What do we know about special observations in the care of psychiatric inpatients?

Review of the literature and developments in practise

Simon Chu, Ph.D C.Psychol AFBPsS
Research Fellow
Ashworth Research Centre, Ashworth Hospital, Mersey Care NHS Trust
simon.chu@merseycare.nhs.uk

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Special observations (SO) of at-risk patients is common practice in acute psychiatric facilities (Bowers & Park, 2001) and the practice of SO has been integral to mental health nursing care for decades (Buchanan-Barker & Barker, 2005). SO is the practise of maintaining an increased level of vigilance 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. While it is acknowledged as one of the most complex, difficult and demanding activities that a nurse can undertake (e.g. Cleary et al., 1999; Department of Health, 1999), there is also growing concern over the practise in terms of rationale and efficacy (e.g. Bowers & Park, 2001; Bowles et al., 2002; Cox et al., 2010). 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 practise. For some, the concept of SO is an illogical response to acute illness and the idea that a nurse would merely observe someone under their care as they experienced a haemorrhage or a stroke is just as alien as carrying out observation in response to acute deterioration in mental health (Buchannan-Barker & Barker, 2005). Furthermore, SO creates a care environment where at-risk patients receive a disproportionate amount of nursing services while also being sometimes intrusive and devoid of meaningful interaction between the nurse and the patient (Bowles et al. 2002). In spite of this, SO is the recommended approach for those patients who are deemed to be at risk (Stevenson & Cutcliffe, 2006)

Many commentators have called for a large scale review of the practise of special observations partly because some evidence suggests that it has become a custodial task rather than a therapeutic intervention (e.g. Barker & Cutcliffe, 1999; Dodds & Bowles, 2001). In addition, the NHS is under considerable financial strain and mental health care in particular is struggling. Recent media reports of inpatient psychiatric wards running at maximum capacity, bed shortages, shortages of experienced mental health nursing staff, and increased morbidity of acute psychiatric patient populations (The Guardian, March 21 2014) mean that ward staff spend less time in direct individual patient contact. The practise of SO can be a resource-sapping activity for a mental health service; while it is difficult to place an exact figure on the practise, Moore et al. (1995) have put the cost at up to 20% of the total nursing budget for a facility, and more recently, Flood, Bowers and Parkin (2008) have put the cost to the NHS of intermittent SO at £45m and constant SO at £35m.

There has been a significant drive recently to assess the position of Special Observations 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.

Terminology

There is wide variation in the terminology used to refer to special observations (e.g. Janofsky, 2009). In the literature (and in hospitals), observations are variously referred to with some combination of
special, close, maximum, enhanced, continuous or constant, and observation, attention or supervision, as well as suicide watch, suicide precaution, intermittent checks, specialling, one-to-one nursing, and a number of other terms (Bowers & Park, 2001). Bowers, Gournay & Duffy’s (2000) survey of 26 NHS trusts in the UK found that only two trusts used the same terminology for the different levels of intensity of observations. In some trusts, Level 1 meant the highest level of observation while in others, Level 1 meant the lowest level. The same terminology could also mean different things in different trusts, e.g. ‘close’ observations could mean intermittent 15-minute checks in one trust, or continuous one-to-one presence of the nurse in another. Different trusts also varied in terms of the number of different levels of observations that they used, with some trusts differentiating between six different levels and others using only two.

The guidelines published by the (now disestablished) Department of Health Standing Nursing and Midwifery Advisory Committee (Department of Health, 1999) recommend four levels of observations (although local trusts are under no obligation to adopt this recommendation). **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, by day and night. **Level 4: Within arm’s length**, where a patient should be kept in very close proximity at all times, day and night. Levels 3 and 4 are commonly referred to as constant observations and it is this terminology will be used throughout this review.

**Prevalence**

Only a handful of papers report the prevalence of SO and, as expected, there is a wide variation in the reported rates. A lack of a standard means of reporting the prevalence/frequency of SO adds further confusion to an already confused picture. Stewart et al. (2010) attempted a synthesis of the rates that are reported and in terms of episodes of SO, the studies suggest a mean of 23 episodes (range: 12.6 – 30.8) of constant SO per 100 admissions per month (averaged over four studies: Kettles et al., 2004; Langenbach et al., 1999; Reid & Long, 1993; Shugar & Rehaluk, 1990). Other studies report the prevalence in terms of the size of the unit (e.g. per 100 beds per month) but this measure makes it difficult to compare across units because it is also strongly influenced by differing admission rates in different units. Nevertheless, Shugar & Rehaluk (1990) report 73.4 incidents of constant SO per 100 beds per month in a Canadian unit, while Jones, Lowe, et al. (2000) reported a rate of 50 incidents per 100 beds per month in a UK unit. Bowers et al. (2007) reported the prevalence of SO in terms of time; 37 hours of constant SO per 100 occupied bed days.

Bowers and colleagues (Bowers, Simpson & Alexander, 2003; Bowers et al., 2005; Stewart & Bowers, 2012) have presented constant and intermittent SO figures for a number of different European countries and it is clear that intermittent SO is consistently used more frequently than constant SO. When indexed by the proportion of patients receiving each type of SO, 47% of patients received intermittent SO in the UK and 16% constant SO, 19% and 14% in Greece, and 14% and 3% in Italy. Bowers et al. (2005) attribute the variation between countries to a complex mixture of factors such as differences in mental health legislation, staffing levels, staff education, local deprivation, demography, psychiatric funding system, availability of alternative services, social tolerance and the
availability of social support. Variation in all of these factors will lead to different admission mixtures. Indeed, prevalence rates may vary widely within the same country and even between hospitals within the same area. One large scale longitudinal study of constant SO and self-harm showed large variations in constant SO use between hospitals, wards and even over time within a ward. This suggests the presence of idiosyncratic practices driven by clinicians with different views of SO policy and similar variations have been reported between wards and between doctors (Porter et al., 1989; Kettles et al., 2004). It is likely that levels of observation tend to be determined by the individual clinical judgments of medical staff rather than systematic objective assessments. Given that prevalence rates vary widely, local or single hospital-based studies (as many of the studies are in this area) are unlikely to be widely generalisable or applicable, and therefore only very broad patterns in these datasets are informative.

**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 practise (e.g. Fazel et al., 2012) and in the case of high secure 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 (e.g. Hodgson et al., 1993; Holzworth & Willis, 1999) and SO is therefore used in reaction to recent behaviour rather than as a preventative measure.

Bowers’ survey of NHS trusts indicated that SO was primarily initiated to reduce the risk of self-harm and suicide, and to prevent aggressive behaviour or absconding (Bowers et al., 2000). These motivations are cited with a good degree of consistency throughout the literature on this issue (e.g. Dennis, 1998; Langenbach et al., 1999; Shugar & Rehaluk, 1990) 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 (Jones, Ward, et al., 2000; Langenbach et al., 1999) fire risk (Childs et al., 1994), sexual disinhibition (Childs et al., 1994), psychotic symptoms (Kettles & Paterson, 2007) self-neglect (Dennis, 1998), first presentation (Kettles & Paterson, 2007; Kettles et al., 2004), safety considerations (Kettles et al., 2004; Shugar & Rehaluk, 1990), and medical conditions (Shugar & Rehaluk, 1990) amongst many others.

Few analyses which have attempted to assess the circumstances that are likely to lead to (or predict) SO being initiated. One large scale study using a logistic regression analysis concluded that patients who had suicidal intent of any level, paranoid or delusional beliefs, moderate to severe agitation or withdrawn behaviour were more likely to receive SO (Kettles, et al., 2004). A more recent study of incident data showed a significant relationship between constant SO and absconding but not self-harm, or physical/verbal aggression (Bowers et al., 2007). Bowers et al. (2003) adopted a novel analytical approach by attempting to create a typology of patients (seven patient ‘types’ were found in their data) and computing the likelihood that each type of patient would be subject to SO. Of their 238 patients, they found that those who fell into the category of ‘abstainers’ (refusing to eat or drink) and ‘medication-ambivalent’ (demanding and refusing prn) were more likely to receive
intermittent SO while 'self-harmers', 'angry absconders' (agression, attempted abscond, missing without permission) and 'angry-refusers' (agression, refusing regular and prn) were more likely to have received constant SO. The ‘absconding-misuser’ (substance misuse, missing without permission, reported absconding) and the ‘protestor’ (refusing to get up and out of bed, refusing to see workers, smoking in no-smoking area) however were not associated with either form of SO.

Stewart and Bowers’ (2012) 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. One study compared forensic and non-forensic inpatient units in terms of the factors that were responsible for initiating SO (Whitehead & Mason, 2006) 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.

Taken together, these studies suggest that a broad range of diverse factors contribute to the likelihood that SO will be initiated and it would be somewhat short-sighted to suggest that it is only initiated in response to a significant risk of self-harm, suicide, aggression, and absconding.

What should nurses do when conducting special observations?

There is a clear absence of an in-depth 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, the nurse’s relationship with the patient, amongst many others. For example, on a very basic level, nurses may simply be asked to sit at a door, watch a patient and keep them safe; while some commentators are highly critical of this more custodial and controlling aspect of observation (e.g. Pitula & Cardell, 1996), even this may be appropriate with certain patients at certain times, and may offer the patient a moment of privacy and solitude (Bowers & Park, 2001). Therefore, there is little benefit in being prescriptive about what nurses should (and should not) do during a period of SO.

However, studies that have investigated the skills required to conduct SO in an effective manner have suggested that a high degree of expertise and competency is required. Mackay, Paterson & Cassells (2005) elicited nurses views of what they do when conducting high level observations and 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 ongoing 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). According to this view, conducting high level 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 (CRAG, 2002) recommended that nurses are trained to have a ‘toolbox’ of practical and psychological interventions to apply during observations. However, there is no guidance 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.

Janofsky (2009) described how a Failure Modes and Effects Analysis (FMEA) methodology was used to identify and correct potential failure points in the SO process. Essentially, Janofsky’s approach was to dissect the process of SO and examine (with reference to the literature and an expert clinical group) how the process could break down, and then develop an ideal observations workflow that minimised the likelihood that a failure would happen (e.g. by improving communication, developing new processes). Janofsky provides no evidence of the efficacy of this process or the SO workflow that resulted from this development, but there is an attractive degree of face validity to the process and the motivation for the endeavour. One of the potential weak points in the SO process that Janofsky (2009) highlights is in a potential breakdown of communication between observers and the surrounding ward staff and Janofsky recommends a more formal and structured means of communication. A further development has therefore been proposed by Bjorkdahl et al. (2011) in terms of the record keeping during constant SO for suicidal patients. Through a structured Delphi consultation, they developed a form for systematic observer documentation in clinical practice, the Suicidal Patient Observation Chart (SPOC) which includes 28 items to be rated hourly. Whilst there has been no data on the clinical effectiveness or impact of this observation chart, Bjorkdahl proposes that systematic use by each observer may reveal otherwise unnoticed patterns in the patient’s illness and recovery, and may contribute to the training of staff in constant SO for suicidal patients. Alternatively, it is also possible that such a prescriptive chart may reduce the likelihood that observers may report issues that are not a part of the SPOC.

**Initiation and termination of special observations**

Guidelines from the Department of Health (1999) 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. For Level 4 SO, the guidelines recommend that a review takes place during every shift.

However, surveys in the literature describing actual practise in different units highlight a large degree of variation in the management of SO. Many of the published surveys have suggested that episodes of SO are largely initiated by a medical doctor rather than a care team (e.g. Kettles & Paterson, 2007; Langenbach, et al., 1999; Neilson & Brennan, 2001). 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 (Cleary et al., 1999), and in another, 94% of nursing staff expressed the view that medical staff dominated the decision-making process (Neilson & Brennan, 2001). 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 (Addo et al., 2010). Furthermore, the level of observations was largely determined by a subjective clinical judgement or a non-validated (usually local) checklist risk assessment (Addo et al., 2010; Duffy, 1995).

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 (Bowers et al., 2000). However, it should be noted that these data came from Trust nursing directors and senior trust staff rather than from responses at ward level concerning actual practise. However, a number of (admittedly older) studies have suggested that both medical staff and nursing staff contribute to SO decisions (e.g. Clark et al., 1999; Hodgson et al., 1993) and that nursing staff may initiate SO if they felt that the patient was at risk and no medical staff were available (Clark et al., 1999). Duffy’s (1995) 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 (Gournay & Bowers, 2000).

There is slightly more consensus that the decision to terminate SO has a greater degree of input from a doctor (e.g. Duffy, 1995; Bowers et al., 2000), 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 (Bowers et al., 2000) and Duffy’s (1995) qualitative study of nurses suggests that SO was typically terminated by a doctor (but again often at the suggestion of nursing staff). However, Duffy observed that normally only ward doctors (rather than duty doctors) would take the responsibility of terminating SO and as a result, the procedure was rarely terminated at weekends when duty doctors were the only medical staff available.

**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 (Goldberg, 1987; Green & Grindel, 1996; Bowers et al., 2000). In Bowers et al. (2000), the most consistent finding was that there was little agreement between different trusts about which staff were qualified to carry out SO. 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 include some debate around the issue of who should conduct SO. That is, regardless of what current practise may be on wards, is there any evidence that some types of staff are more suitable for SO than others? Specifically, debate centres around the question of whether it
is necessary for observers to be qualified experienced nursing staff with whom the patient is familiar, or whether SO may be carried out by non-permanent staff, support workers, students and others. Several sources comment 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 (e.g. Bowers & Park, 2001; Stewart & Bowers, 2012; Ray et al., 2011). One argument is that staff, regardless of status, should be trained to conduct SO and some commentators have recommended the development of such training (e.g. Duffy, 1995; Jayaram et al., 2010) 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 which types of staff are likely to possess 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 (Jones, Ward, et al., 2000). 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.

**Outcomes of special observations – self-harm, suicide and assault**

There is very little 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 (e.g. Bowers & Park, 2001; Manna, 2010). 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. There is one published systematic review of the literature on the efficacy of various containment strategies (Muralidharan & Fenton 2006). Their comprehensive search only found studies 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 effects of containment strategies such as SO are based on case studies and descriptive studies, and there was no good-quality evidence to support or refute the use of this strategy (Muralidharan & Fenton 2006). 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. For example, a national clinical survey in England and Wales found that a fifth of inpatient suicides were among patients under intermittent SO at the time of suicide and 3% were under constant SO (Meehan et al., 2006). Of a US sample of 76 suicides, 27% were under intermittent SO and 3% were under constant SO (Busch et al., 2003). Several other studies give varying rates of suicide under SO (e.g. Appleby et al., 1999; King et al., 2001; Sharma, Persad & Kueneman, 1998) and highlight the fact that being observed does not protect against suicide.
One study found a very low incidence of self-harm (less than 5%) under 15-minute intermittent observations, and concluded that this level of SO was likely to be effective in reducing self-harm (Green & Grindel, 1996). 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 (Bowers et al., 2008) 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, intermittent SO may be useful in reducing self-harm and a recent analysis suggests that suicides are often interrupted by nurses carrying out intermittent SO (Bowers et al., 2011). A UK study reported the adverse incident rates while under SO in a sample of 88 patients admitted to an acute ward (Langenbach et al., 1999). 3% of patients under general observation were involved in adverse incidents and 11% of patients under intermittent SO were involved in incidents. There were no adverse incidents involving patients under constant SO.

Some evidence has also emerged in relation to constant SO. 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 outcomes (Stewart et al., 2009). The use of constant SO was not associated with a reduction in self-harm in the following week, nor was the number of self-harm incidents predicted by constant SO after controlling for the influence of other variables. Furthermore, there was a reduction in the use of constant SO during the study with no corresponding increase in self-harm, thus implying that the impact of constant SO on self-harm was negligible. However, Stewart, Bowers & Ross (2012) suggest 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.

There is scant literature on the impact of constant SO on outcomes, but what little there is suggests that the broad impact is minimal and may be effective only under certain circumstances. However the literature is also clear that there is large variation in the quality of constant SO that is conducted (e.g. Bowers et al., 2000; Gournay & Bowers, 2000). Constant SO is not an all-or-nothing intervention and the efficacy of the intervention is only as reliable as the nursing staff who conduct 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.

**Outcome of special observations – unintended and harmful consequences**

The literature also highlights some unintended negative side effects of SO. For example, Ray et al. (2011) point out that constant SO is likely to be counter-therapeutic if conducted by inexperienced and unskilled staff. 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 on the nurse. The nurse must anticipate the patient’s thoughts and self-injurious feelings to prevent them from acting upon those impulses. Thus the onus of control is on the nurse and this unfortunately does little to foster self-reliance in 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 become more symptomatic because of the lack of privacy enforced by SO and may actually increase the probability of violence (Bowers & Park, 2001). Paranoid patients frequently are able to de-escalate when alone, but when on constant observations, they have no ability to withdraw or disengage. From this standpoint, constant SO are provocative, stimulating and could serve to exacerbate symptoms and agitate patients who are easily aroused (Cleary et al., 1999; Neilson & Brennan, 2001).

It has also been recognised that 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 US study placed the cost of SO at up to 20% of the nursing budget available for a service (Moore et al., 1995) and a more recent economic analysis in the UK estimated that the annual cost of SO to the NHS was £80m (Flood, Bowers & Parkin, 2008). Furthermore, owing to these resource limitations, SO are often deferred to unqualified and/or less experienced ward staff, thus relegating the treatment of patients with the most severe symptoms to the staff with the least experience (Bowers & Park, 2001) and possibly exacerbating the patient’s counter-therapeutic experience of constant SO. One Canadian study has also showed a positive relationship between constant SO levels and staff sickness levels (Philips et al., 1977) but one UK study (Langenbach et al., 1999) has shown no relationship between SO use and staffing levels (although the latter study did not explicitly assess the possible link between SO use and subsequent staff sickness). Given that nursing staff may find carrying out constant SO to be a stressful activity, it may be no surprise that constant SO levels may possibly contribute to staff sickness levels. Certainly, more data is needed in order to clarify this issue.

Dodds and Bowles (2001) outlined an innovative programme to minimise observations on an acute ward with routinely high levels of SO use, and demonstrated significant reductions in self-harm, violent incidents, absconding and staff sickness as a result of this programme. However, it should also be noted that several other factors changed as a result of a reduction in the use of SO, such as an increase in the number of activities offered to patients, an improvement in the communication between nursing staff, medical staff and ward management, and an increase in the level of one-to-one time that nursing staff spent with patients. The previously high levels of self-harm, violence and staff sickness cannot be attributed to the use of SO, but it is clear that the reduction in the use of SO was (both directly and indirectly) a contributing factor to the subsequent improvements.

**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 (e.g. Cleary et al., 1999; Duffy, 1995; Mackay et al., 2005) with some common themes emerging. For example, Duffy (1995) found that SO tended to inspire a rather 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. As such, the interaction between the nurse and patient was viewed more as a parent-child transaction rather than adult-adult transaction. Nevertheless, staff often struggled with the tension between paternalistic and more humanistic inclinations; whilst they were required to observe and control, they also wanted to find a way of restoring the patient’s autonomy and dignity without endangering them and without official support from the organisation. As such, 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 Cleary et al. (1999) who 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. 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 were 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 (e.g. Cardell & Pitula, 1999; Dodds & Bowles, 2001; Fletcher, 1999; Jones, Lowe & Ward, 2000; Pitula & Cardell, 1996) and have drawn broadly similar conclusions. For example, Jones, Ward, et al. (2000) interviewed 18 patients from a number of 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. 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 Pitula and Cardell (1996) describing views from suicidal patients who reported that constant SO could be a highly distressing experience if staff did not interact with them. 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’ (2012) 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.
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 practise and if this practise is to be challenged, and alternatives to be adopted, the culture of mental health nursing needs to be addressed (Cox et al., 2010). 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 (Bowers et al., 2006; Flood et al., 2006) 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. Nurse researchers were recognized clinical experts in acute inpatient care with substantial experience of practice development work. 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 practise, 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 (Bowers et al., 2008), 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 (e.g. Dodds & Bowles, 2001).

Whilst a large part of the intervention that was applied in the City Nurse project (Bowers et al., 2006) 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 (Bowles et al., 2002; Dodds & Bowles, 2001) that stimulated significant improvements 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. Dodds and Bowles (2001) emphasise 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’. 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 (Jackson & Stevenson, 1998). 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 (Buchanan-Barker & Barker, 2005).

Another recent strategy made use of higher levels of patient engagement as part of a zonal nursing approach (Carr, 2012). 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 (Carr, 2012), the level of adverse incidents, patient and staff injuries, self-harm and violence and aggression, all fell significantly within a few months. Fewer agency staff were needed, and the presence of more regular staff was viewed positively by patients. 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 (Dodds & Bowles, 2001) 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 practise from the Clinical Resource and Audit Group (CRAG, 2002) 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 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 CRAG (2002) to enable this process and free nurses to implement therapeutic interventions. When Kettles and Patterson (2007) 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.
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. Kettles & Paterson (2007) 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. 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 (Bowers et al., 2006; Flood et al., 2006) was the presence and advice of a senior clinical nurse specialist who encouraged ward staff in their practise.

Recently, Bowers (Bowers, 2014; Bowers et al., 2014) 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 the six domains of influence are: the patient community, patient characteristics, the regulatory framework, the staff team, the physical environment and outside hospital. This model 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.

There has been one attempt at proposing novel and innovative means of supporting acute at-risk patients. Ray, Perkins and Meijer (2011) have 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). 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. (2011) 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.
Conclusion

Duffy (1995) 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). Almost two decades later, it appears that 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 medical and nursing 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 special observations in minimising risk.

In terms of suggestions from best practise, 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 the 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.

What is clear is that constant special observations is a resource-sapping activity for any service to engage in and, in an ideal world, there would need to be a much stronger evidence base to justify its inclusion as a risk management strategy. However, in the absence of any viable evidenced alternative, special observations are essentially the ‘devil you know’, and have become such an ingrained part of the culture of mental health care that it is difficult to see how this will change.

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Simon Chu, Ph.D C.Psychol AFBPsS
Research Fellow, Ashworth Research Centre, Ashworth Hospital, Mersey Care NHS Trust
simon.chu@merseycare.nhs.uk
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