

Best Evidence Statement (BEST)

Date 7-6-2011

Preventing Patient Self-Harm

Clinical Question

P (population/problem)	Among inpatient psychiatric patients
I (intervention)	does constant observation beginning at admission
C (comparison)	compared to routine safety checks
O (outcome)	reduce the incidence of self harm

Target Population

Children and adolescents ages 6-17 admitted to an inpatient psychiatric unit, with suicidal ideation, previous suicide attempts, or self-injurious behaviors including suicidal and non-suicidal self harm at serious risk of self harm.

Definitions

Routine safety checks is the minimum level of observation for a patient in the Division of Psychiatry. All patients will be monitored at variable intervals of no more than 15 minutes.

Constant observation is a higher level of observation, by monitoring patients visually at all times by a dedicated staff member in the same room, including bathroom.

* These definitions are in accordance with CCHMC Psychiatry Policy PSY 006.

Recommendation

1. It is recommended that direct care providers working on inpatient psychiatric units and performing constant observation use a therapeutic relationship approach. It has been found that a therapeutic relationship is interpreted as more effective than a controlling or isolating approach (Cleary, 2003 [4a], Duffy, 1995 [4a], Vrale & Steen, 2005 [4a]).

There is insufficient evidence, due to a lack of quantitative studies regarding constant observation, to make a recommendation answering the clinical question, due to safety purposes this is an accepted practice. How this is carried out however, varies. A therapeutic relationship approach can be more successful in maintaining patient safety (Schoppmann, 2007 [4a], Cleary, 2002 [4a], Dodds & Bowels, 2001 [5a]).

Discussion/summary of evidence

No quantitative studies were found in the literature search. However such studies might prove to be unethical to withhold intervention due to the vulnerability of patients that require constant observation for self harm. Qualitative research may be the best mode to examine the effectiveness of constant observation by interpreting the perceptions of those who perform and receive constant observation as an intervention. It is found through searching this literature that constant observation is used for decreasing the incidence of self harm; however several factors contribute to constant observation being a successful intervention. Patients placed on constant observation are at a higher risk of attempting self harm and may be in a state of emotional instability (Kettles, 2004 [4a]). The task of constantly observing vulnerable patients can be interpreted as

paternal or controlling in nature (Duffy, 1995 [4a], Fletcher, 1999 [4a], Cardell, 1999 [4a]). By approaching these patients with therapeutic presence direct care providers will be more successful at maintaining patient safety (Schoppmann, 2007 [4a], Cleary, 2002 [4a], Dodds & Bowels, 2001 [5a]). Instead of merely isolating and observing patients on constant observation, building a therapeutic relationship by engaging and interacting with the patient will help reduce the patient's symptoms (Vrale & Steen, 2005 [4a], Cutcliffe & Barker, 2002 [4a]). Hospital administrators need to consider the benefit of a therapeutic approach to constant observation when creating policies, procedures, and guidelines (Bowers, 2000 [4a], Tishler, 2009 [5b]).

Grade of the body of evidence: Moderate

Health Benefits, Side Effects and Risks

1. Health benefits include maintaining a safer environment for patients and staff. Using a therapeutic approach to constant observation not only can lead to decrease in self-harm, but also decrease in aggression by having less confrontations resulting from a controlling approach (Phillips, 2004 [5a]).
2. Utilization of constant observation is associated with large fixed costs (Bowers, 2008 [4b]). Not all patients should be placed at the highest level of observation; therefore a threshold determined by the Suicide Risk Assessment Tool (SRT) should be used to determine those patients who need constant observation as part of their care plan.

References (evidence grade in []; see *Table of Evidence Levels following references*)

1. Bowers. (2000). Suicide and Self Harm in Inpatient Psychiatric Units: a National Survey of Observation Policies. *Journal of Advanced Nursing*, 32(2), 437-444. [4a].
2. Bowers, L. Flood, C. (2008). Nurse Staffing, Bed Numbers, and the Cost of Acute Psychiatric Inpatient Care in England. *Journal of Psychiatric and Mental Health Nursing*, 15, 630-637. [4b].
3. Cardell and Pitula. (1999). Suicidal Inpatients' Perceptions of Therapeutic and Non-therapeutic Aspects of Constant Observation. *Psychiatric Services*, 50, 8, 1066-1070. [4a].
4. Cleary. (2003). The Challenges of Mental Health Care Reform for Contemporary Mental Health Nursing Practice: Relationships, Power, and Control. *International Journal of Mental Health Nursing*, 12, 139-147. [4a].
5. Cutcliffe and Barker. (2002). Considering the Care of the Suicidal Client and the Case for Engagement and Inspiring Hope or Observations. *Journal of Psychiatric and Mental Health Nursing*, 9, 611-621. [5a].
6. Dodds, Bowels. (2001). Dismantling Formal Observation and Refocusing Nursing Activity in Acute Inpatient Psychiatry: A Case Study. *Journal of Psychiatric and Mental Health Nursing*, 8, 183-188. [5a].
7. Duffy. (1995). Out of the Shadows: A Study of the Special Observation of Suicidal Psychiatric Inpatients. *Journal of Advanced Nursing*, 21, 944-950. [4a].
8. Fletcher. (1999). The process of Constant Observation: Perspectives of Staff and Suicidal Patients. *Journal of Psychiatric and Mental Health Nursing*, 6, 9-14. [4b].
9. Kettles. (2004). Is there a Relationship Between Risk Assessment and Observation? *Journal of Psychiatric and Mental Health Nursing*, 11, 156-164. [4a].
10. Phillips, J. (2004). Risk Management of Suicide and Self Harm Within a Forensic Learning Disability Setting. *Learning Disability Practice*, 7,(2), 12-18. [5a].

11. Schoppmann. (2007). Then I Just Showed Her My Arms... Bodily Sensations on Moments of Alienation Related to Self-Injurious Behavior. A Hermeneutic Phenomenological Study. *Journal of Psychiatric and Mental Health Nursing*, 14, 587-597. [4a].
12. Tishler, C., Staats-Reiss, N. (2009). Inpatient Suicide: Preventing a Common Sentinel Event. *General Hospital Psychiatry*, 31, 103-109. [5b]
13. Vrale, Steen. (2005). The Dynamics Between Structure and Flexibility in Constant Observation of Psychiatric Inpatients with Suicidal Ideation. *Journal of Psychiatric and Mental Health Nursing*, 12, 513-518. [4a].

Note: Full tables of evidence grading system available in separate document:

- [Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality](#) (abbreviated table below)
- [Grading a Body of Evidence to Answer a Clinical Question](#)
- [Judging the Strength of a Recommendation](#) (abbreviated table below)

Table of Evidence Levels (see note above)

<i>Quality level</i>	<i>Definition</i>
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5	Other: General review, expert opinion, case report, consensus report, or guideline

†a = good quality study; b = lesser quality study

Table of Recommendation Strength (see note above)

<i>Strength</i>	<i>Definition</i>
“Strongly recommended”	There is consensus that benefits clearly outweigh risks and burdens (or visa-versa for negative recommendations).
“Recommended”	There is consensus that benefits are closely balanced with risks and burdens.
No recommendation made	There is lack of consensus to direct development of a recommendation.

Dimensions: In determining the strength of a recommendation, the development group makes a considered judgment in a consensus process that incorporates critically appraised evidence, clinical experience, and other dimensions as listed below.

1. Grade of the Body of Evidence (see note above)
2. Safety / Harm
3. Health benefit to patient (*direct benefit*)
4. Burden to patient of adherence to recommendation (*cost, hassle, discomfort, pain, motivation, ability to adhere, time*)
5. Cost-effectiveness to healthcare system (*balance of cost / savings of resources, staff time, and supplies based on published studies or onsite analysis*)
6. Directness (*the extent to which the body of evidence directly answers the clinical question [population/problem, intervention, comparison, outcome]*)
7. Impact on morbidity/mortality or quality of life

Supporting information

Introductory/background information

Risk of patients harming themselves is a serious concern on each inpatient psychiatric unit. The risk of patient self-harm increases when there is inconsistent practice in the use of constant observation, especially during new admission and/or transfer from medical units [Local Consensus].

Group/team members

Team Leader/Author: Jason Phibbs, BSW, Mental Health Specialist II. Adolescent Psychiatric/Medical Inpatient Unit

Support/Consultation: Mary Ellen Meier, MSN, RN, CPN, Evidence Based Practice Mentor; Center for Professional Excellence, Research & Evidence Based Practice

Search strategy

Databases: CINAHL, Medline, Cochrane Review, PsychInfo, Google Scholar

Keywords: observation, self harm, suicidal behavior, self injurious behavior, adolescents, inpatient, psychiatry.

Limits: English language, time frame included articles published in the previous 20 years

Retrieved: July 29, 2010, November 22, 2010

Known conflicts of interest

There are no known conflicts of interests.

Applicability issues:

Applicability issues for the implementation of this evidence include the need for a reliable suicide risk assessment at the time of admission and on-going assessment of patient's risk for self harm. Applicability issues include the impact of this evidence on staffing levels for psychiatric units related to increased patient acuity.

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Note

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.

Reviewed by Cincinnati Children's Medical Center Evidence Federation