The Hierarchy of Evidence

The Hierarchy of evidence is based on summaries from the National Health and Medical Research Council (2009), the Oxford Centre for Evidence-based Medicine Levels of Evidence (2011) and Melynyk and Fineout-Overholt (2011).

I Evidence obtained from a systematic review of all relevant randomised control trials.

II Evidence obtained from at least one well designed randomised control trial.

III Evidence obtained from well-designed controlled trials without randomisation.

IV Evidence obtained from well designed cohort studies, case control studies, interrupted time series with a control group, historically controlled studies, interrupted time series without a control group or with case- series

V Evidence obtained from systematic reviews of descriptive and qualitative studies

VI Evidence obtained from single descriptive and qualitative studies

VII Expert opinion from clinicians, authorities and/or reports of expert committees or based on physiology

Melynyk, B. & Fineout-Overholt, E. (2011). Evidence-based practice in nursing & healthcare: A guide to best practice (2nd ed.). Philadelphia: Wolters Kluwer, Lippincott Williams & Wilkins.

National Health and Medical Research Council (2009). NHMRC levels of evidence and grades for recommendations for developers of guidelines (2009). Australian Government: NHMRC. http://www.nhmrc.gov.au/_files_nhmrc/file/guidelines/evidence_statement_form.pdf

OCEBM Levels of Evidence Working Group Oxford (2011).The Oxford 2011 Levels of Evidence. Oxford Centre for Evidence-Based Medicine. http://www.cebm.net/index.aspx?o=1025

Databases searched:	☐ CINAHL (Ebsco)	☐ Medline (Ebsco)	☐ Pubmed (NLM)	☒ Nursing (Ovid)	☐ Emcare (Ovid)
Keywords used:	Observ*, engage", visual				
Search limits:	Year				
Other search comments:					

2017 Nursing Clinical Effectiveness Committee
Co-Chairs: Fiona Newall & Sharon Kinney
Contact: Nursing.Research@rch.org.au

Reference (include title, author, journal title, year of publication, volume and issue, pages)	Evidence level (I-VII)	Key findings, outcomes or recommendations
Department of Health, State of Victoria (2019). Nursing observation and the assessment and immediate management of suicide, self-harm, aggression and absconding risks in psychiatric inpatient units – a review of the literature. https://www.health.vic.gov.au/publications/nursing-observation-and-the-assessment-and-immediate-management-of-suicide-self-harm	V-VI	Formal observation is common practice in inpatient wards as a means of surveillance. Risk management measure prevent adverse outcomes (aggression, self-harm, suicide or absconding. Attracted significant criticism, - resource intensive, other needs compromised, perceived to undermine therapeutic relationship. No only surveillance, may incorporate therapeutic actions – balancing act between safety and therapeutic alliance. evident that specialist skills and experience are needed to perform this role. Limited evidence available Research findings suggest that people respond better to therapeutic forms of formal observation than to ones based on surveillance and control Details meta-analytic results of various risks – where available Combination of assessment instruments and clinical judgement recommended
Department of Health. (2013) Nursing observations through engagement in psychiatric inpatient care. Department of Health guideline.	V-VI	

Guillespie, M., McEwan, S. (2019) From task to intervention: rethinking mental health observation practice in Scotland. British Journal of Mental health Nursing, 8 (1), 28 –33.	VI	Increased complexity of illness experienced by MH inpatients, nursing observation continues to be the main 'the watched and the watcher' intervention. Transformation of risk management through physical observational practices to a more therapeutic, preventative and early intervention approach to mitigate risk Scottish Patient Safety Programme – Improving Observational Practice recommendations tested and discussed.
McAllister, S., Robert, G., Tsianakas, V., & McCrae, N. (2019). Conceptualising nurse-patient therapeutic engagement on acute mental health wards: An integrative review. *International Journal of Nursing Studies*, *93*, 106–118. https://doi.org/10.1016/j.ijnurstu.2019.02.013	VI	The review aimed to 1) explore the constituents of nurse-patient therapeutic engagement on acute mental health wards; 2) map factors that influence engagement using the Theoretical Domains Framework. Results were synthesised into a conceptual model of engagement (UK)
Slemon, A., Jenkins, E., & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, *24*(4), e12199–n/a. https://doi.org/10.1111/nin.12199	VI	This paper argues in inpatient environment, safety is maintained as the predominant value with risk management culture predominates despite evidence refuting their efficacy and negative pt perspectives four exemplars: Close observation, seclusion, door locking and defensive nursing practice. Necessity for shift in perspectives on safety and risk in nursing care. Safety crucial component but shift to support meaningful therapeutic engagement and strength-based approaches more beneficial to patient care and nurses (Canada)
Hartley, S., Redmond, T., & Berry, K. (2022). Therapeutic relationships within child and adolescent mental health inpatient services: A qualitative exploration of the experiences of young people, family members and nursing staff. *PloS One*, *17*(1), e0262070–e0262070. https://doi.org/10.1371/journal.pone.0262070	VI	Complexity of the acute CAMHS inpatient environment. Therapeutic r'ships are the main aspect of inpatient mental health care for YP and their families, essence of the therapeutic milieu, collaboratively built. Barriers, systemic challenges and requirements identified in order to inform positive outcomes, training and policy. (UK)

Glantz, A., Ormon, K. & Sandstrorm, B. (2019). "How do we use the time?" – an observational study measuring the task time distribution of nurses in psychiatric care. *BMC Nursing.* 18:67 https://doi.org/10.1186/s12912-019-0386-3	VI	Need for focus on relationship building in inpatient setting emphasised. Time spent with the patient identified as a barrier. Structured observations of nursing task undertaken, recorded and analysed. Conclusion – nurses spend little direct care time with patients because of ward related tasks.
Chu, S. (2016) Special Observations in the Care of Psychiatric Inpatients: A Review of the Literature and Developments in Practice. ARC Journal of Psychiatry, 1 (1). 21-31.	VII	Special observations (incorporates intermittent and constant observations) are commonly used with associated risk of harm to self, others or absconding to avoid adverse incidents and mitigate risk. Resource intensive, question around efficacy, impact on patient care. Need for stronger evidence – no convincing evidence special observations have positive patient outcomes.
Harrington, A., Darke, H., Ennis, G., & Sundram, S. (2019). Evaluation of an alternative model for the management of clinical risk in an adult acute psychiatric inpatient unit. *International Journal of Mental Health Nursing*, *28*(5), 1099–1109. https://doi.org/10.1111/inm.12621	VI	Typical visual observations are not evidence-based and adverse events still occur (DSH and absconding). Introduction of an engagement-focused model of clinical risk management (adult inpatient ward) undertaken. Mixed outcomes. Did reduce adverse events, preferred by staff over current practices.
Buchanan-Barker, P., Barker, P. (2005) Observation: the original sin of mental health nursing? Journal of Psychiatric and Mental Health Nursing, 12 (5). 541 – 549.	VI	