# Culture of Care

Observation, self-harm and suicide risk

10th November 2025

Dr Leah Quinlivan

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Neurodiverse Connection

Global Black Thrive

NCISH

# Personalised approach to risk: learning sessions

- **Aim:** To overview evidence for key areas in relation to self-harm, suicide, and personalised risk assessment

- **Session 7**: Observation, self-harm, and suicide risk

- **Equity principals**: Trauma informed, autism informed, and anti-racist

| Time | Item |
|---|---|
| 10.00.10.15 | **Welcome and introductions (Leah)**<br>• Leah will welcome attendees. She will highlight the importance of safety and wellbeing. Emma and Leah will overview the importance of considering language, stigma, and trauma for self-harm and suicide throughout our discussions |
| 10.10-10.25 | **Observation and patient safety: context (Leah)**<br>• Leah will overview NCISH data on suicide under observation in mental health services. |
| 10.25-10.45 | **What is the point in observation for self-harm and suicide? (Emma)**<br>• Emma will speak about the purpose of observation in the context of self-harm and suicide, from a lived and learned perspective. |
| 10.45-11.05 | **The importance of psychological and emotional safety (David)**<br>• David will overview the importance of psychological and emotional safety in mental health services and observations. |
| 11.05-11.15 | **Break** |
| 11.15-11.35 | **Surveillance-based technology in inpatient and acute care: Systematic review evidence (Rose)**<br>• Rose will overview evidence on the use and impact of surveillance-based technology initiatives in inpatient mental healthcare. |
| 11.35-11.55 | **Observation and technology in mental health inpatient care (Rose)**<br>• Rose will overview lived experience research, and advocacy work in relation to the use of technology, including Oxevison in mental health inpatient care. |
| 11.55-12.25 | **Panel discussion & Q&A**<br>• Leah, Emma, Pea will facilitate the panel discussion and we welcome any questions or comments. |
| 12.25-12.30 | **Meeting close**<br>• Leah will close the meeting and provide an overview of the next learning and workshop events. |
| 12.30 | **Close** |

# Topic warning, wellbeing and psychological safety

# House keeping

Say hi in the chat section


Be comfortable: camera off or on; take breaks, leave/come back (recording)

Comments & questions in chat

Wellbeing and looking after yourself

Audio off during talks

Hands up

Openness to discussion & diverse opinion

Growth mindset

Be kind, and respectful

# Terms: What is self-harm?

Self-harm: Self-poisoning or self-injury irrespective of apparent motivation or medical seriousness

# Terms and stigma

## Emma Nielsen - Mind your 'C's and 'S's: The Language of Self-harm and Suicide (and why it matters)

The Institute of Mental Health · Friday, 22 January 2016 · 17 Comments

We all say things that we don't mean sometimes. Perhaps the time that you snapped at the end of a long day or said that deliberately hurtful comment in the heat of an argument. Sometimes these instances are easily recognisable (perhaps easily apologised for). However, often our language conveys more subtle messages as well. Even everyday expressions may carry connotations we have not considered and speak to ideas we don't condone. The words we use when we talk about self-harm and suicide show just that; while our language can convey compassion, provide hope, empowerment and optimism, we can also unwittingly express messages that divide and stigmatise.

https://institutemh.org.uk/news/blog/emma-nielsen-mind-your-c-s-and-s-s-the-language-of-self-harm-and-suicide-and-why-it-matters

# Communicating in the chat

Non, judgmental, kind, and compassionate

Sensitive language

No racism, discrimination

Think about wellbeing (you and others)

Mindful of methods & descriptions of self-harm or suicide

Respect privacy

# Suicide, self-harm, and observation in mental health services: Context

Flynn S, Graney J, Nyathi T, et al. Clinical characteristics and care pathways of patients with personality disorder who died by suicide. *BJPsych Open*. 2020;6(2):e29. doi:10.1192/bjo.2020.11

# Psychiatric in-patient care in England: as safe as it can be?

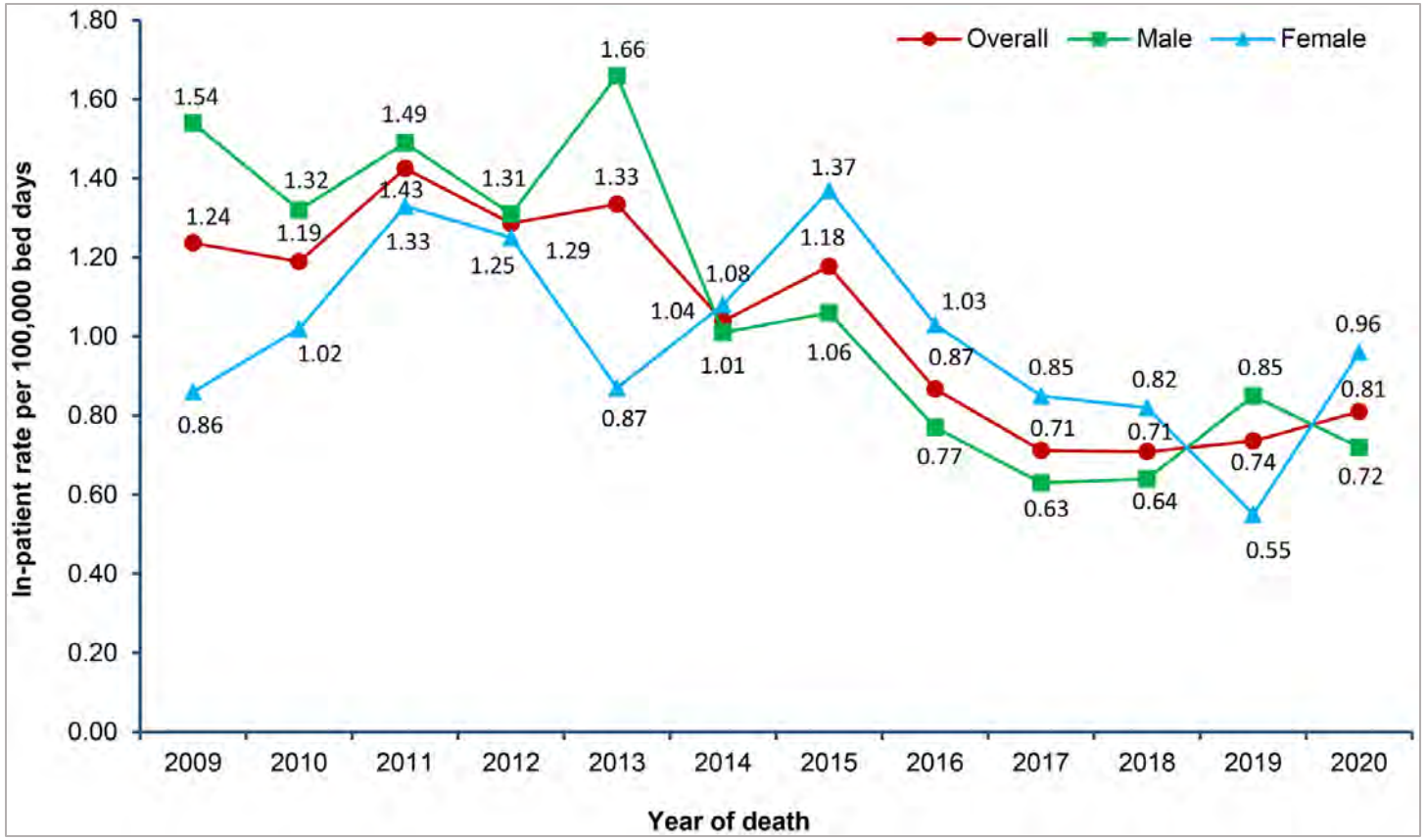



Figure 1. Rates of in-patient suicide by gender, England 2009-2020

**Falling** inpatient suicide rates over the last decade:

- A long-term trend
- 42% fall, but static from 2016
- Falls less apparent in **women**, **younger** in-patients, and women aged **60+** and those with **depression**

Source: Hunt IM,Psychiatric in-patient care in England: as safe as it can be? An examination of in-patient suicide between 2009 and 2020. Psychological Medicine. 2024 Jan 12:1-7.

# Self-harm and patient deaths by suicide

- **76%** Mental health in-patients
- **73%** People with ADHD
- **70%** Autistic people
- **86%** Under 25’s

https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/


# Patient deaths by suicide under in-patient observation

https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

# Observation

- **Level 1:** Low-level general observation

- **Level 2**: Intermittent observation

- **Level 3**: Continuous observation within eyesight

- **Level 4**: Continuous within arms' length

Flynn S, Graney J, Nyathi T, et al. Clinical characteristics and care pathways of patients with personality disorder who died by suicide. *BJPsych Open*. 2020;6(2):e29. doi:10.1192/bjo.2020.11

# Patient safety, suicide, and observation

- **Variable and limited** evidence for efficacy & impact
- **Variable practice**, definitions, reporting, and evaluation
- Lack of clear **guidance/ training**
- **Potential to be harmful** and coercive

Flynn S, Graney J, Nyathi T, et al. Clinical characteristics and care pathways of patients with personality disorder who died by suicide. *BJPsych Open*. 2020;6(2):e29. doi:10.1192/bjo.2020.11

Reen, G. K., et al. (2020). Systematic review of interventions to improve constant observation on adult inpatient psychiatric wards. *International journal of mental health nursing*, *29*(3), 372-386.; https://sites.manchester.ac.uk/ncish/reports/in-patient-suicide-under-observation/; https://www.hssib.org.uk/patient-safety-investigations/patients-at-risk-of-self-harm-continuous-observation/

# Deaths by suicide under enhanced observation 2011-2021

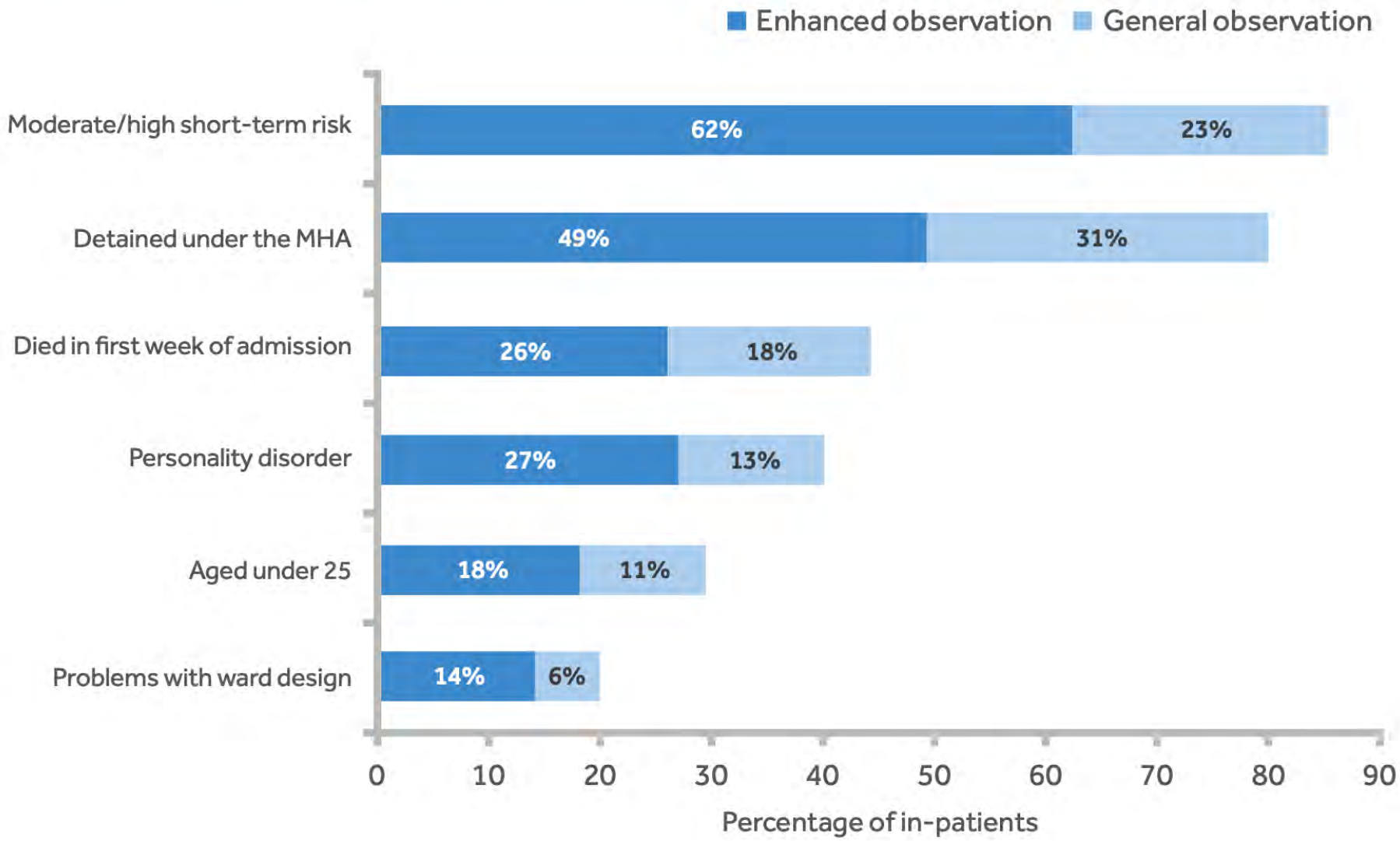
- **166 patients**
- **28%** of in-patient deaths
- **5%** under 18

https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

Flynn S, Graney J, Nyathi T, et al. Clinical characteristics and care pathways of patients with personality disorder who died by suicide. *BJPsych Open*. 2020;6(2):e29. doi:10.1192/bjo.2020.11

# Deaths by suicide under enhanced observation (2011-2021)

Figure 16: In-patient suicide in the UK: characteristics of those under enhanced observation




https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

https://documents.manchester.ac.uk/display.aspx?DocID=3757C

# Patient safety, observation & deaths by suicide (NCISH)

- **61%:** Observation poorly implemented
- **56%**: Less senior staff (e.g., student nurses/assistants, bank staff)
- **33%**: Occurred during busy periods
- **26%:** Poor documentation (patient engagement)
- **25%:** Below required staffing levels
- **23%**: Disrupted due to ward distractions

Flynn, S., et al (2017). Suicide by mental health in-patients under observation. *Psychological medicine*, *47*(13), 2238-2245. https://documents.manchester.ac.uk/display.aspx?DocID=37570

# Patient safety and suicide under observation (NCISH)

"... very few nurses really understood or even were told at the beginning or in the induction **what an observation meant**. They thought it meant **go away**, see someone, **come back and sign the sheet**." Nurse

https://sites.manchester.ac.uk/ncish/reports/in-patient-suicide-under-observation/

Flynn, S., et al (2017). Suicide by mental health in-patients under observation. *Psychological medicine*, *47*(13), 2238-2245

# Patient safety and suicide under observation (NCISH)

"When there are increased levels of observations on the ward, it is more likely that **bank and agency staff** are being used. These staff are more likely to be put on 1:1 observations as **they do not usually know the routine for the ward**. This means that the **rapport with the patient is poor** and often the **observations are carried out poorly**. In my role, I have had to take many papers, magazine etc. from observing nurses and told them to **check the patient**." Nurse

https://sites.manchester.ac.uk/ncish/reports/in-patient-suicide-under-observation/

Flynn, S., et al (2017). Suicide by mental health in-patients under observation. *Psychological medicine*, *47*(13), 2238-2245.

# Change is possible

*International Journal For Quality In Health Care*, 2025, **37(3)**, mzaf070
https://doi.org/10.1093/intqhc/mzaf070
Advance Access Publication Date: 06 August 2025
**Original Research Article**

OXFORD

## Improving therapeutic engagement and observations on inpatient mental health wards in the English National Health Service: lessons from using quality improvement to scale up interventions

**Marco Aurelio[1,*], Sasha Singh[1], Auzewell Chitewe[2], Claire Mckenna[1], Evah Marufu[1], David Bridle[1], Lorraine Sunduza[1], Amar Shah[1,3]**

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**Handling Editor:** Erica Barbazza

**Abstract**

**Background:** Observations on mental health inpatient wards account for a large amount of staff time and cost to organisations. Ideally, observations should support meaningful engagement between staff and service users on wards, benefiting both the recovery of service users and the well-being of staff. However, observation practice is varied, and the therapeutic benefit it brings is questioned in some instances.

**Methods:** Over 18 months, 55 inpatient mental health wards across one English National Health Service (NHS) Foundation Trust employed Quality Improvement (QI) methodology to test interventions aimed at improving observation completion and therapeutic engagement. A standard framework for scaling up was used to sequence the work and support moving from testing a large number of interventions locally to scaling three across the organisation. The three interventions were a board relay, zonal observations, and the use of life skills recovery workers to lead activities. Measures used included general and intermittent observation completion, incidents of violence and agression (physical, verbal and racial), restrictive practice (prone restraint, restraint, seclusion, and rapid tranquillisation), and staff sickness.

**Results:** Sustained improvements were seen in all 10 measures used in this work, as evidenced by shifts in statistical process control charts. General observation completion increased by 1.2%, and intermittent observation completion rose by 1.9%. Incidents of physical violence were reduced by 23%, verbal aggression by 38% and racial aggression by 60. Restrictive practice use also reduced, with restraint reduced by 16%, prone restraint by 35%, seclusion by 38%, and rapid tranquillisation by 26%. Staff sickness also decreased by 16%.

**Conclusion:** Observation completion and therapeutic engagement have been shown to improve with zonal observations, a board relay, and life skills activities led by recovery workers. QI can be used to test and scale interventions rapidly across a system.

**Keywords:** quality improvement; delivery of healthcare; mental health; psychiatry; patient safety

- Tested interventions aimed at **improving observation** completion and **therapeutic engagement**
- 18 months, 55 inpatients wards, 1 NHS Trust
- **QI approach**: improving completion and therapeutic engagement

Aurelio, M., et al. (2025). Improving therapeutic engagement and observations on inpatient mental health wards in the English National Health Service: lessons from using quality improvement to scale up interventions. *International Journal For Quality In Health Care*, *37*(3), mzaf070

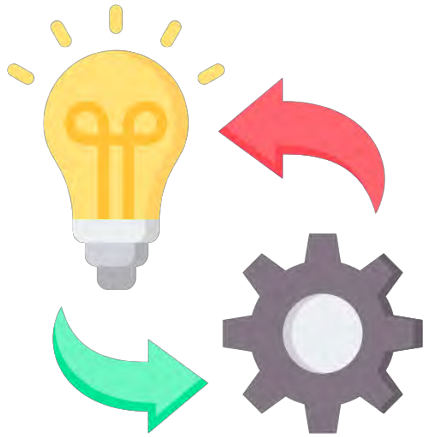
# Changing practice via QI

- **Board relay**: handover board/relay system to ensure duties are visible, tracked and properly handed over
- **Zonal observations**: staff assigned to zones for observation
- **Life Skills Recovery Workers**: staff led meaningful activities (esp during twilight shifts), to increase engagement

Aurelio, M., et al. (2025). Improving therapeutic engagement and observations on inpatient mental health wards in the English National Health Service: lessons from using quality improvement to scale up interventions. *International Journal For Quality In Health Care*, *37*(3), mzaf070

# What happened?

- General/intermittent observation: 1.2% 1.9%
- Physical violence: 23%
- Verbal aggression: 38%
- Racial aggression: 60%
- Restraint: 16%
- Prone restraint: 35%
- Seclusion: 38%
- Rapid tranquilisation: 26%
- Staff sickness: 16%



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# Patient safety and suicide

- Suicide under observation should be a **never event** (NCISH)
- Opportunity for **active engagement & gentle supervision** (NICE, 2022)
- **Therapeutic and skilled intervention**
- **Patient centred,** and part of an overall collaborative care plan
- **QI & Co-design**: Change is possible

Flynn, S., et al (2017). Suicide by mental health in-patients under observation. *Psychological medicine*, *47*(13), 2238-2245.

| | |
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# What is one action or change you can take forward from today's session?

# What will be your first step?

# Next events

- **9.12.25** Relational care and co-regulation for self-harm and suicide prevention

- **12.01.26**: Coroners and suicide

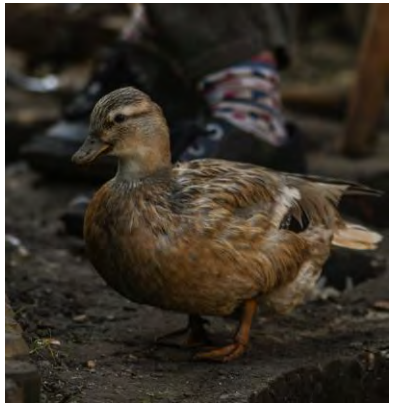
- **29.01.26**: Domestic and sexual violence, self-harm, and suicide

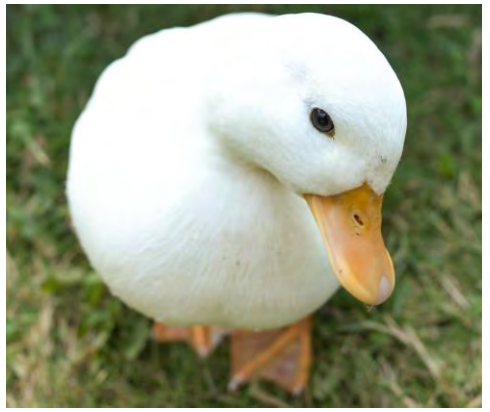
- **17.02.26**: PAR transformation: whole organisation approach

- **27.03.26**: Enabling advocacy &  positive change for self-harm and suicide prevention

# Culture of Care Programme.. Some of our pets!

Koy

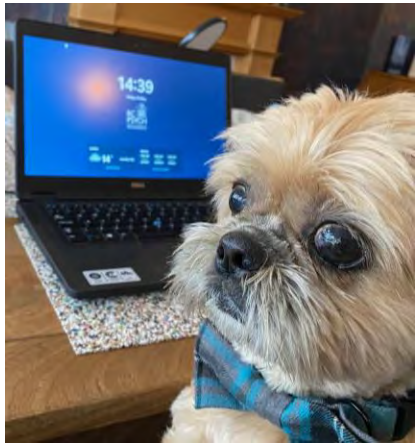




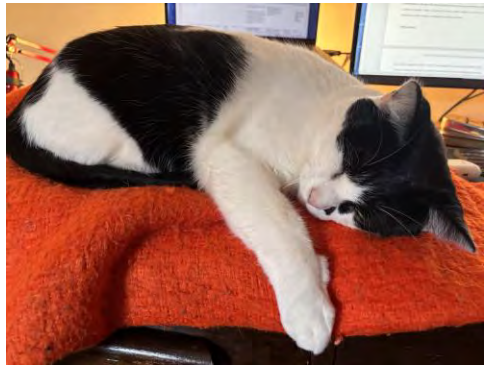
Ida

Kappa

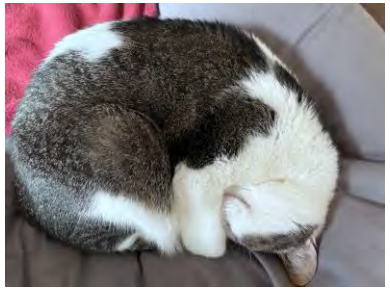
Karja




Basil

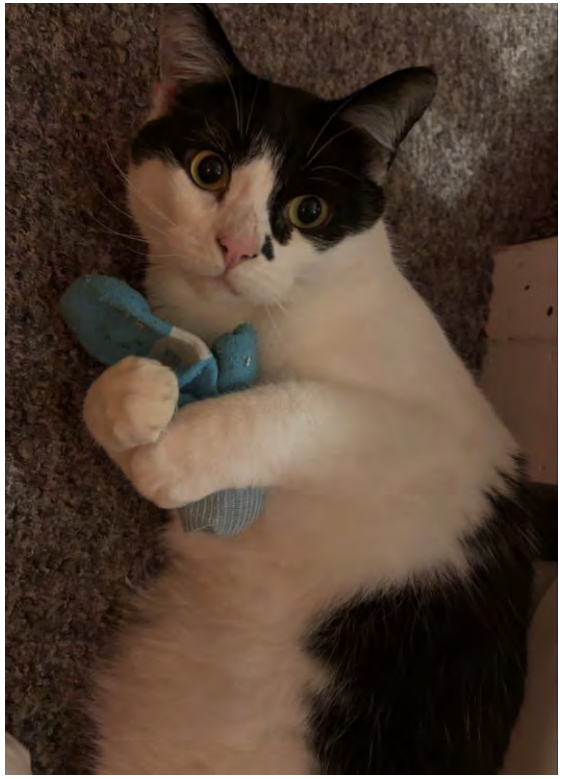


Socrates



Plato

Walter



Socrates & sock

# NCISH

The Manchester Self-Harm Project

@mashproject

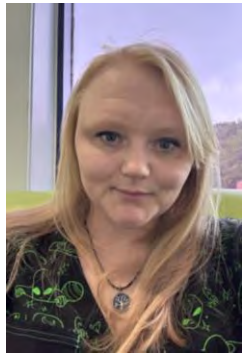
NCISH

@NCISH_UK

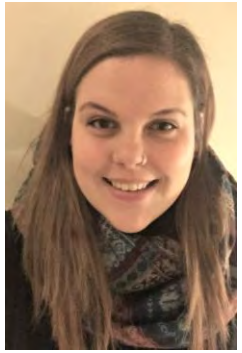
NIHR | Greater Manchester Patient Safety Research Collaboration

@GM_PSRC

# Lived/living experience collaborators


Eloise Curtis


Ellie Wildbore


Dr Emma Nielsen


Pea Myer Higgins


Charlotte Gatherer


Jason Grant-Rowles


Julie Redmond


Lucy Gilbert



**CoC: Safety Delivery group**

(Sal, Jill, Jacqui, Jo, Molly,, Antonia, Sophie, Mark, Brendan, Natasha, Olivia, Harminder)