NS2.1 Short Notice Final Assessment

Final Assessment Report

Melbourne Private Hospital

PARKVILLE, VIC

Organisation Code: 225023
Health Service Organisation ID: Z1010011
Assessment Date: 29 May 2024

Accreditation Cycle: 1

Contents

Introduction

The Australian Council on Healthcare Standards
The Australian Council on Healthcare Standards (ACHS) is Australia's leading healthcare assessment and accreditation provider. ACHS is an independent, not-for-profit organisation dedicated to improving quality and inspiring excellence in health care. We accredit organisations according to either government standards, or our own established standards.

ACHS is approved to accredit the following standards

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care Module (MPS Module)
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards
- National Clinical Trials Governance Framework
- Royal Australian College of General Practitioners (RACGP) Standards for general practices (5th edition) and the RACGP Standards for point-of-care testing (5th edition)
- National Standards for Mental Health Services (NSMHS)
- Rainbow Tick Standards
- EQuIP Standards

Currently there are more than 1,600 healthcare organisations, including their associates, that undertake ACHS assessment and quality improvement programs. ACHS are proud to accredit the majority of all public and private hospitals in Australia.

With representation from governments, consumers and peak health bodies from throughout Australia, ACHS works with healthcare professionals, consumers, government and industry stakeholders to implement healthcare accreditation programs.

ACHS offers a variety of services including accreditation, education and training, data and benchmarking and consulting. We take a partnership approach to continuous improvement, tailored to the needs of individual services and health systems, using our expertise in accreditation, standards development and education.

Australian Commission on Safety and Quality in Health Care
The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The Commission works in four priority areas:

1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value, and outcomes

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme
Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, and
- Any other set of standards that may be developed by the Commission from time to time

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients, and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

Rating scale definitions

Whenever the NSQHS Standards (2nd ed.) are assessed, actions are to be rated using the rating scale outline below:

Rating	Description
Met	All requirements of an action are fully met.
Met with recommendations	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where additional implementation is required. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. **Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.** In circumstances where one or more actions are rated not met, the actions rated met with recommendations at initial assessment will be reassessed at the final assessment. If the action is not fully met at the final assessment, it can remain met with recommendations and reassessed during the next assessment cycle. If the organisation is fully compliant with the requirements of the action, the action can be rated as met.

Rating	Description
Not met	Part or all of the requirements of the action have not been met.
Not applicable	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.

For further information, see Fact sheet 4: Rating scale for assessment

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions **rated not met and /or met with recommendations**, and /or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed. The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one-off assessment with a remediation period of 60 business days. **All actions must be met when the assessment is finalised for the organisation to retain its accreditation.**
For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors, and accrediting agencies on NSQHS Standards implementation, the Primary and Community Healthcare Standards, the Digital Mental Health Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme, and the National Diagnostic Imaging Accreditation Scheme.
Telephone: 1800 304 056
Email: AdviceCentre@safetyandquality.gov.au
Further information can be found online at the Commission's Advice Centre via https://www.safetyandquality.gov.au/

Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *NS2.1 Short Notice Final Assessment*. This approval is current until 31st December, 2024.

Under this authority, ACHS is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Dr Karen Luxford, declare that ACHS has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

No conflicts of interest were evident as part of this assessment and no Consultants or third parties participated in this assessment.

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Lead Assessor	Ann Cassidy	Yes
Assessor	Deirdre McKaig	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Melbourne Private Hospital. The accreditation decision was made on 17/06/2024 and Melbourne Private Hospital was notified on 17/06/2024.

Executive Summary

On 29/5/2024, Melbourne Private Hospital underwent an NS2.1 Short Notice Final Assessment.

Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier	Delivery Type
Melbourne Private Hospital.	101086	Onsite

Summary of Recommendations Subject to the Final Assessment

Facilities (HSF IDs)	Initial Assessment Met with Recommendations	Initial Assessment Not Met
Melbourne Private Hospital 101086	2.05, 3.13, 3.18, 4.05, 4.06, 4.07, 4.15, 8.05, 8.07	1.08

The final assessment was conducted for Melbourne Private Hospital on 29/5/2024. The following report outlines the assessment team's findings.

General Discussion

The Melbourne Private Hospital (MPH) participated in a Final Assessment as described in the ACSQHC Short Notice Accreditation Fact sheet 17. The assessment was conducted on site by the Australian Council on Healthcare Standards on Wednesday, the 29th of May 2024, by two assessors.

The MPH team was well prepared for the assessment with appropriate evidence available for all ten (10) recommendations. During the assessment, the staff were actively engaged in the review of the processes and systems that were the subject of the recommendations, as well as the identification and implementation of the action plans developed to respond to and mitigate the risks associated with the variance identified at the Initial Assessment. Endorsed action plans were registered in the eQuaMS system. Existing Clinical Governance committees have been strengthened with the inclusion of a medical representative on the Medication and Transfusion Safety Committee and the repositioning of the Medical Advisory Committee membership and role and functions in accordance with the draft Healthscope by-laws. The change reflects the appointment of a new Chair and half of the nominated representatives. Reports from patients and a review of both clinical and corporate documentation further validated the progress being made since the Initial Assessment.

In the Clinical Governance and Partnering with Consumer Standards at the Initial Assessment, Actions 1.08 was rated as Not Met, and Action 2.05 was rated as Met with Recommendations. At the Final Assessment, it was clear that progress had been made in addressing the recommendations detailed in the comments, and the Actions were subsequently rated as Met.

Two Actions (3.13 and 3.18) in the Preventing and Controlling Infections Standard were rated as Met with Recommendations, with the recommendations relating to environmental auditing and the evaluation of antimicrobial use data. Corrective actions undertaken, coupled with appointments to the infection Control and Hotel Services Manager roles, have contributed positively to the sustainability of ongoing surveillance programs and outcomes. Both actions have now been rated as Met.

In the Medication Safety Standard, four actions were rated as Met with Recommendations, with the recommendations primarily related to the documentation of a Best Possible Medication History (Action 4.05), medication reconciliation (Action 4.06), and adverse drug reaction (Action 4.07) in the clinical record, and the completion of the Venous Thromboembolism (VTE) screening and intervention section on the National Inpatient Medication Chart (Action 4.15). Evidence presented at the assessment indicated improvements across all actions, resulting in a Met rating being assigned to all actions. However, there is an opportunity to review the end-to-end VTE risk screening and management process to ensure that it is aligned with contemporary practice and meets the needs of the MPH services and patient profile.

Actions 8.05 and 8.07 in the Recognising and Responding to Acute Deterioration Standard, related to the development of systems to identify and respond to mental health deterioration and to clarify the patient escalation (REACH) approach, were rated Met with Recommendations. It was clear at the Final Assessment that a significant review of the system and associated processes had been undertaken and a substantive quality action developed to respond to elements across the system. Policy reviews, a staff education workshop, and the introduction of the patient-informed sunflower tool and mental health escalation pathway have all been introduced. Evaluating the effectiveness and appropriateness of the actions that have been implemented is a key component of the action plan registered in the eQuaMS system. Both Actions have now been rated as Met.

Overall, MPH has made excellent progress since the Initial Assessment and should be pleased with safety and quality systems embedded in the organisation.

Assessor Findings at Final Assessment

Below is a summary of the findings of the assessment team:

ACTION	
1.08	The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems

Initial Assessment Comments	**Initial Assessment Recommendation(s) / Risk Rating & Comment**
A review of the eQuaMS Quality Action Plan indicated that there were actions from 2022 that remained open. A report run by staff at the time of the assessment indicated that from February 2023 to February 2024 there were a total of 167 items on the register. 62 (or 37%) had been completed, and 105 (or 63%) had been commenced but not finalised and closed.	**Rating:** Not Met **Applicable:** Melbourne Private Hospital. **Recommendation:** Action items on the eQuaMS Quality Action Plan should be reviewed, updated with the action taken, and closed in a timely manner. **Risk Rating:** Low

Final Assessment Comments
At the time of the Final Assessment, there had been a considerable improvement in the management of the eQuaMS system. Education sessions have been provided to staff and a report outlining open activities is monitored and circulated to department managers weekly. 80% of actions were closed, with the open actions being recent activities. Conversations with clinical leaders indicated they had ownership of the system and confirmed the process that has been put in place. On this basis, the recommendation has been closed.

Final Assessment Rating	**Applicable**
Met	Melbourne Private Hospital.

ACTION	
2.05	The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
Patients who do not have the capacity to make decisions about their care are identified, and staff are aware of the medical treatment decision maker appointed by the patient. Staff were not aware of the hierarchy of the legislated substitute decision makers that may need to be involved in decision-making, including informed consent. There is an overarching Healthscope policy that mentions substitute decision makers.	**Rating:** Met with Recommendations **Applicable:** Melbourne Private Hospital. **Recommendation:** Following the recent review and endorsement of Healthscope's substitute decision maker policy, ensure an education program for staff is implemented with focus on the identification and use of substitute decision makers. **Risk Rating:** Low

Final Assessment Comments
The Healthscope 'Consent to Medical / Surgical Procedure' Policy has been updated in line with legislation. The Consent to Medical and / or Surgical Treatment Form has been updated to include reference to the substitute decision-maker. Other consent forms such as blood and chemotherapy have also been updated and are awaiting ratification at key National Committees. Staff were able to explain when and how a substitute decision-maker would be engaged and have resource material to assist them. The audit program has been expanded to include this aspect of consent. The action item has been Met and the recommendation has been closed.

Final Assessment Rating	Applicable
Met	Melbourne Private Hospital.

ACTION	
3.13	The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
This recommendation is related to 3.13e where the results of audits to improve environmental cleaning processes and compliance with policy. On-site inspections and review of evidence, that included risk assessments, it was evident that not all maintenance requirements are actioned and may be re-suggested a number of times.	**Rating:** Met with Recommendations **Applicable:** All **Recommendation:** The environmental cleaning audits are reviewed and updated in accordance with the Australian Commission on Safety and Quality in Health Care 'Principles of environmental cleaning auditing' with reference to is the person responsible for each action and an appropriate timeframe for rectification. **Risk Rating:** Low

Final Assessment Comments
Since the Initial Assessment, an Infection Control Manager and a new Hotel Services Manager have been appointed. Together, they have undertaken an Environmental Services Gap Analysis and subsequently developed an Action Plan. The Action Plan is risk rated and has clearly outlined responsibilities, and expected completion dates are documented. The frequency of the cleaning audits in the MARS audit system has been increased and an additional external audit scheduled with ECOLAB. The results of all audits are captured in the action plan and entered into eQuaMS. As a result of these actions and the actions taken to monitor the open actions in eQuaMS (Action 1.08), the recommendation has been closed.

Final Assessment Rating	Applicable
Met	All

ACTION	
3.18	The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
This recommendation relates to Action 3.18e where the organisation takes actions on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement. MPH has an overarching antimicrobial stewardship policy and has completed a National Antimicrobial Prescribing survey in 2023. The results of the survey demonstrated that only five patients were audited and that the results demonstrated a need for improvement.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Using the results of the 2023 NAPS audit, MPH re-audit, over a longer period of time, to increase the sample size. Responses to be reviewed and analysed and resulting actions from the survey be implemented and monitored for improvements. **Risk Rating:** Low

Final Assessment Comments
Evidence presented during the Final Assessment indicated that the process by which antimicrobial use is evaluated and reported through the respective clinical governance committees has been reviewed and actions taken to strengthen the process. The Antimicrobial Stewardship MARS Audit (n=30) and the NAPS quality audit (n=60) have recently been completed, demonstrating an overall compliance rate of 73% across all elements. Where variances have been identified, appropriate action plans have been developed to improve compliance, and these are discussed at the IPC and tabled for discussion at the next scheduled MAC committee. Ongoing audits are incorporated into the national audit schedule which includes the submission of data via the NAPs and NAUSP database. Healthscope and MPH policy on AMS are currently under review. Based on these actions and the performance outcomes, the intent of the Action has been Met.

Final Assessment Rating	Applicable
Met	All

ACTION	
4.05	Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
The National Standard Medication Chart audit results 2023 showed that the Best Possible Medication History (BPMH) documentation is less than the comparison result. Discussion with staff members identified that there is not a good understanding of the process.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Educate appropriate clinical staff about the process of taking a Best Possible Medication History (BPMH), and re-audit BPMH documentation. **Risk Rating:** Low

Final Assessment Comments
A comprehensive review of the process by which clinicians take and record a best possible medication history (BPMH) as early as possible in the episode of care has been undertaken. Areas for improvement have been identified and incorporated within the improvement activity registered in the eQuaMS system. The development and introduction of the paper-based Medication Management Plan, used as an adjunct to the NIMC, provides a record of a patient's medication history on admission and across the care continuum. A comprehensive education program to support the rollout of the new form and practice change has been undertaken. Progressive auditing of compliance with the use of the documentation has increased with the current rate being at 89%. Variances in compliance have been identified and corrective actions identified. At the time of the assessment, 95% of BPMH are recorded in the clinical record. The intent of the action has been Met.

Final Assessment Rating	Applicable
Met	All

ACTION	
4.06	Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
Medication reconciliation requires that the patient's current medication orders are reviewed against the best possible medication history (BPMH), and the documented treatment plan and discrepancies be reconciled.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** An increase in the BPMH is required so that there can be an increase in medication reconciliation, which should be documented in the healthcare record. Re-audit this information. **Risk Rating:** Low

Final Assessment Comments
At the time of the Final Assessment, there was documented evidence which indicated that the process by which a patient's medication is reconciled against the BPMH and current treatment plan has been strengthened through the introduction of the Medication Management Plan. Discrepancies can now be identified and recorded at the point of admission, transfer of care, and at discharge. Issues identified with a corresponding proposed action and assigned responsibility are documented. There is an opportunity to aggregate and categorise these interventions to inform and improve medication safety across the service. The intent of the action has been Met.

Final Assessment Rating	Applicable
Met	All

ACTION	
4.07	The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
Audits identified that the documentation of adverse drug reactions (ADRs) within the clinical records was inconsistent.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Undertake a formal risk assessment that relates to the impact of inconsistent documentation of ADRs at point of care, take remedial action and re-audit on a regular basis. **Risk Rating:** Moderate

Final Assessment Comments
MPH was able to demonstrate that a risk-based approach has been used to identify and mitigate risks associated with the inconsistency of the documentation of ADR at the point of care within the clinical record. Medication auditing activities suggest that 100% of ADR are recorded on the NIMC. A review of the EMR program identified that a change in the way in which ADRs were documented, and appeared, in the EMR Alert section had occurred without staff being aware of the system change. Once identified, a comprehensive staff education and awareness campaign, coupled with weekly compliance and spot audits, indicate that compliance has increased to above the 90th percentile. No incidents have been reported for 2024 that relate to medications being administered where a known allergy or sensitivity has been identified. Ongoing audit is listed on the National Audit schedule, with outcomes reported at the respective clinical governance committees. The intent of the action has been Met.

Final Assessment Rating	Applicable
Met	All

ACTION	
4.15	The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
It was noted in the National Standard Medication Chart (NSMC) audit that improvement is required in the documentation of the VTE risk assessment on the NSMC.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Review the existing policy to provide clarity around the role and responsibility of persons engaged in VTE risk screening process with particular reference to documentation and where this is reported. **Risk Rating:** Low

Final Assessment Comments
At the time of the assessment, Healthscope is currently undertaking a review of the Venous Thromboembolism (VTE) Prophylaxis for adult inpatients. A draft document was sighted and the review referenced in the National Policy and Forms committee meeting minutes (14th May 2024). Within the draft policy, reference is made to the person responsible for the VTE risk screening and the management of pharmacological and / or mechanical prophylaxis. Patients identified as being at risk are to be documented in the clinical record and flagged on the NIMC. This is currently a shared responsibility between nurses and medical practitioners. Education and awareness sessions have been conducted across the clinical units and as a result, audits indicate increased compliance in nurses ticking the box on the NIMC to indicate that a risk assessment has been completed (77%) while 83% have a corresponding prophylaxis order documented by the medical workforce. Results from the audit are reported through to the Medication / Transfusion Safety and Medical Advisory Committee(s. The recommendation has been closed as it pertains to the action relating to the management of high-risk medications. However, there is an opportunity to review the end-to-end VTE risk screening and management process to ensure that it is aligned with contemporary practice and meets the needs of the MPH service and patient profile.

Final Assessment Rating	Applicable
Met	All

ACTION	
8.05	The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
This recommendation specifically references to Action 8.5a, b and c. While there are policies and procedures around the care of the patient at risk of delirium, including prevention, there was no apparent system for those who are at risk of acute deterioration in mental state and a response to individual early warning signs. A proposed project with Melbourne Clinic may assist with these systems in the future.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** It is recommended that MPH develop systems that encompass the risk of mental health deterioration in a patient, that aid members of the workforce to be alert to signs of deterioration. This includes people who have not been previously identified as being at high risk, with delirium being only one component of mental health deterioration. **Risk Rating:** Low

Final Assessment Comments

MPH has developed screening questions for Mental Health and actions to be taken if screening indicates mental health risk. The questions and action items are going live in the EMR on 1/6/2024.

A flow chart outlining the escalation process for deterioration in Mental Health has been developed and this includes initiating a MET call for patients with mental health deterioration.

A Mental Health Clinical Risk Assessment Form has been sourced from The Melbourne Clinic (Healthscope mental health facility). The assessment is completed by the VMO for all patients that have a deterioration in mental health. The Mental Health Clinical Risk Assessment Forms have been added to the MET Team's backpack. Education in mental health deterioration has been provided to MPH clinical staff by staff from The Melbourne Clinic.

Recognising and responding to mental health deterioration has been added to both the Advanced Life Support study day and the Deteriorating Patient Workshop.

ACTION	
8.05	The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
The Terms of Reference for the Deteriorating Patient Committee have been updated to include mental health deterioration and will be presented to the next committee meeting on 4 June for ratification. Reporting of MET calls including mental health deterioration is a standing agenda item on the Deteriorating Patient Committee. The local MPH Medical Emergency Response Policy has been updated to include mental health escalation and assessment processes and is being presented to the Deteriorating Patient Committee on 4 June for ratification. As result of the evidence presented and discussion with key staff, this recommendation is closed.	
Final Assessment Rating	**Applicable**
Met	All

ACTION	
8.07	The health service organisation has processes for patients, carers or families to directly escalate care

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
MPH has a brochure 'You call and we respond' that utilises the nurse call system and the emergency button. On display are instructions to utilise the 'reach' process with a number directed to the Clinical Coordinator. The assessors discussed the process with patients within MPH, with patients indicating that they were not aware of the process. The assessors noted that there were two systems in place and that this made for confusion as to the system to follow.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Clarify the process by which patients, family, and carers access help when they are concerned that a person is acutely deteriorating. Develop and implement an effective communication strategy to inform all stakeholders of the process. **Risk Rating:** Low

Final Assessment Comments

MPH uses the REACH process for patient and carer escalation of care, and signage was present in all the patient rooms viewed at the time of assessment and patients were able to outline how to they would escalate any concerns.

The clinical staff could outline the REACH process and how they informed patients of the process.

Any REACH calls are logged in the incident management system and tabled at the Deteriorating Patient Committee. Nil have been reported to date.

Regular surveys are conducted to monitor compliance with the process. A survey conducted on 16 May 2024 indicated a compliance rate of 92%.

On the basis of the evidence provided at the time of assessment and discussion with staff and patients, this recommendation is closed.

Final Assessment Rating	Applicable
Met	All

Summary of Accreditation Status

A summary of the Accreditation awarded is outlined in the below table:

Health Service Facility Name	HSF Identifier	Accreditation Status
Melbourne Private Hospital.	101086	3 years Accreditation