

## **Engagement and observation: a review of local policies in England and Wales**

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This document is the Accepted Version [AM]

### **Citation:**

ASHMORE, Russell (2020). Engagement and observation: a review of local policies in England and Wales. Mental Health Review Journal. [Article]

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## **Engagement and observation: a review of local policies in England and Wales**

## **Abstract**

**Purpose** - The purpose of this paper is to report on the content of local policies on engagement and observation written by NHS organisations in England and Wales.

**Design/methodology/approach** - Engagement and observation policies were obtained from all (n = 61) National Health Service mental health trusts in England and health boards in Wales via a Freedom of Information Act 2000 request. Data were analysed using content analysis.

**Findings** - All organisations had a specific policy referring to either 'observation and engagement' or 'observation'. The policies varied considerably in quality, length and the breadth and depth of the information provided. Significant variations existed in the terminology used to describe the different types of enhanced observation. Inconsistencies were also noted between organisations regarding: which members of the clinical team could initiate, increase, decrease and terminate observation; who could undertake the intervention (for example students); and the reasons for using it. Finally, despite rhetoric to the contrary, the emphasis of policies was on observation and not engagement.

**Research limitations/implications** - This research has demonstrated the value of examining local policies for identifying inconsistencies in guidance given to practitioners on the implementing of engagement and observation. Further research should be undertaken to explore the impact of local policies on practice.

**Practical implications** - Local policies remain variable in content and quality and do not reflect contemporary research. There is a need to produce evidence-based national standards that organisations are required to comply with.

**Originality/value** - This is the first research for twenty years examining the local policy framework for the implementation of engagement and observation.

**Keywords** Engagement, Observation, Policy

**Paper type** Research paper

## Introduction

Globally observation has a long history as an intervention, undertaken primarily by mental health nurses (MHNs), to reduce the risk to inpatients experiencing acute distress (Robertson, 1861; Williamson, 1885; Savage, 1884; Nolan, 1993, Duffy, 1995; Dong et al., 2005; Prebble, 2007; Victoria State Government Department of Health, 2013). Observation involves allocating a nurse to the care of a patient for a specified period of time to ensure their safety (Stewart et al., 2009; Ray and Allen, 2015) and has been defined as;

“...‘regarding the patient attentively’ while minimising the extent to which they feel that they are under surveillance. Encouraging communication, listening, and conveying to the patient that they are valued and cared for...” (Standing Nursing and Midwifery Advisory Committee, 1999, p. 2).

In the literature a variety of terms are used to refer to observation and its different levels of intensity (Bowers et al., 2000; Bowers and Park, 2001; Stewart et al., 2010). For consistency, the terminology and four levels of observation described by the (now dissolved) Department of Health Standing Nursing and Midwifery Advisory Committee (SNMAC) guidelines (1999) will be used throughout this article (Table I). NICE (2005, p. 32) recommended that the terminology; “...used in this guideline should be adopted across England and Wales to ensure consistency of use”. In addition, following the English Mental Health Act Code of Practice (DH, 2015), the term enhanced observation will be used in the article when levels II-IV are referred to collectively. The Welsh Code (Welsh Assembly Government (WAG), 2016) does not provide guidance on terminology or types of observation.

[Table I near here]

The use of observation is not insignificant. For example, Bowers and Parks (2001) reported that up to 20 per cent of inpatients have experienced one or more types of enhanced observation. In another study, 47 per cent of patients received intermittent observation during the first two weeks of admission, and 16 per cent within reach observation (Bowers et al., 2003a). The reasons given for initiating enhanced

observation include: actual or risk of self-harm; risk of suicide; aggression; risk of violence; absconding; fire risk; self-neglect; taking high doses of medication; a medical condition; decreasing stimulation; after meals for patients with eating disorders; and for patients considered at risk of not taking their medication (Stewart et al., 2010). It has also been suggested that its use may help to prevent: manual restraint; enforced intra-muscular medication; seclusion and referral to psychiatric intensive care units (Stewart et al., 2012).

Despite the continuing ubiquity of observation in inpatient settings, its use was challenged as early as 1884 by George Savage. Savage (1884, p. 19) proposed that observation was: over used; intrusive; often for the benefit of staff; led patients to believe that “they were being dared” to harm themselves; resulted in a breakdown of relationships with staff, with patients referring to those who constantly watched them as “tormentors”; and was not an effective intervention for preventing harm. There is evidence to support this last point (Gournay and Bowers, 2000; Meehan et al., 2006; Stewart et al., 2009; Appleby et al., 2015). For example, The National Inquiry into Suicide and Homicide by People with Mental Illness (Appleby et al., 2015) reported that of all inpatient suicides, 124 (15%) people died while under either intermittent ( $n = 113$ ) or within reach observation ( $n = 11$ ). In contrast, others have reported that observation does reduce suicide and self-harm (for example Bowers and Simpson, 2007; Bowers et al., 2008; Bowers et al., 2011).

Observation has also been criticised for its focus on defensive and custodial practices at the expense of therapeutic engagement (for example Buchanan-Barker and Barker, 2005). Dodds and Bowles (2001) reported that when they replaced observation with structured and individualised ward-based activities they noted a decrease in absconding, self-harm, suicide and violence. Other authors have reported a decrease in the use of level III and IV observation as a result of engaging with the patient (Bowers and Simpson, 2007; Ray et al., 2017).

Regardless of the above debates the Mental Health Act codes of practice for England (DH, 2015) and Wales (WAG, 2016) recommend the use of observation for reducing harm to self and others within inpatient settings. In addition, both codes (DH, 2015; WAG, 2016) are also clear that observation should focus on positively

engaging with the patient and not simply be a custodial activity. In order to facilitate the practice, the English Code places an obligation on local managers to write a policy on the “...use of enhanced observation” (DH, 2015, p. 424, 26.33). Similarly, the Welsh Code recommends that an “observation and positive engagement” policy be produced (2016, p. 185: 26.13). However, the codes provide little guidance on what the content of any such policy should be.

Based on a study undertaken in 1999, Bowers et al. (2000) reported that the content and quality of local policies varied widely, to the extent that they had serious implications for the safety of patients (also see Gournay and Bowers, 2000). In response to this the Department of Health SNMAC (1999) produced practice guidance on Safe and Supportive Observation of Patients at Risk. This guidance was intended to be a template for local organisations to use in developing observation policies to guide practice. Although endorsed by a number of subsequent documents (NICE, 2005; DH, 2006; NICE, 2015), there is no requirement that organisations must follow it. In 2004, Jones and Jackson commented that the impact of this document was unclear as there had been no attempt to; “...explore the extent of implementation of the SNMAC guidance at a national level” (p. 166).

Barnicot et al. have recently commented that observation continues; “...to be governed by local-level policies” (2017, p. 474). However, a search of the major health science databases revealed that since the study by Bowers et al. (2000) there has been no significant research on the content of local observation policies. This study (Bowers et al., 2000) is now twenty years old and, as Kettles and Addo (2009, p. 819) note; “...guidelines and policy documents need to be revisited on a regular basis...” Nor do we know whether policies have addressed the lack of focus on engagement, therefore it seems the time is right to revisit this topic.

## **Aim**

The study aimed to determine the nature and content of local policies on engagement and observation, written by National Health Service (NHS) mental health trusts (MHTs) in England and health boards (HBs) in Wales.

## **Methods**

A Freedom of Information (FOI) Act 2000 request was submitted to all NHS MHTs in England (n = 54) and HBs in Wales (n = 7) providing inpatient care. Organisations were asked to provide: (1) a copy of their engagement and observation policy; and (2) any written information given to patients about the intervention.

## **Ethics**

NHS ethical approval was not required as the study did not involve patients, NHS staff or premises or seek access to care records or other confidential information. Nevertheless, the study was considered and approved by a university ethics review panel. Although the FOI Act 2000 does not require it, all the findings reported in this study have been anonymised.

## **Analysis**

Policies were subject to a combined deductive and inductive content analysis (Elo and Kyngäs, 2008; Bengtsson, 2016; Graneheim et al., 2017). In the deductive element a set of questions developed from the Bowers et al. study was used to explore the policies. For example, 'How does the policy define engagement? 'What reasons are given for initiating observation?' In the inductive element policies were reread in order to identify any categories of importance 'missed' during the deductive stage.

Deductive and inductive analysis consisted of a number of steps. Each document was read and reread line-by-line to identify words, sentences and paragraphs (meaning units) relevant to the study's aim. Each meaning unit was allocated a code that best described its content. Codes were then grouped together to form preliminary categories. Meaning units identified in each subsequent policy were compared to those from previous documents. This constant comparative process led to some meaning units being recategorised and the preliminary categories refined to produce the minimum number discussed below. Following a number of recent qualitative studies (for example, Muir-Cochrane, 2012; Barnicot et al., 2017), the number of organisations providing the same information is given to demonstrate the convergence and divergence of content. Throughout the remainder of the article

each organisation (O) is identified by a code number. Finally, analysis of the data identified insufficient differences between policies produced by English and Welsh organisations to justify reporting the findings of individual countries separately.

## **Findings**

### **Characteristics of policies**

A policy was received from all 61 organisations contacted. Organisations referred to their document as either an 'observation and engagement' policy (n = 42) or an 'observation' policy (n = 19). Policies varied considerably in quality and length. Some policies would have benefitted from closer proof reading to correct errors of spelling, grammar and punctuation. A number of organisations appeared to have simply replicated the policy of another MHT or HB, without correcting any of the errors mentioned above. The length of policies ranged from one to 60 pages. All policies were implemented in 2011 or later and the majority (n = 45) were introduced from 2015 onwards. All organisations required that their policy be reviewed and updated by a specified date given in the document. Seven policies did not appear to have been reviewed by their stated date. Four of the seven policies' review date was overdue by more than 18 months.

Wales advocates the production of 'All Wales' policies. That is; "...policies & procedures... developed and agreed on an all Wales basis to apply to all NHS Wales staff" (<https://phw.nhs.wales/about-us/policies-and-procedures/>). However, an electronic search was unable to identify any single repository for NHS 'All Wales' policies. A further search for an 'All Wales' engagement and observation policy produced one document uploaded to the NHS Wales site (<https://phw.nhs.wales/about-us/policies-and-procedures/>). The document was last reviewed in 2011 and was produced by a single HB. As the site did not offer any further information, it was unclear whether this policy was intended to act as an 'All Wales' template for other boards. Analysis of the remaining HB policies suggested that even if it was intended as an 'All Wales' template it had been adapted at a local level.



## **The purpose of policies**

All organisations agreed that observation should be a supportive, collaborative and therapeutic intervention in which the nurse engages with the patient and “not simply a custodial activity” (O41). In contrast, the stated purpose of the policies focused solely on the implementation of observation. For example, one stated that the; “...policy sets out the process and procedures to support practitioners making decisions related to the implementation, undertaking, reviewing and recording of patient observation...” (O30). A further indicator of the focus of the policies was the fact that observation was referred to 9,222 times and engagement 863 times.

## **Definitions of observation and engagement**

Thirty-eight policies provided a definition of observation. Half of these either paraphrased or stated verbatim the definition of observation given in the SNMAC (1999) document (see above). The other policies provided their own definitions of the intervention, for example; “Observation is a process through which a person learns something about someone else by watching, listening, interacting with and trying to understanding them” (O9).

Fourteen organisations also offered a definition of the term ‘engagement’. Typically, organisations defined this in terms of activities that could be undertaken with patients. For example; “...engaging in conversation, going for a walk (if appropriate), taking part in an activity or ...sitting quietly [with the patient]” (O2).

## **Terminology**

There was wide variation in the terminology used to describe the different levels of observation and the meaning given to each one. Organisations in England attributed the terminology used in their policies to one of five sources (SNMAC, 1999; NICE, 2005; DH, 2006; NICE, 2015; DH, 2015) and those in Wales to one of three (SNMAC, 1999; NICE, 2005; NICE, 2015). However, only 14 policies reproduced the terminology used in their chosen document verbatim. Of the 61 policies reviewed, only 10 used the same terminology to describe the different levels of observation. Fourteen different terms were used to describe intermittent observation (for example “defined observation”, “therapeutic observation”, “individualised care planned

observations”) and 22 to describe within arm’s length observation (for example, “close constant observation”, “continuous observation with close proximity”, “high level nursing intervention” and “specialling”).

A small number (n = 10) of policies had either two (n = 1), three (n = 7) or five (n = 2) levels of observation. The majority (n = 51) however identified four levels of observation. Of these, 29 organisations used numbers to distinguish between the different levels; 10 used the number one to identify the highest level of observation and four the lowest. In contrast, in other organisations (n = 19) a four identified the highest level and one the lowest. Another organisation (O20) used a colour coded system (green, yellow, amber and red) to denote the different levels of observation. Green was used to describe the lowest level of observation and red the highest.

One organisation (O8) did not include the intermittent level of observation in its policy because; “...such a level allows for too many opportunities for a service user, who has been deemed to be at risk, to take opportunities to abscond or cause harm to themselves.” Another organisation (O6) stated that at times it might be appropriate to use ‘flexible observation’, however they did not define what they meant by this term. A further three organisations referred to ‘zonal observation’. This was defined as assigning a; “...staff member...to observe and engage with individuals using specified zones within the ward area” (O31). One of the three (O6) stated that it should never be used within their organisation. The other two (O31 and O52) considered it an option when implementing observation, although neither stated under what circumstances it was appropriate to do so.

### **Initiating, increasing, decreasing and terminating enhanced observation**

Some policies did not provide information on who could initiate (n = 4), increase (n = 12), decrease (n = 16) or terminate (n = 49) enhanced observation.

Initiating enhanced observation was declared a joint medical and nursing decision in 35 policies, an independent nursing decision in 18 and a decision that could be made by any mental health practitioner (occupational therapists, physiotherapists and psychologists) perceiving risk in the remaining four. All organisations agreed that the decision to increase the level of enhanced observation should ideally be

undertaken by the multi-disciplinary team (MDT), although 28 organisations recognised that; “a prompt unilateral nursing decision may be required” (O1).

The decision to decrease the level of observation was also said to be a MDT decision in 18 cases, although eight of these added a caveat that any decision had to be approved by the patient’s consultant. Seventeen policies declared that decreasing the level of observation was a joint medical and nursing decision, five that it was the independent decision of the nurse, and a further five a decision to be taken by the nurse in charge and one other mental health professional. In relation to terminating enhanced observation, of the 11 policies providing information on this: seven stated that it was the decision of the MDT, three of which added that the decision must be approved by the patient’s consultant; three that it was a joint medical and nursing decision; and one that nurses had the power to terminate all levels of enhanced observation.

### **Reasons for implementing enhanced observation**

Policies were examined to determine the indicators for implementing enhanced observation. One policy simply stated that enhanced observation should be considered for “managing risk”. The majority of policies (n = 60) identified a range of indicators for the introduction of enhanced observation. From Figure 1 it would appear that organisations are recommending enhanced observation as an effective intervention for minimising harm to self and others. However, there was less agreement about the appropriateness and effectiveness of the intervention for managing other issues, for example compliance with medication, exploitation, sexual disinhibition and wandering.

[Figure 1 near here]

### **Frequency of general and intermittent observations**

Some organisations indicated how frequently general and intermittent observation should be undertaken.

## General observation

All organisations recognised that general (level I) observation; "...was the minimum acceptable level for all in-patients... [and that] ...the location of all patients should be known to staff though not all patients will need to be kept in sight" (O1). Eight organisations did not state how frequently they expected general observation to be undertaken. Forty organisations required patients to be 'visually checked' once per hour. Only one organisation offered a definition of what they meant by visual checks;

"[This is] where the person undertaking observations personally see's [sic] the patient on observations from a distance no greater than would be reasonable to hold a short conversation with voices at a normal level. It is not acceptable for staff to see a patient at the end of a ward or through a window" (O14).

Thirteen organisations identified nine different intervals of time at which visual checks should be undertaken, these ranged from every 15 minutes to "a minimum of 4 checks across a 24 hour period which is [sic] reasonably spaced out" (O28).

In addition to visual checks, 30 organisations required nurses undertaking general observations to;

"...set aside dedicated time to interact with each patient to assess their mental state and... [undertake] ...an evaluation of the patient's moods and behaviours with risks of disturbed/violent behaviour ..." (O1, p.3).

The majority (n = 21) of these organisations (n = 30) specified that this level of interaction should be undertaken at least once per shift.

## Intermittent observation

Forty-seven policies specified the frequency of intermittent observation. The two intervals most frequently given were every 15 minutes (n = 14) and every 15 to 30 minutes (n = 15). The remaining 18 organisations used combinations of the following intervals: 5, 10, 15, 20, 25, 40 and 60 minutes. For example, one organisation stated that checks should be undertaken every five to 25 minutes.

Nine organisations indicated that some patients might be checked every five minutes. In contrast, a further four stated that a patient must *never* be placed on five minute checks, as this would indicate the need for the person to be nursed at a higher level of observation. In addition, three organisations recommended that the frequency of intermittent observation should be undertaken at: “irregular intervals that cannot be predicted by the patient” (O44).

### **Reviewing observation levels**

Forty-five policies provided guidance on how frequently observation levels should be reviewed. In relation to general observation, one organisation simply recommended that the review should be ongoing and another that there was; “...no need for [a] review at this level” (O19). Another 25 policies suggested a range of intervals from once per shift to once per week. Forty-two organisations referred to intermittent observation and recommended that it be reviewed between once per shift and once every three days. For within eyesight and within reach observation, the majority of organisations recommended that a review should be undertaken either once per shift (n = 21) or daily (n = 22).

### **Who can observe?**

All 43 organisations referring to this subject were in agreement that MHNs were; “...professionally accountable for the implementation of observations” (O1). Two policies stipulated that those nurses must be a Band 6 or above. Some policies allowed MHNs to delegate observation to healthcare support workers (n = 11), bank and agency staff (n = 18) and other registered healthcare professionals (n = 4), for example, medical practitioners, psychologists, and occupational therapists. There was also a consensus that before delegating the task to anyone, MHNs were responsible for determining whether an individual was competent in the attitudes, knowledge and skills of observation.

Thirty-eight organisations clarified the role of mental health nursing student in relation to undertake observation. Fourteen organisations only permitted students to observe registered practitioners undertake the intervention, or undertake it under direct supervision of their mentor in order to enhance their learning. Of the

remaining 24 organisations, three seemed to be suggesting that all students (regardless of the year of their course) could independently undertake all levels of observation and 21 some levels (Table II).

[Table II near here]

### **Informal patients**

Organisations (n = 61) were in agreement that all levels of observation could be applied to informal patients. Thirteen organisations provided further commentary on this issue. They acknowledged that observation was “unavoidably restrictive” (O21) and that informal patients: were not “subject to restrictions on their liberty” (O26); should not, “feel coerced into remaining on the ward with implied threats to use the Mental Health Act if they are unwilling to do so” (O29); and that observation, “...must never become a form of de facto detention for informal patients” (O21, O53 and O58).

Ten policies commented on the implications of enhanced observation for the informal patient’s legal status. Six argued that if informal patients accepted the restrictions associated with enhanced observations, for example not leaving the ward, they could retain their current legal status. However if they objected, it was recommended that the patient should be assessed under the Mental Health Act 1983 (DH, 2007). The remaining four policies required all informal patients placed on an enhanced level of observation to be assessed as soon as possible under the Act (DH, 2007).

### **Leaving the ward**

Twenty-seven organisations provided information on this subject for all enhanced levels of observation and 16 for some levels. There was a consensus that leave could only be taken following a risk assessment and approval by the MDT. Practitioners were also advised to read and comply with leave policies for both formal (section 17 leave) and informal patients.

Twenty-seven organisations permitted patients on intermittent observation to take leave from the ward if escorted by a member of staff, for example to undertake therapeutic activities. Twelve of these stated that patients must remain in the hospital buildings, seven extended leave to the hospital grounds and four permitted

patients to leave the premises. One organisation stated that it would consider overnight leave for patients on enhanced observation if; "...the rationale for observation is unit specific e.g. enhanced observation due to vulnerability whilst on the unit, or it is assessed as [having] therapeutically beneficial; e.g. to facilitate a... person spending time with their family" (O22). Three organisations made provision for the patient's family members, carers and friends to escort the patient on leave.

Eight policies permitted patients on intermittent observation to take unescorted leave following a risk assessment. Six policies required patients on both within eyesight and arm's length observation to remain on the ward at all times. In contrast, a further six policies only required patients on within arm's length observation to; "...remain within the ward environment...at all times" (O5).

### **Information for patients**

Of the 41 organisations that did not provide patients with written information on observation: 21 offered no explanation for this in their FOI responses; two replied that they were developing a leaflet; and eight typically commented that, "The person is advised when developing their care plan about [their] observation levels" (O23). The remaining six organisations stated they provided details about observation in their ward information booklets that were given to patients on admission (copies were provided). This typically consisted of a brief statement, for example; "We usually observe people hourly to ensure their well-being and safety. We may do so more often if we feel that is appropriate..." (O19).

Twenty organisations provided patients with a leaflet outlining the practice of observation, although one stated it was "not used on all wards" (O15). In summary, the content of this information consisted of: a definition of observation (n = 10); a rationale for its use (n = 5); what it aimed to achieve (n = 19); an explanation of the different levels of observation (n = 18); and a description of what might occur during the activity (n = 10). There was no evidence to suggest that the information had been developed in partnership with patients or that it had been assessed for quality and readability.

## **Training**

There was a general recognition that; "...observing [a] patient...is a highly skilled activity..." (O4) and that those undertaking it should; "...know the patient well... be familiar with the ward... and have received formal training..." (O7). Fifty-three policies emphasised the need to undertaking training, however only 36 organisations provided further details of what this should consist of.

Some (n = 11) simply stated that practitioners should have read, understood and had an opportunity to discuss the policy before undertaking observation. Others (n = 25) required all permanently employed clinicians to undertaking some kind of training, for example a one-day workshop. Topics identified as important were: risk assessment; aims of observation; levels of observation; reporting and recording of information; therapeutic opportunities; and attitudes to observation.

## **Discussion**

Despite ongoing debates about its effectiveness and whether it prioritises control and containment over engagement, observation continues to be recommended as an intervention for preventing harm within inpatients settings (DH, 2015; WAG, 2016). The codes of practice for England (DH, 2015) and Wales (WAG, 2016) require organisations to produce local policies on engagement and observation, but offer little guidance on what their content should be. This is the first study, to the author's knowledge, in over twenty years to provide a detailed account of the content of local engagement and observation policies produced by mental health organisations in England and Wales.

Turning to the findings, it was encouraging to see that all organisations did have either an 'engagement and observation' or 'observation' policy - an improvement on the 88 per cent reported by Bowers et al. (2000). This demonstrates, if nothing else, that organisations in England and Wales had met their obligations to their respective Mental Health Act Code of Practice (DH, 2015; WAG, 2016). Despite some consistency in the content of policies examined in the study, there were also significant variability in what was actually included.



The variations reported above (see findings) may reflect the fact that the two codes (DH, 2015; WAG, 2016) offer little guidance on what the content of a policy should be. Similarly, where national guidance on observation does exist (SNMAC, 1999; NICE, 2005; DH, 2006; NICE, 2015), it too on the whole, lacks substance and consistency. Nor do these guidance documents contain clear evidence-based rationales for the inclusion of particular recommendations. Where an organisation did express a commitment to a particular document it was often adapted at a local level. This lack of consistency in what organisations expect practitioners to do, and assumingly how engagement and observation is undertaken in England and Wales, is a potential factor that can increase risk to patients. In addition, a failure to incorporate best evidence into policy documents is likely to contribute to the factors leading to self-harm and suicide by mental health inpatients under observation (Flynn et al., 2017). It is therefore proposed that a standardised national best practice policy, such as an updated version of the SNMAC (1999) template, is developed which organisations are required to comply with.

In relation to the last point, NHS Improvements England (<https://improvement.nhs.uk/resources/national-policy-template-on-supportive-observation-and-engagement/>) made available in February 2019 a template, developed by the Mental Health Nurse Leaders and Directors' Forum (MHNLDf), to; "...support trusts that are developing or updating their...observation/engagement policy". NHS Improvements stated intention for this was to produce a "consistent" approach to the intervention. However, they seem to undermine their goal when they comment that; "Trusts should use their own discretion in adapting or making use of [the] template to fit their specific needs..."

The MHNLDf document (last updated in July 2018) is said to be an; "...evidenced based template informed by best practice" (p. 4). However, the MHNLDf make it clear that; "Its use is entirely voluntary" (p. 4). The MHNLDf should be commended on this template; although on closer examination its content appears to, on the whole, reflect that outlined in the SNMAC (1999) document. In addition, the MHNLDf *have not* created a standardised 'All England' engagement and observation policy that could simply be rebadged and used by individual organisation. What they *have done* is identify a number of areas that they believe are important for organisations to

consider. For some, but not all, of these areas they provide additional annotations about how they might be addressed in local policies. In regard to the document's evidence base, only four articles, consisting of commentaries and literature reviews, published between 2002 and 2010, are cited to support the template's content, despite more up-to-date research being available. Therefore, it would be interesting to know what impact, if any, this document has on producing a standard policy for engagement and observation for MHTs in England.

Previous research has reported wide variations in the terminology used to describe the different levels of observation in local policies (Bowers et al., 2000; Gournay and Bowers, 2000). This study reaffirms these findings. It is now over twenty years since the SNMAC (1999) recommended the use of standard terminology to describe the different levels of observation, therefore it is perhaps surprising to still see such a wide variation within local policies. This might be explained, at least in part, by the fact that national guidance documents, cited by organisations as a template for their policy, have not themselves adopted an agreed language when referring to engagement and observation (SNMAC, 1999; NICE, 2005; DH, 2006; NICE, 2015; DH, 2015). In addition, nor are organisations legally required to comply with the language of any of the above guidelines. To reiterate points previously made in the literature (Bowers et al., 2000; Gournay and Bowers, 2000), there is a need to standardise the terminology used to describe the different levels of observation. A lack of consensus on terminology can, according to Bowers et al. (2000, p. 442); "...only provoke confusion, lack of clarity, and reduce patient safety."

Another area of concern was the lack of consistency on how frequently intermittent observation should be undertaken. The SNMAC (1999, p. 3) guidance advocates that the; "...patient's location must be checked every 15 to 30 minutes..." Of the 47 organisations stating an interval, only 29 complied with this. The remainder (n = 18) suggested intervals of between five and 60 minutes. None of the policies offered a rationale for their chosen intervals. Some authors have questioned the utility of intermittent observation (Jayaram et al., 2010; Appleby et al., 2015), particularly at night when it has been suggested that it serves no purpose and may cause sleep deprivation (Veale, 2019). However, others (for example, Bowers et al., 2011) have reported that it can lead to a reduction in suicide and self-harm. It has also been

suggested that it is an important step in transitioning from eye sight and within reach to the general level of observation (Bowers et al., 2000). Whatever the pros and cons of intermittent observations, organisations need to have a clear rationale for its use. It is also suggested that until evidence exists for the most effective interval for this type of observation, organisations should comply with those recommended in the SNMAC (1999) documented.

In the study undertaken by Bowers et al. (2000), the authors reported that general observation; "...was the least well-defined level in the policies" (p. 442) they studied. This was also the case in this research. From the policies surveyed, organisations in England and Wales, although not explicitly stated, appeared to be proposing that general observation consists of two elements. Firstly, a regular visual checking of the patient's whereabouts. Secondly, in line with the SNMAC (1999, p. 3) guidance, spending time with the patient, at least once per shift, in order to assess; "...the patients [sic] mood and behaviours associated with risk..."

This approach to general and other levels of observation appears more aligned to the traditional view of the intervention, with its emphasis on risk assessment, surveillance and containment at the expense of engaging with the patient (Bowles et al., 2000; Dodds and Bowles, 2001; Buchanan-Barker and Barker, 2005). Both codes of practice (DH, 2015; WAG, 2006) emphasise engagement over surveillance and containment, for example, the English Code states that observation is an intervention that; "...should focus on engaging the person therapeutically" (DH, 2015, p. 289).

A starting point for challenging the traditional approach to observation would be for all policies to contain a clear definition of what is meant by engagement (something that was absent from the majority of documents). Bowles et al. (2002, p. 256) have proposed that; "...the term 'engagement' ...has proved too 'woolly' for sections of our profession... it needs to be clearly explicated if other nurses are to effectively engage with distressed patients without recourse to formal observations." In addition, there was also a lack of guidance (in contrast to observation) on what engagement might consist of, or the type of therapeutic interventions involved in the practice. This finding is consistent with those reported by Horsfall and Cleary (2000) who

noted an absence of references to therapeutic interventions in their detailed analysis of one observation policy in an Australian setting. Taken together, the above points might suggest that, despite rhetoric to the contrary, organisations still emphasise surveillance and containment (based on the content of the policies examined) over therapeutic engagement for managing risk when encountering people in distress.

Policies in the study acknowledged that the engagement and observation of acutely distressed patients was a skilled activity. This has previously been recognised by the SNMAC (DH, 1999), which recommended that both qualified and unqualified (permanent and non-permanent) clinical staff should receive appropriate training to ensure their competency to undertake the activity. There was a lack of consistency between organisations as to what this should consist of, for example some (n = 11) simply required individuals to read the policy while others required the attendance of a half or full day workshop. It is recommended that all organisations provide standardised training on engagement and observation, over and above simply reading the policy. However, it has been suggested that; "...given that there is little agreement about what staff should be doing during...observation, it is difficult to conceive of what such training should involve" (Chu, 2016, p. 23). Whilst acknowledging Chu's (2016) comments, it is suggested that a starting point for training might be the eleven areas identified in the SNMAC (1999) document.

Reviews of the observation literature (Bowers and Park, 2001; Stewart et al., 2010; Chu, 2016) have consistently concluded that it is a poorly researched intervention. It is suggested that this has contributed to organisations developing policies based on local custom and practice and/or guidelines that are over twenty years old (see for example SNMAC, 1999). Therefore, unsurprisingly, this article argues that there is a need for further research to determine the most effective ways of using this intervention. For example, research could explore whether the recommended 15- or 30-minute intervals for undertaking intermittent engagement and observation are actually the most effective. This could help to address the lack of consistency on this issue as reported above.

Finally, the conclusions of the above literature reviews do not mean no evidence exists at all. However, there was an absence of it in all but a few of the policies

examined in this study. For example, policies identified a number of reasons for implementing engagement and observation (Figure 1), such as managing absconding, agitation and violence. However, evidence-based guidance on how these issues could be effectively managed were conspicuous by their absence. For example, Bowers et al.'s (2003b) work on effective anti-absconding interventions and the ten 'Safewards' interventions for reducing conflict and containment in acute inpatient settings (Bowers et al., 2015).

## **Limitations**

It is acknowledged that there is a paucity of evidence examining whether the practice of engagement and observation in England and Wales varies depending on the existence, or absence of any particularly policy or its content. Nor is it clear whether nurses are aware of, consult or follow the policies available to them. It is also possible that there are other organisational policies (for example, those referring to risk assessment and its management) which may affect how practitioners practise engagement and observation.

## **Conclusions**

This study has reviewed all existing local policies referring to the practice of engagement and observation in England and Wales. The Mental Health Act codes of practice for England (DH, 2015) and Wales (WAG, 2016) require organisations to produce local policies on engagement and observation. The SNMAC (1999) document produced a template to help organisations standardise these policies in order to avoid inconsistencies that might lead to increased risks to patients subject to observation. Whilst all organisations in England and Wales now have a policy, the issues leading to the creation of the SNMAC (1999) guidelines still exist and consequentially so do the risks to patients. This suggests that this document has failed to have the impact the SNMAC (1999) intended. To the author's knowledge, these guidelines have not been reviewed for twenty years, therefore it seems the time is right to do so in order to produce new evidence-based national standards that organisations are required to comply with. Finally, organisations need to do more to address the imbalance between engagement and observation in their policies if they are to meet their obligations to their respective codes of practice (DH, 2015; WAG, 2016).

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