

Special Observations in the Care of Psychiatric Inpatients: A Review of the Literature and Developments in Practice

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Abstract: *Special observations are commonly used on mental health inpatient wards as an intervention with acutely ill patients who are at risk of harm to themselves, harm to others or absconding. Attention has turned to looking for alternatives to special observations, partly because of the resources that are devoted to the practice in the context of the strain on services, and partly because of questions around the efficacy of the practice and the impact on patient care. There have been a number of developments that have tried to reduce levels of special observations on wards with varying success. Here, we review the literature on special observations and recent developments in the efforts to reduce the practice. There is no convincing evidence that special observations exert a positive effect on patient outcomes, but conclusive evidence is difficult to gather and there is a need for stronger evidence to inform practice.*

Keywords: *Mental health nursing; coercive measures; control; supportive observations.*

1. INTRODUCTION

Special observations (SO) of at-risk patients have been integral to mental health nursing care for decades [1]. SO is the practice of maintaining an increased level of observation over particular patients when they are acutely ill (and may be at an elevated risk of self-harm, harming others or absconding) with the purpose of maintaining safety and reducing the risk of adverse incidents. However, the primary purpose of SO may differ between services: in a forensic service, the focus of SO may be to reduce risk whereas in an older age psychiatry service, the focus may be more on closely monitoring physical health needs and reducing the risk of harm from accidents such as falls [2]. While it is acknowledged as one of the most complex, difficult and demanding activities that a nurse can undertake [3, 4], there is also growing concern over the practice in terms of rationale and efficacy [5, 6, 7]. The friction between the competing roles in mental health nursing, of compassionate caring on the one hand and the control of risk on the other, is inherent in this practice. Nevertheless, SO is the recommended approach for those patients who are deemed to be at risk [8].

Commentators have called for a large scale review of the practice of special observations partly because evidence suggests that it has become a custodial task rather than a therapeutic intervention [9, 10]. In addition, the general shortage of resources in health services means that ward staff may spend increasingly less time in direct individual patient contact. Given that the practice of SO can be a resource-sapping activity for a mental health service, there has been a significant drive recently to assess the position of SO in mental health care. This review provides a summary of the state of knowledge in the field with a particular focus on developments in strategies to reduce observations.

2. TERMINOLOGY

There is wide variation in the terminology used to refer to special observations both in terms of the number of different levels of observations and the meaning of each level [5, 11, and 12]. The guidelines published by the (now disestablished) UK Department of Health Standing Nursing and Midwifery Advisory Committee [4] recommend four levels of observations. *Level 1: General observation*, the minimum acceptable level for all patients where the location of patients is known at all times. *Level 2: Intermittent observation*, where a patient's location is checked at least once every 15 to 30 minutes. *Level 3: Within eyesight*, where a patient should be kept within eyesight at all times. *Level 4: Within arm's length*, where nursing staff remain in very close proximity to the patient at all

times. Levels 3 and 4 are commonly referred to as constant observations and it is this terminology will be used throughout this review.

3. CIRCUMSTANCES AND ANTECEDENTS OF SPECIAL OBSERVATIONS

The reason for initiating SO of a patient is largely based on an assessment of risk and the need to minimise that risk. However, risk assessment can often be a vague and imprecise practice [13] and in the case of forensic wards where the population is already of a substantially higher risk than usual, the task of recognizing patients who are at particularly acute and imminent risk can be difficult. Surveys of nursing staff that address the antecedents of SO conclude that the main criterion for initiating SO is the patient's current behaviour rather than past or historical risk [14,15] and SO is therefore implemented in reaction to recent behaviour rather than as a preventative measure. One study compared forensic and non-forensic inpatient units in terms of the factors that were responsible for initiating SO [16] and found subtle but important differences in the reasons given by each. Secure units (medium- and low-secure) tended to emphasise assault and threat of assault as the chief reasons for SO whilst the general psychiatric unit emphasised suicidal intent.

Bowers' survey of UK public mental health organisations (NHS mental health trusts) indicated that SO was primarily initiated to reduce the risk of self-harm and suicide, and to prevent aggressive behaviour or absconding [11]. These motivations are cited with a good degree of consistency throughout the literature on this issue [17,18,19] but there are a broader range of antecedents to SO that emerge when nursing staff are interviewed about the reasons for SO, such as assessment [18,20], fire risk [21], sexual disinhibition [21], psychotic symptoms [22], self-neglect [17], first presentation [22,23], safety considerations [19,23], and medical conditions [19] amongst many others.

Stewart and Bowers' [24] dataset comprising reports from every shift in each of 136 UK acute psychiatric wards suggested a link between ward staffing levels and both constant and intermittent SO use. Specifically, the use of both types of SO decreased as the number of qualified staff on the ward increased. It is likely that strength in numbers of experienced staff on a ward made it less likely that a decision to implement SO would be necessary, whereas the presence of acute at-risk patients in combination with a high level of unqualified staff was more likely to result in initiating SO. Thus, it appears that ward staffing levels may also be a driver of SO.

4. INITIATION AND TERMINATION OF SPECIAL OBSERVATIONS

Guidelines from the UK Department of Health [4] indicate that wherever possible, decisions about SO should be made by the multi-disciplinary team and based on an assessment of risk (using a validated risk assessment tool), consideration of the patient's history and an interview with the patient. Decisions concerning the parameters of the observation (e.g. which level of SO to implement, whether the level should be changed, whether SO should be terminated) should be reviewed daily (including weekends) by a doctor and the primary nurse, and in the case of Level 4 SO, guidelines recommend a review in every shift.

Predictably the literature describing actual practice in the management of SO highlights substantial variation across different units. Several published surveys have suggested that episodes of SO are largely initiated by a medical doctor rather than a care team [18, 22, 25]. For example, in one qualitative study, it is clear that nurses viewed SO as a medical 'directive' rather than a decision to which nurses contributed [3], and in another, 94% of nursing staff expressed the view that medical staff dominated the decision-making process [25]. More recently, a Scottish study found a lack of multidisciplinary team involvement in SO decision-making and limited pre-agreed plans for nurses to reduce levels of observation [26]. Furthermore, the level of observations was largely determined by a subjective clinical judgement or a non-validated (usually local) checklist risk assessment [26, 27].

In contrast, a survey of 26 inpatient services in the UK showed that in 50% of services, constant SO could be initiated autonomously by qualified nurses, although in most of these places the procedure could also be invoked by medical staff. In the remaining 50% of services, initiation of constant SO was a joint medical and nursing decision [11]. However, it should be noted that these responses came from trust nursing directors and senior trust staff (and more likely to reflect the trust's policy) rather than from responses at ward level concerning actual practice. However, a number of (admittedly older) studies have suggested that both medical staff and nursing staff contribute to SO decisions [14,28] and that nursing staff may initiate SO if they felt that the patient was at risk and no medical

staff were available [28]. Duffy's [27] qualitative study of nursing staff suggested that whilst doctors were invariably responsible for formally initiating SO, the decision was often prompted by nursing information if not explicitly suggested by nurses. Similarly, in an analysis of inpatient suicides, nurses were involved in the decision to initiate SO in 70% of the cases [29]. With regard to terminating SO, there is slightly more consensus that decisions have a greater degree of input from a doctor [11, 27]; reflecting the fact that termination poses a greater potential risk to patients than does initiation. Bowers' survey of a number of services shows that termination of constant SO was reported by 63% of services to be a joint medical and nursing decision [11] and Duffy's qualitative study of nurses suggests that SO was typically terminated by a doctor (but again often at the suggestion of nursing staff) [27]. However, Duffy observed that normally only ward doctors (rather than duty doctors) would take the responsibility of terminating SO and as a result, SO was rarely terminated at weekends when duty doctors were the only medical staff available.

5. WHO CONDUCTS SPECIAL OBSERVATIONS?

The literature includes some surveys of what type of staff normally conduct SO but there is little consistency. The personnel who conduct SO appear to vary widely, from permanent qualified nursing staff to medical students and nursing students [11,30,31]. In one study, the most consistent finding was that there was little agreement between different trusts about which staff were qualified to carry out SO [11]. While all trusts agreed that permanent nursing staff should be allowed to carry out SO, they did not agree on the status of bank staff, agency staff or nursing assistants. Most notable was the degree of disagreement between trusts in whether student nurses should be used; 24% of trusts allowed nursing students to conduct all levels of SO, 43% allowed students to carry out some levels of SO while 33% did not allow students to conduct any level of SO at all.

A number of sources discussed the issue of who should conduct SO. That is, irrespective of current practice on wards, is there any evidence that some types of staff may be more suitable for SO than others? Specifically, debate centred around the question of whether it was necessary for observers to be qualified experienced nursing staff with whom the patient was familiar, or whether SO may be carried out by non-permanent staff, support workers, students and others. Several sources commented on the fact that engaging acutely distressed patients in a meaningful and therapeutic way is a skilled activity but that it is often assigned to the least experienced and least skilled staff [5, 24, 32]. One argument is that staff, regardless of status, should be trained to conduct SO and some commentators have recommended the development of such training [27, 33] but given that there is little agreement about what staff should be doing during SO, it is difficult to conceive of what such training should involve. In addition, given that there is little agreement about the skills that are required to conduct SO, it is difficult to arrive at any conclusions about the types of staff that are likely to have acquired those skills. Nevertheless, from the patient's perspective, the preference seems to be clear. Patients have reported that being observed by staff that they did not know made them feel less safe [20]. From this point of view, it is not the experience or the level of training that is important, but the relationship between the patient and the observer, something that is particularly important if considering SO as a therapeutic endeavour rather than a risk management activity.

6. WHAT SHOULD NURSES DO WHEN CONDUCTING SPECIAL OBSERVATIONS?

One notable absence in the mental health nursing literature is a lack of thorough understanding of what happens during the use of higher level observations to manage risk. As a result, there is very little guidance on what should ideally happen because this is likely to be based on a complex and fluid interaction between a large number of factors, such as patient presentation, patient history, physical environment, social circumstances, and the nurse's relationship with the patient, amongst many others. There is therefore a cogent argument for not being prescriptive about what nurses should (and should not) do when conducting SO.

However, the perception from nursing staff is that, when conducted well, SO requires a high degree of expertise and competency on the part of the nurse. When Mackay, Paterson and Cassells elicited nurses views of what they do when conducting high level observations, they found a subtle and complex mix of: intervening and taking action (physically, verbally, therapeutically), maintaining safety (of patient and staff), prevention and de-escalation (looking out for warning signs, removing triggers), assessing (monitoring mental state, conduct on-going risk assessment), communication

(discussing, counselling, interacting and engaging with the patient while also feeding back to other staff), and therapy (establishing a therapeutic relationship, trust, rapport, valuing)[34]. According to this view, conducting observations is a highly skilled mental health intervention rather than simply a means of reducing risk through control. As such, conducting SO is a complex skill and the Clinical Resource and Audit Group [35] recommended that nurses are trained to have a ‘toolbox’ of practical and psychological interventions to apply during observations. However, there are no recommendations on what interventions should be applied under what circumstances, and no guidance on the training that should be given in order to support this activity. Thus, while ward staff may have an awareness of what they could and should be doing in order to more effectively support vulnerable patients through SO, there also appears to be an understanding that the specific skills that are a required may be more art than science.

7. OUTCOMES OF SPECIAL OBSERVATIONS – SELF-HARM, SUICIDE AND ASSAULT

There is little convincing evidence in the literature that SO are effective in increasing patient safety. However, sources also broadly acknowledge that it would be impossible to deliver such evidence because of the difficulties in conducting the appropriate studies [5,36]. Patients who are at risk of harm to themselves or others need to be monitored closely and the ethical problems in attempting a controlled trial that included the removal of SO as a risk containment option appear insurmountable. Thus, the fact that no convincing evidence exists in favour of the efficacy of SO does not necessarily indicate that SO are ineffective. A systematic review of the efficacy of various containment strategies [37] found only literature that focused on pharmacological interventions as opposed to containment strategies like formal observation, and found no randomized controlled trials that evaluated the effects of containment strategies. The review confirmed the fact that the evidence base for containment strategies such as SO is based on case studies and descriptive studies, and there was no good-quality evidence to support or refute the use of this strategy [37]. However, studies that have attempted to address this question using other types of evidence have yielded a mix of results.

One specific type of outcome that SO is designed to minimise is self-harm and suicide. However, several studies have highlighted incidents of self-harm and suicide whilst the patient was under SO. Clinical surveys in the UK and the US have shown that 20-30% of inpatients who completed suicide were under Level 2 SO and around 3% were under constant SO [38,39] but several other studies give varying rates of suicide under SO [40,41,42]. Most recently, a survey of inpatient suicides in the UK over a 7-year period showed that only 15% of patients were under some form on SO at the time of their death, with just over 1% under constant SO [2]. Whilst the implication is that, proportionally, suicide under SO is becoming less frequent, these data still suggest that being observed does not protect against suicide.

One study found a very low incidence of self-harm (less than 5%) under Level 2 observations, and concluded that this level of SO was likely to be effective in reducing self-harm [31]. Furthermore, a large scale UK project assessed whether wards with a higher use of SO had lower rates of self-harm compared with wards with lower SO use [43] and unexpectedly found a negative correlation between the use of intermittent SO and incidents of self-harm. The authors acknowledge that the causal relationship between these factors cannot be inferred and that there may well be other explanations for the relationship. Nevertheless, these studies converge on the view that intermittent SO may be useful in reducing self-harm and a recent analysis suggests that inpatients who are in the process of a suicide attempt are often interrupted by nurses conducting intermittent SO [44].

On the other hand, there appears to be no evidence that constant SO reduces the rate of self-harm. A longitudinal analysis of constant SO and self-harm in 16 wards across three hospitals in London showed no significant relationship between constant SO and self-harm occurrence [45]. However, one study suggested that constant SO may be effective in reducing attempted suicide for patients with a known self-harm or suicide risk if they are placed under constant SO on admission [46]. Research on the impact of constant SO is sparse, and while the data suggests that the impact is minimal, the literature also highlights considerable variation in the quality of constant SO that is conducted [11,29]. Constant SO is not an all-or-nothing intervention and the efficacy of the intervention is only as reliable as the nursing staff who conducts it. From an objective standpoint, acutely distressed patients may require close attention and care from a trusted, understanding and experienced nurse, but if ward resources are stretched, the responsibility for care may fall to less experienced staff who may conduct

the observations differently (and perhaps less effectively with a lesser degree of therapeutic engagement). If the impact of those observations turns out to be minimal, should we conclude that constant observations in general have little benefit, or should we conclude that constant observations by inexperienced staff have little benefit? Unfortunately, the quality of the existing data does not allow us to distinguish between these two conclusions.

8. OUTCOME OF SPECIAL OBSERVATIONS – UNINTENDED AND HARMFUL CONSEQUENCES

The literature also highlights some unintended negative side effects of SO. For example, one study points out that constant SO is likely to be counter-therapeutic if conducted by inexperienced and unskilled staff [32]. Keeping a patient under constant observation may imply that staff do not trust the patient, making it difficult to establish therapeutic relationships. In addition, SO devolves responsibility for dangerous behaviour from the patient and places it upon the nurse who must anticipate the patient's self-injurious thoughts and behaviours. If the onus of control is on the nurse, this does little to cultivate self-reliance in the patient. In this situation, the skill and experience of the nurse is crucial in engaging the patient in an effort to counteract the counter-therapeutic side effects of observation. It is also possible that patients who present with anger or paranoia may deteriorate because of the lack of privacy enforced by SO and may actually increase the probability of violence [2, 5]. For some patients, constant SO may be provocative, stimulating and could serve to exacerbate symptoms and agitate patients who are easily aroused [3, 25].

Conducting constant SO can be an enormous drain on nursing staff resources because staff who are monitoring one patient are unavailable to other patients and other duties. One economic analysis in the UK estimated that the annual cost of SO to the NHS was £80m [47] and a recent analysis of constant SO in a single high secure hospital estimated the annual cost to be almost £900k [48]. Because of resource limitations, SO are often deferred to unqualified and/or less experienced ward staff [5] and possibly exacerbating the patient's counter-therapeutic experience of constant SO. Whilst there is some debate in the literature about the relationship between SO use and staff sickness levels [18,49], conducting constant SO is undoubtedly a stressful activity and it may be no surprise that conducting constant SO may contribute to staff sickness levels. Indeed, when one acute inpatient ward implemented an innovative programme to minimise observations, there were significant reductions in staff sickness as well as self-harm, violence and absconding [10]. It should be noted that many factors changed as a result of a reduction in the use of SO, such as changes in patient engagement, improvements in staff communication, and changes in ward management. Nevertheless, while high levels of self-harm, violence and staff sickness could not be attributed to the use of SO, it is clear that the reduction in the use of SO was (both directly and indirectly) a contributing factor to the subsequent improvements.

9. PATIENT AND STAFF VIEWS OF SPECIAL OBSERVATIONS

A number of qualitative studies have examined the views of nursing staff with regards to carrying out SO [3,27,34] with some common themes emerging. One study found that SO inspired a paternalistic view of treatment; that is, doctors knew best in initiating observations and the nurses therefore carried out the treatment in spite of the patient's misgivings and potential discomfort [27]. As such, the nurse-patient interaction became more akin to a parent-child transaction rather than adult-adult transaction. In struggling to restore the patient's autonomy and dignity without endangering them, they often found themselves modifying the observations procedures based on their own assessment of probable behaviour, e.g. allowing the patient privacy in the lavatory or when bathing. This chimes quite well with one study that reported that staff found conducting constant SO to be stressful, tiring, draining and intrusive to the point where nurses' concerns of patient privacy led them to stretch and alter the boundaries of the observations policy [3]. The hierarchical nature of mental healthcare culture also led to significant tensions because nursing staff often felt stuck in between competing professional concerns. On the one hand, doctors asked for observations and the nurse was expected to carry them out whilst also attempting to maintain a therapeutic relationship with the patient. This was particularly difficult when nurses did not feel that SO was appropriate for a patient, and so conducting observations that the nurse felt was unwarranted often led to feelings of powerlessness and resentment.

A small number of studies have reported on the views of patients with regards to SO [10, 50, 51, 52, 53] and have drawn broadly similar conclusions. For example, one study interviewed 18 patients from

a number of acute adult inpatient wards across three hospital sites. All patients had recently been under Level 3 observation (constant visual contact) and the most striking element to emerge across their reports was the relationship between their experience of being observed and their relationship with the observer. Unsurprisingly perhaps, patients much preferred being observed by nurses that they knew (and who talked to them) rather than staff they did not know. Patients felt safer, more reassured and more cared for if the observer was someone they knew and this was particularly true of patients who were feeling suicidal [20]. This highlights the fact that if especially vulnerable patients are observed by staff they do not know (and/or do not talk to them), it may have an acutely negative effect on the patient's experience at a time when they are already feeling particularly vulnerable. This echoes the findings of another study describing views from suicidal patients who reported that constant SO could be a highly distressing experience if staff did not interact with them [53]. Conversely, constant observation could also be a positive experience and several patients reported feeling safe, supported and that interactions with the observing nurse encouraged them to believe that they could resolve their feelings of hopelessness and worthlessness. This again highlights the critical importance of engagement between staff and patients during constant SO; skilled engagement with an experienced compassionate nurse can make the difference between a distressing controlling experience for the patient, and an encouraging, therapeutic and recovery-oriented experience. It appears that constant SO without any engagement with the patient may be a rare occurrence; in Stewart and Bowers' dataset from 136 UK acute psychiatric wards over a 6-month period in 2004-05 and indicated that the use of constant SO without engagement was unusual (frequency of use was in less than one shift in ten) whereas constant SO with engagement was approximately four times more frequent [46].

10. STRATEGIES TO REDUCE THE USE OF SPECIAL OBSERVATIONS

The extant literature on risk containment strategies provide no clear evidenced alternatives to enhanced observations. SO has become deeply ingrained in the culture of mental health nursing practice and if this practice is to be challenged, and alternatives to be adopted, the culture of mental health nursing needs to be addressed [7]. Thus, rather than taking the radical step of proposing alternative strategies, researchers have primarily investigated approaches to reduce the frequency with which SO are employed. Some common themes have emerged from these research efforts and typically involve changes in ward management and teamwork, patient engagement and collaboration, and ward staff autonomy and empowerment.

The City Nurse project was able to reduce the levels of conflict, self-harm and absconding on two acute wards by making gradual changes to the ward management, ward organisation and hence the ward culture [47,54]. Nurse researchers were recognized clinical experts in acute inpatient care with substantial experience of practice development work, and over a one-year period, they supported ward managers in developing leadership, helped to educate ward staff about the potential drivers of conflict and engaged staff with development and change with regard to conflict. Nurse researchers also initiated a higher level of clinical supervision and reflective practice, and improved the quality of handover and communication on the ward. In general, nurse researchers functioned as role models on the wards while advising on the implementation of changes to ward organisation and teamwork. Over the course of the project, the use of intermittent SO reduced substantially (but the use of constant SO and other forms of containment such as seclusion did not reduce) and there were significant reductions in absconding, aggression and self-harm. Despite that fact that a later application of the same intervention (with more rigorous controls) proved to be less convincing [43], the concept of changes in ward leadership, management and teamwork is a naturally appealing and accessible one and has also been a central aspect of other approaches to conflict reduction [10].

Whilst a large part of the intervention that was applied in the City Nurse project involved a reorganisation of management, leadership and ward structure, one aspect of the intervention also involved improving engagement with patients by encouraging staff to reflect on how they interacted with patients and reinforcing the value of spending time with them. Patient engagement was also central to the Refocusing Project [6, 10] that stimulated significant reductions self-harm, violent incidents, absconding and staff sickness on an acute ward with routinely high levels of SO use. The central objective of Refocusing was to reduce SO levels and essentially replace 'control'-oriented interventions with 'care' interventions as well as promote a professional culture amongst nursing staff. Reducing the level of SO allowed nursing staff more opportunity to engage patients in

meaningful daytime activities and increase the amount of one-to-one time with patients, and importantly enabling alternative nursing interventions to be collaboratively developed with the patients. One study emphasised the fact that the precise nature of the activities were perhaps less important than their function; what they refer to as the ‘gift of time’ [10]. Service users often value time spent with nursing staff very highly as being something both social and therapeutic, and is a crucial aspect of mental health nursing [55]. This chimes well with other proposals that the appropriate response to an acute deterioration in mental health is to engage more with the patient and build a psychological ‘bridge’ to connect with them [1].

Another recent strategy made use of higher levels of patient engagement as part of a zonal nursing approach [56]. Here, SO was used minimally as an adjunct to zonal nursing where particular high-risk areas on a ward (e.g. bedrooms, toilets) were locked when not in use and when they were used by patients, staff maintained a presence in the corridor outside. Staff also maintained a constant presence in communal zones and incorporated these approaches with individual patient management plans. As well as establishing zones where higher levels of vigilance and monitoring was standard, daily community meetings were introduced where patients collaborated with staff in planning meaningful activities and a ‘therapeutic day’ (including recreational, therapeutic and physical activities). The increase in the level of patient engagement with activities was marked; whilst activities had been on offer before zonal nursing, the new approach freed nursing staff to take part in supporting these activities and the consequent engagement by patients was significantly higher. Staff also actively approached patients who were reluctant to engage with the planned programme and offered person-centred alternatives. In one medium-secure service where this approach was pioneered [56], the level of adverse incidents, patient and staff injuries, self-harm and violence and aggression, all fell significantly within a few months. Again, this approach highlights the importance of engagement with patients that is made possible by a restructuring of ward processes that free staff time. In a number of innovative developments, the combination of process change, freeing staff time, and patient engagement appear to be central to the significant improvements in self-harm and aggression that follow.

One of the fundamental aspects in both the City Nurse and Refocusing approaches was improving the professional autonomy of nursing staff. In the Refocusing project [10] in particular, the reduction in SO was facilitated by constructive dialogue between nurses, consultant psychiatrists and managers, and nurses gradually assumed more control of the management of observations. Nurses frequently reviewed observation needs, and reduced the level of, and number of observations, in a more responsive manner than was previously possible. This approach is in line with the recommendations of good practice from the Clinical Resource and Audit Group [35] on observations. These guidelines suggest that the decision to alter the level of observations depends on a variety of factors incorporating risk assessment, multidisciplinary dialogue, and a plan for each patient specifying the agreed changes in behaviour that would facilitate a reduction in observation level and also the exact procedure to be implemented. Observation levels may be increased by nursing staff and followed up by consultation with medical staff, but reducing observation levels should ideally be a team decision. Crucially, teams should plan ahead for weekends, clarifying the circumstances in which reductions can be made. A flexible one-page instrument was designed by the Clinical Research and Audit Group to enable this process and free nurses to implement therapeutic interventions [35]. When researchers implemented these guidelines more closely on one acute ward, they saw a gradual reduction in the allocating of high levels of SO and patients who were placed on high levels of SO were on them for a shorter period. Decisions regarding the levels of observation became less medically dominated and moved towards a more multidisciplinary or nursing team approach [22].

However, they also noted a reluctance on the part of some nursing staff to fully engage with the decision-making process, particularly when reducing an individual’s level of SO. Researchers suggested that this reluctance was based, at least in part, on professional insecurities regarding responsibility, or because of an embedded mental health culture that emphasized observations reduction as a medical decision [22]. This highlights the fact that the culture of mental health nursing, as in all cultures, can be a powerful barrier to change; empowering nursing staff to make decisions is only effective if those staff feel able and supported within their organization to take those decisions. With this in mind, an important aspect of the City Nurse project in particular [47, 54] was the presence and advice of a senior clinical nurse specialist who encouraged ward staff in their practice.

Recently, Bowers [57, 58] has proposed a new model of conflict and containment on psychiatric wards (called the Safewards Model) that identifies six broad drivers of tension and dispute, potentially leading to a need for initiation of some type of control (such as SO). The model takes a broad systemic approach to attempt to explain the ward dynamic, and sees the psychiatric ward as a complex and dynamic system where phenomena (such as SO) cannot be viewed in isolation. Rather, factors such as SO must be considered as part of a larger system and SO levels may be affected by the regulations and policies that are active within a service, the characteristics of the staff on an individual ward as well as the structure of management and leadership, the individual patient history and characteristics as well as their relationship with staff, whether the patient community is coherent and supportive of individuals, whether or not the physical environment is conducive to conflict resolution, etc. For most services, the domain through which changes can most easily be effected is the staff team but the consideration of SO through the broader systemic lens of the Safewards Model can also be helpful in understanding the broader dynamic [57,58].

There has been one attempt at proposing novel and innovative means of supporting acute at-risk patients. This study described the development of two processes designed to be a stepping-stone between constant SO and intermittent SO which they term Psychiatric Nurse Availability (PNA) and Psychiatric Monitoring and Interventions (PMI)[32]. PNA is implemented in cases where a patient who is in danger of self-harm or suicide has been able to develop a therapeutic relationship with staff. Rather than being under constant observation, the patient may agree to share in the responsibility for maintaining their safety and talk to staff about any distressing thoughts or feelings that may lead to self-injurious impulses. Named staff are available to talk to the patient at all times and the nurse becomes a partner in helping the patient cope with emotional distress and suicidal thoughts. PMI on the other hand is implemented in cases where a patient is at risk of violence and aggression. Again, a nurse is assigned to be available to the patient at all times but in this case is responsible for manipulating environmental stimuli and assuring the safety of others. Patients may remain in their room with the door closed to decrease environmental stimulation, and staff are nearby, available to respond to sounds of agitation from the room whilst also being able to support the general ward milieu. When the patient is outside the room, staff offer limits, redirection and focus on eliminating or diffusing environmental hazards and triggers. Ray et al. have not been able to fully evaluate the clinical efficacy of these innovations but have shown positive changes in seclusion and restraint, and in staff feelings of personal safety [32].

11. CONCLUSION

Duffy noted that special observations “is a poorly researched phenomenon and there is little information on which to base training and skill-mix decisions” (p.944) [27]. More than two decades later, the state of our knowledge in this field has not moved on a great deal the sense that the most common claim from the literature is that the evidence is sparse. There is very little empirical research that may assist staff in deciding which level of SO is appropriate, or even if SO is appropriate at all, and very little evidence supporting the efficacy of SO in minimising risk.

In terms of suggestions from best practice, the lack of sound empirical work means that it is difficult to base recommendations on anything more than anecdotal and qualitative evidence. The vast majority of the studies in the existing literature are descriptive and together form a weak evidence base. The situation is not helped by the fact that there is such variability in the way that observations are conducted in different studies, and also by the fact that the quality of the observations that are carried out may not meet the intended standards of that service. Nevertheless, there is some limited evidence that intermittent observations may be helpful in reducing self-harm and some indications that constant observations may be of lesser benefit, but further work is needed before firm conclusions may be drawn. Qualitative studies agree that patients (and especially those who are feeling suicidal) feel safer and more supported under observation when the observer is known to them and actively engages with them during constant observations. Observations when implemented as therapeutic intervention (with meaningful supportive engagement and interaction) rather than a custodial risk management strategy may be of enormous benefit to patients. In the past decade, there have been several moves towards developing better structures of oversight with regards to special observations, and the evidence points towards greater involvement of nurses and multi-disciplinary teams in decisions to change (and terminate) levels of observation. This is one aspect of a broader push towards improving ward management and communication, and empowerment of ward staff.

Programmes that have moved towards changing the nature of ward management, patient engagement and staff autonomy have shown encouraging results in reducing conflict and thus the need for special observations. The focus of these programmes has been on enhancing inpatient mental health care in general, and it may be that a more systemic approach would be of greater value than a narrower focus on risk management for acutely at-risk patients.

Constant special observations is a resource-sapping activity for any service to engage in and there is very little convincing evidence that it has a positive effect on patient outcomes, but conclusive evidence is difficult to gather and there is a need for stronger evidence to inform practice.

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