Survey
The questionnaire aimed to survey all multidisciplinary professionals practising in acute adult inpatient mental healthcare settings in Scotland.
Questionnaire items reflected sections 3-5 of the CRAG’s (2002) good practice statement. Five sections sought to examine: personal details and observation policy, and decision making on observation, planning and patient involvement.
A total of 1,663 questionnaires were posted to a convenience sample of the total population of clinical staff in mental health settings. The response rate was 21% (n=350); the rate was highest among nurses, then doctors, then allied health professionals.

Interviews
A total of 38 semi-structured interviews were carried out with all members of all professions and one service user. Participants were recruited from survey respondents. Interview data was transcribed and evidence grouped into thematic clusters. Two researchers analysed these independently, with cross checking on completion.

RESULTS
We present findings in three areas: decision making, risk assessment and observation.

Decision making
Participants were asked whether there was an agreed framework for nurses to reduce observations or area of work. This showed the various agreed frameworks in use.
On the issue of making decisions about observation levels in the team, a significant majority (over 60%) reported that doctors and nurses made these decisions. Although 9% indicated that these decisions were the sole responsibility of the medical profession, more than a quarter (28%) said that they could be made by the whole team.
On the issues of seeking patients’ consent for observations and altering observation levels, we found less consistent results. For the first point, Table 1 shows the “unsure” and “disagree” categories of replies.
Nurses are the most uncertain of the three professional groups over seeking patients’ consent to alter (either to reduce or increase) observation levels (Table 2).

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<thead>
<tr>
<th>TABLE 1. QUESTION 25: YOU ALWAYS SEEK THE PATIENT’S CONSENT TO BEING PLACED ON A LEVEL OF OBSERVATION AGREED BY THE MULTIDISCIPLINARY TEAM</th>
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<tbody>
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<td>Professional group</td>
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<tr>
<td>Nurses</td>
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<th>TABLE 2. QUESTION 26: YOU ALWAYS SEEK THE PATIENT’S CONSENT WHEN INCREASING OR REDUCING LEVELS OF OBSERVATION</th>
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they report as still being in place, are notable. One nurse commented that there was not much discussion or involvement on the patient’s part.
The majority of doctors (58%) and nurses (57%) said that agreed frameworks for nurses to reduce observation levels were in place. However, closer examination of comments indicates that, where they do exist, they are considered primarily as frameworks for reviewing rather than reducing levels of observation. Two comments illustrate this:
- Medical approval: “Only a consultant can reduce observations”;
- Nursing action: “Nursing staff can reduce levels of observation. However, there should be a documented plan in place.”
The interviews provided further insight:

“On my own, I would make decisions about increasing observation, but I would not be allowed to make any decisions about decreasing them” (nurse 35).

Some participants recognised that particular contexts may require flexibility:

“If I felt clinically this person doesn’t need constant observation, this is too intrusive for them, they don’t require it, and I cannot get hold of the consultant, I’m quite happy to make those decisions and to run with the risks associated with that. I would clearly document the decision making process in the case notes” (nurse 38);

“In normal circumstances, it probably is appropriate for an experienced senior nurse to be able to take a decision to reduce it because I appreciate things can change” (consultant 16).

Risk assessment
Participants were asked to consider how they established levels of risk in patients placed on observations in the following areas:
- Objective data – data that we can see and confirm through (validated) risk assessment;
- Third party data – from others who may be involved in some way, such as the police;
- Clinician judgement – the least objective, a nurse saying what she or he thinks;
- Checklist risk assessments – checklists that are usually not validated but which have been devised, often locally, and come into use through local agreement;
- Multidisciplinary team communication – members of the team sharing information. Clinicin judgement and checklist assessment were the most frequently cited means of making decisions. Use of the latter was uneven across the country.
The interviews revealed more complex clinical scenarios involving the combined use of locally developed screening tools, clinicians’ knowledge of the patient, “here and now” clinical presentation and instinct:
Nurse 7: “Yeah, it’s a combination of both obviously, but the risk screen’s more kind of historical factors, and I think your care plan should obviously be based partly on that but mostly on what you’re presenting at the present time.”
Nurse 21: “No, it’s gut instinct.”
Interviewer: “OK.”
Nurse 21: “And professional judgement.”
We also found some evidence of the limited use of risk assessment tools in determining levels of observation: