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The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. HQIP's aim is to promote quality improvement, and it hosts the contract to manage and develop the Clinical Outcome Review Programmes, one of which is the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), funded by NHS England, the Scottish Government, Welsh Government, the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) and the State of Jersey. The programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data. More details can be found at: [www.hqip.org.uk/clinical-outcome-review-programmes-2/](http://www.hqip.org.uk/clinical-outcome-review-programmes-2/)

The interpretation and conclusions contained in this report are those of the authors alone. The study was approved by the Healthcare Quality Improvement Partnership.

# REPORT SUMMARY

## HOW WE CARRIED OUT THE STUDY

We carried out a UK-wide mixed-methods study using quantitative and qualitative data collection and analysis. We collected data from four sources:

- NCISH suicide database
- Serious Untoward Incident reports (SUI), Critical Incident Reviews (CIR) and Serious Adverse Incident (SAI) reports from mental health services
- online survey
- focus groups.

The online survey and focus groups were used to canvas views on the utility of and alternatives to observation. The participants included patients, healthcare assistants, nurses and psychiatrists.

## KEY FINDINGS

- There were on average 18 suicides by in-patients under observation per year in the UK over a 7 year study period. Ninety-one percent of deaths under observation occurred under level 2 (intermittent) observation.
- Compared to in-patient suicides generally, patient suicides under observation were associated with personality disorder, alcohol and drug misuse, detention under mental health legislation and death in the first 7 days following admission.
- A third of suicides under observation occurred off the ward. The commonest location for a death by suicide on the ward was the patient's bedroom and the most frequently used method was hanging.
- Deaths under observation tended to occur when policies or procedures (including times between observations) were not followed, for example:
  - (a) when staff are distracted by other events on the ward
  - (b) at busy periods e.g. 7-9am
  - (c) when there are staff shortages
  - (d) when ward design impedes observation.
- Half of deaths occurred when observation was carried out by less experienced staff or staff who were likely to be unfamiliar with the patient (e.g. health care assistants or agency staff).

- Half of the deaths under constant observation occurred off the ward after absconding and were associated with a breach of procedure.
- Patients have mixed views about observation, some describing the process as intrusive and some as protective.
- Staff often do not see the purpose of observing the patient or how it links to the overall plan of risk management. They view the decision to start or stop observation as influenced by staffing levels and resources.

## KEY MESSAGES FOR SERVICES

- The current observation approach (especially intermittent observation) is not working safely enough. New models need to be developed and evaluated.
- The observation component of a care plan should not be stand-alone; time with a patient is an opportunity for engagement within a comprehensive risk management plan.
- Observation should be seen as an acute intervention - there should be a record of breaches and the transition to general observation should be planned.
- A balance of observation and active engagement should be agreed with the patient where possible.
- The observation component of a risk management plan should follow clear protocols, which should be adhered to, recorded, monitored, including actions to take if the patient absconds.
- As an acute intervention, observation is a skilled task for staff of appropriate seniority.
- Suicide under observation (intermittent or constant) should be considered an NHS 'never event' in England and Wales (or as a serious adverse event in Northern Ireland and Scotland) and should be subject to independent investigation.
- All serious breaches of protocol in the care of patients under constant observation (for example, leading to self-harm and absconding, not only where there is a fatal outcome) should be investigated under NHS incident procedures (SUI, CIR or SAI).

# BACKGROUND

## Suicide in mental health in-patient services

Approximately 5,800 people die by suicide in the UK each year. Of these 1,638 (28%) are in contact with mental health services in the 12 months prior to death. 153 (9%) of the 1,638 mental health patients die by suicide on in-patient wards.<sup>1</sup>

We recently reported a large fall in the number of in-patient suicide deaths.<sup>1</sup> Factors that may have contributed to this fall include improvements in in-patient safety, fewer and shorter admissions and a possible transfer of risk to other clinical settings.<sup>2</sup>

A previous NCISH study found 22% of in-patient suicides occurred under observation, 3% under constant observation.<sup>3</sup> The sample in that report covered 2000–2004; we have not studied observation in detail since then.

## Definitions of observation

Guidance from the Standing Nursing and Midwifery Advisory Committee<sup>4</sup> defined nursing observation as:

*"...regarding the patient attentively, whilst minimizing the extent to which they feel they are under surveillance. Encouraging communication, listening, and conveying to the patient that they are valued and cared for..."*

The National Institute for Health and Clinical Excellence<sup>5</sup> (NICE) published guidance which described four levels of observation (Box 1).

### Box 1: Observation levels in England and Wales

- Level 1:**  
General observation
- Level 2:**  
Intermittent observation (15-30 minute checks)
- Level 3:**  
Within eyesight (constant observation at all times, day and night)
- Level 4:**  
Within arms length (constant observation at close proximity)

In Scotland, the revised Clinical Resource and Audit Group guidance<sup>6</sup> issued in 2002, described three levels of observation (Box 2).

### Box 2: Observation levels in Scotland

- Level 1:** General observation  
The staff on duty should have knowledge of the patients' general whereabouts at all times, whether in or out of the ward.
- Level 2:** Close observation  
Staff should be constantly aware at all times of the precise whereabouts of the patient through visible observation or hearing.
- Level 3:** Special observation  
The patient should be in sight and within arms reach of a member of staff at all times and in all circumstances.

In Northern Ireland, the Health and Social Care Board/Public Health Agency guidance<sup>7</sup> describes two levels of observation (Box 3).

### Box 3: Observation levels in Northern Ireland

- Level 1:** General observation
- Level 2:** Continuous observation
  - A. Within eyesight
  - B. Within arms length

In this report being under observation refers to intermittent and constant observation, and does not include general levels of observation.

## Is observation effective in reducing the risk of self-harm?

The purpose of observation is to keep patients safe and specifically to reduce the risk of harm to themselves or other people.<sup>8</sup>

There is evidence to show that the use of observation can lead to a reduction in self-harm and suicide.<sup>9,10,11,12</sup> In contrast, other studies found a reduction in suicide, self-harm, absconding and violence following the reduction of observation and use of alternative nursing interventions.<sup>13</sup>

The literature is dominated by qualitative studies,<sup>14,15</sup> and studies with small sample sizes<sup>16</sup> which impacts on the validity and generalisability of the findings. The effectiveness of observation has also been questioned as suicides still occur.<sup>17</sup> Therefore it is currently unclear if observation reduces suicide risk.

# BACKGROUND

## Concerns about the use of observation

Observation has been criticised because:

- It is expensive and staff-intensive.<sup>18</sup>
- There are ethical and human rights concerns as patients consider constant observation to be intrusive and undignified.<sup>18,19</sup>
- The process is unpopular with staff, particularly constant observation, with concerns about staff safety and problems over male staff observing female patients and female staff observing male patients.<sup>20</sup>

There are also concerns about how observation is carried out:

- Observation procedures are not consistently explained to patients.<sup>15</sup>
- Not all staff interpret levels of observation in the same way leading to non-adherence to observation policies.<sup>8</sup>
- There is frequent use of agency or bank staff who may not know the patient they are observing.<sup>13</sup>
- There is a lack of engagement with the patient.<sup>13</sup>
- Observation can lead to an increased risk of violence against members of staff.<sup>13</sup>

## AIMS OF THE STUDY

In a UK sample, to:

- determine the characteristics of in-patients who died by suicide under observation
- explore the service-related antecedents of in-patient suicides including staffing levels and skill mix, ward design and observation policies and practices
- explore patient and staff perspectives on the utility of observation and how to improve practice.

# METHOD

## Study design

The study was conducted using a mixed-methods approach combining quantitative and qualitative data collection and analysis.

## Data collection

Data were collected from four main sources (Figure 1). A detailed breakdown of the data collection is provided in Appendix A.

### 1. NCISH suicide database

A full description of NCISH data collection processes can be found elsewhere.<sup>1</sup> For this study, we included in-patient suicides occurring between 1st January 2006 and 31st December 2012 in mental health services in the UK. We included deaths which occurred while the patient was under observation, i.e.

- level 2 intermittent observation
- level 3 within eyesight
- level 4 within arms length or equivalent in devolved nations.

### 2. Online survey

An online survey was opened on the NCISH website on 14th February 2014 and was closed on 30th April 2014. The survey was used to record the experiences of mental healthcare staff and patients of either

undertaking observations or being observed. Responses were provided anonymously. The survey was advertised via:

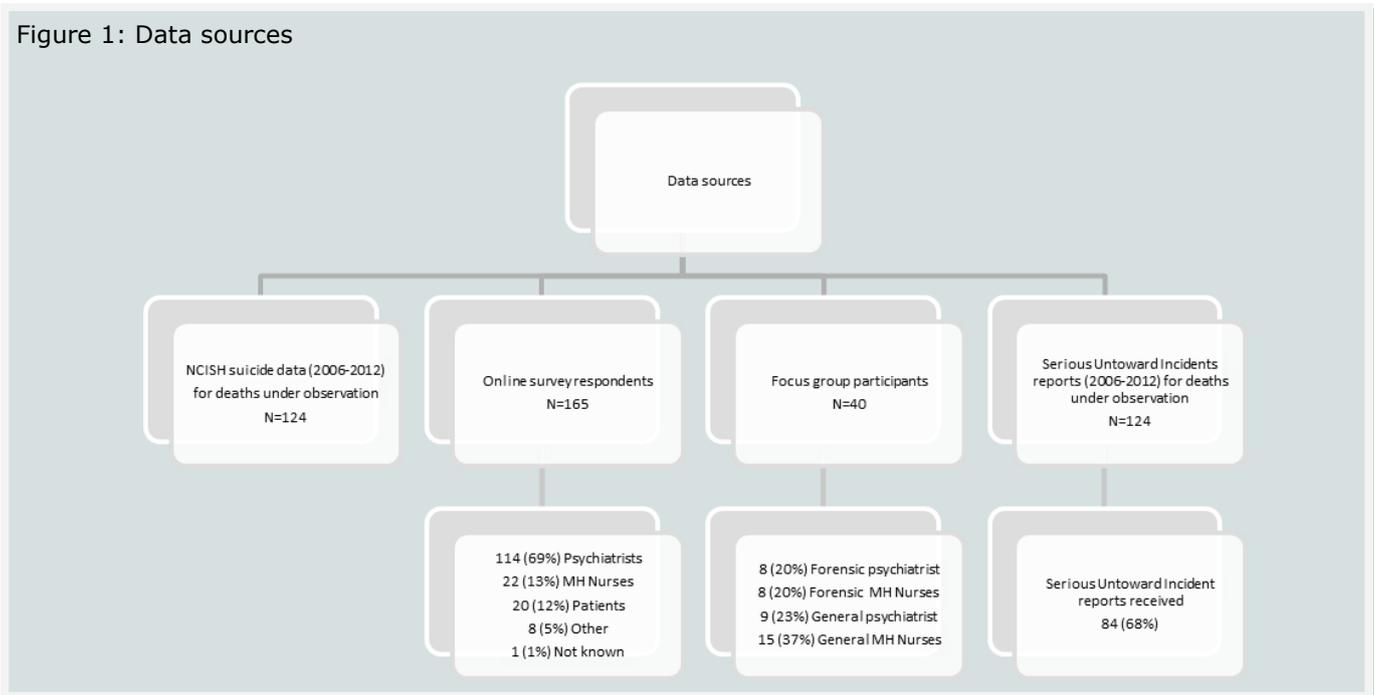
- the NCISH website, Facebook and Twitter
- sending letters to the Royal College of Psychiatrists; Royal College of Nurses and the NHS Confederation to inform members of the study.

The responses were used to inform the content of the proforma used for the analysis of the SUI reports. We specifically invited the participants to provide responses to the following:

- Using examples where possible, tell us about your experience of observation
- What are the main positive or negative aspects of observation?
- How would you change the practice of observation?

### 3. Serious Untoward Incident (SUI) reports

We used the NCISH suicide database to identify patients who died under observation between 1st January 2006 and 31st December 2012. We then contacted the service providers where the patient was treated to request a copy of the SUI/CIR/SAI report. These reports detail the findings from an internal



## METHOD

investigation identifying what went wrong and what lessons can be learned.

SUI reports were received in 62 (74%) cases, Critical Incident Reviews in 13 (15%) and brief internal reviews and summary reports in 9 (11%). The reports are collectively referred to as SUI reports for the remainder of this report.

#### 4. Focus groups

Six focus groups were conducted with current and former general mental health nurses, forensic mental health nurses, general psychiatrists and forensic psychiatrists. In total 40 people participated (Figure 1).

A topic guide was used to facilitate the discussion. The guide was used flexibly to ensure progression of the discussion about the key areas of concern, and to enable new topics to be raised. Prompt questions included:

- What is observation for?
- What is your experience of conducting observation with patients at risk of self-harm and suicide?
- How useful do you think observation is in managing risk?
- What are the common problems encountered with observation?
- How can we improve the process?
- What are the alternatives to constant and intermittent observations?

Informed consent was obtained from all of the participants before the focus groups commenced. The focus group discussions were digitally recorded and transcribed verbatim.

#### **Statistical analysis**

Descriptive data from the NCISH suicide database and the SUI reports were presented as numbers and percentages. All proportions were provided as valid percentages. If an item of information was not known for a case (i.e. data were missing) the case was removed from the analysis of that item. The denominator in all estimates was the number of valid cases. Pearson's chi square tests were used to examine associations between subgroups.

#### **Qualitative analysis**

Thematic analysis was used to explore the responses from the online survey and from the focus groups. This method of analysis was used as it enabled themes to emerge naturally rather than matching responses to a pre-determined list of categories. The data were refined and recoded until no new themes emerged. The findings were discussed among the research team to ensure an accurate and consistent interpretation was achieved and that the views of the participants were represented appropriately.

# FINDINGS

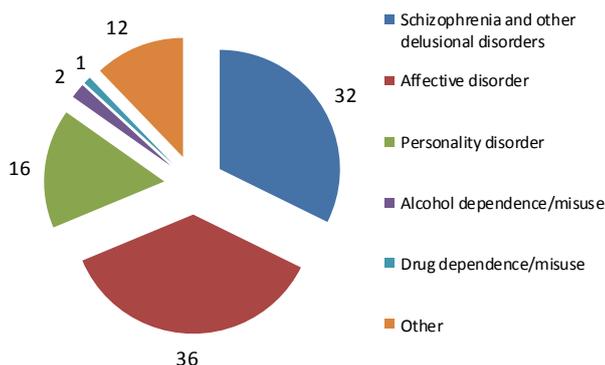
## 1. NCISH STUDY SAMPLE FINDINGS

Between 1st January 2006 and 31st December 2012 in the UK, there were 124 in-patient suicides under observation, 15% of all in-patient suicides, an average of 18 per year. Of these in-patient suicides, 113 (13%) died while under level 2 (intermittent observation) and 11 (1%) under level 3 or 4 (constant observation).<sup>†</sup>

Although guidance in Scotland and Northern Ireland does not recommend an intermittent level of observation, as in England and Wales, we found 3 patients (38%) in Scotland and 2 patients (67%) in Northern Ireland were being checked intermittently (every 5-25 minutes).

- Most were male (79, 64%). The median age was 41 years (range 21-83).
- The majority had a history of self-harm (97, 78%).
- The most common diagnoses were affective disorder and schizophrenia and other delusional disorders (Figure 2).

Figure 2: Primary diagnosis (%) of patients who died under observation



<sup>†</sup> Note: percentages do not tally with the total figure due to rounding.

## Characteristics of the final in-patient admission

- Most patients (113, 91%) were on level 2 observation (intermittent) at the time of death.
- 40 (32%) were detained under mental health legislation.
- 42 (34%) died within 7 days of admission.
- 46 (37%) died off the ward, of whom 39 (91%) left without staff agreement.
- The most common methods of suicide were by hanging/strangulation (67, 54%) and jumping from a height or in front of a moving vehicle (28, 23%).

## Deaths occurring on the ward

- Of the 78 (63%) suicides on the ward, the most common method was by hanging/strangulation (59, 76%).
- 51 (67%) deaths occurred in the patient's bedroom.
- Sheets and towels (16, 30%) and shoelaces (10, 19%) were the most commonly used ligatures.

## Comparison of in-patient suicide under observation and other in-patient suicide

Patients under observation at the time of death were more likely to have a diagnosis of personality disorder, to be an alcohol or drug misuser, to be detained under the Mental Health legislation and to have died within 7 days of admission (Table 1).

## FINDINGS (CONTINUED)

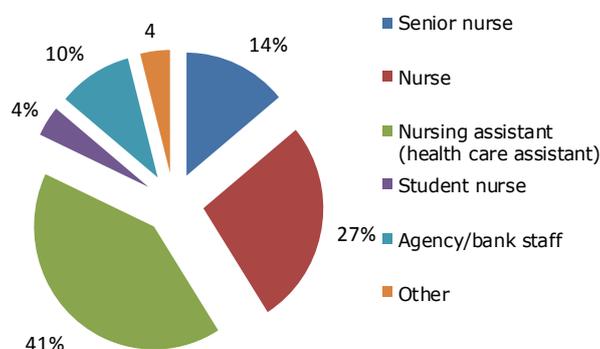
Table 1: Characteristics of in-patient suicide under observation and other in-patient suicide

Characteristics:	Under obs. N=124		Other in-patients N=727		P-value
	N	%	N	%	
Alcohol misuse	56	46	248	35	0.02
Drug misuse	49	40	199	28	<0.01
Affective disorder	44	36	357	49	<0.01
Personality disorder	19	16	61	8	0.01
General adult acute ward	92	76	597	85	0.01
PICU ward	7	6	15	2	0.02
Detained under the MH Act	40	32	166	23	0.03
Died within 7 days of admission	42	34	78	11	<0.01
Died on the ward	78	63	151	21	<0.01
Died by hanging	67	54	317	44	0.03
Died by self-poisoning	3	2	73	10	<0.01

(24%).

- 29 (35%) deaths occurred during busy periods on the ward (11 between 7am and 9am, 7 between 1pm and 3pm and 11 between 7pm and 9pm).
- There were said to be problems with the ward design in 14 (27%) cases. For example, the nurses station was located away from the bedrooms, bedrooms were along lengthy corridors with fire doors; the observation windows in bedroom doors were obscured.

Figure 3: Staff undertaking observation at the time of death



### 2. SERIOUS UNTOWARD INCIDENT REPORT FINDINGS

We received reports for 84 (68%) of the in-patient suicides under observation identified on the NCISH database during 2006-12. The findings presented below are from the SUI reports.

#### Self-harm and suicidal ideation during the final admission

- 27 (33%) had a previous episode of self-harm. The most common method was by cutting.
- 51 (75%) expressed suicidal ideas.

#### Staffing and environment

- Observations were undertaken by a nursing assistant/health care assistant in 21 cases (41%) and by agency/bank staff in 5 cases (10%) (Figure 3).
- Staffing was below required levels in 20 cases

#### Suicide under constant observation<sup>†</sup>

- There were 11 deaths under constant observation.
- 7 (64%) were male.
- 5 (45%) had a diagnosis of schizophrenia.

The number of suicides under constant observation was small, it was therefore difficult to identify differences in the characteristics of those who died by suicide under level 3 or 4 (constant) compared to those on level 2 (intermittent) observation. However, patients under level 3 or 4 were more likely to be detained under Mental Health legislation.

<sup>†</sup> Note: this includes close or special observation in Scotland and continuous observation in Northern Ireland

## FINDINGS (CONTINUED)

Six suicides by patients under constant observation occurred off the ward. Patients ran away from their observer either when they asked to go outside for fresh air (2 patients); 1 ran off when escorted on a cigarette break, and 1 when permitted to use the laundry. One patient left the ward when staff were restraining another patient, no SUI report was received for the remaining case.

Deaths occurred on the ward because the observer was not being vigilant, for example the patient was within eyesight but not being observed because:

- they were under bed covers
- the observer became distracted by other patients on the ward.

Staff members beginning their shift misunderstood the prescribed level of observation when the task was handed over to them, consequently the patient was not kept under constant observation as required (2 cases). Boxes 4 and 5 give illustrative examples.

Box 4: Case example: suicide under level 3 or 4 (constant) observation who died on the ward

The patient was being observed while under the bedcovers and the door to his room was slightly ajar (8 inches). The nurse occasionally approached him to check he was breathing. The patient managed to arrange pillows to look as though a body was in the bed and then hanged himself from a window, out of view of the observer.

Box 5: Case example: suicide under level 3 or 4 (constant) observation who died off the ward

The patient was escorted outside for a cigarette but kept walking away from ward. He told the observing health care assistant that he was leaving and could not be persuaded to return. The observer returned to the ward to report the absconson. The patient died by jumping in front of a train.

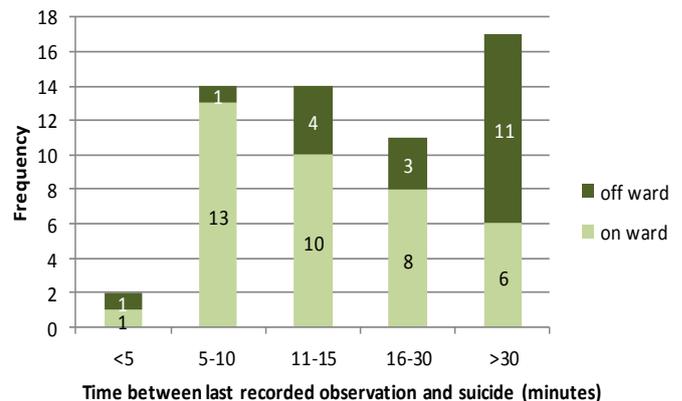
### Suicide occurring under level 2 (intermittent) observation

113 (91%) occurred under level 2 intermittent observation, we received SUI reports on 76 of these. Most suicides on the ward occurred within 15 minutes of the last observation (Figure 4). Problems with the

implementation of the observation policy were noted in 38 (59%) reports including:

- the policy was not adhered to and/or the observation was not carried out as required (12, 31%), for example the patient had been given unescorted leave
- observations were not recorded adequately (11, 28%), and in some cases the records were falsified (5, 11%)
- the observers were confused about what they should be doing and how to do it (8, 21%), for example the handover information was not clear as to why observation was being carried out and what level of observation was required
- the ward was short staffed as other patients were also under observation (6, 15%)
- in 10 (21%) the observation was not carried out within the prescribed time interval
- the observers were distracted by other incidents/patients on the ward and did not complete observation as prescribed (4, 10%).

Figure 4: Intermittent observation: time between the last recorded observation and suicide



## FINDINGS (CONTINUED)

### 3. ONLINE SURVEY & FOCUS GROUP FINDINGS

The online survey was completed by 165 people, and 40 people participated in the focus groups. The characteristics of the survey respondents are presented in Figure 1 and Table 2 (Appendix A). The themes emerging from the survey and focus groups overlapped; to avoid duplication we combined these into five themes.

#### (i) WHAT IS OBSERVATION INTENDED TO ACHIEVE?

The participants reported that the main reasons for using observation were to:

- assess risk to self or others
- monitor how patients respond to being on the ward.

Observation had a specific purpose in certain mental health sub-specialties. In forensic settings (i.e. medium and high security) it was used mainly to manage the risk of violence. In Learning Disability and Old Age Psychiatry, observation was used to monitor physical health needs and to reduce the risk of harm from accidents including falls. We asked participants to focus on observation to reduce the risk of harm to self.

#### (ii) WHAT GOES WRONG WITH OBSERVATION?

##### ***Inadequate staffing levels***

Staff said that decisions to place a patient on observation, particularly levels 3 or 4, were not always driven by clinical need, but by staffing levels and resources. For example, if staffing levels were low with limited availability of agency/bank staff, a patient may not be placed under observation. Staff also indicated that resource and staffing problems could influence decisions to take people off observation, perhaps earlier than was clinically appropriate.

##### ***Staff knowledge and experience***

Staff reported that frequently the importance of observation was not recognised as a key intervention to be used as part of a risk management plan for the most seriously ill patients who were a risk to themselves. They said they often did not know what they were being asked to do when observing or why

they were doing it.

*"...it was following an in-patient suicide, very few nurses really understood or even were told at the beginning or in the induction what an observation meant. They thought it meant go away, see someone, come back and sign the sheet." Nurse*

Staff undertaking observation frequently had insufficient knowledge about the patient being observed, in particular about their risk to themselves. The least qualified members of staff or agency or bank staff were often used to conduct observation.

*"When there are increased levels of observations on the ward, it is more likely that bank and agency staff are being used. These staff are more likely to be put on 1:1 observations as they do not usually know the routine for the ward. This means that the rapport with the patient is poor and often the observations are carried out poorly. In my role, I have had to take many papers, magazine etc. from observing nurses and told them to check the patient." Nurse*

##### ***Lack of adherence to policy***

Staff reported that non-adherence to the observation policy occurred due to:

- ignorance of the policy, particularly with unqualified and agency staff
- confusion with terminology e.g. levels of observation
- complacency.

Staff believed that observation policies can also be too restrictive. Many felt that personal property should not routinely be taken away from patients.

*"I dislike the process of banning objects used in suicides from units and would prefer we concentrated on maintaining/improving the quality of care (we have banned belts, toilet brushes, bin bags, bathroom doors...) - realistically one could make a ligature out of a sheet/item of clothing as easily as a belt." Psychiatrist*

Staff said observation should be patient centred, tailored to an individual's risk assessment and management needs and not a 'catch all'. The intervention should ideally be used flexibly and

## FINDINGS (CONTINUED)

responsively with patients placed on and off observation at times of need, also patients should be more involved in planning their care and risk management.

### **Lack of engagement**

Observation is supposed to provide an opportunity to engage with patients, 'being with' rather than 'watching' them, but this happens infrequently. Participants described the reasons engagement with patients was poor as:

- the severity of illness and complex needs of in-patients
- the risk of violent behaviour (commonly requiring containment)
- shorter admission periods (no time to build a relationship)
- junior or agency or bank staff did not know the patient or did not have the skills to engage with people with serious mental illness.

### **(iii) DO PATIENTS FEEL SAFE AND CARED FOR UNDER OBSERVATION?**

The general consensus was that the practice was intrusive with a lack of privacy and loss of dignity.

*"I have been put under close observation several times. At worst it has been a male nurse allocated for arms length observation including following me to the bathroom and toilet. This has been so distressing, so traumatising that I have restricted fluids so I did not have to go to the toilet in front of him. Twice I soiled myself rather than expose myself on the toilet." Patient*

Patients described the lack of engagement as distressing. It fostered the view that staff were not interested in their welfare and did not care for them.

*"You feel like a prisoner. It is so so traumatic. You don't feel they care about your welfare - you are seen as causing them an extra burden. After my last experience I have now packed a kit that is hidden so that if I am detained I can commit suicide." Patient*

It can lead to increased risk by causing frustration, helplessness, hostility towards staff, and "acting out" behaviour.

*"...he was placed on constant obs and the presence of the nurse was actually causing the frustration that led to the behaviour, the aggression, you know, so you could see the clenched fists starting and it was purely associated with the proximity of the nurse 24 hours a day." Psychiatrist*

The process can also be difficult for those who undertake the observation.

*"...he hated me, hated me, hated me for a couple of weeks, and it felt like a lifetime afterwards. But he came up to me, a while later and said, you've probably saved my life." Nurse*

Despite the intrusive nature and often negative experience of being under observation, when recovered, patients often acknowledged the importance of observation in keeping them safe from harm.

*"I felt safer from myself with someone firm but kind and non-judgemental being with me all the time. I felt known and understood and supported rather than just being on my own and trying to cope and failing." Patient*

### **(iv) HOW IS THE TRANSITION FROM CONSTANT OBSERVATION MANAGED?**

Staff and patients said that the process of observation needs to be an integral part of the risk management plan including a plan for when to reduce/stop observation. This rarely occurs. Staff and patients described decisions to reduce observation levels as difficult because:

- patients can become dependent on observations and may find it difficult to take responsibility for their own safety
- by keeping patients under observation staff can manage their own anxiety and limit the potential for blame if an adverse incident occurs

## FINDINGS (CONTINUED)

- some nursing staff said that they (nursing staff) should be able to stop observation if it is part of an overall management plan.

Maintaining observation may also be problematic because nurses often request levels be lowered due to lack of resources (i.e. when too short staffed to undertake observation). This can influence clinical decisions.

### (v) HOW CAN WE DO IT BETTER?

#### **Clinical practice**

##### Intermittent observation

Several staff raised the issue of whether level 2 (intermittent) observations should be used at all.

*"I think you are observing the patient or you aren't. 15 minutes is plenty of time to kill yourself and people do. 15 minute obs are a fig leaf to reassure staff that they haven't gone from eyesight obs to no obs... We had a patient who hanged herself a minute before she was scheduled to be observed, she died because the obs took place 5 minutes late." Psychiatrist*

It was acknowledged that moving from constant 1:1 observation to general observation may leave the patient feeling unsupported. In these circumstances it was felt that intermittent observations could be used but in the context of a risk management plan which involved and engaged patients in planned activities.

##### Observation in practice

The practice could be improved by:

- improving relational security through engagement
- encouraging participation in programmes and activities tailored to the individual patient
- maintaining continuity of staff to develop familiarity with the patient
- improving the skills and competency of those undertaking observation

- using a multi-disciplinary team approach to decision making, including involvement of the patient in decisions to come off observation

- adopting a flexible and dynamic approach to undertaking observation.

##### Observation process

- improving the process of recording and documenting observations
- using unscheduled independent audits to improve practice and adherence to policies
- disseminating examples of good practice to provide opportunities for learning
- increasing funding and resources to enable adequate and appropriate staffing levels in in-patient services.

#### **Environment**

Staff also commented on environmental factors that may help in undertaking observation. CCTV was said to be less intrusive and could be used to observe patients particularly when stepping down from constant observation but as part of an overall risk management plan. Zonal observations (observing an area not an individual) could be used in the same way.

#### **Examples of good practice**

The Safewards model, developed for nursing care, has reduced incidents of conflict including self-harm and suicide and the use of containment measures (including observation) on mental health wards.<sup>21</sup>

A Mental Health Team Discussion Framework on 'Reducing Suicide Risk' will be published by Healthcare Improvement Scotland in April 2015. The focus of the framework is to help multidisciplinary teams provide safer services and reduce risk. Revised guidance for therapeutic observation practice is also due to be published in November 2015. Enquiries can be made to the Suicide Reporting and Learning System team. [hcis.suicidereviewteam@nhs.net](mailto:hcis.suicidereviewteam@nhs.net)

## KEY MESSAGES

- The current observation approach (especially intermittent observation) is not working safely enough. New models need to be developed and evaluated.
- The observation component of a care plan should not be stand-alone; time with a patient is an opportunity for engagement within a comprehensive risk management plan.
- Observation should be seen as an acute intervention - there should be a record of breaches and the transition to general observation should be planned with the patient.
- A balance of observation and active engagement should be agreed with the patient where possible.
- The observation component of a risk management plan should follow clear protocols, which should be adhered to, recorded, monitored, including actions to take if the patient absconds.
- As an acute intervention, it is a skilled task for staff of appropriate seniority.
- Suicide under observation (intermittent or constant) should be considered an NHS 'never event' in England and Wales (or as a serious adverse event in Northern Ireland and Scotland) and should be subject to independent investigation.
- All serious breaches of protocol in the care of patients under constant observation (for example, leading to self-harm and absconding, not only where there is a fatal outcome) should be investigated under NHS incident procedures (SUI, CIR or SAI).

## STRENGTHS, LIMITATIONS AND ACKNOWLEDGEMENTS

### STRENGTHS

- The quantitative data consisted of a national study, covering all UK countries over a 7 year period. Data are therefore generalisable.
- Thematic analysis of the qualitative data generated by the survey and focus groups enabled a detailed exploration of patient and staff experience and perceptions of observation policy. This rich source of information enhanced our national survey data.
- The online survey sample was open to all participants providing an unrestricted, anonymised and confidential platform for patients and staff to participate in the research.

### LIMITATIONS

- This was a study of cases in which observation had not been effective in preventing suicide. It was not designed to measure how effective observation is overall.
- Although the information obtained from patients and healthcare workers in the survey was valuable, insightful and varied, the people who participated were not necessarily representative of staff and patients nationally. This is especially true in the case of patients, 20 of who took part.
- The SUI reports provided valuable information but were not designed for research and varied in quality and detail.
- The qualitative data interpretation was subjective and may have been influenced by the research team's previous knowledge and experience of in-patient suicide.
- This is a case series of serious incidents with no comparison with cases where observation practice did not end in suicide.

### ACKNOWLEDGEMENTS

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# APPENDIX A: DATA COLLECTION, PARTICIPANTS AND ETHICAL APPROVAL

## DATA COLLECTION AND PARTICIPANTS

The data collection process for obtaining Serious Untoward Incident Reports is shown in Figure 5. We recorded a response rate of 68%. Characteristics of the survey participants have been provided in Table 2.

Figure 5: Data collection: Serious Untoward Incident

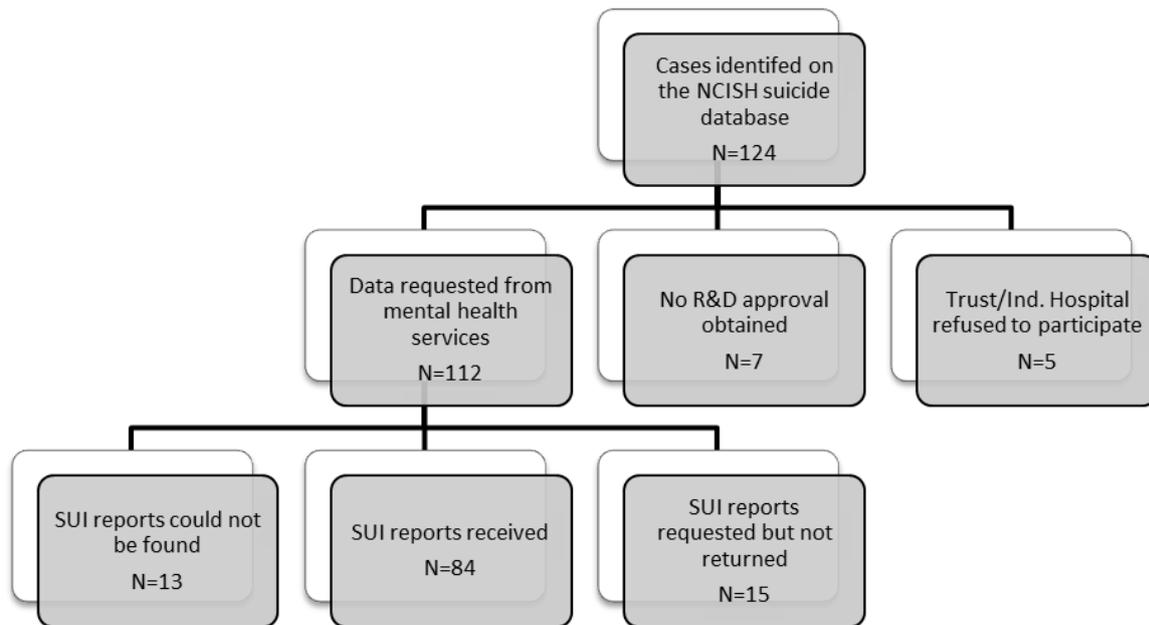


Table 2: Online survey respondent characteristics

Respondent characteristics	N	%
<b>Sex of respondent:</b>		
Female	75	47%
Male	85	53%
<b>Occupation:</b>		
Psychiatrist	114	69%
Nurse	22	13%
Patient	20	12%
Other	8	5%
<b>Type of ward experience:</b>		
General psychiatric ward	100	72%
Secure unit ward	30	22%
Adolescent unit	3	2%
Older people's ward	4	3%
Psychiatric Intensive Care	2	1%

## ETHICAL APPROVAL

Approvals were sought and received from the University of Manchester Research Ethics committee (19/12/2013); NRES Committee North West (09/05/2014); Health Research Authority (amendment to existing approval) (03/01/2014); and Research Management & Governance approvals from individual NHS Trusts. A list of members of the NCISH Independent Advisory Group is presented in Appendix B.

## APPENDIX B: Independent Advisory Group for the Mental Health Clinical Outcome Review Programme

Name	Role	Organisation
<b>Ben Thomas (Chair)</b>	Director of Mental Health and Learning Disability Nursing	Department of Health, England.
<b>Richard Bunn</b>	Consultant Forensic	Belfast Trust, Shannon Clinic, Northern Ireland.
<b>Jeremy Butler (Lay representative)</b>	Former non-executive Director at the National Patient Safety Agency and the Berkshire Healthcare NHS Trust	Member of Hospital Managers Panels under the Mental Health Act.
<b>Jonathan Campion</b>	Consultant Psychiatrist	Visiting Professor of Population Mental Health, University College London; Director of Population Mental Health, UCL Partners; Director for Public Mental Health, South London and Maudsley NHS Foundation Trust, England.
<b>*Carolyn Chew-Graham</b>	Professor of General Practice Research and General Practitioner	Keele University, England.
<b>Mick Dennis</b>	Professor of Psychiatry for Older People and Honorary Consultant Psychiatrist	Swansea University and Abertawe Bro Morgannwg University Health Board, Swansea, Wales.
<b>*Caroline Dollery</b>	Clinical Director	East of England Strategic Clinical Network for Mental Health Neurology and Learning Disability, England.
<b>Vanessa Gordon</b>	Head of Mental Health, Patient Safety	NHS England.
<b>Michael Holland</b>	Consultant Psychiatrist and Associate Medical Director for Revalidation and Quality	South London and Maudsley NHS Foundation Trust, England.
<b>Sarah Markham</b>	Visiting Researcher and Service User	Mental Health Clinical Outcome Review Programme, England.
<b>Ian McMaster</b>	Medical Advisor	Department of Social Services and Public Safety (DHSSPS), Northern Ireland.
<b>John Mitchell</b>	Principal Medical Officer for Mental Health	Mental Health and Protection of Rights Division, Scottish Government, Scotland.
<b>Jenny Mooney</b>	Director of Operations	National Clinical Audit and Patient Outcome Programmes, Healthcare Quality Improvement Partnership (HQIP), England.
<b>John Morgan</b>	Consultant General Adult Psychiatrist	Leeds and York Partnership Foundation Trust, England.
<b>Sian Rees</b>	Interim Director	University of Oxford Health Experiences Institute, Department of Primary Care Health Sciences, England.
<b>Tina Strack</b>	Associate Director, Clinical Outcome Review Programme	Healthcare Quality Improvement Partnership (HQIP), England.
<b>Geraldine Strathdee</b>	Consultant Psychiatrist and National Clinical Director for Mental Health	NHS England.
<b>Sarah Watkins</b>	Senior Medical Officer	Department for Health and Social Services and Children (DHSSC) and Department of Public Health and Health Professions (DPHHP), Welsh Government, Wales.