Focus on psychiatric observation

The very act of placing a patient under observation is paternalistic in nature, and is at odds with the focus of mental health care, which is to form a therapeutic relationship with clients. Louise Bouic discusses a framework that can help bring about more positive outcomes for both the nurse and client by promoting the process of engagement.

Observation is a very common activity within mental health settings, particularly in acute inpatient units. It is almost entirely carried out by nursing staff, but the decision whether to place a client onto ‘observation’ lies either with the medical team, or nursing staff. Although it is a common activity, the effects and outcomes of the process are poorly researched (Duffy 1995, Shugar and Rehaluk 1990). Scant empirical evidence exists about it and there are no national standards at present.

Following a programme of visits to acute inpatient units in 1999, the Department of Health produced a report, titled Addressing Acute Concerns (SNMAC 1999) which included guidance on observation. Ritter (1998) also produced guidelines at the Bethlem Royal and Maudsley Hospitals, which featured in the same Department of Health project.

Keywords
- patients: satisfaction
- patients: empowerment
- multidisciplinary teams

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to a double-blind review.
Who is observed and why
Observation is usually implemented in response to deliberate self-harm, suicide attempts, and violence and aggression (Duffy 1995). The most commonly identified groups placed on constant observations are: young male clients with schizophrenia, for suicide risk; older depressed female clients, for risk of suicide; and clients with personality disorders, for behavioural management and violence to others (Bowers et al 2000).
A study looking at inpatient observation identified that nearly two out of three patients placed on constant observation required this for 72 hours or less (Shugar and Rehaluk 1990). Exceeding this time was found to be counterproductive as it caused more behaviour management problems than it prevented (Shugar and Rehaluk 1990). This may be attributable, at least in part, to clients feeling they are “more of a problem to staff” after a longer time frame (Neilson and Brennan 2001). Most constant observation was found to be initiated in the first week of admission, with nearly half beginning on the day of admission (Shugar and Rehaluk 1990).
Local observation policies should be individualised and allow for flexibility for each client, rather than being ‘set in stone’ (Duffy 1995). The same rules cannot be applied necessarily to all clients with the same results. A study demonstrated that certain high risk client groups exist; those who react to constant observation by displaying increasingly life-threatening self-harming behaviours until observation is reduced; and those who appear to be improving until observation is reduced, and then successfully commit suicide (Pauker and Cooper 1990). It must also be recognised that, ultimately, clients will make their own decisions, and nurses cannot always prevent people from harming themselves or committing suicide.

Gournay and Bowers (2000), in a study of 12 inpatient clients who successfully committed suicide, identified that for one patient the nurse had been within arm’s length, and five had a nurse watching them at all times. Further research identified that from 20 to 33 per cent of completed suicides took place while the client was on constant observation (Cutliffe and Barker 2002).
Work has been carried out in a trust in Bradford, which is now being incorporated into other trusts, around reducing, and potentially eliminating, constant observations (Dodd and Bowles 2001). This trust advocated a more ‘care engagement’ orientated system, and the results have shown that over an 18-month period, deliberate self-harm reduced by two thirds, violence and aggression by a third, and there was no increase in the suicide rate.

The nurse’s role
The main aim of mental health care is to form a therapeutic relationship with clients. In line with this philosophy, inpatient care is attempting to move away from a custodial relationship, to one which empowers clients and operates from a more equal power base. The role of primary nurses, or named nurses, should be clear in the observation process: they should have a central part in both observing the patient, and in co-ordinating the care they receive while on observation (Duffy 1995).
Observation should form part of the care, not exist as a custodial ‘add-on’: Constant observation should be seen as a therapeutic activity: it may be perceived as an opportunity to protect the patient, to give him or her hope, and permission to live, and to improve his or her mental state (Fletcher 1999, Whittington and McLaughlin 2000). Engagement should be the primary focus of observation (Whittington and McLaughlin 2000).
In one study, 13 out of 20 patients identified positive feelings associated with constant observation. They viewed it as protecting them, and this was most emphatically felt when staff were perceived to be friendly and willing to help (Cardell and Pitula 1999). Optimism, acknowledging the client as a human being, and distraction with activities and conversation were also viewed very positively (Cardell and Pitula 1999). Frequently, patients who have attempted to commit suicide encounter attitudes of disapproval from healthcare staff. This often serves to intensify their feelings of distress. Displaying unconditional acceptance and regard for them is therefore of paramount importance (Cutliffe and Barker 2002).
However, clients have associated constant observation with feelings of anger, rebelliousness, punishment, discouragement and anxiety. Patients have described nurses as unsympathetic, punitive and distancing. Particular negative behaviours identified were lack of acknowledgement of the client and lack of information about their constant observation (Cardell and Pitula 1999). Patients stated that these behaviours intensified their feelings that life wasn’t worth living, that they did not matter, or even exist (Cardell et al 2000).

Table 1. Structure of framework

| Containment: | ■ Sustains the physical and psychological wellbeing of the client  
| ■ Removes the ‘burden’ of self control  
| ■ A rapid, calm response is needed, using early and least restrictive interventions |
| Support: | ■ The patient feels secure, comfortable, less anxious, and less distressed  
| ■ Nurses should develop therapeutic relationships and be gentle, respectful and compassionate  
| ■ A focused, intentional attempt to understand the world of the patient, and to be available to them, particularly to understand the events leading to admission |
| Structure: | ■ Organisation of time, place and person to reduce anxiety  
| ■ Environment should be secure, structured, non-intrusive, low-stimulus, and supportive  
| ■ There should be activity and interaction |
| Involvement: | ■ Encourages the active participation of the patient with the social environment  
| ■ Skilled nursing judgement is required to judge what is appropriate – activities such as movement, exercise, relaxation, music, art and diversional activities have been shown to be effective |
| Validation: | ■ Affirms the patient’s individuality – doing this through getting to know him or her, as a person |
and Pitula 1999).

The majority of time (80 per cent) spent during constant observations has been identified as ‘non-interactional’ (Whittington and McLaughlin 2000). Of the time that was spent interacting, the focus was mainly on social ‘chit-chat’, rather than on therapeutic discussion. Nurses have identified concerns over their abilities to respond to issues that may be raised by clients, such as abuse, bereavement and trauma (Westhead et al 2003).

Staff express feelings of anger, inadequacy, and fear of ‘causing’ suicide attempts (Bowers et al 2000, Barker and Cutliffe 1999, Fletcher 1999, Westhead et al 2003). This highlights the need for staff that observe clients to be skilled communicators, and to possess assessment and decision-making skills (O’Brien and Cole 2003). Staff identify that they avoid talking too much to patients about their feelings as they ‘don’t think it is healthy’ or fear precipitating events. Patients perceive this avoidance negatively: ‘no feelings’, ‘authoritarian’, ‘feel worthless’. Sitting outside the bedroom, or away from the client, was seen as controlling and custodial (Bowers et al 2000).

Patients’ experiences

Three main themes emerged when investigating patients’ experiences of being observed: physical protection, restoration, and distressing experiences (Pitula and Cardell 1999). The distressing experiences related to lack of supportive interactions, frequent staff changes, and lack of privacy. It has been shown that assigning observations to unfamiliar staff, and staff who lack knowledge, can lead to inconsistency in care, and a reduced sense of stability for the client (Neilson and Brennan 2001). Patients have expressed that being observed by people that they know help them to feel safer, more reassured and cared for (Jones et al 2000). O’Brien and Cole (2003) have formulated a framework for use in close observations, based on the work of Gunderson (1978), Delaney (1992) and Creedy and Crowe (1996). This framework is a five-part structure, outlining the interventions required by nurses, and the emotional impact on the client (see Table 1).

Ethically, if a patient is judged to be an acute risk to themselves or to others, the demands of paternalism are used to justify overriding the rights of the patient to autonomous choice. As nurses, there exists a duty of care to the patient: if clients are mentally ill, their rights to autonomy are reasonably outweighed. However, this assumes, as is common practice, that having a suicidal wish implies the presence of mental illness. Continually observing another adult, even when they are carrying out private and personal activities such as bathing, makes it difficult to maintain adult-to-adult interactions: it is suggested that this struggle with paternalistic control, and the resultant ‘infantilisation’ of the client, contributes to the lack of engagement by some staff when carrying out observation (Duffy 1995).

‘Observation’, is by the very nature of the word, something that is ‘done to’ people. This falls outside the nature of mental health nursing, where the aim is to work together in partnership; and is likely to strongly contribute to both staff and patients’ dislike of the procedure (Barker and Buchanan-Barker 2004). However, it is clear that staff who do succeed in relating to observed clients as another adult, by reaching out to the client, and attempting to understand their lived-in experience, through the process of ‘engagement’, achieve a generally more positive outcome to the observation (Barker and Buchanan-Barker 2004, Duffy 1995). [Louise Bouic BSc(Hons), RN(M), Dip HE, MA, senior lecturer, Staffordshire University Faculty of Health & Sciences, Shrewsbury]

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**References**


