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The use of observation on patients who self-harm: Lessons from a learning disability service



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ABSTRACT

Background: Observation is an important approach to care that is commonly used in in-patient learning disability services to prevent self-harming behaviours. It is often implemented when there is a perceived increase risk of self-harm. Most nurses who implement observation have little or no training in the use of this practice. The literature on this subject is also biased towards mental health settings with learning disability services much neglected.

Aim: To explore nurses' knowledge and understanding of the use of observation on patients who self-harm in a learning disability service in the United Kingdom.

Design: and methods: This study adopted a qualitative approach, and utilised interpretative phenomenological analysis as a design and as a tool of analysis. The study was conducted in a secure learning disability service in the United Kingdom. Data were obtained from registered nurses using individual interviews ($n = 20$) and focus groups ($n = 3 \times 5 = 15$).

Data were analysed thematically using the principles of interpretative phenomenological analysis.

Results: Three superordinate themes emerged from data analysis: 1) observation: its meaning, 2) observation: does it prevent self-harm? 3) Observation: making it work.

Conclusion: Observation is a useful practice in in-patient learning disability services, which can be used to prevent or reduce the incidence of self-harm in these settings. This approach should therefore be an integral part of nurses' daily therapeutic activities in in-patient learning disability services.

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1. Introduction

This study was carried out in a learning disability service. One of the primary focuses of nurses working in these settings is to prevent self-harm (Duperouzel & Fish, 2010). Interventions that encourage nurse-patient interactions are considered effective for achieving such a goal (Stewart & Bowers, 2012). Observation is one of such interventions that can be used to provide a period of safety for patients when they are at risk of harm to themselves or others (Duperouzel & Fish, 2010). The Standing Nursing and Midwifery Committee (SNMAC, 1999) defines it as ‘regarding the patient attentively’ while minimising the extent to which they feel they are under surveillance. Acknowledging this, observation is both a custodial activity and a forum that offers an opportunity for nurses to interact therapeutically with patients. Notwithstanding this opportunity, negative accounts of being observed are noted in the literature sources.

Patients often describe observation as intrusive, controlling and humiliating, as they believe it violates their personal integrity (Wallace, 2007). Despite this, observation is still used in learning disability services. Its continuing use is attributable to the conflicting dual role of nurses: maintenance of safe environments and care provision. Mason, Mason-Whitehead, and Thomas (2009) agree with this and assert that the role of nurses includes observing patients to prevent self-harm. This ‘keeping an eye’ function carries the risk of impeding nurses’ therapeutic roles, and enabling patients to feel angry and devalued. Such negative emotions can perpetuate patients’ self-harming behaviours (Sandy, 2013). In spite of this, the use of observation in learning disability services is largely a neglected area of investigation.

2. Background and literature review

Patients in in-patient learning disability services need to be observed for their own or others’ safety (Khan, Rice, & Tadros, 2012). The SNMAC (1999) offers four categories of observation: ‘within arms length’, ‘within eyesight’, ‘intermittent’, and ‘general’. The category that nurses use to ensure safety is influenced by hospital policy and acuity of patients’ illnesses. High-risk behaviours, such as self-harm require the ‘within arms length’ category. This category involves assigning a nurse to observe the at-risk patient with a greater intensity than that which any patient generally receives (Stewart, Bilgin, & Bowers, 2010). The ‘within eyesight’ category is adopted for patients who pose a risk to the self or others (Department of Health (DH), 2006). In this case, the at-risk patient is kept at all times within sight of the nurse assigned to observe the same. In relation to the ‘intermittent’ category, patients are checked at specific and regular intervals to ensure safety. The ‘general’ category requires nurses to know the whereabouts of all patients at all times.

The SNMAC (1999) recommends the use of these categories on patients with risk of self-harm and violence. It also recommends for observation to be undertaken by skilled healthcare workers whose remit is to create opportunities for therapeutic engagement, and assessments of patients’ mental states

and behavioural presentations. This is consistent with the principle of ‘reciprocity’, which states that if a patient’s freedom is restricted because of observation requirements, then healthcare workers are obliged to engage with the patient and provide care (The Scottish Government, 2002). Despite the adherence to this principle, self-harm and suicides still occur in clinical areas while patients are under observation (DH 2006). This could be a function of patients’ increased desperation to use self-harm to cope with their distress (Klonsky, 2007). However, patients have reported positive experiences of being observed. Some claim that it enables them to feel secure and understood by nurses (Jones, Lowe, & Ward, 2000). Others report that it prevents them from self-harming, and alleviates their feelings of loneliness and suicidal ideations (Jones et al. 2000). Given the uncertainties about the role of observation in preventing self-harming behaviours, further research is needed to better understand this intervention.

3. Aim

To explore nurses’ knowledge and understanding of the use of observation on patients who self-harm in a learning disability service in the United Kingdom.

4. Research design and methods

4.1. Design

This study utilised a qualitative approach and interpretative phenomenological analysis (IPA) as a design. IPA was used here for a number of reasons. It stresses that the meanings that a phenomenon hold for people can be understood through participant–researcher interactions (Sandy & Shaw, 2012; Smith, 2005). Access to these meanings can be possible if researchers adopt ‘an insider’ stance and a hermeneutics of questioning stance. The stance of ‘an insider’ requires researchers to use their preconceptions to understand individuals’ experiences of a phenomenon and the meaning they attribute to it. The hermeneutics of questioning stance requires researchers to stand alongside participants and ask critical questions over things they say. Adopting this double hermeneutic position enabled the researcher of this study to develop understanding of observation.

4.2. Study site

The study was conducted in a learning disability service in the west of England. This service comprised seven locked clinical areas with six registered nurses working in each area. These nurses had either a bachelor degree qualification in mental health nursing or learning disability nursing. They attained their respective qualifications from higher education institutions in England.

4.3. Sampling and data collection

The nurses of the study site were met at a meeting in which the aim and eligibility criteria of the study were discussed.

Each nurse was given an information leaflet, and a letter of invitation to take part in the study. Forty nurses made contact with the researcher and expressed their willingness to participate. Sampling was criteria purposive. Thirty of the 40 nurses met the inclusion criteria for participation, and were therefore eligible to be interviewed. A follow-up letter was sent to each of the 30 nurses confirming the date, time and venue of the interviews.

Individual and focus group interviews were used as data collection methods. Data were collected in November and December 2011 using a semi-structured interview guide designed according to IPA guidelines. The sample size of the individual interviews was 20 and that of the three focus group interviews was 15 with five nurses per group. All interviews were held in a designated room of the learning disability service, and were conducted in two phases. Phase one involved the individual interviews, while phase two involved the focus group interviews. The researcher of this study conducted all interviews, and they lasted for 45 min to an hour. A research assistant assisted the researcher by making notes of observations during the focus group interviews. The participants did not know the researcher and research assistant, and all interviews were audio-recorded.

4.3.1. Inclusion criteria of the study

Registered mental health nurses or learning disability nurses:

- With two or more years of using observation on patients who self-harm in the learning disability service.
- Who are willing and feel safe to share their experiences and views of observation with others.

4.4. Ethical considerations

Permission to conduct this study was gained from the National Research Ethics Services. The main ethical threats were in the areas of consent, confidentiality and anonymity. All aspects of the research were explained to participants. Informed consent was obtained from participants, and they were free to withdraw at any time. All data were stored securely in accordance with the privacy and data collection laws. As regards anonymity, at the point of transcription names were substituted for code numbers, and in all reports, including this paper, great care was taken to change any information by which a participant could be identified.

4.5. Data analysis

All interviews were transcribed verbatim and transcripts were analysed manually by the researcher according to IPA guidelines. Analysis proceeded in parallel with the interviews, and was conducted iteratively throughout the interview period until category saturation was achieved. The analysis was conducted in stages by the researcher. Each transcript was initially read to familiarise with the accounts presented. This was done line-by-line and notes were made of anything interesting about participants' accounts. Themes were developed from the notes. The emergent themes were compared, and similar themes were clustered. This resulted in the development of a master list of themes containing super-

ordinate themes, sub-themes and quotes to illustrate where in the transcripts the themes could be found.

5. Results

Three superordinate themes emerged from data analysis: observation: its meaning, observation: does it prevent self-harm? and observation: making it work. The initials 'IN' and 'FG', which stand for individual interviews and focus groups respectively, are used at the end of each excerpt to identify their source.

5.1. Observation: its meaning

This theme relates to participants' meanings of the intervention of observation. All the participants were able to explain what observation means.

Observation should be a flexible forum to therapeutically engage and assess patients' mental states in order to inform clinical decisions. Observation is also about maintaining the safety of patients and others (FG).

Observation is about ensuring that patients and others are safe. It is also about engaging patients in meaningful activities (FG).

The allocation of the care and supervision of a patient to an individual nurse was described by participants as an integral aspect of observation. They noted that patients might experience distress when being observed.

Patients do not always feel safe when being observed. They often describe the intervention as intrusive and distressing (IN).

Observations can cause distress in patients. The use of activities may alleviate this distress. The use of activities enables patients to focus their thoughts on the activities rather than on self-injury (FG).

The use of meaningful activities to alleviate the distress which observation might cause was recommended by participants. They considered the distractions from self-harm provided by observation therapeutic; it could reduce patients' suicidal feelings. Despite this therapeutic value, participants reported that nurses do not always engage patients in activities and/or conversations during observation.

Some nurses just sit down and watch the doors to the patients' bedrooms. They just guard the patients. Observation is about engaging patients (FG).

Guarding the patients and not engaging them in conversations and/or activities is disrespectful, invalidating and humiliating (IN).

Observation was considered by all participants an important intervention for engaging and providing therapeutic support to patients.

Engaging patients rather than guarding creates opportunities for assessment of patients' behaviours, including physical and mental states (IN).

Although engagement is important for assessment and provision of therapeutic support, these clinical activities must be done with the patient (IN).

Some participants were of the opinion that observation should not be a 'fit for all' intervention, but rather a patient-centred approach.

We should avoid a blanket approach to observation. So, we only ban the use of objects, such as belts if indicated by risk assessments. The level of observation used is determined by the patient's risk of self-harm (FG).

Patients' personal property should not be routinely taken away from them. Such actions should be informed by outcomes of risk assessments and policy (IN).

I do not know the differences between the categories of observation. That is why I often take away patients' personal properties when I suspect that they are at risk of self-harm. Some other nurses tend to do the opposite (IN).

5.2. Observation: does it prevent self-harm?

This theme relates to the therapeutic value of observation. It offers participants' views on whether this intervention prevents patients' self-harming behaviours.

5.2.1. Prevents self-harm

Several reasons for the use of observation were provided by participants. They claimed that it could be used to manage behaviours that challenge, like self-harm.

I know there are so many reasons why we observe patients. Here, we mostly observe to prevent them from hurting themselves (IN).

When we sit with patients we usually ask them to tell us about how they are feeling. Through these conversations, we can tell whether they have plans to hurt themselves (FG).

Participants felt that spending time with patients allows for assessment and identification of signs of impending self-harm. They stressed that the identification of signs allows for immediate intervention and subsequent prevention of self-harm.

When we observe patients from a distance and / or sit close to them, we can sometimes tell if they intend to hurt themselves (IN).

Sitting close to patients falls in the 'within arms length' category of observation. This category offers instant opportunities to remove objects to prevent self-harm because of the closer proximity of the allocated nurse (FG).

The best approach to stop patients from harming themselves is to take away anything in their possession or vicinity that is sharp (IN).

The removal of objects that could cause harm was seen by most participants as an effective approach to self-harm prevention. But they stressed that such an approach should be informed by outcomes of risk assessments.

Any risk assessment decisions, such as taking away patients' properties must consider the risks and benefits involved (IN).

Even though we should sometimes take items patients might use to hurt themselves, I believe their consent must be obtained at all times (FG).

Observation was reported by participants as a critical activity for the assessment of the risk of self-harm in learning disability services. This is because it enables nurses to focus on the patients despite distractions in the clinical areas. Attaining such a focus may enable nurses to accurately predict the severity of risk, and identify appropriate levels of care.

Assessment during observation helps us to determine suitable levels of care patients may need. It also helps us to prevent self-harm and avert death (FG).

Though my presence during observation often angers them, they often describe my presence as helpful. Some have even thanked me for preventing them from harm, and others thanked me for saving their lives (IN).

When we listen to patients, they feel 'cared for', and this reduces their risk of self-harm. But some nurses do not believe that observation can prevent self-harm (FG).

5.2.2. Does not prevent self-harm

There was an agreement among participants that some patients in learning disability services have been exposed to traumatic events, like sexual abuse. They reiterated that patients with these experiences use self-harm to cope with their distress, and resist urges to commit suicide.

Some patients cannot do without cutting. A female patient told me that each and every scar on her body represents a period she escaped death (IN).

Patients often stress that they do not want to kill themselves, and so self-harm to avert death when extremely distressed (IN).

The notion that self-harm could lead patients to accidentally or intentionally kill themselves was mentioned by some participants. They stated that prevention of fatal outcomes is a very good reason for intervening when patients are in acute states of distress.

Observation is the intervention we commonly use to stop patients from hurting themselves. The type we use

depends on the patients' intentions to harm themselves (FG).

Observing patients frustrates and angers patients. Such a cocktail of emotions exacerbates patients' need for self-harm (FG).

Participants stressed that the use of observation to prevent self-harm may increase patients' desperation in their attempts to hurt themselves.

Observation of any kind may restrict patients' freedom. It makes them to feel more hopeless and helpless, and to self-harm covertly and more seriously (IN).

5.3. Observation: making it work

This theme relates to discussions on how observation can be improved in order to prevent or minimise patients' risk of self-harm.

5.3.1. Patient involvement

Generally, participants were of the opinion that nurses assigned to observe patients are required to treat the latter as resourceful people, capable of assuming control of their lives.

Patients should be provided with explanations of the reason for being observed, type of observation, and the role of the observer (FG).

The patients should also be offered an opportunity to discuss any concerns they might have with the nurse allocated to observe them (IN).

Participants believed that such an approach to patient involvement demonstrates that patients' wishes are valued and respected. They however stressed that nurses need to always take into consideration safety issues when respecting the wishes of patients.

Patient's wishes are to be respected. But we must do so within the safety boundary requirements of the level of observation the patient is on (FG).

The risk decisions that nurses make must be informed by risk assessment, and patients should be an integral part of this process (IN).

It was frequently emphasised by participants that observation is about caring with rather than caring for patients. They stressed that it is only through such partnership that nurses could effectively explore patients' reasons for self-harm.

If we were to achieve the goals of observation, preventing self-harm, we must involve patients in its process (IN).

It is sometimes difficult to involve patients in initiating observation because of the immediate moral reaction of nurses to prevent harm. But nurses should always try to involve them (IN).

5.3.2. Engagement in meaningful activities

Engaging patients in activities was considered by participants an important approach to minimise the distress the former might experience during observation. They noted that the assessment of patients' mental states and risk they posed can occur during the conversations that take place around activities.

Activities enable us to assess patients' needs, wants and mental states. Patients often talk to us freely during activities. Activities distract them from harming themselves (FG).

As nurses we must demonstrate willingness to engage patients in activities. We must also demonstrate willingness to listen to patients' concerns (IN).

According to some participants, patients who self-harm prefer nurses who are prepared to engage them in activities, and committed to listen to their concerns.

We generally do not have time to listen to patients' concerns because we are often occupied with administration work (IN).

Patients often feel unsupported by us because we do not listen to them. So most of our patients have lost hope in us, and this often makes them to self-harm (FG).

We constantly need to instil hope in patients by involving them in activities. Failing to do so enables them to repeatedly hurt themselves (FG).

5.3.3. Establishing a therapeutic relationship

A trusting relationship was considered by participants a fundamental premise for instilling hope and enabling patients to resist urges to self-harm.

Therapeutic relationship is the medium through which quality care can be delivered. So nurses must establish and strengthen their relationships with patients during observation (IN).

Nurses are often not trusted by patients who self-harm. So, developing a rapport with patients would help to restore trust, and creates a base for addressing the difficulties that often lead to self-harm (IN).

Most nurses are reported by participants to be ill-equipped to work with patients who self-harm. They stressed that nurses do not always treat patients who self-harm with respect and compassion.

Some patients have reported experiences of rejection and labelling. One said that some nurses have called her names like 'mad' and 'attention seeker' (FG).

Ascribing labels to patients distracts us from providing care. It also deters us from developing rapport with patients, and it often perpetuates patients' need for self-harm (FG).

5.3.4. Training and education

Only few nurses in the learning disability service were reported by participants to be trained in observation despite the view that it is an important intervention for preventing self-harm.

I am not trained in how to observe. Most of my colleagues are also not trained in observation. So, we have been implementing it incorrectly (FG).

Allowing nurses who are not trained in observation to observe patients is doing a disservice to patients. We should remember that observation is a skilled intervention (IN).

Participants believed that training nurses how to observe would improve the quality of observation. So, the absence of nurses trained in observation could result in sub-standard application of the same.

Observation involves the detection of signs of imminent self-harm. Nurses who are not trained would have difficulty in recognising signs of imminent self-harm (IN).

Training in observation should include therapeutic engagement, distress management, distress tolerance, and staffing issues, such as how to handle staff fatigue (FG).

Training was not seen by participants as a one-off activity, but was seen as an ongoing lifelong learning experience. They also emphasised for training to assume a multidisciplinary format.

Others, like psychologists should be trained in observation. Patients are to be involved as co-facilitators. This approach would result in change in attitudes toward patients who self-harm, and would also allow patients to present themselves as experts in their lives, and as individuals beyond their diagnosis and self-harming behaviours (FG).

6. Discussion

Observation is an intervention frequently used in learning disability and mental health services in the United Kingdom to prevent self-harming behaviours (Duperouzel & Fish, 2010). But healthcare professionals often question its therapeutic value in relation to the prevention of self-harm. Nurses are the healthcare professional group that often implements observation. Thus, their knowledge and understanding of this intervention are critical for its effective implementation. This study explores nurses' knowledge and understanding of the use of observation on patients who self-harm. Its outcome reveals that nurses are aware of the meaning and reasons for using observation. They refer to it as an intervention for preventing acutely distressed patients from harming themselves or others, a view which Duperouzel and Fish (2010) echo in their study. Observation involves the allocation of the care and supervision of the 'at risk' patient to an individual nurse

over a defined period. The rationale for such allocation is to ensure the safety of the 'at risk' patient and others. Nurses are the healthcare professionals who are usually allocated to directly observe patients who are at risk of self-harm (Stewart & Bowers, 2012). This means that less time is available for the support and care of other patients in the clinical areas.

There are variants of the intervention of observation. The category nurses use at any point in time is influenced by the acuity of patients' illnesses, and outcomes of risk assessments (DH 2006). For instance, the 'within arms length' and 'within eyesight' categories are used on patients with a high risk of self-harm or violence towards others (Stewart et al. 2010). In contrast, the 'Intermittent' and 'general' categories are used on patients with a low risk of these behaviours. This suggests that observation is not a 'fit for all' intervention, but it is a therapeutic and patient-centred intervention that requires nurses to address patients' individual risk assessment and management needs. Hence, the approach of removing patients' personal property that is sharp from their possession, in the name of self-harm prevention, is to be adopted with caution, and implemented only if indicated by risk assessment.

Observation creates opportunities not only for assessment of patients' mental and physical states, but also for preventing self-harm (Stewart & Bowers, 2012). This is particularly the case for the 'within arms length' and 'within eyesight' categories. The preventive function of these observation categories is attributable to the closer proximity of the allocated nurses to the patients, as it allows for immediate therapeutic engagement using, for example, activities. The engagement that activities provide is regarded here as highly therapeutic because of their role in reducing patients' thoughts and feelings of self-harm, and subsequent self-harm prevention. The focus that nurses attain when engaged with patients during periods of distress enables them to predict the severity of risk and identify the level of care the latter may need. Despite this therapeutic value, this study notes that nurses do not always engage patients in activities when undertaking observation; they tend to sometimes guard the patients. It is for this reason that Khan et al. (2012) refer to observation as a custodial activity.

The 'keeping an eye' function of observation prevents self-harm (Mason et al. 2009). Given that self-harm serves as a common strategy that patients use to cope with acute distress and avert suicide (Klonsky, 2007), preventing the use of this familiar method is denying them of the benefits associated with it. Hence, the custodial function of observation carries the risk of enabling patients to feel angry and disrespected (Wallace, 2007). Similar emotional experiences of patients are reported by participants of this study. They note that patients often describe observation as controlling and humiliating, especially when it involves the removal of personal item from their possession. While such experiences may perpetuate the need for self-harm, the removal of personal items seems to indicate that patients cannot be trusted on their own. Given that trust is necessary in a therapeutic relationship (Edward & Hewitt, 2012), the intervention of observation seems to threaten the prospects for establishing such a relationship. Such threats may damage the self-esteem of patients, and lead them to self-harm covertly with increase in lethality.

Patients' involvement in the observation process is a potent approach to improve its application and prevention of self-harm. This is because involving patients enable them to feel valued and respected as resourceful people who are capable of making decisions on their lives. Involvement of patients also indicates nurses' willingness to work with the latter as partners in their quest of self-harm prevention. However, this study notes that nurses sometimes experience difficulty working with patients who self-harm. This is often a function of the emotions, like anger that self-harm evokes, which in turn may hinder the quality of observation.

Strategies for strengthening the nurse–patient relationship may improve how patients are observed and engaged in clinical practice (Edward & Hewitt, 2012). An example revealed in this study includes engagement of patients in activities of their choice. Feelings of hopelessness and helplessness are usually experienced by patients who self-harm (Sandy, 2013). Engaging this patient group in activities may not only enhance their feelings of hopefulness, but it may also distract them from harming themselves. Participants therefore stipulate for the use of activities to be an integral part of all training in the intervention of observation.

This study reveals that observation is a highly skilled activity for caring with patients in periods of distress. Yet most nurses of the study site are not trained in this intervention. It is therefore not surprising for participants to report inconsistencies in its application, such as the use of blanket approaches. The use of blanket approaches, like routine removal of personal properties, indicates nurses' limited knowledge and understanding of observation. Thus, training nurses in this intervention will equip them with appropriate skills and knowledge of how to observe and prevent patients from self-harm. The acquisition of appropriate skills and knowledge would also ensure consistency in the application of observation. Consistency in the use of this intervention can be further enhanced if training adopts a multidisciplinary approach, and involve patients as co-facilitators. Involving patients as facilitators of training may cultivate positive attitudes among healthcare workers toward patients who self-harm. Positive attitudes, such as acceptance of patients as humans who are in need of care and compassion, may strengthened nurse–patient relationships and reduce self-harming behaviours.

7. Rigour of the study

This study adopts the framework of trustworthiness posited by Guba and Lincoln (1994). This framework includes five criteria; credibility, dependability, confirmability, transferability and authenticity.

The production of stable data is what Guba and Lincoln (1994) refer to as dependability. Confirmability relates to the degree of agreement between two or more researchers about the accuracy, meaning and relevance of data. It is also about ensuring that the findings of a study represent participants' narratives. Credibility refers to researchers' approaches to ensure the believability of study findings. These criteria were assured here using a number of approaches. All interviews were audio recorded and transcribed verbatim. All interviews

were guided by an interview schedule, and notes were also taken during interviews to capture the non-verbal reactions of participants. Individual and group interviews were followed immediately by a debriefing session to alleviate anxieties participants might have experienced, and if indicated, to refer for psychological support. Member checking was carried out. This means transcripts were sent to participants to determine their accuracy, and in all cases participants were satisfied. With regard to authenticity, this criterion requires researchers to provide detail descriptions of a range of participants' lived experiences and feelings in relation to a phenomenon studied. Transferability refers to the degree to which the results of a study can have utility in other settings similar to the study area. These criteria were assured here by writing a manuscript with detailed descriptions of the methods and context of the study, and participants' varied lived experiences of observation.

8. Limitations

There are some limitations to the study. It focused on nurses' perceptions on the use of observation, and did not attempt to obtain patients' views. The study was carried out in a single learning disability service. The nurses of the study setting are probably different from nurses of other learning disability services. The study results are based on retrospective accounts of nurses' experiences of observation. Such accounts are subject to memory bias. However, these accounts provided valuable insights and context for understanding observation and its implementation.

9. Recommendations

Given that only nurses were involved in the study, there is a need for future qualitative studies to include patients and other healthcare workers. Doing so would generate more insight into observation, which in turn would help to improve its application in practice. To address the issue of memory bias, it is important for future studies to adopt a prospective cohort design that may include patients, nurses and other healthcare workers as participants. Again, the adoption of such an approach would enhance understanding of this intervention as well as improve its use in clinical settings.

10. Conclusion

This study adds to the body of knowledge that the intervention of observation does not always prevent self-harm, as it sometimes contributes to its incidence. However, participants provided suggestions for how observation can be improved to prevent self-harm or reduce its incidence. An example of this includes the need for training in observation. Training is needed not only to equip nurses with the necessary attitudes, skills and knowledge of how to observe, but also to ensure consistency in the application of this intervention. With the right skills, knowledge and attitudes, nurses can use the intervention of observation to prevent or reduce self-harming behaviours.

Author contribution

P.T.S: conceptualized the research project, collected and analysed data, and wrote the manuscript.

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