Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies

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There is little empirical literature on observation as a psychiatric nursing procedure to prevent patients from harming themselves or others. National guidelines for this practice do not exist, with a consequence that local policies might be variable in content and quality. This paper reports a national survey of observation policies and usage based upon a stratified random sample of 27 psychiatric inpatient service providers in England and Wales. Extreme variation in terminology and practice was encountered. The terminological confusion is likely to reduce nurses' clarity about their responsibilities and increase risks to patients. Further variation exists from place to place as to whether, and to what extent, student nurses and family members should be entrusted with the responsibility to observe patients. More than one in 10 services of the sample still have no written observation policy, and four in 10 have no clinical recording system of the procedure in place. Nurses commonly amend the procedure and terminology on an *ad hoc* basis. The results of this survey confirm that the Department of Health should set national standards for the policies and procedures for patient observation and that as an interim step practice guidance should be issued to all nurses (and other mental health workers) involved in this procedure.

Keywords: survey, inpatient, observation, suicide, self-harm policies, national, health care, psychiatry

INTRODUCTION

One of the most common methods used in containing the disturbed and threatening behaviour of acutely ill psychi-

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atric inpatients is to allocate their care and supervision to an individual nurse. This method is typically used to prevent suicide, aggression, absconding, and to manage sexually disinhibited behaviour. A variety of terms are used in the literature to refer to this procedure, some of the most widespread being 'special', 'close', or 'constant observation' (Ritter 1989, Hardy & Mingella 1997). The procedure is utilized at different levels, ranging from the most intensive (the nurse being within arms reach of the patient at all times) to the least (periodic checks on the patient). For convenience, in this paper the term constant observation (CO) will be used to refer to any increased level of observation of a greater intensity than that which any patient generally receives, and which is coupled with allocation of responsibility to an individual nurse or other worker.

In the United Kingdom (UK), policies and procedures for CO are developed and implemented at a local level. Little published guidance exists, save for Ritter's (1989) manual of guidance for psychiatric nurses based upon those developed and utilized at the Bethlem and Maudsley Hospital in London. The survey reported in this paper was commissioned as part of a programme of work which has underpinned a report by the Standing Nursing Midwifery Advisory Committee on Acute Inpatient Care in England and Wales (SNMAC) (Department of Health 1999).

LITERATURE REVIEW

Our literature review shows that there has been no empirical research carried out in the English-speaking world, leaving the procedure based on clinical pragmatism and tradition. However, there is some descriptive research. For example, some research suggests that between 3 and 13% of admissions receive some form of CO during their stay (Tardiff 1981, Shugar & Rehaluk 1990). However, we also know that inpatient populations are changing, and recent work (Gournay *et al.* 1998) suggests that people admitted to inpatient wards are increasingly likely to suffer more serious forms of mental illness, and to have a much greater level of disturbance. Therefore, it may well be that these changes in population are mirrored by an increase in the use of some form of CO. Other research (Porter *et al.* 1998) suggests that the rate of use of CO can vary widely between individual wards.

Three main types of patients are placed on CO: young male schizophrenia sufferers who are judged a suicide risk or who have behavioural problems; older female depressed patients who are a suicide risk; and those suffering from personality disorder (Phillips *et al.* 1977a, Childs *et al.* 1994). Which professional staff have the authority to initiate and terminate CO varies from place to place (Goldberg 1987, Childs *et al.* 1994, Duffy 1995) as does its duration (Shugar & Rehaluk 1990, Green & Grindel 1996, Lehane & Rees 1996, Pitula & Cardell 1996). The financial costs have been crudely assessed by some (Goldberg 1987, Heyman & Lombardo 1995) and are reported by Moore *et al.* (1995) to be US $450 000 per annum for one psychiatric hospital, or 20% of the nursing budget.

Further variation exists on who is allowed to carry out CO (Margolis *et al.* 1965). Two studies report that nurses frequently make unofficial modifications to the procedure based upon their own individual judgements and assessments (Aidroos 1986, Duffy 1995). There is little agreement between authorities on what nurses should do during CO (Blythe & Pearlmutter 1983, Reid & Long 1993, Duffy 1995). However, there is evidence that nurses find CO stressful (Phillips *et al.* 1977b) and it is disliked by patients (Pitula & Cardell 1996, Liebling *et al.* 1997).

Thus, overall, we have a picture of a procedure that is universally acknowledged as being essential to protect the most vulnerable people. However, at the same time, there seems to be enormous variation in its application, and, as noted above, a lack of consensus between practitioners and researchers regarding what it is and how it should be carried out.

THE SURVEY

Aim

The aim of the survey was to undertake a survey of a random, stratified sample of National Health Service Trusts, which provide a mental health service, across England and Wales, in order to ascertain how the process of observation is being applied in services. We also set out to ascertain the nature and content of policies on observation within these services. We were particularly interested to examine whether there was variation in the practice and policy of observation in our sample.

Method

Sample methods

In order to obtain a random sample of trusts which was reasonably representative of mental health services throughout England and Wales we used the approach developed by the Clinical Standards Advisory Group for their work on schizophrenia (Gournay & Beadsmoore 1996). This entailed dividing Trusts across each of the eight regions of the NHS in England, and those in Wales, into three groups, i.e. predominantly urban areas, suburban or rural. (The authors took advice from researchers in the Royal College of Psychiatrist's Research Unit and colleagues in the mental health branch of the English Department of Health which confirmed that this was the simplest and most effective method for obtaining a representative sample of mental health services). Using a random number table, Trusts were then randomly selected from the lists for each group for each English region and for Wales.

Questionnaire

A first version of the questionnaire was constructed by the authors based upon a review of the literature, and from the authors' clinical and legal experience. The questionnaire (see Appendix I) contained a total of 23 specific questions in 14 sections. It requested information regarding the process and policy of observation for each responding clinical service. In turn, we also requested copies of official policies on observation from each service. The questionnaire design ensured that respondents did not have to repeat data which were in the policy documents submitted by the services. The questionnaire was then sent to a group of experts, including the Nursing Officer for Mental Health at the Department of Health, the Mental Health Advisor of the Royal College of Nursing, the Mental Health Officer from the United Kingdom Central Council for Nursing Midwifery and Health Visiting, several clinicians from both nursing and medical backgrounds in various positions of seniority, and other nurse researchers.

After receiving feedback from this group, the questionnaire was revised and then sent to three nursing directors in three different mental health services in London, the Midlands and the north-west of England. The purpose of this piloting was to ensure that the questions were framed in the most suitable fashion, and that the questionnaire, together with the policy documents from each service, yielded all of the data that were required. The questionnaire consisted of 12 pages and took approximately a day to complete (some questions required the nursing director to obtain information from others, e.g. precise staff ratios).

The feedback from the piloting of the questionnaire and the feedback from the individual experts was then submitted to a specially convened mental health subgroup of SNMAC. This subgroup comprised 15 individuals (including several members of the main SNMAC committee) who had a wide range of experience in matters of policy and practice relating to observation in psychiatric settings. This subgroup did not suggest any further modification. Following this final process, a final version of the questionnaire was sent to the directors of nursing of a random stratified sample of 27 NHS Trusts providing psychiatric inpatient services in England and Wales. (NHS Trusts are the core unit of health service delivery in the UK and generally cover populations of between 250 000 and 500 000.)

A full version of the questionnaire can be obtained by contacting any one of the authors of this paper. We should point out that, as there was considerable evidence to suggest a wide variation in definitions of terms and in the content of policies and procedures, the questionnaire was constructed in such a way as to make no *a priori* assumptions about levels of observation. Obviously, it is impossible within the context of such policy research and with limited funding, to develop a questionnaire which conforms to the highest standards of reliability and validity. However, it must be said that, because of the exhaustive consultation procedure, the face validity of the questionnaire was reasonably robust.

The questionnaires were distributed in July 1998. In order to maximize the response rate, Trust nurse directors were contacted by telephone in advance to secure their support for the project. The questionnaire was also accompanied by a covering letter from the Department of Health SNMAC secretariat, and up to two follow-up phone calls were made in cases where the response was slow. Twenty-four responses were eventually received (89% response rate), including 23 observation policy documents (from 21 Trusts).

Data entry and analysis

The questionnaire required the respondent to provide simple information either in categories or in numbers. Therefore, data entry simply required the responses to be entered and coded on a database. To ensure accuracy of such coding, each of the three authors was provided with copies and each author entered data independently. Therefore, accuracy of coding was ensured. As none of the questions required rating or interpretation, issues of inter-rater reliability did not arise.

RESULTS

Observation policies

As the data and information gathered in the pilot phase of our work was exactly the same as that gathered in the main survey we have been able to provide results for 26 sets of policies. We should also note that we have provided the central and most important findings in this paper (important being defined by the Department of Health, who commissioned this work). There is obviously a great amount of detail not reported; this detail will be the subject of future publications.

Most Trusts do appear to have written policies on CO, with 88% of respondents being able to supply copies of these. This still leaves more than one in 10 Trusts that apparently have no written policy. Various reorganizations of mental health services in the UK have led to the existence of multiple and varied policies between hospitals on different sites, and one responding Trust was able to supply copies of three different CO policy documents, all of which were currently in use. All policies obtained during this survey were first formulated in 1985 or after, with the larger proportion being created and implemented in the early 1990s. All policies were said (by the respondees) to be in imminent need of review. The use of systematic risk assessment tools of any variety in conjunction with CO policies was much rarer, with only 37%

of respondents confirming that these were in use and only 33% able to provide copies of their risk assessment policies.

Record keeping

The recording of CO is patchy. Forty-six per cent of Trusts reported that they kept no central records of CO usage and would not therefore be in a position to estimate their spending on this procedure, or the variance in its usage between wards. In 38% of cases no clinical recording system was in place other than, possibly, some form of note kept in medical or nursing records. One respondent indicated that careful records were kept, not for clinical purposes, but to aid with billing extra contractual referrals at a higher rate when CO was utilized. Others (54% of the sample) who report systematic central record keeping indicate that the data produced were regularly reviewed at a senior level.

Terminology

Of the 26 policies supplied by respondents, only two used the same terminology for the different levels of intensity of constant observation. Table 1 displays the results, and demonstrates that when numbers are used to indicate levels, the numbers used mean different things in different locations. For example, in some locations 1 meant the highest level of observation and 3 the lowest, while in other areas 3 meant the highest and 1 the lowest. It is also important to note that the same words mean different things in different places. For example, in some locations 'close' means intermittent 15-minute checks, whereas, in others, it means the continuous one-to-one presence of the nurse, but not within arm's length. Similar considerations apply to numbered levels of CO: those with an equivalent number is not necessarily the same thing in operation terms.

In one location a completely unique colour coding system is in use. When the questionnaire responses from each mental health service were examined, and then compared with the official policy documents of the service, it became clear that there was considerable difference in terminology between the questionnaire responses and the official policy. This, in a sense, confirmed the terminological confusion, both between, and within, individual mental health services.

Responsibility for implementation

Thirteen respondents (50%) replied that in their location CO could be initiated autonomously by qualified nurses,

Table 1 Terminology used by each individual Trust in their policy for different levels of constant observation

*Trust no.	⇦ Higher					Lower ⇨
1	Constant	Close	General			
2	Constant	Frequent	Intermittent			
3	Constant	Close	Discreet			
4	Continuous	Routine				
5	High	Medium	Low	General		
6	Level 1	Level 2	Level 3			
7	Level 1	Level 2				
8	Level 1	Level 2A	Level 2B	Level 3	Level 4	Level 5
9	Level 1	Level 2	Level 3			
10	Constant	Close	Intermittent			
11	Level 1	Level 2A & B	Level 3			
12	Maximum	Intermittent	Periodic			
13	Level 3	Level 2	Level 1			
14	Level 3	Level 2	Level 1			
15	Continuous	Close				
16	One to one	Close	Unobtrusive			
17	Red	Orange	Blue			
18	Special	Close				
19	Special	Close	Defined	General		
20	Special	Continuous	Close	General		
21	Special	Close				
22	Special	Close	Timed			
23	Specialing	Close	1 in 5	1 in 10	1 in 15	
24	Specialing	Close				
25	One to one					
26	Total	Close	Primary	Routine		

although in most of these places the procedure could also be authoritatively invoked by medical staff. In the remaining 50% of cases the initiation of CO was declared to be by joint medical and nursing decision. By contrast, termination of CO was reported by 63% to be a joint medical and nursing decision. This probably reflects the fact that termination poses a greater potential risk to patients than initiation.

Most respondents indicated that it was not necessary for a patient to be detained under the Mental Health Act for CO to be used. However, it was commented by some respondents that any informal patient who expressed concern or rejected this level of care would be assessed rapidly for compulsory detention. Other responses showed that in some locations all new admissions (or all new compulsory admissions) were the subject of higher than normal levels of observation.

Who observes?

Wards rely most frequently on their existing staff establishment to carry out CO. If this does not suffice, overtime or bank staff are those who are next most frequently used. Twenty-nine per cent of respondents reported that they often used agency nurses. However, this obscures the fact that there was considerable disparity between locations as to which staff were used to provide the different levels of CO. It is clear that no agreement exists as to whether agency nurses, bank nurses or nursing assistants should be permitted to carry out all levels of CO. The only group of staff over whom there was full agreement was qualified staff, with all respondents agreeing that they should be able to carry out all levels. The most acute disagreement was about the potential role of student nurses and family members. With respect to student nurses (on placements from university courses), 24% of respondents allowed them to carry out all levels of CO and 43% some levels, but in 33% of locations they were not allowed to carry out CO at all. A similar split was evident for the involvement of family members, with 55% allowing their involvement in some or all levels, and the remainder not allowing their involvement at all.

Location of observation

Opinions were divided as to whether patients under CO should be confined to the ward. Six policies stated categorically that they should and 11 that escorted leave or escorted attendance at occupational therapy, etc., was allowable at the discretion of staff and subject to staff availability.

Duration of observation

The average duration of CO reported by respondents was 72 hours, with a range of 3–4 hours at its shortest and 10 days at its longest. On rare occasions CO was reported to last up to 100 days. If CO is maintained from existing staff establishments, resources are withdrawn from the remaining patients on the ward. If overtime, bank or agency sources are used (as they frequently are), the financial cost can mount quickly, exerting pressure on nursing budgets which generally have little flexibility. The most common difficulty in implementing policy was reported to be the lack of staffing and budgetary resources. Some localities which had psychiatric intensive care units stipulated that transfer to this facility was indicated if CO exceeded 72 hours.

Gender and ethnicity

The gender of the patient is nearly always considered in the decision about which member of staff to allocate to carry out CO. However, this is managed in most places by allocating female staff to female patients at times when toileting and bathing are required. The gender of the allocated nurse was also reported by some respondents to be determined by the sexual behaviour of the patient or their propensity for violence. Ethnicity is said to be a consideration by half of the respondents, and religion rarely. Staffing constraints were seen as a particular problem in some localities, especially in relation to ethnicity. Language problems with non-English speaking patients were also noted. When religion was taken into account, many respondents linked this to gender issues. One reply made a strong case for the allocation of staff to CO who had pre-existing good relationships with the patient.

Patient information

Most policies received mentioned that the patient should be given a rationale for the implementation of CO, even if they were not in agreement with the decision. Only one respondent was able to forward specific written information that was given to patients explaining the procedure.

The objectives of continuous observation

Respondents were asked for what purposes CO was used in their locality, and the results to this question can be found in Table 2. It is clear from this table that there is most agreement that CO is an effective nursing strategy primarily to reduce the risk for self-harm or completed suicide, with the next most common targets being the prevention of aggressive behaviour or absconding. There is less agreement between respondents about other scenarios of difficulties in the nursing management of patients, possibly where the risks are less tangible. The use of CO in conjunction with ECT (electro-convulsive therapy) or seclusion appears to be uncommon, possibly

Table 2 Why is constant observation used?

Percentage of respondents who used CO for each of the problems listed	Problem requiring use of constant observation
90–100%	Potential self-harm/suicide
	Actual self-harm/suicide
80–89%	Aggressive behaviour
	Prevention of absconding
70–79%	Self-mutilating behaviour
	Psychosis
	Acute confusional state
	Potential violence to others
	Actual violence to others
60–69%	Impulsiveness
	Medical conditions requiring monitoring or treatment
50–59%	Withdrawal from drugs/alcohol
	Inability to make a 'no suicide' contract
	Violence to property
40–49%	Agitated behaviour
	Patients in seclusion
	Wandering
	Risk of falls
	Decrease stimulation from the environment
	Before ECT

Note: Question 14 of our questionnaire asked for what purposes CO was used and listed the different behavioural patterns/problems indicated above.

indicating that the links between CO policy and other nursing procedures have not been thought through or made overt. However, one respondent did provide integrated observation and seclusion policies. Also evident is some variation in opinion about the efficacy or usage of CO in relation to elderly patients suffering from acute organic mental illnesses.

In summary therefore the results of this survey confirmed considerable variation between, and indeed within, individual mental health services concerning the policy and practice of CO.

DISCUSSION

The most prominent finding of the survey was the variation in terminology and content of the different levels of CO and who should undertake them. The confusion around the language to be used, coupled with possible resistance of staff to full implementation of new polices, is a recipe for confusion. In some cases this may have disastrous consequences for patients. Many psychiatric nurses in England and Wales often move jobs from Trust to Trust, and agency nursing staff (who are frequently used to undertake CO) work in many different places. Each time there is a change of location, professionals have to learn to accommodate a new policy with new terminology. This compounds the difficulty for each individual member of staff and it is obvious that the variation in policies may lead to difficulties (agency staff in particular) in adjusting to the change of work location, and a possible resistance to changing individual practice. Whatever the cause, this can only provoke confusion, lack of clarity, and reduced patient safety.

Although there is good agreement about the higher levels of CO, on what the nursing role should be and how it should be carried out, the rationale and meaning of mid-range and lower levels of CO are less well defined. The use of intermittent checks is a case in point. There is much variation in how frequently these are carried out, and it may be disputed that these can be effective. Fifteen minutes is sufficient time to complete a suicide, seriously self-mutilate, seriously assault another, or abscond quite some distance from the ward. Nevertheless there is probably a need to reduce CO from continuous contact to the minimum level (general observation) via this intermediate level.

The general observation that every psychiatric patient should be subject to, was the least well-defined level in the policies that we studied. In fact, most Trusts do not define the content of general observation at all, despite the fact that it is the starting point for promoting patient safety. Perhaps this is because higher levels of observation are conceived of as being delivered to individual named patients. However, general observation may be helpfully thought of as the observation and monitoring of the physical geography of the ward, and as a component of constant review of safety in the light of the opportunities the ward and its contents provide for harm to come to

patients. Thus general observation should be an established part of the ward routine and followed rigorously and regularly by nurses, as part of their everyday practice to maintain the safety of patients.

General observation means auditing the ward regularly for isolated areas that provide opportunities for unobserved self-harm or violence, e.g. corners, alcoves, rooms, toilet areas and bathrooms, which are not in continuous sight. These should then be checked frequently throughout the day and night. Those areas that present particular risks, such as kitchens and bathrooms, should be kept locked. Access to the means of suicide should be considered as part of the framework of general observation. This should thus include: patient searches (when indicated); locker and cupboard searches; property checks on entry or admission to the ward; use of safety glass or polycarbonate; restrictions on the opening of windows; use of small panes or wire mesh glass; closed-in pipe-work to reduce hanging points; use of secure cupboards for clinical reagents and cleaning fluids as well as medications; regular changes of bed linen and bed making so that the capacity to hoard medication in the mattress or pillows is reduced, etc. All these measures may be conceived of as part of the routine of general observation that promotes the safety of all patients on the psychiatric ward.

Given that the most common identified problem in implementing CO policies is a lack of staff and financial resources, it is remarkable that so few locations have instituted any form of central monitoring of CO usage. This lack of information must weaken any case for a specific cost allowance for this nursing care activity. Those Trusts that can account precisely in cost terms are able to construct a good case to their funders for extra finance.

Lastly, it should not be forgotten that good relationships with, and knowledge of, patients are the foundations of patient safety. The establishment of such relationships is the heart of psychiatric nursing acute inpatient work, for which psychiatric nurses are specifically trained. Such relationships promote a strong therapeutic alliance to which the patient can become committed, and facilitate the sharing of suicidal thoughts and impulses. Linked to a competent, systematic, research-based risk assessment, they enable the proper identification of those patients who require CO in the first place.

CONCLUSIONS

The conclusions of this survey are very clear. The results of the survey showed that guidance from the Department of Health is vital. Indeed, as a consequence of this survey the Department of Health/SNMAC issued a guidance document, which suggested standard terminology and also set out core principles and procedures for all levels of observation in mental health services (Department of Health 1999). Nevertheless, evaluative research into the efficacy of CO is required and the observation methods contained in the SNMAC guidance requires careful evaluation. Finally, Trusts should ensure better record keeping to assist in making a case for specific funding for the nursing resources used in CO.

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References

Aidroos N. (1986) Nurses' responses to doctors' orders for close observation. *Canadian Journal of Psychiatry* **31**, 831–833.

Blythe M. & Pearlmutter D. (1983) The suicide watch: a re-examination of maximum observation. *Perspectives in Psychiatric Care* **3**, 90–93.

Childs A., Thomas B. & Tibbles P. (1994) Specialist needs. *Nursing Times* **90**, 32–33.

Department of Health (1999) *Addressing Acute Concerns.* Report by the Standing Nursing Midwifery Advisory Committee. Department of Health, London.

Duffy D. (1995) Out of the shadows: a study of special observation of suicidal psychiatric in-patients. *Journal of Advanced Nursing* **21**, 944–950.

Goldberg R. (1987) Use of constant observation with potentially suicidal patients in general hospitals. *Hospital and Community Psychiatry* **3**, 303–305.

Gournay K., Ward M., Thornicroft G. & Wright S. (1998) Crisis in the Capital. *Mental Health Practice* **1**, 10–14.

Green S. & Grindel C. (1996) Supervision of suicidal patients in adult inpatient psychiatric units in general hospitals. *Psychiatric Services* **47**, 859–863.

Hardy S. & Mingella E. (1997) Understanding suicidal behaviour. In *Mental Health Nursing Principles and Practice* (Stuart G.W. & Sundeen S.J. eds), Mosby, London, pp. 237–252.

Heyman E. & Lombardo B. (1995) Managing costs: the confused, agitated, or suicidal patient. *Nursing Economics* **13**, 107–118.

Lehane M. & Rees C. (1996) Alternatives to seclusion in psychiatric care. *British Journal of Nursing* **5**, 974–979.

Liebling H., Chipchase H. & Velangi R. (1997) Why do women harm themselves? *Feminism and Psychology* **7**, 427–437.

Margolis P., Meyer G. & Louw J. (1965) Suicidal precautions. *Archives of General Psychiatry* **13**, 224–231.

Moore P., Berman K., Knight M. & Devine J. (1995) Constant observation: implications for nursing practice. *Journal of Psychosocial Nursing* **33**, 46–50.

Phillips M., Peacocke J., Hermanstyne L. *et al.* (1977a) Continuous observation, Part I — who needs it? *Canadian Psychiatric Association Journal* **22**, 25–28.

Phillips M., Peacocke J., Hermanstyne L. *et al.* (1977b) Continuous observation, Part II — absenteeism amongst nursing staff as a response to the extra workload. *Canadian Psychiatric Association Journal* **22**, 29–30.

Pitula C. & Cardell R. (1996) Suicidal inpatients' experience of constant observation. *Psychiatric Services* **47**, 649–651.

Porter S., McCann I. & McGregor A. (1998) Auditing suicide observation procedures. *Psychiatric Care* **5**, 17–21.

Reid W. & Long A. (1993) The role of the nurse providing therapeutic care for the suicidal patient. *Journal of Advanced Nursing* **18**, 1369–1376.

Ritter S. (1989) *Bethlem Royal and Maudsley Hospital Manual of Clinical Psychiatric Nursing Principles and Procedures*. Harper & Row, London.

Shugar G. & Rehaluk R. (1990) Continuous observation for psychiatric inpatients: a critical evaluation. *Comprehensive Psychiatry* **1**, 48–55.

Tardiff K. (1981) Emergency control measures for psychiatric inpatients. *Journal of Nervous and Mental Disorders* **169**, 614–618.

APPENDIX I: SUMMARY OBSERVATION QUESTIONNAIRE TO TRUSTS IN ENGLAND AND WALES

1. i) Do you keep any records of constant observation centrally?
1. ii) If these records are kept, what information is held in them?
1. iii) Are there any specific clinical records kept?
1. iv) Is there an information leaflet given to patients about the procedure?
2. i) In your clinical area, what is the relationship of constant observation to the Mental Health Act?
2. ii) In your clinical area, are patients on constant observation confined to ward?
3. i) Do you use any standardized risk assessment tools in the decision to use constant observation? If so, please attach a sample copy.
3. ii) Please comment on who carries out this risk assessment.
4. In your clinical area, who has the authority to initiate constant observation?
5. In your clinical area, who has the authority to terminate constant observation?
6. In your clinical area, what terms are used to describe different kinds of constant observation, and what do each of them mean/entail?
7. In your clinical area, which personnel carry out constant observation? (a list of staff types is provided).
8. Are there any of the following factors considered in relation to decisions about who carries out constant observation?
   a) Gender
   b) Ethnicity
   c) Religion
9. Which of the following staffing resources are used most often to provide constant observation (rank in order of frequency from most frequent to least frequent — 1–5), staffing resources listed are current establishment, staff on overtime, bank nurses, agency nurses, others.
10. i) What are your current staff/patient ratios in acute general psychiatric wards, i.e. WTEs/total number of beds?
10. ii) What is the ratio of qualified to unqualified nurses on your acute general psychiatric wards?
11. i) If you have a local observation policy, what year was it first formulated?
11. ii) When was the observation policy last reviewed?
11. iii) When is your observation policy next due for review?
12. i) Please tell us, in your estimation, what is the typical duration of constant observation, i.e. from time it is initiated to time it is terminated in your locality?
12. ii) What, in your estimation, is the range of typical usage (in terms of time) of constant observation?
13. Are there any difficulties in the implementation of the constant observation policy, e.g. resources, different interpretations by the profession, building design, etc.
14. For what purposes is constant observation used in your locality?
    (A list of 20 different behavioural patterns/diagnostic categories was provided — see Table 2).

Note: The above questions were put into a questionnaire which spanned 10 sides. As noted above, copies of the full questionnaire are obtainable from any of the authors. Each question was framed in such a way that there was space for a free text. Some of the questions included examples and some prompts; some of the questions also asked for copies of other information, for example risk assessment procedures.