

Therapeutic Visual Observation for Mental Health Alcohol and Other Drugs Services

Background and purpose

Effectively recognising and responding to acute deterioration is one of the eight National Safety and Quality Health Service Standards (Second edition).

Passive and routinely conducted observation with a focus on documenting the physical integrity of a patient is not sufficient to increase the likelihood of safety and wellbeing; rather a patient's clinical status is most effectively determined through interaction and therapeutic engagement with the patient and their support persons.

Coronial investigations, root cause analyses and clinical incident reviews have identified mental health visual observations as a key issue which, when conducted using a more individualised therapeutic approach, could reduce adverse events including suicide, incidents involving physical violence and sexual safety incidents.

Moving from passive observation of immediate physical integrity to an individualised and trauma informed approach to ordering and performing visual observations represents a cultural shift which is already being achieved in most Queensland public mental health alcohol and other drug services (services).

Following the release of *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events occurring in 2002-2003*, Queensland Health developed the Mental Health Visual Observations Clinical Practice Guideline 2008 (the 2008 Guideline).

The 2008 Guideline identified a standardised approach to visual observations and clarified roles and responsibilities regarding ordering and performing visual observations for mental health units and emergency department services with designated mental health areas.

The Therapeutic Visual Observation (TVO) for Mental Health, Alcohol and Other Drugs Services Guideline 2020 (the TVO Guideline) builds on the 2008 Guideline, supporting the shift from passive observation of immediate physical integrity to an individualised and trauma informed approach, reinforcing the value of therapeutic engagement as part of visual observations and better reflecting the high-quality standards of care achieved by clinicians in Queensland services.

The TVO Guideline provides guidance for TVO and is intended to support services to develop local policies and procedures in relation to TVO. The TVO Guideline should be implemented by individual services in a way that is relevant to local context and provides adequate staffing levels with the appropriate skill mix required to perform TVO.

Scope

The Guideline is intended for use in all Queensland public mental health and alcohol and other drug acute and secure inpatient services, for all age groups. The term patient is used since the Guideline applies to inpatient settings. The Guideline can be applied to other clinical environments, and services should

consider applicability in other bed based settings, such as emergency departments, paediatric inpatient units and community care units.

Although there are some references to physical observations, this document relates to TVO. Clinicians should refer to local Hospital and Health Service policy/procedures, state and national standards and guidelines which outline requirements for physical observations.

Related documents

Legislation, standards, procedures, guidelines

- *Mental Health Act 2016*
- *Mental Health Act 2016* Chief Psychiatrist policies
- Managing ligature risks in Queensland public mental health alcohol and other drug inpatient units 2016
- Recognising and managing potential environmental hazards in Queensland public mental health and alcohol and other drug inpatient units 2016
- Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services 2017 (children, adolescents and adults)
- Sexual Health and Safety Guidelines for Mental Health Alcohol and Other Drug Services 2016
- Guideline for the operation of high dependency units (HDUs) in mental health services (2014) (under review)
- National Safety and Quality Health Service Standards (second edition) 2017

Forms, templates, tools

- Queensland Adult Deterioration Detection System (Q-ADDS) Tools
- Queensland Health Children's Early Warning Tool (CEWT)

Principles of Therapeutic Visual Observation

Therapeutic visual observations (TVO) are:

- a purposeful task performed by clinicians with the appropriate training and skills
- an active process of observation and engagement with patients to benefit treatment, support recovery and enhance safety. Observation is grounded in therapeutic engagement and is an active process that extends beyond merely the identification of presence and safety
- a team responsibility, whereby all members of the treating team have a role in contributing to the effectiveness of observations and patient safety in parallel with the allocated TVO clinician
- informed by, and in turn inform, a patient's clinical assessment, risk assessment and care plan, including history of trauma
- informed by a patient's age, developmental stage, gender and cultural background and language

- provided in the least restrictive environment possible, in the least intrusive way possible - patient preferences, privacy and dignity must be balanced with the need to maintain safety
- discussed openly, in partnership with the patient and their family/carers, including the reasons for, and the process of, observation – clinicians will use their understanding of how inpatient settings can influence behaviour to help patients feel comfortable and promote recovery
- documented in a timely and descriptive way - clinicians are accountable for the information recorded for TVO
- conducted in alignment with workplace health and safety regulations
- ordered, allocated and communicated following a consultative, multidisciplinary approach
- flexible to respond to individual needs of the patient, within an overall standardised approach for the ordering, allocating and documenting of TVO.

Levels of TVO

Appropriate levels of engagement during observations will be guided by individually identified clinical risks, the level of TVO ordered, clinical judgement and patient preference, e.g. it may be inappropriate that a patient on 15 minute observations be spoken with by the observing clinician at every interval.

Consideration should be given to the use of activity, discussion and distraction processes but recognition should also be made of the need for silence and as much privacy as is safely achievable (NHS Scotland, 2002¹).

Services should ensure local policies and procedures for TVO reflect the following three levels of TVO:

1. General observation
2. Intermittent observation, categorised as specific time periods within the intermittent value range as required
3. Continuous observation.

Note: Child and youth mental health acute inpatient services utilise intermittent and continuous observation categories only. TVO for young people receiving care in the Adolescent Extended Treatment Centre will be determined by individualised assessments by the treating doctor. Patients under 18 receiving care in an adult unit should be cared for under continuous observations upon admission until a thorough risk assessment is completed to inform the most appropriate level of TVO.

Any concerns in relation to a patient's physical health status or deterioration, e.g. for patients with delirium, substance intoxication or withdrawal, should be addressed separately using the appropriate process such as the Queensland Adult Deterioration Detection System (Q-ADDS) or Children's Early Warning Tool (CEWT) in conjunction with the appropriate level of TVO.

Any changes to intermittent TVO frequency should be clearly documented and communicated to the patient. Regular discussion should take place with the patient about their experience of the observations with all attempts made to accommodate patient needs and preferences.

¹ NHS Scotland, 2002, Engaging People – *Observation of People with Acute Mental Health Problems: A Good Practice Statement*

1. General observation

General observation is the minimum level of observation and applies to patients with no identified risk factors that would require intermittent or continuous observation.

Patients clinically appropriate for general observations are over 18 years of age and have been assessed as being at lower risk whilst in their current setting of:

- suicide or deliberate self-harm
- causing harm to others
- vulnerability due to special needs (e.g. physical or intellectual disabilities, pregnancy, older persons, falls or potentially unstable medical condition)
- other vulnerabilities (e.g. sexual vulnerability)
- leaving or attempting to leave the clinical environment placing themselves or others at risk of harm.

This level of observation may be carried out by a staff member allocated specifically to this patient (as part of a general clinical shift case load) or may be carried out by a TVO clinician allocated specifically to TVOs for a number of patients (to be determined locally).

Specific consideration of and instructions about TVO should occur when determining observation intervals relating to any planned changes during specific periods, including day and night, specific staff shifts, meals etc. Such instructions should be clearly documented in the patient's care plan and communicated within the treating team.

Service procedures should identify acceptable time intervals for conducting general visual observations. The period of time between general observations should not exceed four hours.

Documentation of the TVOs should occur in addition to the standard clinical entry that will be made in relation to the patient's mental state and care over that period.

When reviewing orders for TVO, the patient's treating team should incorporate any feedback from allocated TVO clinicians and review all TVO documentation that may be available in addition to the standard multidisciplinary team input that will be available.

General observations can be increased by a medical officer in collaboration with the treating team or other nursing and allied health staff available at the time of the order revision.

If clinically indicated, and in the absence of a medical officer, a registered nurse utilising their professional judgement may increase TVO from general to intermittent, or general to continuous. This decision to increase TVO should be reviewed in collaboration with the treating medical team as soon as reasonable.

2. Intermittent observation

Patients clinically appropriate for intermittent observations have been assessed as being at higher but not imminent risk whilst in their current setting of:

- suicide or deliberate self-harm
- causing harm to others
- vulnerability due to special needs (e.g. physical or intellectual disabilities, pregnant women, older persons, falls or those with a potentially unstable medical condition)
- other vulnerabilities (e.g. sexual vulnerability)
- leaving or attempting to leave the clinical environment placing themselves or others at risk of harm.

The order for intermittent TVO must identify the risk factors (as above), purpose of observation and the frequency of such observation. In general, within an acute inpatient unit, observations should range from every 15 minutes to two hours. This may be modified after appropriate assessment of individual situations by clinical teams for long stay inpatients e.g. in an adolescent extended treatment centre.

Intermittent TVO would usually be carried out by a specific TVO clinician whose clinical task (for a designated period) solely relates to the therapeutic observation of patients under this category, however different arrangements are possible.

Consideration must be given to maintaining appropriate levels and mix of staffing at times when patients are on intermittent observations.

Intermittent TVO should be carried out by clinicians in a sensitive manner in order to cause as little as possible intrusion.

When documenting intermittent TVO, the physical sighting of the patient and their location must be documented along with a brief statement of any other relevant information which may be obtained from interacting with the patient.

Frequency of intermittent TVO can be increased or decreased or ceased by a medical officer in collaboration with the treating team or other nursing and allied health staff available at the time of the order revision. If clinically indicated, and in the absence of a medical officer, a registered nurse utilising their professional judgement may increase the frequency of an intermittent TVO or increase the TVO from intermittent to continuous. This decision to increase TVO should be reviewed in collaboration with the treating medical team as soon as reasonable.

3. Continuous observation

Continuous observation is the level of observation required for patients assessed as being at imminent risk whilst in their current setting of:

- suicide or deliberate self-harm likely to cause serious injury
- causing harm to others
- sexual disinhibition or other vulnerability
- leaving or attempting to leave the clinical environment and placing themselves or others at risk of serious harm.

The clinician ordering TVO must ensure consideration is given to any necessary specific instructions, e.g. in relation to meal, toilet and bathroom observations. Consideration must be given to the patient's gender preference in the allocation of the continuous TVO clinician. Clinical interaction and engagement with the patient is a critical aspect of this level of observation.

Staff safety must also be taken into account and any immediate identified risks to staff should inform an individual plan that addresses clinical staff safety, including consideration of need for placement within a more secure setting or more than one clinician allocated to undertake continuous TVO.

Continuous observation requires the TVO clinician to always be in visible contact with the patient. Clinicians undertaking continuous TVO must focus only on the immediate care of the patient for whom they are caring, with no service provision to any other patient.

Clinicians maintaining visible contact with patients on continuous observations may do so across a range of different physical environments, and with differing proximity between clinician and patient, guided by the individualised risk assessment and the physical environment.

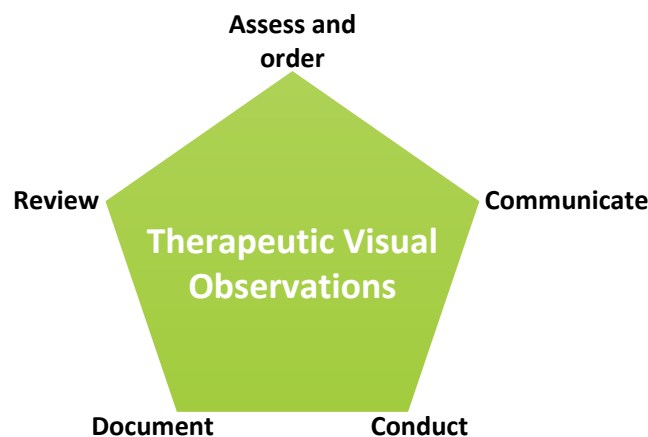
Continuous TVO can be provided 'within eyesight' where visible contact is maintained at all times and the clinician remains within reasonable physical proximity of the patient to enable a safe and timely response to risks, or 'within arms' length' where staff remain in close physical proximity to the patient, with no physical or environmental barriers between the patient and the clinician. Treating teams and TVO clinicians need to be mindful of the privacy and dignity of the patient being balanced with the safety of the patient.

Local procedures should ensure that an individual staff member should not undertake a continuous period of observations for more than two hours.

Written entries must be made in both the patient's clinical record and on the TVO recording document at the completion of each period of continuous observation. Continuous TVO can only be decreased to a lower level of observation by a medical officer and must include consultation with the nursing staff and treating team.

TVO practices in detail

There are a number of steps involved in performing TVO.



1. Assess and order TVO

An initial decision in relation to observations will be made on a patient's arrival at the inpatient unit and, wherever possible, should be made by a medical officer in collaboration with the senior registered nurse on duty. Where this is not possible, or where a medical officer is not present on arrival, nursing staff will determine the level of TVO required in collaboration with senior clinical staff and will document this.

The level of observation is based on an individualised assessment which should consider the patient's current mental state, the current assessment of risk, any prescribed medications and known side effects, and the views of the patient and carer in relation to the admission (as far as is possible). An interdisciplinary (medical and nursing), and when possible multi-disciplinary, approach to the allocation and ordering of therapeutic visual observations should always be employed. Consideration must always be given to the purpose of the TVO.

The level of TVO ordered should be clearly documented in the patient's clinical record and form part of the patient's care plan. Documentation should include comment on issues pertinent to the delivery of TVO, such as the patient's preference, trauma history, identified alerts, changes required for night time

observations, how observations intersect with periods of leave from the ward, and action to be taken in the event that the patient is exhibiting signs of deterioration or is absent.

Local service procedures should clearly outline staff roles in ordering observations.

2. Communicate the plan for TVO

Where possible, and at an appropriate time, the patient and carer should be provided with information about the level of observations, the aims of observation and how this may change during the admission.

Information should be made available in the patient's preferred language where possible. A copy of the patient's care plan which should include the level and purpose of the TVO ordered should be provided to the patient.

3. Conduct TVO

The TVO level allocated for a patient must be clearly documented and communicated to relevant staff at the commencement of their shift.

TVO is an active process that involves therapeutic engagement and the purposeful gathering of clinical information. It is not passive and should not be restricted to the visual medium. The therapeutic nature of TVO is intended to complement the therapeutic engagement by all members of the clinical team at all stages of care.

Clinicians undertaking observation should:

- promote an active role in engaging positively with the patient
- be made aware of and consider salient features of the patient's clinical and social history, including risk and protective factors and particular needs
- be familiar with the facility, the local procedures for emergency response and potential risks identified in the environment.

At the commencement of any period of TVO (i.e. at the beginning of a shift or commencing a shift of continuous TVO) staff should inform the patient that they will be undertaking observations with them, the purpose of this observation and how it will occur. All subsequent changes to this plan should be communicated clearly.

Clinicians performing intermittent or general TVO may be involved in other activities, depending on clinical need and the number of patients they are observing, provided the completion of TVO is not impeded. Assistance from other staff should be sought if further intervention is required for patients exhibiting signs of clinical deterioration or other concerns, or who are noted to be absent. If, at any time, the allocated TVO clinician is required to perform another task, responsibility for TVO must be handed over to another clinician.

4. Document TVO

Documentation requirements vary depending on the level of TVO ordered. However, irrespective of the level of TVO, the following minimum standards must be met.

The TVO recording document (paper or electronic) must:

- be an individual document for each patient which is made part of their clinical record
- be completed by the clinician responsible for the TVO
- record the actual time the patient was observed
- record the TVO clinician's observation of the patient and their location.

The TVO document will be in addition to, and separate from, the clinical notes made by the clinical nurse allocated for that patient. Appendix C provides an example of effective TVO documentation forms.

Documentation must be completed contemporaneously. Any gaps in intermittent or continuous TVO must be accounted for. It is never appropriate to sign ahead of time for TVO not yet undertaken.

5. Review TVO

Review of TVO should occur at least every 24 hours, unless less frequent review is deemed clinically appropriate by the treating team and documented in the patient's clinical chart. Changes to the level of TVO should be made in a multidisciplinary meeting where feasible, and if not then either an interdisciplinary meeting (medical and nursing) or a nursing meeting as appropriate. Any such meeting must include appropriate nursing representation. Any decisions to change orders to or from continuous observations or with other resource implications should involve the registered nurse in charge of the shift or their delegate. All decisions to change levels of TVO should be documented with rationale and be communicated to the patient.

In undertaking a review of the level of TVO clinicians must take into account any changes in mental state or exhibited/potential risks in the previous observation period and any potential risks for the next observation period.

If observations above a general level are in place for more than one week, consideration should be given to a specific review of the level of observation by the treating team psychiatrist and the multidisciplinary team with discussion focussed on current risks and a risk management strategy. This would usually occur during case reviews, either routine or ad-hoc.

Audit and evaluation of TVO practices

Monitoring and auditing TVO practices inform continuous improvement in clinical care and provides an opportunity for problem solving to be initiated should safety issues be identified.

Hospital and Health Service procedures should support monitoring and audit of TVO practices and identification and appropriate escalation and management of organisational risks.

Examples of such monitoring at different tiers include -

Tier 1 – programmed real-time reviews of documented TVO information during a shift by a senior clinician.

Tier 2 – random visits by a senior clinician, such as a Nurse Unit Manager, to an inpatient ward to perform a spot audit of real-time documentation.

Tier 3 – service-wide, periodic clinical audit of processes and documentation related to TVO.

Variations in observation across the day

Therapeutic observations are a continual clinical process that occurs as part of all interactions across the day. Unless specified, the level of TVO should remain consistent throughout the day.

It may be clinically appropriate to change TVO level at specific times such as night, when less intrusive observation may assist sleep hygiene whilst maintaining safety. Alternatively, certain times during the day and/or night might incur an escalated risk.

Specific consideration of and instructions about TVO should occur when determining observation intervals relating to any planned changes during specific periods, including day and night, specific staff shifts, meals etc. Such instructions should be clearly documented in the patient's care plan and communicated within the

treating team, with clear handover of such observation requirements and clarity on the level of engagement at specific times.

Services should consider the design of patient's bedrooms to include appropriate viewing panels in bedroom doors and ambient lighting to facilitate effective and unobtrusive observation of patients and their physical surroundings. It is vital that clinicians can sight the patient clearly enough to allow monitoring of:

- whether the patient appears to be awake or asleep
- signs of oxygenation (e.g. respirations, unobstructed airway, colour)
- position (to ensure safety and comfort)
- behaviour (if awake).

In some circumstances, particularly if the patient has been sedated, it can be difficult to determine if the person is asleep or has an altered level of consciousness. Patients with an altered level of consciousness require airway protection and careful monitoring.

Observation in High Dependency Units (HDU)

High Dependency Units (HDUs) are designated intensive care areas in a separate potentially lockable area within an authorised mental health inpatient facility, designed to provide for the safe management of patients requiring specific and detailed attention to their mental health needs. Such patients have been assessed as requiring a higher level of individual observation, care and engagement than is available in the general ward area. Because of this, a nursing staff member is always to be present within the intensive care area. The role of of this staff member should be discussed with all patients within this setting.

The minimum requirement for TVO in a HDU is every 15 minutes (intermittent level).

Whilst a staff member is always present within the HDU area, it should not be assumed that the patient is always being observed, e.g. when in the bedroom or bathroom. If continuous observation is required for the patient they should be ordered and documented.

Staff education and training

Hospital and Health Services are responsible for providing education and training associated with TVO for all staff involved in observation practices. Local orientation policy and procedures should ensure all clinicians undertaking TVO are appropriately trained and confident to carry out the task. Clinicians should:

- understand the purpose of TVO, how it benefits patient care and contributes to recovery
- understand the local service policy/procedures and how they align to these Guidelines
- be able to identify situations that require assessment or intervention and then refer or act appropriately
- understand the process to follow when a patient is unable to be located, is at imminent risk or is exhibiting signs of acute deterioration (mental state, cognition or physiological)
- be proficient in communication and documentation associated with TVO.

Appendices

Appendix A – Observation practices consistent with a recovery framework

Appendix B – Techniques for eliciting information about psychosocial wellbeing

Appendix C – Example of TVO form

Document approval

Document custodian

Director Clinical Governance, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division

Approval officer

Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Approval date: 26 August 2020

Version control

Version	Date	Prepared by	Comments / reason for update
V1.0	1/09/2020	Mental Health Alcohol and Other Drugs Branch	First publication

Appendix A: Observation practices consistent with a recovery framework

The following information has been reproduced with the permission of the Department of Health and Human Services, Victoria and has been taken from the publication - *Nursing Observations through Engagement in Psychiatric Inpatient Care, 2013*.

Domain	Examples of good observation practices
Promoting a culture of hope	<ul style="list-style-type: none"> • Note behaviours and events that indicate positive signs of recovery and remind people receiving care and others of these occurrences.
Promoting autonomy and self-determination	<ul style="list-style-type: none"> • Engage people in ongoing dialogue and enquiry about their needs, wishes and experiences. • Discuss with people about the need for observation and how it will occur. • Invite feedback on how these practices could be modified to enhance care. • Avoid practices that people may experience as traumatic.
Collaborative partnerships and meaningful engagement	<ul style="list-style-type: none"> • Demonstrate empathy and respect in all interactions with people and their significant others. • Use person-centred humanistic language, rather than identifying people as their diagnosis. • Elicit people's preferences and give them maximum choice in big and small decisions and be accommodating and flexible in responding to their preferences. • Work to understand what is important to people. • Support people to make sense of their experiences and to find positive meaning. • Acknowledge and respond to people's views, understandings and experiences. • Work with people in a way that supports their cultural identity and values. • Work to understand people's triggers for episodes of 'unwellness' and what they find works well for them in their recovery efforts. • Use inquisitive and active listening and personalised, supportive, positive and hopeful language. • When people do not express their points of view, actively seek their viewpoint through gentle enquiry. • Use aspects and examples from one's own life and experiences to create a friendly, professional relationship. • Use professional skills and expertise to provide people with optimal choice and tailored support.

Domain	Examples of good observation practices
Focus on strengths	<ul style="list-style-type: none"> • Ask people about their strengths, what they have done well and what they have found easy. • Use enquiry that emphasises solutions to situations rather than just the problems. • Assist people to tap into existing strengths and resilience by considering what has worked well for them in the past. • Encourage self-sufficiency in accordance with people's wishes and goals. • Assist people and their significant others to assess their own needs and to choose how those needs are met. • In history taking and reflections with the person, include recognition of areas of functioning where there are no problems and times in their lives when they did cope well. • Emphasise successes and achievements prominently at first contact. • Encourage people to take personality strengths that are causing problems in one area and use them to improve functioning in another (for example, a young client can find drugs at any time in any part of town – can that tenacity and resourcefulness be focused on obtaining housing?) • Support people to approach new challenges or to revisit old challenges.
Holistic and personalised care	<ul style="list-style-type: none"> • Routinely enquire about people's wishes, support needs, goals, values and interests and use this information to personalise care. • Support people to enjoy full physical health and to address health concerns when they present.
Family, carers, support people and significant others	<ul style="list-style-type: none"> • Talk with families and significant others about how things are for them, how they understand the needs of the person with mental illness and how they can support what is needed for that person.
Community participation and citizenship	<ul style="list-style-type: none"> • Be aware of the cultural, social and historical factors that limit people's access to resources and opportunities.

Domain	Examples of good observation practices
Responsiveness to diversity	<ul style="list-style-type: none"> • Understand how cultural differences affect people and their experiences. • Understand different cultural communication styles and use respectful ways of communicating. • Use non-technical language and use the services of an interpreter when necessary. • Recognise that different people have different understandings and experiences of community and that community has different significance for different people. • Respectfully enquire about the backgrounds and cultural needs of people. • Use innovative practices to meet the different needs of people. • Understand and demonstrate respect in relation to different understandings and meanings attributed to mental health across different cultures. • Recognise the diverse family and kinship structures across different cultures and the need for family work to accommodate these. • Be aware of personal values that may unintentionally affect practice. • Develop knowledge of concepts of Aboriginal and Torres Strait Islander social and emotional wellbeing and the historical and contemporary factors that impact on Aboriginal and Torres Strait Islander Australians' wellbeing.
Reflection and learning	<ul style="list-style-type: none"> • Reflect on whether one's professional practice is aligned with a recovery approach. • Reflect on one's own values, development needs and limitations.

Appendix B: Techniques for eliciting information about psychosocial wellbeing

Technique	Description
Ask open-ended questions	Open-ended questions have the potential to elicit more information about people's thoughts and feelings than closed questions that encourage brief responses. Obtaining more information through open-ended questions means that people may need to answer fewer questions, which may reduce the chances of them feeling interrogated. Requests for information, for example, 'Please tell me about your morning', may yield more useful responses than the ubiquitous 'How are you?' to which many people are conditioned to give a brief, positive reply.
Listen and attend to body language	The words people use do not usually represent the whole message that they are trying to convey. Nurses should pay attention to how words are spoken, as well as other aspects of body language (for example, proximity of person to nurse, facial expressions, nodding, positions of arms and legs or the direction in which the person is facing). The words 'I'm fine' can have different connotations for a person who is relaxed, comfortably sitting on a chair, and maintaining eye contact with a nurse than for someone who is sitting on the floor, hugging their legs and staring at the floor. Equally, nurses' non-verbal communication can affect how people perceive them and the richness of the information that may be disclosed during interactions. Nurses with open postures, who speak calmly, who show genuine interest in people through verbal utterances and non-verbal gestures, and who demonstrate empathy, even when people introduce challenging material to conversations, may be more likely to make more insightful observations than nurses who, for example, appear rushed and uninterested.
Use paraphrasing and reflections	Paraphrasing is restating someone else's words in other ways. Nurses who wish to paraphrase what people have said may begin a sentence with, for example, 'So, what I hear you're saying is ...'. More broadly, reflections involve not only restating what has been said, but also feeding back other observations, such as how people appear to be feeling or their behaviour. A nurse may say, for example, 'You seem quite sad when we talk about this part of your life.' Paraphrasing and reflecting on people's responses are ways that nurses can help people to feel heard and may elicit more information without having to ask further questions. These techniques enable nurses to demonstrate they have understood what people have said. They can also be used to move a person's attention to topic areas on which a nurse wishes to develop richer understandings of people's lives and what they are experiencing.
Summarise	Summarising what people have said at or near the end of an observation encounter can be a powerful way of demonstrating that people have been heard and understood. It also provides people with the opportunity to correct any misunderstandings.

Appendix C: Example TVO form – page 1 of 2



2019/07 V4

DO NOT WRITE IN THIS BINDING MARGIN

Developed by QH, Sunshine Coast Hospital and Health Service



Queensland Government

Mental Health Visual Observation Form

Note: Daily at 2400 hours or, where changes / reviews have occurred, a new form will be commenced

Date: / / Bed No.:
 Treating Unit:
 SCUH-MHADU NGH-MHAU
 SCUH-MHAU NGH-MHICU
 SCUH-MHICU CCU
 SCHU-MHOPU
 MHA status:
 Voluntary Recommendation for Assessment Classified
 Treatment Authority Treatment Support Order Forensic Order

(Affix patient identification label here)
 URN:
 Family Name:
 Given Names:
 Address:
 Date of Birth: Sex: M F I


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EXAMPLE ONLY

Predicted Time	Actual time sited	Place	Key	Initial	Predicted Time	Actual time sited	Place	Key	Initial	Predicted Time	Actual time sited	Place	Key	Initial	Predicted Time	Actual time sited	Place	Key	Initial	Staff Signature Block							
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0545					1145					1745					2345												
0600					1200					1800					0000												

Frequency: 15 minutes 30 minutes hourly 4 hourly Other:
 Place: G = Gym T = Toilet/shower C = Courtyard D = Day room/ lounge L = Laundry Q = Quiet room S = School CR = Consult Room TR = Treatment room O = Other
 SMR = Sensory modulation room O = Off ward B = Bedroom HR = Handover room
 Key: ✓ = Awake S = Sleeping V = Verbal response not sighted R = Reviews/assessments G = Group program AWA = Absent without Authority L = Leave T = attending treatment (ECT, Xray)
 Risk category: AWA RTS = Risk to self RTO = Risk to other VUL = Vulnerability SR = Suicide risk Agr = Aggression A = Arson Other (specify)

Example TVO form – page 2 of 2

 Queensland Government Mental Health Visual Observation Form <small>Note: Daily at 2400 hours or, where changes / reviews have occurred, a new form will be commenced</small>		Date: / /		Bed No.:		(Affix patient identification label here)																			
		Treating Unit: <input type="checkbox"/> SCUH-MHADU <input type="checkbox"/> NGH-MHAU <input type="checkbox"/> SCUH-MHAU <input type="checkbox"/> NGH-MHICU <input type="checkbox"/> SCUH-MHICU <input type="checkbox"/> CCU <input type="checkbox"/> SCHU-MHOPU				MHA status: <input type="checkbox"/> Voluntary <input type="checkbox"/> Recommendation for assessment <input type="checkbox"/> Classified <input type="checkbox"/> Treatment Authority <input type="checkbox"/> Treatment Support Order <input type="checkbox"/> Forensic Order		URN:		Family Name:		Given Names:		Address:		Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I							
Page 2 of 2	Predicted Time	Actual time sited	Place	Key	Initial	Predicted Time	Actual time sited	Place	Key	Initial	Predicted Time	Actual time sited	Place	Key	Initial	Predicted Time	Actual time sited	Place	Key	Initial	Staff Signature Block				
																						Staff name <i>(Print full name)</i>	Sign / Initials	Staff name <i>(Print full name)</i>	Sign / Initials
	0015					0615					1215					1815									
	0030					0630					1230					1830									
	0045					0645					1245					1845									
	0100					0700					1300					1900									
	0115					0715					1315					1915									
	0130					0730					1330					1930									
	0145					0745					1345					1945									
	0200					0800					1400					2000									
	0215					0815					1415					2015									
	0230					0830					1430					2030									
	0245					0845					1445					2045									
	0300					0900					1500					2100									
	0315					0915					1515					2115									
	0330					0930					1530					2130									
	0345					0945					1545					2145									
	0400					1000					1600					2200									
	0415					1015					1615					2215									
	0430					1030					1630					2230									
0445					1045					1645					2245										
0500					1100					1700					2300										
0515					1115					1715					2315										
0530					1130					1730					2330										
0545					1145					1745					2345										
0600					1200					1800					0000										
Frequency: <input type="checkbox"/> 15 minutes <input type="checkbox"/> 30 minutes <input type="checkbox"/> hourly <input type="checkbox"/> 4 hourly <input type="checkbox"/> Other:																									
Place: G = Gym T = Toilet/shower C = Courtyard D = Day room/ lounge L = Laundry Q = Quiet room S = School CR = Consult Room TR = Treatment room O = Other SMR = Sensory modulation room O = Off ward B = Bedroom HR = Handover room																									
Key: ✓ = Awake S = Sleeping V = Verbal response not sighted R = Reviews/assessments G = Group program AWA = Absent without Authority L = Leave T = attending treatment (ECT, Xray)																									
Risk category: <input type="checkbox"/> AWA <input type="checkbox"/> RTS = Risk to self <input type="checkbox"/> RTO = Risk to other <input type="checkbox"/> VUL = Vulnerability <input type="checkbox"/> SR = Suicide risk <input type="checkbox"/> Agr = Aggression <input type="checkbox"/> A = Arson <input type="checkbox"/> Other (specify):																									