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Investigation report

Patients at risk of self-harm: continuous observation

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A note of acknowledgement

We would like to thank the patient, Emily-May, whose experience is documented in this report. We would also like to thank Emily-May's mother, who gave generously of her time to support this investigation. In addition, we are grateful to the healthcare staff involved with the investigation for their openness and commitment to support improvements in this area of care.

About Emily-May

Emily-May was 18 years old at the time of this investigation. She had lived in mental health facilities since she was 14 years old. Emily-May has a close relationship with her mother and younger sister, rabbit and family dog. She loves cooking, especially cakes, is very creative and was a keen dancer. Emily-May had complex mental-health needs and a history of self-harming. During the 4 years since her first admission, she had transferred between mental health and acute hospital settings (for treatment of self-harm or other physical conditions), approximately 19 times.

Approximately 20 months after the reference event took place, Emily-May was making good progress on her recovery journey and had just become an informal patient at the mental health hospital (this means that Emily-May was no longer detained in hospital under the Mental Health Act, but was completing her care there voluntarily). Emily-May explained that she was “not just surviving” but was “now thriving” and was keen to support positive change with regard to continuous observation.

About this report

This report is intended for healthcare organisations, policymakers and the public to help improve patient safety in relation to the continuous observation of adults (that is, people aged 18 and over) who are at risk of self-harm and being cared for on an

acute hospital ward. An acute hospital is where patients are treated for physical illness or injury, or have surgery. The investigation's findings may be applicable to other care settings and other vulnerable groups of people. This report does not consider technology-assisted means of continuous observation, as these are not currently in use in the acute hospital setting.

This is a legacy investigation completed by the Health Services Safety Investigations Body (HSSIB) under The NHS England (Healthcare Safety Investigation Branch) Directions 2022.

Terminology in this report

The professions involved in the practice of continuous observation in mental and physical health settings tend to be registered nursing staff, trainee nurses and non-registered staff (healthcare workers and healthcare assistants). This report uses the term 'healthcare support workers' when referring to non-registered staff.

The recruitment of staff from outside the UK is an important means of contributing to the supply of a skilled workforce needed to deliver healthcare. The investigation includes findings in relation to potential challenges in therapeutic engagement for some patients where skilled healthcare workers from other countries may not have shared language or cultural connections.

In line with Department of Health and Social Care guidance this report uses the term 'international recruitment' when referring to migrant workers, moving temporarily or permanently for employment in England. These workers are referred to in a variety of ways in published literature and professional guidance including as overseas workers, international workers, and an internationally educated workforce. This report uses the term 'overseas health professionals' in line with NHS health careers terminology.

Executive summary

Background

The aim of this investigation is to help improve patient safety in relation to the use of continuous observation with adult patients in acute hospital wards who are at risk of self-harm. It includes a real patient safety event, referred to as 'the reference event', through which to explore the use of this intervention in reducing the risk of patients self-harming.

Self-harm – where a person intentionally hurts themselves through self-poisoning or injury, irrespective of the apparent purpose – is one of the commonest reasons for people attending an acute hospital (a hospital that treats physical rather than mental health problems). Continuous observation is one method that is used to keep people who are at risk of self-harming safer while they are in a hospital ward.

This report uses the term ‘continuous observation’ to describe the practice where one or more members of staff continuously engage with and observe a patient to reduce their risk of self-harm. It is commonly used in hospitals as a way for staff to monitor and assess the mental and physical health of a person who might harm themselves.

The reference event

The reference event involved a patient called Emily-May, who was at high-risk of significant self-harm. Emily-May was being cared for in a mental health hospital where she was detained under the Mental Health Act to allow for her mental disorder to be treated. Emily-May was taken to an acute hospital after self-harming, where she had surgery to repair her wounds and stayed in an intensive care, and then a high dependency unit. A high dependency unit in an acute hospital looks after patients who need more intensive monitoring and treatment than is possible on a general ward but slightly less than that given in an intensive care unit.

While in the high dependency unit, Emily-May self-harmed while two members of staff were continuously observing her.

The investigation of the reference event found a range of factors that may have influenced the effectiveness of continuous observation at preventing patients in an acute hospital setting from self-harming.

The investigation

The reference event was referred to the Healthcare Safety Investigation Branch (HSIB) by the acute hospital that cared for Emily-May. An investigation was undertaken to explore the activity of continuous observation and its use in reducing the risk of patients self-harming while being cared for in a hospital ward.

The investigation engaged with three acute hospitals; three mental healthcare providers; specialist staff; and national bodies (such as government departments and professional bodies) that influence policy and strategy within the NHS.

Findings

- There is a lack of evidence about how to optimise the safety and quality of continuous observations of adults, or when it is most appropriate to use this intervention.
- Decisions about when to use continuous observation are made at healthcare provider level. This is because there are limited national guidelines and standards on when and how continuous observation should be carried out, and a lack of clear guidance on the training needs and competencies of staff doing this.
- Variation exists within and across healthcare settings in the terms used to describe continuous observation, its purpose, when it should be used, how it is done, and which staff carry out this intervention for patients at risk of self-harm.
- In order to create the conditions in which staff can best carry out continuous observation, consideration of human factors principles is needed to understand the complexities of this intervention and the environments in which it may take place.
- Formal processes are often not in place to anticipate and support effective collaborative working where mental health staff work alongside physical health staff in an acute hospital to provide care to a patient at risk of self-harm.
- When staff caring for a patient at risk of self-harm have witnessed a significant self-harm event this can be traumatic and staff cannot always access the support that they need.

HSSIB makes the following safety recommendations

Safety recommendation R/2024/025:

HSSIB recommends that the Department of Health and Social Care, through the National Institute for Health and Care Research (NIHR), assesses the priority, feasibility and impact of future research into the efficacy and acceptability of continuous observation of mentally unwell adult patients. The research should take into account different care settings in which continuous observation may take place (including physical and mental health hospitals) and the different staff groups involved in carrying it out.

Safety recommendation R/2024/026:

HSSIB recommends that NHS England, working with relevant stakeholders, produces national guidance for staff undertaking continuous observation of mentally unwell adult patients, along with a training and competency framework to provide staff with the necessary skills for this intervention in different care settings (including physical and mental health hospitals). Development of this guidance should include engagement with human factors principles to understand the complexities of the task of continuous observation and the environments in which it may take place.

Local-level learning

The following prompts are provided to help acute hospital (physical) and mental healthcare providers to work in collaboration:

- Is there a shared understanding of the different roles and responsibilities of mental and physical healthcare staff in caring for a patient, including checking their personal belongings for items that could be used to self-harm. Are the different roles and responsibilities documented in care plans and shared at shift handover?
- Is there a shared approach to supervision and support for all staff involved in caring for patients who may self-harm in hospital?
- Is there a clear and comprehensive process for handing over a patient's care to staff on the receiving ward?
- Is there a shared approach to, and understanding of, how to respond if the patient were to self-harm?
- Is there a physical healthcare hospital policy for the care of patients with mental health needs which includes continuous observation?
- Is there a mechanism for regular communication and review of a patient's risk of self-harm and need for observation?
- Is there comprehensive, clear, and accessible documentation available to both mental and physical healthcare staff?
- Is there a process to ensure staff undertaking continuous observation who are new to an acute hospital ward are introduced to staff and the environment, including rest facilities and access to relevant patient records?

- Is there a mechanism to allow for shared learning and reflection between care providers involved in caring for patients at risk of self-harm?
- Is there a process to promote respectful and kind interactions and communication between the staff at different healthcare providers?

These further prompts are for healthcare providers to consider how they can support staff whilst continuously observing a patient at risk of self-harm:

- Are there arrangements in place to provide appropriate support for all staff providing this intervention?
- Are staff being regularly rotated so that they are not undertaking continuous observation for more than 2 hours in line with national guidance?
- Are staff having adequate breaks, with ready access to water and food?
- Are staff supported to speak with or engage in an activity with the patient where appropriate?

1. Background and context

1.1 Introduction

1.1.1 The aim of this report is to help improve the care of adult patients who are at risk of self-harm and are being continuously observed in an acute hospital ward setting. This section provides background information about self-harm and the care of people who have self-harmed.

1.2 What is self-harm?

1.2.1 The National Institute for Health and Care Excellence (2022a) defines self-harm as 'Intentional self-poisoning or injury irrespective of the apparent purpose of the act'. Self-harm is a symptom of a wide range of mental health problems, as well as being associated with many adverse social circumstances. Most self-harm injuries are caused by people cutting themselves and it is more common among those aged between 15 and 24 years (Office for Health Improvement and Disparities, n.d.).

1.3 How common is self-harm?

1.3.1 Self-harm is one of the commonest reasons for people going to an acute hospital. On and between 1 April 2021 and 31 March 2022, 93,895 people were admitted to hospital as an emergency due to self-harm in England (Office for Health Improvement and Disparities, n.d.). The actual number of people who self-harm will be much greater than this as only a minority will go to hospital (Office for Health Improvement and Disparities, 2023).

1.3.2 For some people, self-harm is a one-off event, but repetition is also common, with 20% of people repeating self-harm within a year. People who have self-harmed are at greatly increased risk of suicide, with a 30 to 50-fold increase in risk in the year after they have been treated in hospital (National Institute for Health and Care Excellence, 2000).

1.4 How are people who have self-harmed cared for in an acute hospital?

1.4.1 There is national guidance that covers the assessment, care and prevention of recurrence for children, young people and adults who have self-harmed. It applies to all sectors that work with people who have self-harmed (National Institute for Health and Care Excellence, 2022a).

1.4.2 When a person is admitted to an acute hospital following an episode of self-harm, this guidance states that their care should include:

- Referral to a liaison psychiatry service (or an equivalent specialist mental health professional) for an assessment of the person's needs.
- A joint decision between mental health and acute hospital staff about the need for observation, and ensuring that it is:
 - 'by appropriately skilled and trained healthcare staff
 - with the informed consent of the person or within an appropriate legal framework
 - reviewed regularly'.

1.4.3 If a person attends health or care services for frequent episodes of self-harm, or if treatment has not been effective, the guidance states that a multidisciplinary review should be carried out. This should include the person and those involved in their care and support, and others who may need to be involved, to agree how the person should be cared for. This should be documented in a 'care plan' which

should be written with and agreed by the person who self-harms (National Institute for Health and Care Excellence, 2022a). The care plan should describe the care or treatments to be provided along with their associated goals.

1.4.4 The guidance highlights a number of considerations to help a person be safer after they have self-harmed. These include:

- ensuring continuity of care, whenever possible, in the staff caring for the person
- ensuring that the care plans of people who have self-harmed can be accessed by all professionals and practitioners involved in their care
- assessing the safety of the person's environment
- considering removing items that may be used to self-harm and involving the person who has self-harmed in this decision.

1.5 What is continuous observation?

1.5.1 This report uses the term 'continuous observation' to describe the clinical intervention of continuously engaging with and observing a patient to reduce their risk of self-harm. Observation may be carried out by one or more staff members. The investigation found that other terms can be used to describe this intervention such as 'enhanced', 'specialist', 'specialling', 'constant', 'close' observation, 'one-to-one' or 'two-to-one' observation.

1.5.2 The National Institute for Health and Care Excellence (2015) defines two levels of continuous observation. The first level involves keeping a patient within eyesight or at arm's length of a nurse. The second level is for those at highest risk of harming themselves or others and involves the patient being kept within eyesight of two or three staff members and at arm's length of at least one staff member.

1.5.3 National guidance states that healthcare organisations should 'Ensure that an individual staff member does not undertake a continuous period of observation ... for longer than 2 hours. If observation is needed for longer than 2 hours, ensure the staff member has regular breaks' (National Institute for Health and Care Excellence, 2015).

1.5.4 Continuous observation involves therapeutically engaging with the patient. This means making efforts to develop rapport and trust with the patient to inform assessment of their mental state, risk assessment, decision making and to promote beneficial change in the patient.

1.6 What skills, training and supervision do staff need to carry out continuous observation of a person who has self-harmed or is at risk of doing so?

1.6.1 National guidance on caring for a person who has self-harmed says that observation 'should be seen as an opportunity for active engagement as well as sensitive supervision' (National Institute for Health and Care Excellence, 2022a). This guidance states that training for staff caring for people at risk of self-harm should be provided on a regular and ongoing basis at a level appropriate to the responsibility of the staff member (National Institute for Health and Care Excellence, 2022a). Training should include:

- exploring staff attitudes, values, beliefs and biases
- treating and managing episodes of self-harm, including using active listening skills to defuse the situation and avert self-harm
- being culturally competent through respecting and appreciating the cultural contexts of people's lives
- education about the underlying factors, triggers or motives that may lead people to self-harm
- assessing the needs and safety of the person who has self-harmed (relevant to their role and environment).

Furthermore, if staff are involved in 'observing people who have self-harmed', the guidance says these staff should be trained in 'therapeutic observation methods, including engagement and rapport building'.

1.6.2 National guidance makes clear that staff who work with people who self-harm should have the opportunity for regular, high-quality formal supervision from senior staff with relevant skills, training and experience. Supervision should, among other things, focus on skill development and reflection on their practice (National Institute for Health and Care Excellence, 2022a).

1.6.3 There is a national self-harm and suicide prevention competence framework for adults and older adults which includes competencies for staff to carrying out observation (including continuous observation) (National Collaborating Centre for Mental Health, 2018a,b). The framework, commissioned by Health Education England, was developed to be widely applicable including to clinical staff, the public, non-clinical staff and organisations working with people at risk of self-harm and suicide. Deciding which of the competencies apply to the various staff groups,

employers and professional bodies is left for local agreement. The framework also describes the organisational requirements such as training and supervision (National Collaborating Centre for Mental Health, 2018a).

1.7 What does it mean when a person is detained?

1.7.1 The Mental Health Act (MHA) is the legal framework which covers the assessment, treatment and rights of people with mental disorder (Mental Health Act 1983). People kept in hospital (detained) under the MHA need urgent assessment or treatment for mental disorder and may have been assessed to be at risk of harm to themselves or others. If criteria are met, a person may be detained against their wishes, or because they are judged to be unable to make that decision. A code of practice sets out how the MHA should be implemented in practice (Department of Health, 2015), supplemented by case law as it emerges. The MHA has different parts and sections for different circumstances, guiding treatment for mental disorder in different healthcare settings.

1.7.2 Most people at risk of self-harm being continuously observed will be detained under the MHA. This means that the continuous observation is not voluntary.

WARNING: section 2 and 3 of this report contain details of a patient self-harming.

2. The reference event

The investigation used the following patient safety event, referred to as ‘the reference event’, to explore the clinical intervention of continuous in reducing the risk of patients self-harming while being cared for in an acute hospital ward. The time frame explored by the investigation was from when Emily-May was admitted to the acute hospital up until she first self-harmed. The mental health hospital staff told the investigation that Emily-May was a patient at high-risk of self-harm and that this had often proved difficult to manage.

Emily-May’s story

2.1 Emily-May was staying in a residential mental health hospital (MHH), where she was detained under the Mental Health Act. She had been moved to this MHH 18 days previously because it was nearer to her family home.

2.2 Following a life-threatening self-harm event, Emily-May was taken, under sedation (medication-induced sleep), by air ambulance to the nearest hospital equipped to take people with major trauma. Two MHH staff went to the hospital by car, taking with them Emily-May's mental health records, including her care plan.

2.3 At the hospital, Emily-May had surgery to repair her wounds. Whilst under sedation, she was moved from the operating theatre to the intensive care unit (ICU).

2.4 Sedation was discontinued the following day, allowing Emily-May to gradually wake up. As Emily-May was not yet fully alert and mobile, just one member of MHH staff was allocated to be with Emily-May, including continuously observing her (see 1.5). As part of these observations, staff were to ensure that Emily-May was 'within eyesight' and that her neck, face and hands were visible at all times to quickly identify any attempt to self-harm.

2.5 Later that day, Emily-May was moved from the ICU to the high dependency unit (HDU). The HDU is a ward for people who need more intensive monitoring and treatment than is possible on a general ward but slightly less than that given in intensive care. The ratio of nurses to patients is lower than in intensive care but higher than a general ward. Emily-May continued to be observed by one member of staff from the MHH. Emily-May was in a four-bedded bay along with three other patients. She continued to have various tubes and equipment attached to her for monitoring and treatment.

2.6 The following day, the number of staff assigned from the MHH to continuously observe Emily-May was increased to two. This was because Emily-May had been assessed to be at significant and high risk of her self-harming and/or leaving the hospital. At one point in the morning, a member of staff from the MHH asked Emily-May to move the blanket away from her face so they could see it. Later in the day, Emily-May became 'agitated' when a nasogastric (NG) tube (a fine tube that is passed through a person's nose, down the back of the throat and into their stomach) was placed. She wanted to remove the NG tube and it was documented: 'Emily[-May] needs a lot of reassurance, explanation of who people are and what is going on due to her fragile psychological state.'

2.7 By the end of that day, Emily-May had been assessed as physically well enough to be cared for on a general ward. However, she remained in the HDU because there was no appropriate ward bed available.

2.8 During the evening, when two staff from the MHH were with Emily-May, she became distressed during nutrition being given through her NG tube. An HDU nurse stayed with Emily-May for approximately 1 hour listening to her concerns and providing support. This nurse documented that Emily-May had described 'her frustration of seeing lots of different people looking after her ... and no-one taking the time to talk and be more personable'.

2.9 Later, while the hospital nurse was away from the bedspace, Emily-May asked a member of the MHH staff for a pen, and was seen to write on some tissue paper. Emily-May returned the pen to this member of staff and placed the note under her pillow, not wishing to share what she had written. Emily-May appeared to go to sleep while being continuously observed within eyesight by the two members of staff from the MHH.

2.10 Written evidence from the MHH staff observing Emily-May states that she attempted to cover her face using the bedcover although she had been told that staff needed to see her face, neck and hands. According to this evidence, Emily-May declined to keep her hands visible, explaining that she was cold. However, she agreed to move the bedcover away from her face. Emily-May was described as lying with her back to the two MHH staff, who were both sitting on the same side of the bed. Towards midnight, the MHH staff said that Emily-May appeared to be 'starting to sleep', indicated by her breathing pattern. They stated that 'the room was dark' so it was 'difficult to observe movement in her [Emily-May's] body and face'.

2.11 At about midnight the MHH staff observed that 'the sound of her [Emily-May's] breath was heard loudly'. One of the MHH staff asked Emily-May if she was 'OK' but did not get a response. They used the torch on their mobile phone to look more closely at Emily-May and noticed she had in her hands an object with blood on and that she was bleeding from her neck. The MHH staff realised that Emily-May had self-harmed and alerted the HDU staff. Emily-May was treated for her significant injury and later transferred to an operating theatre to repair her neck wound.

Emily-May remained in the HDU at the acute hospital for a further 7 days, during which time she self-harmed again. Emily-May was discharged from the acute hospital to another MHH.

3. Analysis and findings - the reference event

This section details the findings from the reference event. The investigation considered the factors which influenced Emily-May's care from the time she was admitted to the acute hospital up until she first self-harmed there.

The analysis and findings are explored within two themes: collaborative working to reduce the risk of Emily-May self-harming, and the continuous observation of Emily-May.

3.1 Collaborative working to reduce the risk of Emily-May self-harming in the acute hospital

3.1.1 At the time of her transfer to the acute hospital Emily-May had been at the MHH for 18 days so staff were still getting to know her. After she went into the acute hospital, Emily-May's mental healthcare continued to be provided by MHH staff. Emily-May's care plan stated that she was to be continuously observed within eyesight by two members of staff at all times. Emily-May's care plan was informed by a risk assessment, undertaken by staff from the MHH before her transfer to the acute hospital. It identified her to be at 'significantly high risk of self-harm' and a 'change of environment' was listed as one of her triggers.

3.1.2 The MHH staff implementing this care plan were registered nurses (RNs) specialising in mental health (RNs (Mental Health)) or adult physical health (RNs (Adult)) and some were healthcare support workers (HCSWs) not registered in either mental health or physical health nursing. The majority of staff were internationally recruited and many had been living and working in England for a few years or less.

3.1.3 From discussions with the MHH director and staff, the investigation found that the focus of continuous observation when Emily-May was in the acute hospital was to prevent her leaving and/or self-harming.

3.1.4 Although managing the risk of self-harm was the responsibility of the MHH staff, the acute hospital staff caring for Emily-May were also involved in mitigating this risk because they were interacting with her. However, based on the evidence gathered, it did not appear that there was a collaborative discussion about her level of risk of self-harm, and how both teams could best work together to respond to that risk on a shift-by-shift basis. From the evidence, it appeared that beyond sending Emily-May's MHH care records, the MHH and acute hospital teams worked 'in silos' (separately) in relation to minimising her risk of self-harm.

3.1.5 An example of the importance of collaboration between the two teams is illustrated by evidence about Emily-May's possessions that only came to light after Emily-May had self-harmed in the acute hospital. A search of Emily-May's washbag, following the self-harm event in the acute hospital, revealed several metal objects similar to those that she was thought to have used to cut her neck. Both the MHH and acute hospital staff assumed that the other had checked Emily-May's belongings for potentially hazardous objects.

3.1.6 The MHH director said that as the MHH was a rehabilitation facility and acute hospital admissions were not usual or expected. Reflecting this, HCSWs interviewed said that they had no prior knowledge or briefing about the scenario that they found themselves in with Emily-May at the acute hospital.

3.1.7 Staff from both the MHH and acute hospital told the investigation that sharing Emily-May's care was challenging for a number of reasons. The MHH HCSWs interviewed told the investigation that they were anxious about going to the acute hospital, which had an entirely different focus of care and was a very different physical environment than they were used to working in. They also felt awkward in a space where clinical colleagues were caring for patients who were physically very sick. They did not feel they could move furniture or assume any autonomy in the environment because it was not their hospital or ward.

3.1.8 When talking about the MHH HCSWs, one of the acute hospital doctors said: "I am not sure that the mental health staff were particularly confident caring for her mental health on a high dependency medical unit." The investigation asked the MHH HCSWs what would have helped them. They said introductions to the staff at the beginning of their shift and agreement about each other's roles and potential risks that may occur during that shift would have been helpful. One said that it would have been helpful to understand all the machines as they found the noises they were making "daunting". From discussions with the investigation it was apparent that some MHH HCSWs were not familiar with, or had any experience of, providing care in the acute hospital setting.

3.1.9 The MHH HCSWs interviewed described variation in whether they were provided with an orientation to the ward area at the hospital. Several HCSWs said they had to explain to the acute hospital staff why they were there, and said that at times they felt unwelcome.

3.1.10 Acute hospital staff shared experiences of having cared for other patients who had self-harmed. They described being able to apply some of the knowledge they had acquired to Emily-May's care, although there were no formal procedures in

place. They understood that each patient, and their triggers, risks and needs, differed and said they would have liked clearer guidance from the MHH on how best to support Emily-May. Staff described the care plan provided by the MHH as an “outline” and that they felt “stuck and isolated”. Acute hospital staff sought support from their liaison psychiatry team, but were told it would be better for Emily-May’s mental health team to guide and direct her care. It was not until after Emily-May self-harmed in the acute hospital that in-depth collaborative discussions took place to agree Emily-May’s mental healthcare. During consultation on the final report, the MHH said that co-ordination via the acute hospital liaison psychiatry service would have been helpful. The role of liaison psychiatry was not within the scope of the investigation, so was not explored.

3.2 Continuous observation of Emily-May

3.2.1 One of the key strategies relied on to reduce Emily-May’s risk of self-harm was continuous observation within eyesight by two people. The MHH director said that HCSWs were allocated to the acute hospital to carry out Emily-May’s continuous observation which mirrored the working arrangements at the MHH. To ensure continuity of care, the MHH director rostered HCSWs who had previously observed Emily-May and were familiar with her care plan.

Engagement while observing Emily-May

3.2.2 The evidence gathered by the investigation indicated that MHH staff understood their role was to “watch” Emily-May for attempts to harm herself. The staff’s understanding mirrored the MHH director’s view that they were there to make sure that Emily-May did not self-harm. There was little evidence of therapeutic engagement from interviews or documentation in Emily-May’s care records. Some staff described engagement with Emily-May as being challenging at times. Reflecting this, one staff member said that if you “were friendly and Emily[-May] liked you” then she would talk, otherwise she was “quiet and will stay away”. For other staff these challenges did not appear to exist and they spoke about the value of having shared cultural references, such as age, hobbies, and place of growing up, that provided ready-made topics of conversation.

3.2.3 Documentation in the acute hospital nursing records provided further evidence that the focus of the MHH HCSWs was on watching rather than engaging with Emily-May. For example, there is an entry by the acute hospital nursing staff the night before Emily-May self-harmed stating that she became ‘upset’ because the MHH HCSW had not introduced themselves to her, nor ‘spoke to her all shift’. The

acute hospital nurse documented that they had comforted Emily-May so that she was able to settle to go to sleep. Therefore, on this occasion, it was acute hospital staff making efforts to engage with Emily-May rather than the MHH HCSWs.

3.2.4 Continuous observation can be intrusive and distressing for patients (Barnicot et al, 2017; Chu, 2016; Reen et al, 2020). Emily-May's care plan reflects this: it documents that when she was admitted to hospital she had said "I don't want many people in my room" and "I don't want someone to sit down and be looking in my face". National guidance states that staff can anticipate that restricting a person's liberty and freedom of movement can trigger violence and aggression (National Institute for Health and Care Excellence, 2015). Staff involved in continuous observation need, therefore, to have strategies to facilitate patient engagement to mitigate this risk.

3.2.5 When asked what they understood continuous observation to mean in practice, some MHH HCSWs said engaging and interacting with the patient. Others said, it meant watching, and if necessary, physically intervening to prevent the patient from absconding (leaving the hospital) or harming themselves.

3.2.6 Emily-May told the investigation that she particularly did not like being observed by staff who did not speak fluent English and/or did not interact with her. She said that she did not feel she had a relationship with them and did not feel they "cared about her". From her perspective, being observed in this way felt like being watched by "strangers". Emily-May said that she enjoyed "ordinary conversation, having a cup of tea and chatting". She wanted people to talk to her as "a human". One of the MHH HCSWs reflected on their relationship with Emily-May and said that it was a good relationship which was easier to achieve because of the similarity in their age and shared knowledge of the local area and social context.

3.2.7 The investigation found that Emily-May did not engage with some MHH HCSW because there were limited attempts to try to engage or interact with her, rather than due to the HCSWs background. The nurses from the acute hospital told the investigation, and recorded in the hospital records, that they witnessed some MHH HCSWs not engaging with Emily-May. However, it is not clear whether these particular staff members had given up after previous repeated attempts to engage with Emily-May, or whether they had made limited attempts at engagement.

3.2.8 The investigation was told by several MHH HCSWs who had English as a first language that many of their overseas health professional colleagues struggled to 'connect' with patients because of language barriers and because "where they are from, they don't have none of this – self-harming – not to the extent that it is here".

Emily-May said that MHH HCSWs “sat at the end of the bed facing her” and this made her feel “very uncomfortable” as “most of the time [they are] just sat staring at you”. Further evidence of the value and importance of engaging rather than simply watching was provided by several of the acute hospital staff. They said that Emily-May “needed engagement, she needed a very structured day and consistency in approach to her care which is difficult with care [staff] rotating in and out”. Another said that the hospital staff “treating her like a human who has hobbies and interests she really engaged with”. One nurse described an MHH HCSW who “had talked to Emily[-May]... engaged with her and would do things with her and talk to her whereas others would just sit”.

3.2.9 Overall, the investigation found that the understanding of the task of observing Emily-May varied between staff members. In addition, the ability to successfully engage was influenced by culture, age and language.

Training and competencies for continuous observation

3.2.10 The MHH director said that all the HCSWs caring for Emily-May (including those who observed Emily-May on the night she self-harmed in hospital) had completed training on self-harm, engagement and observation. They said there was not a competency assessment in place at that time, but the MHU director said they had introduced this as a result of the learning from this incident.

3.2.11 The HCSWs interviewed reflected on the training they received by the MHH. One said that the training had not included engaging with patients and that they had only learned about this by experience. Another said that irrespective of training it was helpful to shadow more experienced staff to learn how to apply communication skills in practice. They said it was variable whether staff had the opportunity to do this.

3.2.12 There are national challenges with the recruitment of staff for roles in mental health settings. One of the HCSWs who observed Emily-May at the hospital were in their 6-month induction period with the MHH. This meant that the task of observation was sometimes provided by staff with limited experience, in an unfamiliar environment, without an RN (Mental Health) on hand to support them. The MHH director said that the HCSWs found it difficult to work in the hospital environment because it was such a different one from the MHH and Emily-May was such a vulnerable and potentially challenging patient to care for. One HCSW reported being particularly nervous as Emily-May had previously attacked her.

The acute hospital environment

3.2.13 Acute hospital environments, particularly intensive care and high dependency units (HDUs), create additional risks for patients at risk of self-harm. The staff from both the acute hospital and MHH told the investigation that risks arose from, for example, medical equipment, the ability to open windows, potential ligature points (points where something could be attached for the purposes of self-harm) and the availability of cutlery. Neither organisation had a process in place for occasions when a patient who was at risk of self-harm was admitted to hospital.

3.2.14 One HCSW said that at the MHH the environmental risks had either been removed or, if that was not possible, staff were aware of them. In a new environment the risks were likely to be different, potentially leading to different, unpredictable, behaviours.

3.2.15 The space surrounding the bed in an intensive care unit or HDU contains equipment that may be used during a patient's care, such as monitoring equipment and electrical leads, as well as an area for clinical records. The investigation was told by hospital staff that they had 'significant concerns' about the difficulty in reducing the opportunities for Emily-May to self-harm in this environment. In the HDU where Emily-May self-harmed, she was in a 4-bedded bay. The night that Emily-May self-harmed, causing a significant injury, the two MHH HCSWs were observing Emily-May from one side of the bed. The investigation was told that this was due to equipment on the other side which could not be moved. The lighting was dimmed to help patients in the bay to sleep. Emily-May was lying in the foetal position with her face away from the HCSWs. When one of the HCSWs went to check on Emily-May because they had noted a change in her breathing, they used the torch on their mobile phone. The restricted physical space around the bedside limited where the HCSWs could sit to observe Emily-May. Their visual observation of Emily-May was further restricted by the subdued lighting.

3.2.16 Staff from the acute hospital told the investigation that they had thought about how the intensive and high dependency ward areas could be designed in the future to minimise the risk of self-harm. Meanwhile, an environmental checklist was being developed to reduce the potential for injury to patients at risk of self-harm.

Vigilance

3.2.17 In the MHH, HCSWs carried out observation for 2-hour periods, in line with national and local guidance. In the acute hospital, HCSWs were observing Emily-May for 12-hour periods, including a 1-hour break. The MHH director said that there

was no policy about how breaks were taken. The hour break could be taken all at once or could be split, depending on staff preference and local needs. Reflecting on this, the director said that with “hindsight there needed to be more [breaks]”.

3.2.18 Both the MHH HCSWs and the hospital staff raised concerns about the safety risks associated with such long observation periods. In the week after Emily-May self-harmed in hospital, one HCSW documented concerns about staff being ‘exhausted’ and starting to ‘rest their eyes’ while doing observations. They explained that the shifts felt ‘really long’ and were ‘made longer by transport ... issues’. In addition, hospital nurses reported seeing HCSWs drifting off to sleep at night.

3.2.19 In addition to the rostered shift, staff needed to travel the approximate 70-minute car journey from the MHH to the acute hospital. Taxis were arranged to take HCSWs there. The HCSWs were rostered to work 12.5-hour shifts, which included 30 minutes for handover between the incoming and outgoing staff. Long working hours and inadequate rest breaks are factors that put staff at risk of fatigue, especially staff who work overnight (see section 4.3.7).

3.3 Summary

3.3.1 The findings from the reference event investigation showed that there was very limited collaborative working to reduce the risk of Emily-May self-harming when she was transferred from the MHH to an acute hospital. Although Emily-May was continuously observed within eyesight there was a lack of therapeutic engagement with her. The MHH staff carrying out continuous observation within eyesight did not have an assessment of their competencies to ensure they had the skills and abilities to carry out this intervention. Furthermore, continuous observation is a tiring intervention that is challenging to carry out for prolonged periods. Additional safety risks arose from the intensive care and high dependency ward environment. These issues are explored further in section 4.

4. Analysis and findings – the wider investigation

This section provides an overview of the findings from the wider investigation. The investigation explored the challenges to providing effective continuous observation of adult patients at risk of self-harm. The investigation has focused on patients being observed in an acute hospital setting. Many of the staff that the investigation spoke with said that the investigation’s findings would also be applicable to the

mental health hospital setting. The appendix provides information about the decision to go ahead with the wider investigation, the evidence gathered and how it was analysed, and the subject matter advisors involved.

The investigation found variation within and across healthcare settings as to why, when, how, and by whom continuous observation was carried out. There was also limited evidence of the effectiveness of observation and no consistency in patients' experiences of this clinical intervention. In addition, the investigation found that the growing financial pressures and staff shortages within healthcare have resulted in the intervention of continuous observation being increasingly scrutinised at ward, healthcare provider and national levels.

This section describes the investigation's findings and associated evidence under the following headings:

- What is continuous observation?
- What competencies do staff need for continuous observation?
- What helps and what hinders continuous observation?

4.1 What is continuous observation?

This section explores what is meant by the term continuous observation, the purpose of this intervention and which staff carry it out. Consideration is then given to the evidence base supporting its use.

4.1.1 The investigation found variation in the terms used to describe continuous observation, its purpose, and which staff carried out this clinical intervention for patients at risk of self-harm.

Terms used

4.1.2 Staff interviewed by the investigation referred to continuous observation in many ways including 'close observation', 'supportive observation', 'constant observation', 'one to one', 'two to one' and so on (where the first number refers to how many staff are observing the patient), and 'specialling'. The investigation found that staff and local policies used these terms interchangeably: "I could be a temporary member of staff at two different trusts on different days and the language and terminology would be different." Similarly, national guidance uses different terms for practices that encompass continuous observation, such as 'enhanced observation' (Department of Health, 2015) and 'clinical observation' (National Institute for Health and Care Excellence, 2022a) (see 1.5).

4.1.3 Although different terms for 'continuous observation' were used interchangeably, there was not a shared understanding of what it meant in practice and its purpose. Several staff said that the word 'observation' in any terminology to describe this intervention is not helpful, as "it doesn't convey what we are doing". For example, there were differences in understanding between physical and mental health staff of the term 'clinical observation', which reflected the different focuses of their work. The investigation was told during interviews that to a physical health nurse the term clinical observation suggests monitoring physical health measures such as heart rate, temperature and blood pressure. To a mental health nurse it suggests assessment of mental state through monitoring a patient's emotions, thoughts and behaviours.

Purpose of continuous observation

4.1.4 The investigation was told of different purposes of continuous observation. The two main purposes were:

- safety focused (reducing the risk of harm both to the patient and others)
- supporting the patient in whatever way seemed most appropriate.

4.1.5 This aligns with the Mental Health Act code of practice, which states:

'There may be times when enhanced levels of observation are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. Enhanced observation is a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively (for example, through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc).' (Department of Health, 2015)

4.1.6 Staff and subject matter advisors told the investigation that some healthcare providers gained false assurance from a patient being on continuous observation, believing that this intervention eliminated the risk of self-harm. Whereas, the staff and subject matter advisors said, at best it can only reduce this risk and allow staff to quickly call for help in the event of a patient self-harming. At worst it can increase a patient's risk of self-harm.

4.1.7 Staff and subject matter advisors told the investigation that there is no reliable way of predicting when a patient may self-harm, meaning that patients can be continuously observed for long periods of time. Furthermore, they said that in

practice reducing the risk of a patient self-harming was often about preventing the patient leaving the ward, making continuous observation “custodial in a lot of cases rather than anything else”.

4.1.8 In relation to the purpose of supporting the patient, those interviewed said that it was important for continuous observation to be patient-centred, which meant engaging the patient, providing reassurance, and building trust and rapport. As a subject matter advisor said: “It’s not a matter of watching somebody and stopping somebody from doing something.” However, some staff appeared to view this ‘engagement’ as a “higher level” of continuous observation which may contribute to the mismatch between how observation is described in policies and guidance and what is sometimes seen in practice.

4.1.9 The investigation was also told that the purpose of continuous observation was “dependent on the person being observed”, “their individual needs” and “whether [it was being carried out] in a physical or mental health setting”.

4.1.10 In addition, mental health staff and subject matter advisors said that it was the therapeutic effect of support and engagement that reduced the risk of a patient self-harming and kept the patient safe, and not the custodial element of observation. Several staff and mental health subject matter advisors questioned whether this level of therapeutic engagement was possible in the acute hospital environment where the priority was to treat the patient’s physical health condition and transfer them back to mental health services for their mental healthcare as quickly as possible.

Staff carrying out continuous observation

4.1.11 There is variation in the type of staff allocated to undertake continuous observation of patients in both mental health and acute hospital settings. Staff groups carrying out this intervention include registered nurses specialising in mental health (RNs (Mental Health)), learning disability (RNLDs), adult physical health (RNs (Adult)), and healthcare support workers (HCSWs) with both mental health and physical health experience.

4.1.12 Staff undertaking continuous observation can be substantive (‘permanent’ staff) or temporary; temporary staff might be employed for a single shift or for a longer period of time. Those interviewed highlighted the importance of staff continuity to build trust and rapport with the patient.

4.1.13 The investigation was told that it was common to:

- rely on temporary staff because of national staff shortages
- use HCSWs because of the national shortage of qualified nurses and the financial pressures healthcare providers face.

There are national programmes of work underway to increase the number of RNs (Mental Health) and HCSWs to address these workforce shortages (Health Education England, 2022; NHS England, 2024).

4.1.14 The investigation heard different opinions about the knowledge, skills and experience that staff needed to continually observe a patient at risk of self-harm. Some said that it was “very patient dependent”, with some patients needing a RN (Mental Health) and others a HCSW.

4.1.15 The investigation was told that the requirement for continuous observation was typically based on the advice of a mental health professional, either after the patient had been assessed at an acute hospital, or after transfer from a mental health hospital. Where the acute hospital was funding the staff undertaking the observation, hospital staff made a decision about which staff group would be suitable. If a dedicated RN (Mental Health) was requested but unavailable, then the continuous observation would need to be carried out by a RN (Adult) or HCSW.

Evidence base for continuous observation

4.1.16 Staff and subject matter advisors told the investigation that there was not a robust evidence base to support the use of continuous observation to reduce the risk patients harming themselves or others. In addition, they said that many patients found the practice intrusive and for some it increased their risk of harm. Without an evidence base, staff and subject matter advisors questioned the continued use of continuous observation. They cited the findings of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) to support these concerns. The 2024 NCISH report sets out findings relating to people aged 10 and above who died by suicide while under the care of mental health services between 2011 and 2021 (National Confidential Inquiry into Suicide and Safety in Mental Health, 2024). During this decade, in England, 142 ‘mental health inpatients’ on ‘enhanced nursing observation’ (which includes continuous observation) died by suicide. Discussing the report, a representative from the NCISH told the investigation that although the nature of the study meant it could not be concluded from the results that high observation levels do not prevent suicide, they

did highlight that the current system of continuous observation is not working safely enough in mental health services. Comparable information is not available for acute hospital settings.

4.1.17 A systematic review of continuous observation of adults on mental health wards showed that this intervention is 'frequently' used 'to manage patients at risk of harming themselves or others' (Reen et al, 2020). The authors concluded that:

"Despite its widespread use, there is little evidence of the efficacy of the practice or of its impact on patients and nursing staff. Unnecessary use of this practice can be restrictive and distressing for all involved and can cause considerable strain on healthcare resources." (Reen et al, 2020)

This review also explored patients' experience of being continuously observed. Patients were more likely to report positive experiences when the staff 'interacted' with them, for example if they 'showed care and concern'. Patients also 'commonly report feelings of distress, anxiety, isolation and rebelliousness'. The reasons given for these negative feelings included feeling 'restricted', having 'little or no privacy' and 'very little interaction' with the staff observing them (Reen et al, 2020).

4.1.18 Other studies looking at continuous observation also found that patients perceive this intervention as intrusive (Barnicot et al, 2017) and disliked the sense of being passively observed (Deering et al, 2023). Patients valued times when staff made efforts to build rapport and a trusting relationship (Insua-Summerhays et al, 2018). Building on this, Chu's (2016) review of the literature concluded that 'patients (and especially those who are feeling suicidal) feel safer and more supported under observation when the observer is known to them and actively engages with them' during continuous observation.

4.1.19 Reflecting this evidence, an expert with previous experience of being continuously observed in both mental health and acute hospital settings following self-harm told the investigation that the key ingredients were "kindness, humanity [and] engagement". They described that they were in hospital at the time of the World Cup, and had not seen their sons for months, but "knew that they would be watching [the World Cup]. Therefore, the person observing who was willing to talk about the games and to share something of his perspective of football, didn't know that what he was doing, was keeping me close to my children ... it was an extraordinary gift on his part ... it was profoundly moving". They reported looking forward to them being the observer "because I knew then I was a bit closer to the

boys and I couldn't get closer to them in physical terms. I couldn't get close to them emotionally but I could love them through thinking of them watching football and how that went for them ... I still think of that person and how grateful I am to him”.

4.1.20 The investigation made contact with researchers who were identifying mental health practices which patients or carers with ‘lived experience of mental health challenges’ thought were of little value and/or potentially harmful. Continuous observation of patients in hospital was one of the most commonly identified practices (Shah, 2023). The researchers are undertaking further work to explore whether the intervention is one which should be reduced or even stopped.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/025:

HSSIB recommends that the Department of Health and Social Care, through the National Institute for Health and Care Research (NIHR), assesses the priority, feasibility and impact of future research into the efficacy and acceptability of continuous observation of mentally unwell adult patients. The research should take into account different care settings in which continuous observation may take place (including physical and mental health hospitals) and the different staff groups involved in carrying it out.

4.2 What competencies do staff need to carry out continuous observation?

This section considers relevant guidance and standards, then explores the training and competencies that staff need to carry out continuous observation. Competence is the combination of knowledge, skills and behaviours that a person has and their ability to apply them successfully.

4.2.1 Subject matter advisors agreed that continuous observation was a “skilled activity”, but that this was often not acknowledged in practice with the intervention often given to HCSWs, which meant that “the least qualified and knowledgeable staff are caring for the most vulnerable and distressed”. The investigation found that there is limited national guidance or agreed standards about how continuous observation should be carried out, the training needed, and the competencies that staff require to do it.

Guidance and standards

4.2.2 The investigation observed that the lack of national guidance and standards has resulted in considerable variation in local policies on observation, including continuous observation. The investigation found that these local policies were informed by a variety of national documents. The most commonly cited were:

- the Mental Health Act 1983, its code of practice (Department of Health, 2015), and other legislation such as the Mental Capacity Act 2005
- National Institute for Health and Care Excellence guidance on self-harm (National Institute for Health and Care Excellence, 2022a) and violence and aggression (National Institute for Health and Care Excellence, 2015).

4.2.3 This variation was demonstrated by a review by Ashmore (2020) of 61 engagement and observation policies from mental health providers in England and Wales. The review found that the policies varied in clarity, quality, terminology and focused on observation rather than patient engagement. Additionally, the review found inconsistencies between providers as to who could initiate, undertake, increase, or stop observation. Regarding training, most policies 'emphasised the need' for this, but only two thirds of these policies described what the training should consist of. Ashmore (2020) recommended that there was a need for evidence-based national standards that organisations were required to comply with.

4.2.4 Reen et al (2020) reported that continuous observation of adults on mental health wards was a 'highly variable practice, and how and when the practice is conducted is dependent on the setting, the staff and the patient'. Guidelines 'on exactly what should happen' during continuous observation were 'not well defined'. The research authors suggested 'standardizing parts of the practice to reduce variability'.

4.2.5 Reflecting Reen et al (2020) and Ashmore's (2020) findings, subject matter advisors told the investigation that "a national steer would be helpful".

4.2.6 Although the competencies needed for observation (including continuous observation) have not been defined at a national level, subject matter advisors told the investigation that RNs (Mental Health) had the competencies needed. This is because the competencies were covered by the training requirements for RNs' (Mental Health) professional registration. There was no such agreement that these competencies would have been gained by RN (Adult) training. Furthermore, there was particular concern about HCSWs, where there was no certainty about the training they had received regarding mental health and specifically continuous observation. In addition, without professional registration of this staff group, there is no national oversight and assurance about staff competence and performance.

4.2.7 A review by NHS Resolution, 'Learning from suicide-related claims' (Oates, 2018), recommended that heads of nursing in mental health trusts ensured that all staff (including bank staff, student nurses and HCSWs) 'should not be assigned the job of conducting observations on a ward or as an escort until they have been assessed on that ward as being competent in this skill'. Further, it recommended that agency staff need to have been trained before they are expected to complete observations. The investigation recognises that this may be challenging in practice given that staff are sometimes required at short notice.

4.2.8 A representative from NHS England told the investigation that in 2018 the Mental Health Nurse Leaders and Directors Forum had approved a national policy template on supportive observation and engagement (which includes continuous observation). This was 'an intended starting point for mental health service providers to develop their own policies in line with local need'. However, those interviewed were not aware of this document and it was not referenced in any of the observation policies reviewed by the investigation.

4.2.9 The investigation spoke with representatives from the Mental Health and Learning Disability Nurse Directors Forum. They are working collaboratively with experts by experience (people with lived experience of using mental health and/or learning disability services) to meet the gap in guidance and to agree the competencies required for observation. Although this National Therapeutic Observation Project is focused on observation in the mental health setting, the learning is likely to have relevance to the acute hospital setting. The representatives told the investigation that best practice guidance is due to be published in 2024.

Training and competencies for observation

4.2.10 Staff and subject matter advisors told the investigation that "stigma" and "prejudice" still exists towards people with mental health problems, particularly those who self-harm. As one nurse working in an acute hospital said: "... people tend to avoid speaking to the patient, which is the worst thing you can do because you're not going to build trust."

4.2.11 The investigation also spoke with an expert who had experience of mental health problems who echoed the impact of stigma. They said that "it is very difficult to talk about [self-harming] and it's particularly difficult for generalist staff". The expert spoke of "hostility between the clinical team and the person themselves because [staff think] just snap out of it. Why don't you pull yourself together or here we go again, this is ridiculous".

4.2.12 The investigation observed that this stigma and prejudice has implications for the training of staff, including those who may be involved in continuous observation. The investigation heard that training varied between providers in terms of how it was delivered, its scope and content. In addition, there was variation in the level of supervision staff received and whether there was any competency assessment of their practice before they were expected to carry out this intervention.

4.2.13 There is no national guidance on the training requirements and competencies needed for observation and the national self-harm guidance available at the time of the reference event did not mention continuous observation (National Institute for Health and Care Excellence, 2004; 2011). National guidance on managing patients displaying violent or aggressive behaviour does include continuous observation as an intervention but does not give detailed information on the training needed (National Institute for Health and Care Excellence, 2015). This means that it is left to individual healthcare providers to decide the training requirement.

4.2.14 Updated self-harm guidance by the National Institute for Health and Care Excellence (2022a) details the training and supervision needed for staff who work with people who self-harm, including staff who carry out observation. However, the guidance does not specify the competencies required as this is the remit of training organisations, professional, regulatory and academic bodies. These training requirements include 'engagement and rapport building'. To accompany its guidance, the National Institute for Health and Care Excellence produces associated 'quality statements'. These statements can be used by bodies who are responsible for seeking assurance about the quality of care and resources in place to achieve this. Although the guidance on self-harm contains details of training, there is no associated quality statement about the training aspect.

4.2.15 Several subject matter advisors mentioned the self-harm and suicide prevention competence framework for adults and older adults commissioned by (what was formerly) Health Education England (National Collaborating Centre for Mental Health, 2018a). This framework includes competencies for staff carrying out 'observation of people at risk of self-harm and suicide' and 'organisational competencies' such as:

- 'An ability to ensure that observations are conducted by individuals who have had training ... and who understand their role and responsibilities'

- ‘An ability to ensure that practitioners conducting observations are supported and supervised, in line with their level of experience’ (National Collaborating Centre for Mental Health, 2018b).

However, it is not clear which staff group the observation competencies are intended for as they are described as an ‘intervention skill for mental health professionals’ but the document adds that these competencies ‘might also be applicable to other health care professionals with responsibility for observation, such as ... acute general hospital staff’.

4.2.16 Another staff competency that many of those interviewed said was needed for effective continuous observation was proficiency in the English language. Those commenting on this said proficiency was needed to be able to document and communicate effectively and build rapport with patients. Related to this, the investigation heard from staff and subject matter advisors about the potential risks posed by the recruitment of overseas health professionals if there was limited assurance about their proficiency in English and differing beliefs about self-harm and approaches to care.

4.2.17 National guidance recognises the importance of cultural competence, which includes ‘understanding of religious, racial, cultural, sex and gender identity, educational, and economic factors’ (National Institute for Health and Care Excellence 2022a, 2022b). Their guidance states that all training on working with people who have self-harmed should be culturally competent so that staff are able to recognise such factors and provide sensitive care.

4.2.18 Overall, evidence gathered by the investigation suggests that it would be helpful for there to be national guidance and standards along with a competency framework for staff undertaking continuous observation in different care settings including acute hospitals.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/026:

HSSIB recommends that NHS England working with relevant stakeholders, produces national guidance for staff undertaking continuous observation of mentally unwell adult patients, along with a training and competency framework to provide staff with the necessary skills for this intervention in different care settings (including physical and mental health hospitals).

Development of this guidance should include engagement with human factors principles to understand the complexities of the task of continuous observation and the environments in which it may take place.

4.3 What helps, and what hinders, continuous observation?

This section explores the factors, other than policies and guidance (see 4.2.2 to 4.2.9) and issues relating to staff skills, training, experience (see 4.2.10 to 4.2.17), that can influence the effectiveness of continuous observation of a patient at risk of self-harm.

Hospital environment

4.3.1 Staff and subject matter advisors told the investigation that the acute hospital environment, with its focus on physical health, has particular risks for those with mental health problems. They expressed concern that patients can sometimes experience delays in transfer from an acute hospital to a mental health ward because they are perceived to be in a 'safe place'; as one staff member said: "Risks in the acute hospital are not really recognised or appreciated."

4.3.2 In contrast with mental health hospital wards, acute hospital wards have many unsecured entrances and exits making it is easier for a patient to leave the ward. A subject matter advisor highlighted that patients at risk of self-harm will often leave the ward in order to be able to self-harm.

4.3.3 On an acute hospital ward, fixtures and fittings (such as coat hooks), along with medical devices and equipment, and even cutlery, may create opportunities for a patient to self-harm that do not exist in a mental health hospital. Those interviewed said it was important for the physical environment to be risk-assessed for individual patients. When identified risks could not be removed, this needed to be documented in the patient's care plan along with the measure required to mitigate these risks. One subject matter advisor said that "highly intrusive" continuous observation could often be avoided if the environment was designed in such a way as to reduce the risk of self-harm and suicide. They told the investigation about an acute hospital that had designed a specific room for patients with mental health problems and was including one such room in each ward as they were refurbished.

4.3.4 The investigation was told that, wherever possible, patients on continuous observation were placed in a side room. This was to provide some privacy and a safe space for the patient. In addition, staff said that caring for patients requiring this level of observation in a side room minimised the impact on other patients on the ward.

4.3.5 Staff and subject matter advisors said that acute hospital wards are often busy, stimulating, noisy, brightly lit and have limited space for moving about. They said that this environment was unhelpful for those with mental health problems. In addition, a consultant liaison psychiatrist stated that daily routines are often important to somebody struggling with mental health problems and that these can “go out the window” in an acute hospital. Echoing the impact of the environment, an acute hospital nurse said it was a “huge factor on a patient's journey and their experience”.

4.3.6 In another investigation HSSIB has explored [‘Keeping children and young people with mental health needs safe: the design of the paediatric ward’](#) (Health Services Safety Investigations Body, 2024a). While not focussed on adult patients, the findings in this investigation may have wider applicability.

Vigilance and fatigue

4.3.7 Vigilance describes a person’s ‘state of alertness, watchfulness and preparedness to attend to critical information that is not yet present’ (SKYbrary Aviation Safety, n.d.). Vigilance may be affected by factors including noise and fatigue. Vigilance has ‘long been recognised as difficult to sustain, at a constant level of performance, over a period of time’. It has been acknowledged that ‘humans are not well designed to remain stationary, monitoring and alert for long periods of time’ (Pickup et al, 2014). Of note, HSSIB is undertaking an investigation into [‘Fatigue risk in healthcare and its impact on patient safety’](#) (Health Services Safety Investigations Body, 2024b).

4.3.8 These findings are mirrored by Barnicot et al (2017) who explored patient and staff experiences of continuous observation. Their evidence showed that staff found it hard to sustain vigilance, which could be both ‘emotionally and physically draining’. In their research, ‘lapses’ in vigilance were linked to ‘staff growing tired, letting their guard down at night’, and carrying out continuous observation ‘for long periods’.

4.3.9 Research findings were echoed by staff and subject matter advisors. They told the investigation that carrying out continuous observation was “intense” and “tiring”. Emphasising the difficulty of continuous observation at night, one person

said: “It is just really hard to maintain that focus ... probably every 40 minutes or so I would need one of the other nurses to come in so I could then splash my face with cold water or have a coffee or something. It would take real effort to be able to do it [continuous observation] in a sustained way.”

4.3.10 The investigation was told that on mental health wards the staff carrying out continuous observation would change every 1 to 2 hours. In addition, the wider team was available for support, especially if a patient was “distressed and unpredictable”. In contrast, for a patient in an acute hospital, one member of staff may be carrying out observation over a 12-hour shift.

4.3.11 The National Institute for Health and Care Excellence (2015) guidance on managing violence and aggression states that individual staff should not undertake continuous observation for longer than 2 hours. On occasions when it is needed for a longer time, arrangements should be made for the staff member to have regular breaks. However, no similar information was contained within National Institute for Health and Care Excellence (2022a) guidance on self-harm. Overall, the investigation found that in order to create the conditions in which staff can best carry out continuous observations, consideration of human factors principles is needed to understand the complexities of this intervention and the environments in which it may take place. This is therefore included within the preceding safety recommendation.

Professional support

4.3.12 The investigation was told of a number of different ways that access to mental health professional support is provided in an acute hospital. These include liaison psychiatry services and dedicated mental health leads. Subject matter advisors highlighted the need to empower the physical healthcare staff by offering them “support to understand a patient’s needs [and] what they can and can’t do about that”.

Liaison psychiatry service

4.3.13 Liaison psychiatry services in acute hospitals ‘address the mental health needs of people being treated primarily for physical health problems and symptoms’ (Royal College of Psychiatrists, 2013). In England, liaison psychiatry services are typically commissioned, managed and delivered as part of mental health services rather than acute hospital services. This means these staff are employed by the mental health provider but are based in the acute hospital, where they work collaboratively with the physical healthcare staff.

4.3.14 Staff and subject matter advisors told the investigation of the importance of liaison psychiatry. They described the particular value of this service in assessing patients, liaising with mental health service providers, agreeing a plan of care, as well as providing ongoing mental health advice while patients are in the acute hospital. For patients newly admitted direct to the acute hospital (rather than transferred from a mental health hospital), a member of either the ward team or liaison psychiatry team would be the professional to recommend continuous observation when they deemed this appropriate for a patient at risk of self-harm.

4.3.15 The investigation was told by subject matter advisors that there was variation in the liaison service provision across acute hospitals. However, NHS England had committed to increasing the proportion of acute hospitals meeting a minimum mental health liaison service standard, 'working towards 100% coverage' after 2023/24 (NHS England, 2019). NHS England are monitoring progress against this objective through an annual survey. Furthermore, subject matter advisors said liaison services had experienced an ever-increasing workload, particularly since the COVID-19 pandemic, and that this was not always adequately resourced. As one nurse in an acute hospital said, "they're so, so busy and they're so stretched" and they "deal with the entirety of the hospital".

4.3.16 The Liaison Psychiatry Quality Network (also known as the Psychiatric Liaison Accreditation Network) shared the results of a survey that suggested that adults with a mental health need can be in the acute hospital for some time (personal communication pre-publication, 2023). Of the 21 services across England that responded, approximately a third reported at least one patient on a general hospital ward waiting more than 2 weeks to be admitted to a mental health bed within the last month, (about two thirds reported that this had occurred over a longer time period).

Mental health leads

4.3.17 The investigation spoke with several mental health professionals employed by an acute trust who described their function as being the "mental health lead". They said their role was both strategic and to support physical healthcare staff in caring for patients with mental health needs. Their role was in addition to the liaison psychiatry service, and they provided an interface between liaison psychiatry and physical health staff. Explaining the need for their role, the leads said there were differences between how mental and physical healthcare staff work. These differences included clinical language and philosophy of care. Reflecting this, one lead said that their role was about: "... capturing the spirit of something from a mental health point of view and translating it into a way that fits [with physical

health]. It's about how we help somebody to live with risk and tolerate risk rather than this idea that we can rule it out. I think that doesn't translate well to acute wards, acute hospitals. It's a really hard concept for folks to grasp. So it becomes much more about the task.”

Multi-agency working

4.3.18 Multi-agency working is when more than one healthcare provider is involved in providing care to a patient. These providers will usually need to liaise with each other to discuss and co-ordinate care arrangements. It is well recognised that there can be challenges in the co-ordination and collaboration required in this scenario (Millar et al, 2023). In the context of this investigation, there is a need for communication and collaboration about the plan of care when a patient is transferred from a mental health provider to an acute hospital. This is particularly relevant for patients at risk of self-harm and when continuous observation is being used to mitigate the risk. The investigation found that formal processes were not in place to anticipate and support effective collaborative working. Staff and subject matter advisors told the investigation about factors which hindered collaborative working in the context of a patient at risk of self-harm. These included:

- a lack of understanding between acute (physical) and mental healthcare staff about each other's roles and approaches to care
- provision of temporary staff to undertake observation who were not familiar with the patient and/or working with the mental health provider
- lack of shared access to a patient's electronic care records.

4.3.19 Staff and subject matter advisors also highlighted factors which helped collaborative working in the context of a patient at risk of self-harm.

Those interviewed said that currently collaboration sometimes worked well but that this was largely down to the efforts of individuals and ward teams. The following prompts are provided to help acute hospital (physical) and mental healthcare providers to work in collaboration:

Local-level learning

- Is there a shared understanding of the different roles and responsibilities of mental and physical healthcare staff in caring for a patient, including checking their personal belongings for items that could be used to self-

harm. Are the different roles and responsibilities documented in care plans and shared at shift handover?

- Is there a shared approach to supervision and support for all staff involved in caring for patients who may self-harm in hospital?
- Is there a clear and comprehensive process for handing over a patient's care to staff on the receiving ward?
- Is there a shared approach to, and understanding of, how to respond if the patient were to self-harm?
- Is there a physical healthcare hospital policy for the care of patients with mental health needs which includes continuous observation?
- Is there a mechanism for regular communication and review of a patient's risk of self-harm and need for observation?
- Is there comprehensive, clear, and accessible documentation available to both mental and physical healthcare staff?
- Is there a process to ensure staff undertaking continuous observation who are new to an acute hospital ward are introduced to staff and the environment, including rest facilities and access to relevant patient records?
- Is there a mechanism to allow for shared learning and reflection between care providers involved in caring for patients at risk of self-harm?
- Is there a process to promote respectful and kind interactions and communication between the staff at different healthcare providers?

4.3.20 Staff told the investigation that, as well as it being uncomfortable for patients to be continuously observed, it could also be uncomfortable and at times “stressful” for the staff observing. In addition, on occasions when a patient was “particularly anxious or unsettled or in distress”, it could make the staff observing “frightened”. One subject matter advisor said that nurses have a “sense of moral injury” when they are required to carry out continuous observations as it can “feel abusive” and intrusive.

4.3.21 In the reference event, the investigation was told by staff and managers from the mental health unit and acute hospital that both staff groups had been deeply affected by their experiences while caring for Emily-May. Restorative supervision has been provided to help support these staff.

4.3.22 Another subject matter advisor told the investigation that when a patient does something “extremely disturbing” this can be very traumatic for staff. In these circumstances (as seen in the reference event) staff can be “nervous”, “scared”, and “won’t talk to the patient” or deliver the “best possible care”. This advisor said there needed to be systems in place to help staff deal with trauma, which included time and space to talk and reflect along with supervision and training. Discussing this point, a representative from NHS England told the investigation that it is mandated within the NHS contract for healthcare providers to offer nurses access to restorative clinical supervision (NHS England, 2022a). This supervision addresses the emotional needs of nurses by providing ‘thinking space’, which reduces stress and burnout (NHS England, 2023).

4.3.23 Evidence gathered during the investigation indicated that the current provision does not adequately address the support needs of staff. In addition, these arrangements do not include other staff groups or agency staff. HSSIB has explored this in its investigation into [Temporary staff – involvement in patient safety investigations](#) and made a safety recommendation to ensure this support is available to agency staff (Health Services Safety Investigations Body, 2024c).

4.3.24 The Royal College of Psychiatrists (2022) published a framework entitled ‘Supporting mental health staff following the death of a patient by suicide’. This gives mental health providers and ‘other policy makers’ guidance that, if implemented, can mitigate the damaging impact on staff of the death of a patient by suicide. A representative from the Royal College of Psychiatrists told the investigation that this framework was equally applicable for staff caring for patients at risk of self-harm.

4.3.25 Those interviewed said that staff carrying out continuous observation are often scared of being blamed or “scapegoated” if the patient manages to self-harm while being observed. One consultant mental health nurse said there was an “absolute fear of scrutiny” even though it is not possible to entirely prevent self-harm.

4.3.26 Talking about the investigation of events where patients under continuous observation had self-harmed, staff and subject matter advisors spoke of the tendency to blame staff and the lack of support for staff involved. This has been explored in a previous investigation by the Healthcare Safety Investigation Branch (2021), ‘[Support for staff following patient safety incidents](#)’. The NHS England Patient Safety Incident Response Framework recognises the need to support staff following patient safety incidents and includes specific guidance for NHS providers about this (NHS England, 2022b). However, the investigation heard that temporary

staff may not benefit from support arrangements in the same way as permanent staff and may not be involved with learning from the incident. HSSIB (2024c) explored this further in its investigation '[Temporary staff – involvement in patient safety investigations](#)' and made safety recommendations to address this gap for agency staff.

Healthcare providers can also consider how staff continuously observing patients at risk of self-harm can be supported by using the following prompts:

Local-level learning

- Are there arrangements in place to provide appropriate support for all staff providing this intervention?
- Are staff being regularly rotated so that they are not undertaking continuous observation for more than 2 hours in line with national guidance?
- Are staff having adequate breaks, with ready access to water and food?
- Are staff supported to speak with or engage in an activity with the patient where appropriate?

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6. Appendix: Investigation approach

Decision to investigate

The reference event was referred to the Healthcare Safety Investigation Branch (HSIB) by the acute hospital where Emily-May received care as an inpatient after she had self-harmed. HSIB's Chief Investigator authorised a national investigation based on HSIB's patient safety risk criteria:

Outcome impact – what was, or is, the impact of the safety issue on people and services across the healthcare system?

Continuous observation is a widely used intervention used to mitigate the risk to adults who are at high risk of self-harming while in hospital. Observation is one component of a wider plan of care to support the person's mental health. Where a person is continuously observed in a mental health setting, but it is not effective at preventing self-harm, the person may have injuries requiring admission to an acute hospital or the injuries may be fatal. Where self-harm occurs while a person is under continuous observation in hospital it impacts on the patient, their family and those caring for them.

Systemic risk – how widespread and how common a safety issue is this across the healthcare system?

This risk occurs across England in mental health and acute hospital settings and can involve multiple staff groups, including doctors, nurses and healthcare support workers. There has been an ever increasing number of people with complex mental health needs also requiring care in the acute hospital setting.

Self-harm is more common among people between 15 and 24 years of age and it is one of the commonest reasons for people going to an acute hospital (Office for Health Improvement and Disparities, n.d.).

Learning potential – what is the potential for an HSSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?

The Healthcare Safety Investigation Branch has previously investigated the [provision of mental healthcare to patients in the emergency department](#) (Healthcare Safety Investigation Branch, 2018), but not those admitted to hospital. In a review of mental health services in acute trusts between September 2017 and March 2019, the Care Quality Commission (CQC) suggested a number of steps to improve practice, including that all acute general trusts needed to have a mental health strategy, and they found that integration between mental and physical health was still poor, resulting in disjointed care. Indeed, the CQC found that acute hospital staff felt ‘unsupported and unprepared to meet the mental health needs of their patients’ (Care Quality Commission, 2020).

Mental health is one aspect of current quality improvement work by the NHS England patient safety team which they would welcome HSSIB exploring further.

In September 2022, the National Institute for Health and Care Excellence (NICE) published new guidance that set out ‘the responsibilities of non-mental health specialists when caring for people who self-harm [including] those working in general hospital settings’ (National Institute for Health and Care Excellence, 2022a). This new guideline updates and merges two previous guidelines on self-harm, in response to HSIB’s work in this area ([Healthcare Safety Investigation Branch, 2018](#)). This investigation is timely as it may offer insights into the implementation of this NICE guidance in practice.

Evidence gathering and verification of findings

Evidence gathering

The investigation was carried out between August 2022 and December 2023. To explore the reference event, the investigation interviewed Emily-May, her mother and staff from the mental health unit and acute hospital staff who were involved in her care. The investigation also gathered evidence from the acute hospital’s and mental health unit’s clinical records and reviews related to Emily-May’s care. Further evidence was gathered from relevant local and national policies and guidance, and legislation and literature.

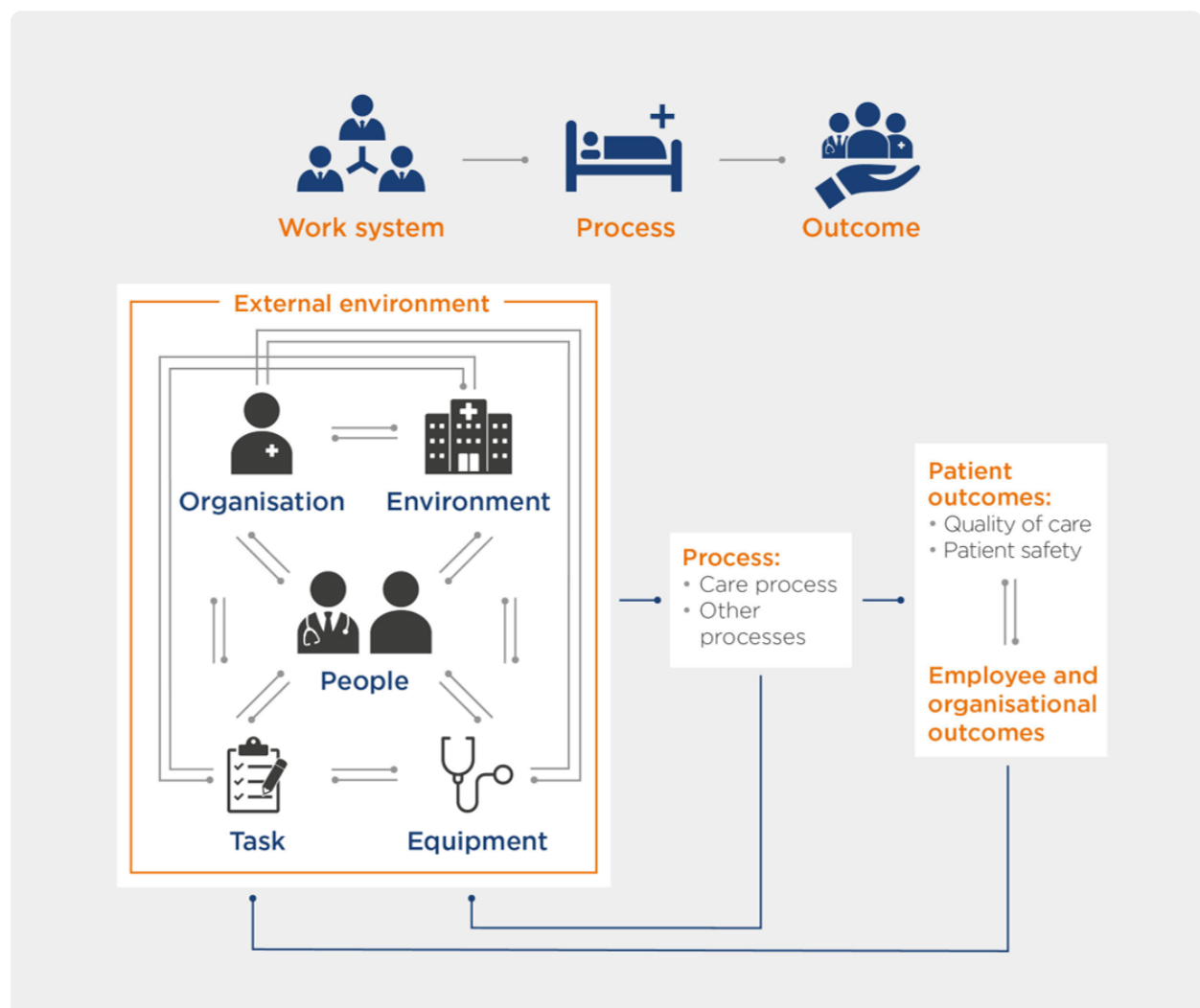
For the wider national investigation, evidence was collected through interviews and meetings with the stakeholders listed in table A. Further evidence was gathered from relevant literature, local and national policies and guidance.

Analysis of the evidence

To help understand the healthcare system, the investigation used the Systems Engineering Initiative for Patient Safety (SEIPS) (Carayon et al, 2006; Holden et al, 2013).

SEIPS provides a human factors framework for understanding the work system (that is, the external environment, organisation, internal environment, tools and technology, tasks, and people), work processes (including physical, cognitive and social/behavioural aspects), and the relationship between these and the resulting outcomes in healthcare (see figure A).

Figure A The SEIPS framework



Stakeholder engagement and consultation

The investigation engaged with stakeholders and subject matter advisors to gather evidence during the investigation. This also provided an overall sense check of the information and helped ensure factual accuracy. The stakeholders contributed to the development of the safety recommendations based on the evidence gathered.

Table A Stakeholders engaged with during the investigation

Reference event and comparison organisations	Individuals	National organisations
Physical healthcare: • Two acute hospital trusts that also provide specialist services to a wider area (one large, one medium sized in different parts of the country) • One acute hospital trust Mental healthcare: • Two independent specialist providers • One large NHS specialist provider	• Emily-May and her mother • Mental health expert by experience x 1 • Researcher exploring continuous observation x 4 Mental health hospital staff: • Healthcare support workers x 7 • Nurse manager (independent provider) x 3 • Regional medical director (independent provider) x 1 • NHS director/associate directors of nursing x 2, professional quality lead x 1 • NHS patient safety manager x 1, practice educator x 1 • Nurse consultant (NHS) x 3 • Nurse x 1 Acute liaison staff (employed by mental health trust 'in reaching' to acute physical health hospitals):	• Care Quality Commission • Department of Health and Social Care • Mental Health and Learning Disability Consultant Nurse Forum • Mental Health Nurse Leaders and Directors Forum • Mental Health Leads in Acute Hospital Forum • National Institute for Health and Care Excellence • NHS England • NHS Resolution • Royal College of Nursing Mental Health Forum • Royal College of Psychiatrists • SANE (charity providing emotional support and

Reference event and comparison organisations	Individuals	National organisations
	• Consultant psychiatrists x 5 • Senior nursing leads x 2 Physical health hospital staff: • Deputy divisional head of nursing x 1, matron x 2 • Ward sisters x 4, deputy sister x 1, ward nurses x 4 • Advanced critical care practitioner x 2 • Critical care consultant x 1 • Specialist practitioner (safeguarding) x 1 • Dual registered nurse x 1 • Consultant/nurse lead for mental health x 2	information to people affected by mental illness)