Within mental health services the use of increased levels of observation by healthcare practitioners is not an unusual event. The introduction of such observations are seen as a means of reducing risks related to a variety of situations such as suicide, self-harming, aggression and violence. The use of observation is sometimes perceived as different from other practitioner interventions in terms of a focus on controlling the situation. This paper explores the degree of opportunity offered for therapeutic interaction by this process, although all too often not utilised to its full potential.

An increased level of observation attracts a myriad of different and therefore potentially confusing expressions, which include:

- Continuous
- Enhanced
- Constant
- Supportive
- Close
- Raised
- Levels (1 – 4)
- Special

These terms may be used to either have the same or different meanings dependent on the area / country of practice. It is important to consider developing a degree of consistency in the meaning associated with specific terminology. Without this, there exists a clear potential for confusion when practitioners move to another area / country unless explicit material is made available for clarification. This is demonstrated in an article by Sharrock et al (2006) when exploring the positive role of the mental health nurse working in liaison with staff in non-mental health settings. In their article, the following expression is noted when discussing strategies: ‘increased levels of observation and surveillance’, but in a context markedly removed from that introduced within this work.
Observation – opportunities for engagement

A range of literature has emerged indicating the rationale behind increased levels of observation and good practice. East London and the City Mental Health NHS Trust (2005) indicated that ‘supportive observation will be seen as an integral part of a therapeutic care plan’, whereas Jones et al (2000) highlighted marked variations in patient perception dependent on the degree of engagement by the nurse. A nurse who engaged with and was known to the patient provided a safer and more reassuring experience than one who was a stranger and did not engage with them.

In the context of a prison service, the Joint Committee on Human Rights (2004) recommend that new prisoner receptions should receive a minimum of a week of close observation and assessment in a dedicated area. Bowers et al (2000) highlighted the amount of inconsistencies that were identified as a result of their survey and recommended the establishment of national standards, with practice guidance issued to all mental health workers as an interim measure.

Burton (2005), in commenting upon her own experience of being a patient, remarked on the need for ‘more explanation and discussion about the purpose of the observations’ that took place. Her experience had initially been expressed thus: ‘Every time I entered the social area a nurse would be there…if I retreated to my room to be alone a nurse would frequently knock on my door and look in on me’. The experience was one that identified a lack of communication between the service user and nurses about what was happening and why.

This may appear a logical and therefore expected experience but observation is not always viewed by the nurse as a positive process. A small pilot study by the author identified a number of variables that influenced the attitude of the practitioner to observation, including:

- the patient is someone known / unknown to them;
- observation being viewed as an individual and not a team responsibility;
- initiating observation without information (for example: upon commencing duty while other staff are engaged in the team handover);
- allocation on a ‘who’s available’ rather than a planned and integrated process of care;
- no apparent criteria related to qualification, experience, knowledge or preparation (either in relation to the patient or the proposed observation).

Practitioners who perceived that observation was something that was ‘different’ to other aspects of care due to some of the above elements regarded it in a rather negative fashion, occasionally likening it to escorting a patient (unfortunately escorting a patient was viewed in the same rather negative light). In this context, it was occasionally regarded as a chore rather than an opportunity to engage with and support the patient. This reflects some of the author’s own experience of practice some thirty years ago when the essential ingredients for any protracted period of observation of a patient were a cup of coffee and a newspaper / magazine. The role was associated with ‘guarding’ rather than engaging with the patient. Not all
practitioners subscribed to this practice, but unfortunately observation was still viewed as an activity with little therapeutic value.

A recent document with a specific focus on guidelines for good practice in prisons (DH 2006) directly contradicts some of the previous points related to observation and recommended that:

- prison officers undertaking observation duty should be considered to be part of the care team;
- the person carrying out the observation should be approachable and listen to the service user;
- staff responsible for carrying out observations must be appropriately briefed;
- training in observation should be incorporated into induction.

Cleary et al (1999) indicated that, in an Australian context, any patient who is considered at risk from suicide is observed on a one-to-one basis by a registered nurse. Their work includes concerns expressed by those interviewed about the levels of responsibility and stress associated with 'special observation'. Neilson and Brennan (2001) concur with the view that this level of observation can invoke varying degrees of stress but emphasise that this can be the case for both parties – staff and service users. Hewitt and Edwards (2006) explored ethical issues on the prevention of suicide in mental health settings and alluded to observation as a part of this preventative process.

O’Brien and Cole (2003) indicated the need for a review of observation policies linked to the acknowledgement that close observation is highly demanding of specialised psychiatric nursing skills. By way of contrast, the experience of Reynolds et al (2005) reported that although their study demonstrated an improvement in the quality of observation after training, healthcare support workers were the predominant staff involved in this activity.

The concept that an increased level of observation is reserved for situations where a patient’s behaviour gives rise to a concern that they and / or others may be at risk, has resulted in this process being generally reserved for only those circumstances where risk is seen to constitute a major concern. This focus becomes the tenet for an understanding of what increased observation is for and when. Winship (2006), in an article on restraint, explores the ambivalence that can be present in a close monitoring situation. The indication is that close observational activity should be followed, where possible, by a period of ‘less intensive’ activity. There is an inference that very close observation is a form of restraint or ‘holding’. Kettles et al (2004) concluded that there is a clear correlation between risk assessment and observation levels. It potentially results in less contact with the patient when they are not considered ‘at risk’ and therefore less opportunity for the patient to engage in a meaningful experience with the healthcare professionals. This is rather uncomfortably highlighted in the work of Coatsworth-Puspoky (2006) who indicates that: when hospitalised, many clients observed that the nurses did not interact with clients beyond the nurses’ station’. However, in another twist to the consideration of the potential value, Buchanan-Barker and Barker (2005)
indicate that the current organisational preoccupation with risk has resulted in a perceived misuse of observation. Marshall et al (2004) indicate a diversity of opinion regarding observation, ranging from a potentially therapeutic activity to a costly activity whose 'function and effectiveness... has been challenged' (p8).

Billings (2001) offers a more positive perspective, in citing the work of Jones et al (2000), highlighting the potential value of an interactive process in observation, and questioning the perception that close observation is reserved for only 'the most extreme circumstances'. This is further reinforced by Vrale and Steen (2005) who, in their qualitative study into nursing observation with service users expressing suicidal ideation, indicated one nurse who stated: 'we had to do special observation to create an alliance' (p516).

Some ambivalence arises from the Standing Nursing and Midwifery Advisory Committee (1999) guidelines on 'safe and supportive observation of patients at risk', when they state: 'Whereas most nursing interventions are intended to help patients achieve their own goals, observation is deliberately designed to frustrate the patients' aims' (p2). This specific element contains the inference that observation is about preventing rather than enabling and that other interventions are required for that purpose.

Adams (2000) reviewed the process of introducing locked doors in order to reduce the risk of patients absconding and placing themselves and / or others at risk. A related finding was that the level of 'close observations' fell quite dramatically in what the author then referred to as 'sentinel nursing'. Patients commented quite negatively on the observation that did occur: 'Patients commented that staff would often sit and watch the patient without attempting to engage them in conversation' (p328).

Bouic (2005) in an attempt to counter such a focus emphasises the fact that observation should form part of the care and not exist as a custodial 'add-on'. Page (2006) suggests that observation is necessary, in part, to reassure people that due process has been followed through the requisite record keeping. He also introduces the hitherto unmentioned use of CCTV as a part of this process. Schrader (2005) in her work indicates that CCTV is utilised within an observation cell that secludes individuals deemed to be at significant risk. Here observation is seen purely in terms of monitoring and the author states that 'observation alone does little to help the woman overcome her distress'. The use of this technology may have some beneficial potential but may result in both ethical dilemmas and the risk of staff relying on cameras and forgetting about the interactive and therapeutic aspects required within the process.

Conclusion
In summarising, it is apparent that there are still areas of practice in which observation is not necessarily viewed in therapeutic terms. The variations in determining which practitioners are considered able, willing and / or competent to engage in the process are also a matter of concern. One theme that emerges strongly from the literature is that of training. Irwin (2006) indicates the evidence supporting the value of observational training. Irrespective of who observes the service user, a need for
an understanding of the elements of this complex process is required. It might be pertinent to finish by indicating the work of Mackay et al (2005) who in a qualitative study identified the acronym IMPACT as a starting point when looking at training needs (Fig. 1).

The only reservation would again link to the view that this process is reserved exclusively for individuals who are at risk in terms of self-harm, suicide or violent behaviour. The application of these principles in a wider context might go some way to altering the perception that some practitioners still maintain in relation to the role and potential therapeutic opportunities offered by the interaction available in observation.

References:
Bouic L (2005) Focus on psychiatric observation. Mental Health Practice 8(8): 17-19
Mackay I, Paterson B & Cassells C (2005) Constant or special observations of inpatients

Fig. 1: IMPACT through Observation

<table>
<thead>
<tr>
<th>I</th>
<th>Intervening</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Maintaining the safety of the patient and others</td>
</tr>
<tr>
<td>P</td>
<td>Prevention, de-escalation and the management of aggression and violence</td>
</tr>
<tr>
<td>A</td>
<td>Assessing</td>
</tr>
<tr>
<td>C</td>
<td>Communication</td>
</tr>
<tr>
<td>T</td>
<td>Therapy</td>
</tr>
</tbody>
</table>


Schrader T (2005) Close Your Eyes and Throw away the Key: Mental Health of Female Prisoners. *New Doctor* 83: 4-8


