OFFICE OF THE HEALTH OMBUDSMAN

Proactive activity—snapshot report

Health service's response to referral of systemic issues impacting on patient safety and staff culture (October 2024).

Wider learnings and recommendations for service improvements

The proactive activity highlights the opportunity to improve the quality and safety of inpatient mental health services by:

a) Conducting regular audits, reconciling with CCTV recording, to monitor adherence to visual observation requirements.

b) Ensuring staff receive appropriate training in violence prevention through conflict resolution and de-escalation techniques.

c) Embedding a de-briefing framework for significant incidents that is timely and includes all frontline staff involved, clinical and non-clinical.

d) Encouraging the reporting of clinical incidents and occupational violence, ensuring transparent and meaningful feedback to staff regarding quality and safety.

e) Reviewing rostering arrangements to optimise teamwork, patient engagement and care planning.

f) Implementing processes to ensure clarity in responsibilities for nursing led tasks, including undertaking visual observations.

Background

Under the *Health Ombudsman Act 2013* (the Act) the Health Ombudsman may take immediate action in relation to practitionersin certain circumstances to protect public health or safety. The Office of the Health Ombudsman (OHO) had received a number of complaints and notifications relating to the Mental Health Service within a Queensland Hospital where nursing and security staff were referred to the Health Ombudsman for consideration of immediate action to address serious risks identified in their conduct and performance of their duties.

In response, a proactive activity was commenced to review all complaints and notifications received by the OHO relating to the Mental Health Service over the previous 12 months, to identify potential systemic issues.

Issues investigated

While the OHO and the service had taken action to address risks in individual matters, the review identified the recurrent incidents of:

- staff failing to undertake visual observations and being observed sleeping on their shift
- staff falsifying clinical record documentation
- excessive use of force and physical restraint, and use of inappropriate language.

The OHO's functions under the Health Ombudsman Act 2013 (the Act) includes identifying and reporting on systemic issues in the way that health services are provided. Consistent with the OHO's objectives to protect public health and safety and to drive safety and quality improvements in services, the OHO

carefully considered the options to address these apparent systemic issues in the most timely and effective way.

Section 92 of the Act provides for the Health Ombudsman to refer a matter to a State or Commonwealth entity with functions to deal with the matter.

The Health Ombudsman determined in the first instance the health service was best placed to consider the concerns and report any findings and rectification actions.

Key findings

The health service engaged positively with the referral which aligned with service improvement actions being undertaken within the mental health service. Pursuant to section 93 of the Act, the health service reported their findings and resultant actions taken to the OHO.

The report detailed the actions taken to immediately address concerns, projects underway to support ongoing change to the culture, safety and quality of the health service, and governance improvements to encourage clinical incident reporting and to measure the effectiveness of changes implemented.

Strategies implemented included:

- Reminding all staff of their legal obligations to undertake observations
- Increased management support for the mental health workforce
- The implementation of a debrief framework which includes an on-the-spot debrief process following all significant incidents, that are informal and clinically led, and involve front line staff including security personnel
- Numerous quality improvement projects commenced:
  - to ensure a nurse is allocated to each patient who will be responsible for shift-by-shift services. This provides clear responsibilities for nursing led tasks including visual observations and provides continuity of care
  - to improve rostering in the Mental Health Service to have dedicated staff allocated to inpatient units, ceasing rostering across three separate units, to promote teamwork, increase patient engagement, and improve communication and care planning for patients and families
  - to encourage safe work practices and improved governance with additional training for the mental health workforce including increasing staff participation in MAYBO training[1] (aim to have 90% of staff trained).

The health service engaged an external consultant to undertake a review of the culture within the Mental Health Service with the most recent survey results indicating an improvement in the overall culture and noting significant improvements in the organisational culture.

The health service noted the July 2024 figures for length of seclusion in Queensland reflected the Mental Health Service had improved models of care and safety resulting in staff providing quality care with minimal use of restrictive practices (seclusion).

The report provided by the health service demonstrated that the issues impacting on the safety and quality of the mental health services had been clearly identified and that actions were being taken to address these concerns and to improve the culture, safety and quality of the service.

[1] Conflict resolution and personal safety training for nurses and hospital staff.