

appropriate interval for checking the thyroid function is determined.

Comment

This project confirmed the existence of a high prevalence of thyroid disorders among people with Down's syndrome. Fourteen out of the 69 subjects (20%) had hypothyroidism, and a further seven (10%) had sub-clinical hypothyroidism, while there was one definite and one sub-clinical hyperthyroidism. A sex difference was noted, with 12 of the 25 females (48%) and 9 of the 44 males (20%) having clinical or sub-clinical hypothyroidism, while the two cases of hyperthyroidism were male. Thyroid disorder was sufficiently commonly found to make a regular review both of the thyroid function tests and medication worthwhile. Although this system was devised for use with

a group of in-patients, it could be adapted for use with people with Down's syndrome living in the community.

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Who is watching them? A study of the interpretation of the observation policy in a mental health unit

CHRISTINE M. HODGSON, Registrar; JOANNE KENNEDY, Registrar; PALOMA RUIZ, Senior House Officer; MICHAEL LANGENBACH, Registrar; STEVE MOORHEAD, Registrar, Mid-Trent Psychiatric Rotational Training Scheme; and OLA JUNAID, Senior Registrar, Mapperley Hospital, Nottingham NG3 6AA

The study

Observation levels are widely used in the management of acutely disturbed psychiatric patients (Shugar & Rehaluk, 1990). Although clinicians are involved in decisions about observation levels, there is rarely any specific training and very little formal structure to the decision making process. We report a survey of the views and knowledge of clinical staff regarding observation levels. Questionnaires were sent to all the nurses of the six acute psychiatric wards in the Nottingham Mental Health Unit, and all the doctors involved in the care of patients on these wards.

Findings

The response rate to the questionnaire was 65% overall, with 46 (60%) of the 77 doctors responding

and 53 (71%) of the 75 nurses responding. Of the doctors, 26% were consultants, 22% senior registrars, 22% registrars and 30% senior house officers. Over half of the nurses were staff and enrolled nurses (57%). Ward managers and deputy ward managers each comprised 13%, and untrained staff 17%.

Staff views on observation levels

Respondents were asked to rank five factors in order of how important they were in assessing a patient's level of risk of harm to self or others, scoring 5 for most important and 1 for least important: A – mental state examination; B – past history of the patient; C – patient's current behaviour; D – patient's expressed intentions; E – intent implied from the patient's behaviour. For each grade, the median score allocated to each of the five choices was calculated. There was wide variation in replies among doctors (Kendall's coefficient of concordance of 0.22). However, the

nurses were more consistent (Kendall's coefficient of concordance of 0.70, significant association at $P < 0.01$). Doctors placed more emphasis on the importance of mental state examination, with the consultants and registrars ranking it most important. Only senior medical staff rated the past history of the patient highly, in contrast to most other staff rating it least important. Patients' current behaviour was ranked most important by all grades of nursing staff and senior house officers. Patients' expressed intentions were ranked highly only by untrained staff and deputy ward managers.

Respondents were asked to state who they thought made the decision about the level of observation chosen for a newly admitted patient, and whom they thought should make this decision. Almost half (47%) were satisfied that the combination of staff determining observation levels should be doing so. However, there was ambiguity as to who actually made the decision. The majority (79%) of staff stated that a combination of doctors and nurses made the decision, and 84% felt this should be the case. The majority thought that the duty doctor was and should be involved in the decision. Only 58% of the senior house officers compared with 80% of the registrars were happy with this arrangement. Most consultants and senior registrars thought the senior doctor on call made the decision, but only three nurses agreed this happened in practice. All of the consultants and senior registrars thought that they should make the decision. Most nurses thought that the senior nurse on duty and the admitting nurse were and should be involved in the decision. Doctors put more importance on the senior nurse on duty than the admitting nurse.

Half (54%) of the doctors and 28% of nurses felt that staffing levels did influence observation levels chosen. Thirteen per cent of the doctors, but no trained nurses, thought that staffing levels should have an influence.

Staff knowledge of observation levels

All of the consultants, ward managers and deputy ward managers, and almost all (97%) of other trained nurses claimed to have read the policy. The figures were less for the other grades, with 60% senior registrars, 40% registrars, 50% senior house officers and 67% untrained staff having read the policy. Less than a sixth of consultants (17%) and senior registrars (10%) were able to define special

observations correctly; only untrained staff scored worse with none giving a correct definition. The percentages of other grades giving correct answers were 50% registrars, 29% senior house officers, 29% ward managers, 57% deputy ward managers and 43% other trained nursing staff.

Comment

The greater emphasis that doctors placed on the importance of mental state examination may represent a different emphasis in training and use of this approach between the professions. It is widely accepted that the best indicator of dangerousness is a past history of dangerous behaviour (Scott, 1977). However, only senior medical staff rated this factor highly.

The majority of respondents agreed with a team decision for choice of observation level—i.e. a combination of medical and nursing staff. Fewer senior house officers (58%) than registrars (80%) were content with being involved in the decision, possibly reflecting the greater experience of registrars. Senior medical staff thought that they were more involved in the decision than did other staff.

Conclusion

Our study suggests that even within a single unit there is wide variation in the factors which determine observation levels. We were surprised and unable to account for the widespread inability to define special observations. The results of this study are specific to Nottingham Health Authority, but if the findings were found to be more widespread we would like to make the following recommendations:

- (a) formal structured training should be introduced for junior doctors and nursing staff
- (b) the use of observation levels should be subjected to periodic audit, and
- (c) this may be a suitable topic for continuing medical education.

References

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