

Health service investigation— snapshot report

Investigation focus: Review into hospital and health service compliance with therapeutic visual observations (TVO) in a mental health facility (March 2025).

Wider learnings and recommendations for service improvements

The investigation identified opportunities for improvement and proposed recommendations relating to:

- Amendment to the procedure for TVOs to specifically prohibit retrospective signing for TVOs not undertaken.
- Progression of the plan to move to electronic recording of TVOs.
- Nurse Unit Manager to continue TVO practice auditing consistent with Tier 1 and Tier 2 monitoring required by Therapeutic Visual Observations for Mental Health and Other Drugs Services, Queensland Health Guideline, until electronic recording can be introduced.
- Upon implementation of electronic recording of TVOs, strengthen the Tier 3 clinical audit tool with reporting to patient safety committee.

Background

The Office of the Health Ombudsman received mandatory notifications in relation to a number of registered practitioners who, it was alleged, had placed patients at risk of harm because they had not completed TVOs as required. During the assessment of these notifications, the OHO identified references to a common practice/ward culture that 15-minute visual observations at the health service were not adhered to (despite procedural requirements) on overnight shifts, with nursing staff using their own clinical judgement as to when to perform visual observations. The OHO identified that TVOs are critical for ensuring patient safety and quality of care in mental health services.

Issues investigated

The OHO's systemic investigation addressed the following issues:

- Whether the issues identified with the individual practitioners were indicative of a wider systemic issue
- Whether the health service has appropriate policies and procedures in relation to the performance of TVOs
- Whether concerns were appropriately raised by staff and rectified by the health service when raised
- Whether appropriate action had been taken where concerns were raised regarding an employee's conduct or performance
- Whether clinical staff were afforded the opportunity to take appropriate breaks with relieving staff in place
- Whether staff were encouraged to raise workload concerns and, when raised, were they addressed.



Key findings

The health service engaged positively with the OHO during the investigation, facilitating a site visit and staff interview. The OHO noted that the service has independently taken steps to move towards digital recording of visual observations, which will allow this information not only to be recorded within the patient's clinical record but also enable more accurate auditing of visual observations owing to digitally recorded time stamps.

The investigation also found:

- The service has policies and procedures in relation to visual observations and rest/meal breaks but these had not always been adhered to.
- The conduct appears limited to the staff identified and reported by the service.
- The OHO investigation identified improvements to policies and procedures which would further clarify nurses' obligations in relation to retrospective recording of visual observations.