Are nurses empowered to make decisions about levels of patient observation in mental health?

Mental health nurses are crucial in doing special observations. This study looked at nurses’ views on whether they are involved in and empowered to make decisions...

INTRODUCTION

The special level of observation is an intensive and skilled intervention carried out because of a patient’s serious mental and/or physical state, following clinical assessment. When under special observation, a patient should be in sight and within arm’s reach of a member of staff at all times and in all circumstances. (Clinical Resource and Audit Group, 2002).

This article discusses selected findings from a survey of mental health professionals working in acute adult inpatient services in Scotland on decisions on special observations. While multidisciplinary and multi-agency teamworking are vital when reviewing observation levels and using risk assessment tools, CRAG (2002) said that mental health nurses have a crucial role.

While our findings tally with many CRAG (2002) recommendations, certain areas are underdeveloped. We suggest that multidisciplinary teams should address decision making, and that the therapeutic dimension of special observations should be enhanced and alternatives to it considered.

BACKGROUND

Significant policy development on special observations has only taken place in Scotland in the last 15 years (CRAG and Scottish Medical Education Group, 1995). Although much literature discusses carrying out special observations (O’Brien and Cole, 2003; Bowers and Park, 2001), research on decision making by multidisciplinary teams has received little attention in mental health practice.

LITERATURE REVIEW

A review of the literature enabled us to identify related and relevant issues.

In terms of the practice itself, Neilson and Brennan (2001) noted that medical staff often initiated increased observation levels and nursing staff were frustrated when they were not consulted over such decisions. While there is evidence supporting multidisciplinary collaboration, the fact that this occurs may suggest it is not meaningful to junior staff involved (Kettles et al, 2004).

The practice has been questioned in terms of its therapeutic value, ethical dimensions and the implications for nursing resources. Of these, the therapeutic value is most pertinent to mental health nursing (Bowles et al, 2002; Cutcliffe and Barker, 2002). Further criticism of the practice came with Buchanan-Barker and Barker’s (2005) depiction of special observations as the “original sin” of mental health nursing, as the practice reinforces nurses’ subservience to doctors.

Although many papers have examined risk assessment (Woods and Kettles, 2009; Woods et al, 1999) and observation audits (Neilson and Brennan, 2001; Porter et al, 1998), few have attempted to connect risk assessment with the levels of observations prescribed. Kettles et al (2004) demonstrated such a relationship, but indicated the importance of recognising variables in assessment content between different clinical contexts.

AIM AND METHOD

The two-stage study aimed to explore decision making in acute care multidisciplinary teams in Scotland, focusing particularly on mental health nurses’ practice in patient observation. The NHS ethics service granted approval. Participants gave informed consent by letter for each stage of the process. Coding of all data ensured confidentiality and anonymity.
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). This may reflect the long established ways of thinking among nurses in the study about increasing or decreasing observation levels. The local variations regarding practice in seeking patients’ consent, given the local conditions and the “traditions” that 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 indicated 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);

“Their knowledge of the patient, the local circumstances, the clinician’s knowledge of the patient, the confidence in the patient’s ability to make decisions, and the context in which the decision is being made” (nurse 38).

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.

Clinician 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:

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<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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<th>TABLE 2. QUESTION 26: YOU ALWAYS SEEK THE PATIENT’S CONSENT WHEN INCREASING OR REDUCING LEVELS OF OBSERVATION</th>
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“I think the worst part about it is that we always react to situations, we don’t anticipate much and we don’t do very much in the way of formal, regular or repeated risk assessments in order to anticipate things, and in order to include the patients in the approach and in the decision making” (nurse 35).

Observation
On the actual practice of special observations, we found a number of significant features.

Almost 30% of respondents reported that special observations occurred on a daily basis. Higher levels on a daily or weekly to monthly basis were reported in the north of Scotland. Placing the practice of special observations in the national context. The Millan (2001) principles are embedded in the Mental Health (Care and Treatment) Scotland Act (2003) and are viewed as a "blueprint that will guide the practice of mental health nurses and others" (Scottish Executive, 2006) (Box 1).

Although over half of respondents were familiar with the Millan principles, a significant minority in each profession were not. Respondents in the west and east central areas showed the greatest familiarity. Findings from the interviews support these and other results:

“I’m not familiar with it at all” (nurse 10);

“I think we absolutely do. I mean, the least restrictive practice is something... any time I’ve been involved in a discussion about observation and changes to someone’s observation, I think that particular principle has been discussed...” (nurse 33).

Other findings focus on the strengths, weaknesses and future development of policy:

“If I think the advantages of you are engaging more therapeutically with a patient: You’re seeing them maybe at crisis point and hopefully build up a therapeutic relationship with them at the same time” (nurse 25);

“The disadvantages are there that are certain patients who do not like to be observed, whether it be constant, general or special observation, and it maybe increases their feeling of paranoia or their suspiciousness...” (nurse 25);

“Moving towards an engagement policy, less punitive, more thought put into it, needs a change in professionals’ attitude” (nurse 3);

“More involvement of service users” (nurse 26).

DISCUSSION
The findings suggest that the observation practice for acutely ill patients in these settings generally follows the CRAG (2002) policy document, which is encouraging. We did, however, find areas of practice that are underdeveloped. These include: multidisciplinary team involvement; pre agreed plans for nurses to reduce levels of observation out of hours; and the use of fully validated risk assessment tools.

Concerns about the therapeutic dimensions of patient observation practice and the issue of realistic alternatives to it suggest that continued and critical evaluation is crucial. The findings need to be considered in the national context. The adoption of recovery models of care (Scottish Executive, 2006; Scottish Recovery Network, 2006), featuring greater client participation, may sit uneasily with practices that give the appearance of restriction and control. One way to resolve this may be to recognise that some patients require this intervention for limited and specific periods during their overall journey.

IMPLICATIONS FOR PRACTICE
The wider multidisciplinary team should make time to develop, implement and monitor local frameworks to allow nurses to reduce special observations. Practitioners should engage with clients in ways that enhance the therapeutic intent of special observation through better involvement of service users in decision making. Validated risk assessment tools should be implemented.

CONCLUSION
Our findings suggest that nurses working in acute adult mental healthcare settings need to address issues in the practice of special observations carefully.

In the areas of decision making, risk assessment and wider issues relating to observation, there is a need to ensure that local practice follows national policy recommendations more closely.

REFERENCES


