Methods of observation in mental health inpatient units

AUTHOR Mathew J Page, MSc, RN (Mental Health), DipHE, is clinical nurse specialist/unit manager, Montpellier Unit, Gloucestershire Partnership NHS Trust.


Observation is a common procedure that is controversial as it may be experienced by patients as oppressive. This article discusses the nature of observation in mental health inpatient units, concluding that the practice is likely to continue as it provides a written record of what has occurred. However, the quality of nursing intervention is more likely to have a significant impact on patients than observation.

As a formal process with policies and procedures, nursing observation has evolved from the age-old practice of nurses checking patients’ safety and well-being. The challenges of maintaining the safety of people who have a disturbed behavioural state are obvious and were no doubt exponentially greater at earlier points in history, particularly before the development of psychopharmacological therapy. Early accounts of inspections at Victorian institutions are likely to upset the most ‘hard-nosed’ modern mental health nurse. Scull et al (1996) describe mechanical restraint practices that sound as though they may even have traumatised hospital inspectors, while the effects on inpatients are unimaginable. The Standing Nursing and Midwifery Advisory Council (1999) guidelines for observation suggest that it must be conducted according to a graded policy, from intermittent checking of whereabouts up to having a nurse within arm’s reach.

As a level of observation, the practice is necessarily intrusive. Dodds and Bowles (2002) suggest that changing the philosophy of observation from control to care can have dramatic effects. Barker and Cutcliffe (1999) are right to argue that clinical risk should be a point of contention. Should it be nurses who have the expertise in delivering the intervention, or medical staff, or a combined approach? Barker and Cutcliffe (1999) argue that levels of observation are generally set by a doctor and then nurses perform a subservient role of ensuring the patient’s safety during the doctor’s absence. Dennis (1998) argues that there should be consultation between the two disciplines.

Observation continues to be one of the most common interventions in inpatient mental health care (Meiklejohn et al, 2003; Bowers et al, 2002; Porter et al, 1998). Whatever the method, or procedure of the professional imposing and applying of a level of observation, the practice is necessarily intrusive. Dodds and Bowles (2002) suggest that changing the philosophy of observation from control to care can have dramatic effects.

Evidence on patients’ experiences

Published work on observation generally falls into one of two groups – the effects of observation on patients or the much more substantial body of work on policies and practice. Much of the research focuses on the most intensive type of observation: constant observation (Jones et al, 2000a; Fletcher, 1999; Ashaye, 1997; Cardell and Pitula, 1999). Many of the patients’ negative experiences associated with observation are due to the high level of intrusiveness necessary when observing someone constantly (Bowles et al, 2002).

Cardell and Pitula (1999) suggest that there are some positive effects of observation, including the sense of support experienced by individuals being observed. Non-therapeutic effects of observation were found to include patients feeling that observers were unempathic and remote, and that patients were not given sufficient information as to the purpose of the process. This is supported by Ashaye et al (1997) and Jones et al (2000).

Wan et al (2005) showed that patients found the practice of intermittent observation reassuring for a number of reasons, including threats from other patients and the risk of medical problems associated with medication.

Rosenhan’s (1973) famous ‘pseudo patients’ (individuals without mental illness) experiment still has something to offer on the issue of patients’ experiences. The pseudo patients found that staff and patients existed in entirely separate parts of the institution. Staff isolated themselves and only came into patients’ areas to perform care giving. Over 20 years on this study still has an almost prophetic relevance. Such practice today compounds the notion that observation is the only way in which nurses seek to manage clinical risk.
Building structure and observation

The structure of an inpatient ward can greatly affect the way in which observation is undertaken and presumably the patient’s experience. Allowing a patient to engage in a normalising interaction with a peer may be possible in a well-designed ward that has internal windows, whereas on another ward the interaction would have to be regularly disrupted by a nurse appearing in the room.

Foucault’s (1975) discussion of the history of the prison addresses some concepts that resonate with modern mental healthcare. He describes how hospitals became designed as instruments of medical action, to allow better observation and ensure the best calibration of treatment.

Prisons, Foucault asserts, function as a microscope on conduct, creating fine analytical divisions that are an apparatus of observation.

In Foucault’s (1975) estimation the ultimate institution would allow a single gaze to see everything constantly – the panopticon.

At the centre of the panopticon an attendant can look through windows into a ring of cells circumnavigating the central pillar. Illumination is arranged in such a way that inmates can be seen from the tower but they cannot see their observer.

Foucault (1975) concludes that inmates, whether they be ‘madmen’, condemned men, workers or schoolboys, can all be adequately observed. From the inmates’ perspective the potential to be under constant surveillance contributes to a sense of complete powerlessness. It is irrelevant who undertakes the surveillance, as is their motive, for the effect on the individual is the same.

Modern facilities

Many institutions continue to reflect some of the characteristics of the panopticon. The newly built low secure unit, where the author is employed, is one such facility. From the main office one can see into all of the communal areas and down the bedroom corridor, thanks to well-designed lines of sight and use of internal windows. The unit was also the first to install infrared closed-circuit television in its bedrooms as a means of performing non-disruptive night-time observations (Warr et al, 2005; Page et al, 2004).

Mc Cahill and Norris (2002) discuss how the use of CCTV could create a panoptic phenomenon. However, the observations they make about the common use of CCTV in the open street suggest that the non-continuous surveillance provided by this form of technology is not conducive to the panopticon. Within a secure psychiatric unit it may be argued that the potential for continuous surveillance exists and there is a real possibility of creating a panopticon.

The ward design may mean that observation is easily achieved but this is not without its risks. A ward where one can see from one end to the other may mean that staff do not move around and therefore stand less chance of engaging with patients. By making the office the panoptic hub of a ward, staff are encouraged to migrate there, which will isolate them from patients.

Mitigating potential negative effects

The concerns about methods of observation and their ability to oppress those who are subject to them are rightly expressed in clinical and academic circles. However, the type of observation must not be seen as the philosophy of care itself. Many other variables will greatly affect the experience of the patient, not least of which is the quality of the relationships with staff.

These relationships are the protective factors against creating a disempowering panopticon. Given that patients derive reassurance from and acknowledge the necessity of observation (Warr et al, 2005) conducting it in a way that is least intrusive is imperative. Nurses have a unique opportunity to build relationships with patients through day-to-day activities. The quality of these relationships will affect how patients tolerate less palatable interventions.

The use of unfamiliar agency or bank staff in the delivery of observation, whether constant or intermittent, will not necessarily create the desirable sense of security but may leave a patient feeling anxious and intimidated. On the other hand the appearance of a friendly face at a door may create an opportunity for engagement. Where CCTV is used for night-time observation, a relationship of trust must exist between the staff and patients, and this will only be achieved through building relationships.

Observation as a means of maintaining safety is likely to continue, as the requisite record-keeping associated with it reassures managers, commissioners and service users that due process has been followed. Like all technology, CCTV has the potential to liberate or oppress but it is beginning to establish itself as a method of improving the patient’s experience of observation.

In commissioning new buildings designers should consider how best to use the available space and technology to provide the opportunity for unobtrusive observation. At the same time they need to be mindful that making an office the central point from where most of the ward can be seen is likely to encourage staff to remain in that office, thereby avoiding contact with patients.

The observation policy must not be allowed to prescribe a philosophy of care, as observation is just one of the hundreds of activities that mental health nurses engage patients in on a daily basis.

The employment of high-quality nurses in sufficient numbers will have a much more significant effect on patients than the detail of the observation policy.

REFERENCES


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net