and the time the referral is made.

Healthcare Staff referring service users to the inpatient unit for admission should speak to the Inpatient Unit nurse in charge of the shift to discuss the reason(s) for admission, giving as much information as possible.

We have gone for an open door policy to empower all prison staff to ensure that all prisoners that they feel need inpatients admissions are considered for admission. The Inpatient Unit has a limited capacity, so we actively manage this through the weekly ward round where we review patients and try and keep the system flowing from the point of admission to discharge. In essence, when the patient is admitted to inpatient healthcare a care pathway is identified: be it a temporary stay, long-term stay or a transient stay for onward transfer to outside services. These are all incorporated into the care plan.

There is active liaison with the court diversion services based at the courts we serve to identify those going through the criminal justice system with healthcare needs that will need to be cared for in healthcare inpatients units.

There are Inreach teams actively working with remand and sentenced patients, collecting background information and identifying patients who need to be transferred to inpatients.
There is on-going outpatient clinics at all times during the week for patients with mental illnesses and other identified long-standing needs and they may be admitted.

In addition, we provide an open service to all prison staff particularly officers who may have concerns at any time about a prisoner on the house block. We work closely with the segregation unit staff on a daily basis to review and admit prisoners who are exhibiting signs of acute mental illnesses.

3. Suicide Prevention Strategy

Suicide strategy is described as an essential component of mental health within the prison setting and it is helped by having an open door policy as a referral pathway in to inpatients. The exit pathway, is the area we have as a team, worked to manage our beds successfully. In preparation before arrival to inpatients it is important that there is close liaison between the referring source, inpatient staff and prison staff.

The officer in charge and the nurse in charge will co-ordinate the admission and the appropriate placements within healthcare for the admission.

The admitting nurse will obtain as much information as possible of the service users' history, current presentation and care needs. Inpatient staff will liaise with relevant general and adult mental health services to obtain discharge summaries of any inpatient admissions and General Practitioners and community Mental Health Teams for any salient background information. This is much assisted by the admin team. It is good practice to contact care co-ordinators of known service users should they be contacted to provide relevant information as soon as it is practically possible.

4. Admission

When a service user arrives at inpatients, the nurse nominated to receive the hand-over of care must ensure the client undergoes an assessment of risk, and be assessed for the level of observation i.e. General, Intermittent or Constant).

As soon as practicably possible, the named nurse in conjunction with the inpatient psychiatrist, general practitioner or substance misuse doctor must set a date to undertake a thorough health and social care assessment to determine immediate and long-term care needs. This can be part of the admission process undertaken by the doctor or as part of the weekly ward round. Referrals to local and relevant services should be made as soon as practically possible.

Admissions to healthcare under physical restraint are in exceptional circumstances only where a healthcare professional assesses the risk of harm to the service user and others to be immediate and high. The intervention should be planned and a nurse must accompany the service user from the area of transfer. On arrival the service user will be allocated a cell and every attempt will be made to de-escalate the situation quickly. On arrival, an initial assessment will take place to decide the level of unlock required and the nature and frequency of any observations to be made.

5. Assessment of Risk and Observation Levels

The assessment of risk is an on-going process. Factors relating to risk prior to the service user arriving at the inpatients must be taken into account during their stay.

When performing risk assessment it is important to identify and focus on risk behaviour so staff should ensure that they have the relevant information on which to assess risk.

Attempts should be made to obtain some information about the index offence to try and establish any potential link with mental illness. A current mental state examination and physical health assessment should be carried out as this will help guide the management of risk. Staff should ensure they are aware of the frequency of a particular risk behaviour in a given population.

Offending behaviour risks should be incorporated into the service user's care plan for Multi-Disciplinary Team discussions if they are linked to their mental illness. For service users convicted of violent and sexual offences, liaise with the public protection unit (probation) to ensure multi agency working for public protection.

The inpatients unit observation is based on the Greenwich Prisons Inpatients Units Observation Policy. (please see appendix 2)

All patients are checked visually at least once an hour. Others may be checked more frequently than that and there would be patients who would require constant watch if they are at high risk of serious self-harm or suicide.

Healthcare staff will record in patients' clinical records daily compliance with patients' observation levels and all patients will have their observation levels reviewed at the weekly Multi-Disciplinary Team meeting.

6. Orientation and Information

All service users should be given support and reassurance when they arrive at the department. The allocated nurse or officer must orientate them to the environment and to the daily regime including meal times. Service users should be told that they can practice their faith and be allowed access to representatives from their faith during their stay in the department.

It is important that service users are given as much information about their health problems and treatment in the unit. This can contribute to their involvement and may alleviate anxiety and fear. Caution must be taken to avoid overburdening service users at the early stage of their care. Skill must be used to determine what is appropriate for each individual's needs.

Nursing staff should assist service users to understand information relevant to them by providing both documentation and verbal explanations.

Nursing staff should immediately ascertain the service users need for an interpreter and ensure interpreters are arranged for meetings. The minimum frequency of staff meeting with an interpreter is once a week. A conference telephone is available for interpretation using "Language Line".

The service user should be informed when they will with members of the Multi-Disciplinary Team including their responsible doctor.

7. The Care Plan

The admitting nurse is responsible for compiling and activating the initial assessment and care plan within the first 24 hours of admission. A doctor (Psychiatrist or GP, depending on the reason for admission) would also see the service user within 72hours of admission as part of the overall care planning. The named nurse is responsible for the on-going assessment, planning, implementation and evaluation of care and for keeping care planning and other documentation accurate and up to date. Each care plan must be evaluated weekly, fortnightly or monthly, and changed in accordance with need.

A registered nurse will act as the named nurse. For physically ill service users this will be an adult nurse, for substance misuse and mental illness it will be a mental health.

The care plan is informed by:

- Assessment and admission documentation.
- Previous history.
- Collateral information from other professionals.
- Ward rounds, clinical meetings and CPA meetings.
- The service user's general presentation.
- The service users expressed wishes.

The needs and interventions documented in the care plan are prioritised with risk and observation levels taking precedence.

Levels of Observation

General Observation - Healthcare staff will record all observations on the prison observation forms, and these written records will be kept in the Healthcare Unit. A summary of the observations is made in Systmone at the end of each shift. General observation is the minimum level of observation for all inpatients.

At this level staff must check on the physical and mental wellbeing and whereabouts of all patients on the Healthcare Unit every hour; or every 30 minutes if their admission to the Healthcare Unit is due to mental disorder. The frequency of observations can be increased by healthcare staff; and this decision must be recorded in Systmone, and recorded in the care plan.

Healthcare staff must record the whereabouts of the patient on the paperwork provided and check their wellbeing. Reductions in observations can only be made following a Multi-Disciplinary Team discussion, and must be recorded in Systmone. Patients general observations must be monitored at night/when asleep; again this should be done in the least intrusive way possible.

At the commencement of every shift, a member of healthcare staff from the outgoing and incoming shift must together physically check the location and wellbeing of all patients on the healthcare unit. The healthcare staff from the outgoing shift must verbally

handover any pertinent information, and signs the form to show that this has been carried out.

ACCT Plan Observations - Increased observations will usually be managed under the Assessment Care in Custody and Treatment (ACCT) process in partnership with prison staff. The level / frequency of observation will be outlined in the patient's ACCT care plan.

The observation form must be completed and details recorded (after each observation in the ACCT) stating the patient's location, mental state and any risk behaviours noted. Healthcare staff must also make appropriate records in the ACCT plan. Patients on an ACCT plan will be monitored at night/when asleep; again this should be done in the least intrusive way possible.

A review of the patient's level of observation should be conducted regularly and in line with the ACCT care plan policy; the outcome of this review must be recorded on Systmone. It is good practice to involve the multidisciplinary team and the patient as far as possible in this review; including, where possible, the ward doctor or responsible clinician.

If a patient remains on an ACCT plan for longer than 7 days, a formal multi-disciplinary review of their care and observation level **must** be held. This review must involve medical staff and any decision made regarding the observation level along with the rationale for this decision must be recorded on Systmone.

8. Communication Channels

Effective communication channels are essential for the service user's well-being, as well as for thoughtful discharge and aftercare planning.

Inpatient department handovers provide the opportunity for day to day issues to be mentioned and addressed, whereas ward rounds and or Multi-Disciplinary Team meetings should look at both short and long-term needs of the clients. The clinical lead and registered nurses are responsible for conveying information between the department and Multi-professional meetings.

9. Discharges

Discharge to a houseblock - Discharge planning should commence from the moment of admission. All discharges from the department will either be planned through ward rounds or following assessments with psychiatrists, at the GP's surgery or with the substance misuse team. For complex cases or where adjustments may need to be made, house block managers shall be invited to participate in the discharge planning process. The named nurse must discuss with the service user their impending return to the house block. This will allow the service user to make plans for their return to ordinary location and to identify any concerns they may have surrounding this. This is particularly important for vulnerable prisoners. It will also give the named nurse the

opportunity to put in place a support plan with the service user. The healthcare staff should liaise closely with discipline staff and operational managers for issues relating to cell sharing risk assessments, Rule 45 paperwork and potential conflicts with other prisoners. Following this discussion, a discharge plan will be devised and implemented. A cell sharing risk assessment review will be completed by inpatients for all service users returning to a house block.

A health care exit report from will be completed by the named nurse and given to the house block nurse and to the residential staff together with a verbal handover.

A copy of this form shall be scanned onto the electronic clinical record (SystemOne) and an entry made outlining any medical or psychiatric follow up required. The primary care team on the accepting house block must ensure that the service user is seen within one week of his discharge from the inpatient department and an entry made in the medical record to that effect.

For service users who are being cared for under ACCT a case review should be held as part of the discharge process.

When a patient with a physical illness, primary care mental illness or acute substance misuse problems wants to be discharged against medical advice, they will undergo capacity assessment and when they are deemed to have the capacity to make an informed decision, they will have to sign a disclaimer before being discharged.

10. Transfer to Mental Health Units

All service users who are transferred to psychiatric units from the Greenwich Prisons will be transferred under the Mental Health Act 193, amended 2007. In 2015 Oxleas NHS Foundation Trust appointed a Transfers co-ordinator (A Senior Nurse) for the Greenwich prison to co-ordinate all the transfers. Therefore these transfers are managed by a senior nurse practitioner who liaises with the inpatient teams about the progression once the referral to outside service is made.

A comprehensive discharge summary containing relevant details of the service user's behaviour, mental state, physical health and medication during their time as an inpatient must accompany the gentleman to the accepting psychiatric unit. A registered mental health nurse must accompany the client to the psychiatric unit to deliver the psychiatric papers (this requirement is under guidance from the MHA commission April 2005).
if the release date is known, then preparation for support on release should be made well in advance. If a service user is already subject to CPA prior to coming to prison then the inpatient staff will invite the existing team to attend a CPA meeting at the prison prior to release. If the service user has a sentence of 12 months or more they will be subject to supervision by probation services and the probation officer should be invited to the discharge CPA meeting. For service users with comorbid drugs and alcohol problems, there should be joint work with the prison substance misuse team to liaise with the relevant drug treatment agencies for post-discharge arrangements.

If the service user is released abruptly, for example, from court, the inpatient staff will contact the care co-ordinator, if relevant and the service users GP to alert them of his

release. Initially, information will be delivered via telephone. It should then be followed up in writing, which should be faxed to them without delay. This brief discharge summary should inform them of the discharge address, current health issues, medication and any treatment plans. For service users who had been admitted for drugs and alcohol withdrawal problems, the prison substance misuse team should be informed of the discharge immediately so that they can liaise with the relevant drug treatment agencies.

11. Transfer Back from Hospital

There are occasions when service users will be transferred from hospital back in to the prisons healthcare inpatients units. What has been agreed is that the transfer co-ordinator will attend CPA meetings of transfers back in to the Greenwich prisons to ensure there is a full line of communication to update the inpatient teams on the expected return of prisoners to the healthcare inpatients units. It can be a complex situation accepting prisoners back from secure hospital settings straight into the inpatients units and this may have to be discussed with the receiving prison senior management team.

12. Individuality, Race, Equality and Cultural Diversity

Staff will comply and refer to the prison's statement of intent on equalities and diversity and the prison's core values.

Cultural and spiritual diversity must be respected and wherever possible, related needs must be discussed with the service user. Identified cultural and spiritual needs and how these will be met must be recorded in the service users care plan.

During admission, every effort must be made to provide a trained interpreter for service users with very little or no understanding to the English language, particularly during the initial assessment and at each formal meeting.

13. Training/Implementation Plan

Training session to be arranged for inpatient department staff.
Policy to be presented at healthcare staff meeting by clinical lead for inpatients.

14. Compliance and Auditing

Submissions to Inpatient Operational Management Group and Greenwich Quality Board; Patients Safety, Clinical Effectiveness and Patients Experience Groups' comments and amendments.

Resubmission to inpatient Operational management Group with amendments for policy leads' signatures. Policy becomes guidance.

Copies of drafts with tract changes kept on record.

Ratified through Clinical Governance Committee.

Appendices:

1. End of Life/Palliative Care Policy
2. DNAR Policy

Standard Operating Procedure for Access to Care for Adults with Palliative and End of Life Care Needs in Greenwich Prisons

Background:

The purpose of this SOP is to:

- Provide consistent, rapid access to palliative and end of life care within HMP Belmarsh
- Provide direct access to specialist palliative care
- Simplify and clarify the process for patients and carers to facilitate choice and ensure they receive the right care at the right time by the most appropriate clinician
- Ensure direct access avoiding unnecessary delays
- Ensure that best practice is achieved at all times
- Provide clear guidance regarding the accountability and role of all staff involved in the process

Statement:

This SOP supports staff, patients and carers to make individual decisions about the requirement for direct access to doctors and specialist palliative care. Within HMP Belmarsh, health care and the prison is committed to the delivery of palliative and end of life care in a non-discriminatory way to ensure equity of access to high quality services.
It is recognised that there is continuing work within End of Life care that will link into this SOP.

Responsibilities:

Compliance with this SOP will be the responsibility of all health care staff within HMP Belmarsh and prison staff who care for adults with palliative and end of life care needs.

Training:

It is the responsibility of Oxleas NHS Foundation Trust to provide training to all Healthcare and Prison staff who are responsible to deliver palliative and end of life care.

Dissemination:

A copy of the SOP will be available for all staff on trust intranet sites. Ward, department and service leads will be responsible for ensuring relevant information is cascaded to all clinical staff in their area.
Following a clinical assessment and/or a diagnosis that a patient cared for as an inpatient or on the house block has an advanced life limiting illness, the clinical practitioner will communicate with the wider multidisciplinary team, including the Medical Lead/ General Practitioner, palliative care team and the District Nursing service. The following steps will be taken:

Step 1: Discussion as end of life approaches

- Allocation of key worker (Prison Palliative Link Nurse) to have on-going discussions with patient regarding his understanding of diagnosis/prognosis.
- Family involvement should be considered as early as possible. A referral to the Family liaison officer should be done at this stage.
- Contact details of Next of Kin to be updated and recorded. Prisoner's consent to contact NOK must also be obtained.

Step 2: Assessment, Care Planning and Review

- A holistic assessment (physical, social, spiritual, psychological) is carried out and documented. This includes discussion of the Advance Care Plan and preferred and permitted place of care and death.
- If the patient consents a referral is made to the Hospice Community Team.
- The Care plan should be discussed at Prison Palliative Care Liaison meeting (monthly) and the Greenwich & Bexley Community Hospice Multidisciplinary Meeting (weekly).
- Use of restraints, early release on compassion and release on temporary license should be considered at an early stage.
- Carers' needs (both family-friends outside the prison and close friends in the hospice) should be assessed.
- As the condition changes regular assessments are carried out to reflect changing needs and wishes.
- The use of Coordinate My Care (CMC) Record (electronic record informing London Ambulance Service re patient's care plan and wishes) should be considered. The use of CMC for patients in the prison remains within Oxleas NHS Foundation Trust End of Life care Policy. Training of staff would be essential.
- Resuscitation status should be reviewed on an on-going basis.

Step 3: Coordination of care

There is an established process:

- To discuss patients on the End of Life Register with Specialist Palliative Care Team at the monthly Prison Palliative Care Liaison meeting and when patient referred to the hospice at their weekly Multidisciplinary meeting. The prison health staff can attend this meeting or use telephone conference facility to participate in the meeting.
- To record the plans discussed at the Prisons Palliative Care meeting using the Prison palliative care meeting template.

- To consider care in the hospice inpatient unit when appropriate
- To update CMC record.

Step 4: Delivery of High quality services

The care delivered in the prison should be equitable to the care in the community. The following should be considered:

- Safe and effective medication, including emergency medication available in prison pharmacy. Advice regarding medication can be obtained from the hospice 24/7. Prisons have contact details. Advise also available from electronic guidelines – http://book.pallcare.info/index.php
- Specific needs such as mobility aids, pressure relieving equipment, hoist, hospital bed, interpreter, diet should be addressed.
- The prisoner should be offered the same written information about his condition as any other patient in the community
- Care in the Wing – what is needed to make this possible
- Support and information to family- close friends
- Support of informal carers in the prison
- Staff support – both health and other staff

Step 5: Care in the last days of life

- Ensure that prison has NOK up to date contact details, including if & when NOK wants to be contacted.
- Consider transfer to hospice if this is permitted and hospice is the prisoner's preferred place of death.
- Consider if acute admissions appropriate. Update CMC record and local care plan.
- Review security measures.
- Review visiting by family-friends.

Step 6: Care after death (Could be unexpected death/suicide)

- How to break bad news – Family Liaison Officer (FLO) to inform Next of Kin.
- The Prison Chaplain and the Prison Care Team will offer support to the prison staff and other prisoners.
- The hospice will offer support to family members and/or signpost them to support in their local area.
- Return of property.
- Viewing of the body.
- Funeral costs

Use of restraint

A risk assessment will be completed by the Security manager of the prison to determine the level of restraint required for the safe custody of the offender. The risk assessment will consider the following:

- The offender's medical condition. Where there is doubt, the prison medical officer must be asked to advise on any medical objections to the use of restraints, and assess the offender's ability to escape unaided.
- The custodial category of the offender.

- The nature of the offences, the risk to the public and hospital staff, including the risk of hostage taking.
- The offender's motivation to escape the likelihood of outside assistance and conduct while in custody.

- The physical security of the hospital/hospice including the consulting room and where possible, other areas where tests or treatment may take place.

Release on temporary license/ compassionate grounds

- Release on temporary licence (ROTL):

Any release on temporary licence will only take place once the prisoner has satisfied a stringent risk assessment carried out by a designated ROTL Board at the establishment. Governors have an overriding duty, when considering any release, to ensure that both public safety and public confidence in the judicial system are maintained. There is no automatic right of entitlement for release on temporary licence to be granted

- Release on compassionate grounds:

Chapter 12 of PSO 4700 and chapter 12 of PSO 6000 give details of the circumstances in which compassionate release may be considered.
http://www.justice.gov.uk/offenders/psos/pso-4700-indeterminate-sentence-manual
http://www.justice.gov.uk/downloads/offenders/psipso/pso/pso-6000.pdf

Policies/guidelines required

DNACPR:

As noted above the PSI 64/2011 (Ministry of Justice 2013) requires the prisons to have a DNACPR policy. The project group has recognised that the existence of a DNACPR order requires a substantial amount of training of both prison health and operational staff. Training must be provided so that staff are clear in which circumstances they would not attempt CPR as previously the accepted protocol was that they **must** attempt CPR as they are not qualified to state that the person has passed away.

Access to Coordinate My Care (Electronic Palliative Care Coordination System)
The training for access to CMC will be part of the training provided for prison health care staff.