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NEW THINKING NEEDED ON SPECIAL OBSERVATION

Len Bowers and Alan Simpson

It's been a long haul, but the City-128 research report on the use of special observation to reduce self-harm on acute psychiatric wards was finally released in May 2007, more than two years after we first started collecting data, and eight years after the idea was conceived back in 1999.

This is the largest project we've ever worked on, involving literally thousands of people in many different organisations. It brought together professors and staff from four Universities, 26 NHS Trusts and 136 acute psychiatric wards in England. Over the period of the project five research assistants worked with the 136 wards to collect 7,887 questionnaires from staff, and a further 1,361 from patients. In addition ward staff completed 45,989 end-of-shift reports on the frequency of self-harm, special observation, violent incidents, absconding, rule breaking, alcohol/substance use, medication refusal, manual restraint, prn medication, and much more. Just getting the data onto computer (using scanners) took many months, and much further time has been invested in carefully analysing the results.

And that wasn't all. Sixty patients were interviewed about their fears and anxieties on the wards, and 15 staff were interviewed about the time taken dealing with adverse incidents so that we could calculate the financial cost to the NHS. The response from inpatient nurses up and down the country has been brilliant, and a significant part of the credit for producing and finishing this project is theirs.

The primary gaol of the project was to assess the relationship between special observation and self-harm. For instance, do wards that use a lot of constant special observation have lower rates of self-harm compared to wards where observation is used less?

Preventing self-harm and ultimately suicide is a major concern on acute psychiatric wards and ensuring the safety of patients and others is the primary goal of acute mental health care (Bowers et al 2005). The latest figures from the confidential inquiry into homicides and suicides show there has been a steady decline in the number of suicides amongst psychiatric inpatients (Appleby et al 2006). However, more than three inpatient suicides still take place each week and every suicide is a tragedy for the person and their family, and is often devastating for the staff directly and indirectly involved (Bowers et al 2006). Reporting of self-harm amongst psychiatric patients remains high (NPSA 2006) and self-harm is a strong predictor of suicide (Appleby et al 2006).

With regard to the use of observation in relation to self-harm and suicide, Appleby et al (2006) reported that over a five year period, 185 (22%) in-patient deaths occurred in people who were (or were supposed to be) under observation. Eighteen (3%) were said to be under one-to-one observation. Previous reports have suggested that between 10% (Goh et al 1989) and 21% (Department of Health 1999) of completed suicides occur during observation. A literature review found no controlled trials on the use of special observation (Bowers & Park 2001); however the courts are in no doubt that

failure to follow special observation policies can result in serious harm to patients and is negligent (Gournay & Bowers 2000).

There has been a lot of controversy over the use of observation in recent years. Some characterise this debate as a polarisation between observation and engagement (Cutcliffe & Barker 2002). Use of special observation has been portrayed as impersonal guard duty, infantilising, disliked by patients, directed primarily at protection of the organisation from scandal. Instead it is argued that psychiatric nurses should concentrate on developing personal relationships with patients and engaging with them in the resolution of their personal and psychological difficulties. Others have argued that observation and engagement are not incompatible, and that the proper practice of special observation includes the processes of engagement and interaction with the patient (Bowers, Gournay & Duffy 2000).

There is little robust empirical evidence that helps to resolve this debate. Bowles & Dodds (2001) report a single ward case study where the use of special observation was reduced to zero and this was characterised as an example of 'engagement'. Official statistics indicated a dramatic drop in many kinds of conflict behaviour. However the intervention involved many other new practices, alongside the abolition of special observation. The 'Tidal Model' also incorporates 'engagement' and has become popular in the UK and elsewhere (DH 2002a). This model has been subject to two published evaluations, each based on a single ward before and after natural experiment. The first had equivocal outcomes (Stevenson et al 2002), and the second was more positive, with falls in self-harm reported (Gordon et al, 2005).

The nursing concern about special observation reflects a wider process of review of its function against a backdrop of reduced bed numbers, higher inpatient acuity and rising rates of compulsory detention. This has been reflected in the issuing of new guidelines (SNMAC 1999, DH 2002a) and a review of special observation as part of a major strategy to reduce suicides (DH 1999a).

There are a number of small-scale studies systematically examining the patients' perception of special observation (e.g. Jones et al 2000). These have found a mixed bag of positive (feeling understood, secure, reduced dysphoria and suicidal thoughts) and negative (feeling isolated, degraded, or coerced) reactions. Similar studies have solicited patients' views on other containment methods, but none have elicited any comparative evaluation.

So, what did we discover from the City-128 data? The big surprise was the significance of intermittent observation (regular checks on patients at intervals). We have previously reported, based on interviews of nurses, that intermittent observation was considered to be ineffective (Clarke et al 1999), and similar negative comments have been made by the confidential inquiry into homicides and suicides (Appleby 2006). Yet we found in the City 128 data that the use of intermittent observation was inversely correlated with self-harm rates. In other words, the more intermittent observation used on a ward, the lower the rate of self-harm (whilst controlling for other factors, like the type of patients admitted). Whereas the use of constant special observation, whether that was accompanied with engagement or not, had no relationship to self-harm rates.

A bit of caution needs to be exercised about these results. First of all, they don't mean that we should stop using constant special observation. Constant observation remains a legitimate and necessary intervention in high risk situations (Appleby et al 2006) and such judgements are necessarily clinical decisions taken by the multidisciplinary team weighing up all the available evidence at the time.

Secondly, our results may reflect that self-harm leads to greater use of constant special observation, which then reduces the occurrence of self-harm. These effects would therefore cancel out and would result in exactly the lack of relationship we found. In a somewhat similar fashion, the inverse correlation between intermittent observation and reduced self-harm might be due to some other factor we haven't measured. In research we sum this up in the aphorism "correlation doesn't prove causality". Nevertheless these results do suggest a more important role for intermittent observation than has previously been considered, and it might be a good idea to increase our use of this measure. Maybe intermittent observation works because it puts nurses out on the ward, making them more accessible and visible to patients, which provides greater reassurance and security. This is currently our best guess, and we recommend more research into this type of observation.

Similar cautions apply to other findings from the data. For example we found self-harm rates were associated with the ward door being locked, but it is impossible to know whether the ward doors were locked because more patients at risk of self-harm were present, or whether locking the door makes patients feel trapped or confined, triggering them to self-harm. We have been commissioned to conduct some more research into this, and will be contacting the City-128 wards in a few months time with some additional questionnaires for staff, patients and visitors.

We didn't find any association between self-harm rates and the intensity of any common ward safety and security measure (e.g. banned items, restrictions on in patients, searching of property, drug and alcohol monitoring, etc). We half expected to discover that wards with higher levels of security were safer places, but failed to discover any evidence to support this. We also expected to find evidence that staff attitudes and functioning were important, and that more positive staff attitudes to patients would be associated with lower rates of self-harm. Again the findings did not support this conclusion, and no association was found with leadership, team functioning, burnout or ward atmosphere.

However the presence of qualified nursing staff and the provision of patient activity sessions were both associated with lower rates of self-harm. We cannot firmly deduce that these relationships are causal, but it seems reasonable that the availability of skilled support and the provision of meaningful activity would both contribute to better patient well-being. Wards that have no or weak programmes of patient activity sessions should give serious thought to remedying this deficit, especially as this recommendation has been made in previous policy guidance (Department of Health 2002). Imaginative suggestions for improving the inpatient environment are available as part of the Star Wards project (Janner 2006). The finding that qualified nursing staff availability is an important factor means that the Healthcare Commission should give serious thought to including nurse staffing levels in their inpatient care standards (Allen 2007).

There is much more to come from the City-128 study. Other collaborators are working on papers reporting findings from the patient interviews, and other aspects of the data. The final report to the study funders (Bowers et al 2007) can be downloaded from www.citypsych.com. The vast dataset that has been accumulated is being used in many different ways and will ultimately lead to a whole series of findings that will guide inpatient mental health nursing practice in the future. Those findings will stimulate yet more research, creating a cycle of improvement for patients. For us, that is what it is all about.

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