NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Melbourne Private Hospital

Parkville, VIC

Organisation Code: 225023
Health Service Facility ID: 101086
Assessment Date: 03/03/2020 to 05/03/2020

Accreditation Cycle: 1

Contents

Preamble

How to Use this Assessment Report
The ACHS assessment report provides an overview of quality and performance and should be used to:

1. provide feedback to staff
2. identify where action is required to meet the requirements of the NSQHS Standards
3. compare the organisation's performance over time
4. evaluate existing quality management procedures
5. assist risk management monitoring
6. highlight strengths and opportunities for improvement
7. demonstrate evidence of achievement to stakeholders.

The Ratings:
Each **Action** within a Standard is rated by the Assessment Team.

A rating report is provided for each health service facility.

The report will identify actions that have **recommendations** and/or comments for each health service facility.

The rating scale is in accordance with the Australian Commission on Safety and Quality in Health Care's Fact Sheet 4: Rating Scale for Assessment:

Assessor Rating	Definition
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.
Not Met	Part or all of the requirements of the action have not been met.
Not Applicable	The action is not relevant in the health service context being assessed.

Suggestions for Improvement
The Assessment Team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating. Suggestions for improvement are documented under the criterion level.

Recommendations
Not Met/Met with Recommendation rating/s have a recommendation to address in order for the action to be rated fully met. An assessor's comment is also provided for each Not Met/Met with Recommendation rating.

Risk ratings are applied to actions where recommendations are given to show the level of risk associated with the particular action. A risk comment is included if the risk is rated greater than low.
Risk ratings are:

1. E: **extreme (significant)** risk; immediate action required.
2. H: **high** risk; senior management attention needed.
3. M: **moderate** risk; management responsibility must be specified.
4. L: low risk; manage by routine procedures

Executive Summary

Introduction

Melbourne Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 03/03/2020 to 05/03/2020. The NS2 OWA required 3 assessors for a period of 3 day(s). Melbourne Private Hospital is a Private health service. Melbourne Private Hospital was last assessed between 14 March 2017 and 16 March 2017. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Melbourne Private Hospital	101086

General Discussion

Melbourne Private Hospital (MPH) offers a comprehensive range of private healthcare services across a variety of specialties for patients residing in the Melbourne CBD and rural and regional locations in Victoria. Led by a dedicated and committed executive team it was evident care and services are delivered safely.

The assessors acknowledge the executive, the Quality and Infection Control Manager, Nurse Unit Managers, clinical and support staff, medical staff, pharmacists and the consumer consultant for their active participation during the assessment. The assessors appreciated the comprehensive information provided prior to the assessment and at the time of the assessment. Evidence was available to support all actions in the National Safety and Quality Health Service (NSQHS) Standards 2nd edition being rated Met.

Significant progress has been achieved in relation to compliance with the current ACSQHC Advisories which have all been actioned and where a gap analysis and action plan is required, these have been completed and remain ongoing.

The assessors were impressed with the seamless integration of clinical services which was clearly evident when visiting the clinical and support departments including Pharmacy. The collegial relationship with the Royal Melbourne Hospital (Melbourne Health) is commendable.

MPH demonstrates a culture of quality and safety across the hospital through their integrated governance system that actively supports and manages patient safety, quality and risks. Continuing to initiate and be responsive to improving safety and quality of patient care services is of paramount importance. Processes of reporting, auditing, review, critical analysis and reflection was evident.
The system for managing incidents and complaints is well embedded and effectively managed. Open disclosure policies and processes are in place and the clinical workforce has been trained.

The patient electronic medical record (eMR) is well integrated and appropriate to good patient care. Further enhancements are occurring regarding the uploading of the existing hard copy medical record forms into the electronic platform.

Clinical performance and skills management has established systems in place to support, monitor and evaluate clinician's performance across all disciplines. Staff education and training in respect of patient safety and quality is comprehensive.

Credentialing and Scope of Practice is managed in accordance with Healthscope policies and By-laws. The MAC is very involved in the credentialing re-credentialing and scope of practice for all craft groups. The engagement of the VMO's is highly impressive.

Clinical practice is evidence based and staff clearly understand their responsibilities. There are mechanisms in place to support the early identification, intervention and management of patients at increased risk of harm with relevant and appropriate systems to escalate the level of care in the event of unexpected deterioration.

The hospital's greatest challenge is the limited space available to expand clinical services and deal with high activity. However, the executive and Healthscope Corporate are continuing to investigate ways to work with Royal Melbourne Hospital (Melbourne Health) in service planning and building capacity.

Consumer participation is actively sought. The engagement of patients' families and carer(s) in activities that improve safety and quality was evident. The Consumer Consultant provides feedback on patient information and reviews the patient experience survey results.

Patient's Rights and Responsibilities are well respected and included in information compendiums, brochures, the website and at the point of care. Cultural diversity and respect and recognition of Aboriginal and Torres Strait Islander people is at the forefront of all conversations.

Preventing and Controlling Healthcare Associated Infections is evident in all clinical units and support departments. An Antimicrobial Stewardship Program is established. Improvements have been made to the membership of the Committee to strengthen the clinical workforce's understanding and use in relation to best practice prescribing and use of antibiotics guidelines.

Robust surveillance monitoring and Infection Control Indicators are audited, and results reported regularly. The low infection rate is testament to the efficacy of the systems in place.

There are established processes in place to manage medication safety. Documentation of patient information, continuity of medication management and the reconciliation of medicines are audited regularly with good results. The engagement of the clinical pharmacists is highly regarded and a benefit to the clinical departments service.

Comprehensive Care strategies and procedures provide continuous and collaborative care. The Comprehensive Care Plan has addressed key care criteria and audits are in place to identify areas for improvement. Consumers are well engaged in decision-making and providing feedback; this includes screening and assessment, identifying goals of care and care plans for identifying patients at end of life.

Systems and processes to recognise, prevent and manage delirium, cognitive impairment, self-harm and suicide, violence and aggression, as well as restrictive practice, restraint and seclusion have been clearly embedded in every day practice.

It is also noted by the assessor team when visiting departments, that the staff had a good understanding of the importance in recognising and managing mental health issues and the procedures and clinical support readily available. This education and training also included support staff.

Communicating for safety includes patient identification and procedure matching, transfer of care and matching of patients and their care and are well documented and audited for compliance at every point of care of the patient's journey.

Clinical Handover is supported by good local processes, which were developed in collaboration with clinical staff, patients and carer(s). The information provided and communicated to staff on the "Huddle Boards" and patient whiteboards is impressive.

Blood management systems and blood product transfusions are safe, appropriate, effective and efficient.

Skilled, caring and responsive staff are educated in recognising and responding to clinical deterioration with good systems to escalate unexpected deterioration in a patient health status. Events are diligently monitored and reported.

At the time of the assessment, the executive and staff's commitment and tireless efforts in providing patient-centered care to patients, carer(s) and families was evident. MPH should be proud of their ongoing commitment and dedication in improving care and services to whom they serve.

Further comments and suggestions for improvement have been included in the Standard Summaries.

Summary of Results

Melbourne Private Hospital achieved a met rating for all **applicable** actions in all standards that were assessed and has achieved Accreditation (3 Years).

Melbourne Private Hospital achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

Further details and specific performance to all of the actions within the standards is provided over the following pages.

Melbourne Private Hospital

Sites for Assessment

Sites for Assessment - Melbourne Private Hospital

Melbourne Private Hospital HSF ID:101086	
Address: Royal Parade PARKVILLE VIC 3052	Visited: Yes

Melbourne Private Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

Action 1.1	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.2	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.3	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.4	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.5	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.6	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The governance of the Melbourne Private Hospital (MPH) and the committee structure have clear and concise lines for reporting and communication. Committees are well organised with current terms of reference (TOR). The Strategic Plan has a strong business focus in addition to clear safety and quality strategies with anticipated outcomes to be achieved.

MPH demonstrates a culture of quality and safety across the hospital through their integrated system of governance that actively supports and manages patient safety, quality and risks. The Healthscope Safety and Quality Plan and Strategic Plan includes feedback from partnering with consumers. The MPH Quality Plan is aligned to the Healthscope Plan. MPH has engaged a consumer representative who now attends the Quality Committee meetings. At the ward and department level there is evidence of the staff's understanding of their responsibilities in regard to monthly reporting of Key Performance's (KPIs), incident management and consumer engagement.

Policy documents about cultural diversity acknowledge the needs of Aboriginal and Torres Strait Islander patients, their carer(s) and families. Evidence provided demonstrated local community input regarding the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.

Patient experience surveys are undertaken quarterly. Overall Satisfaction results show an improvement from 77.2% in January – March 2018 to 85.6% in July to September 2019.

The senior hospital executive access and review daily the hospital's survey results via Qualtrics the Healthscope's electronic Patient Experience Portal. The results are discussed frequently at various forums with results presented to senior management and the Board.

There are internal and external audits, internally through inter department benchmarking and external benchmarking including ACHS Clinical Indicator programs and comparing MPH performance against other hospitals in the Healthscope group.

Patient safety and quality systems

Action 1.7	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.8	
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	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.9	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.14
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

There is a raft of Corporate policies and procedures, as well as MPH local policies that underpin all aspects of the business. These are all available on the Healthscope intranet (HINT).

Safety and quality in health care as a major theme of business decision-making was demonstrated through the MPH Safety & Quality Plan that recognises clinical governance is an essential component of the overarching planning of the hospital. Communication to the workforce and consumers on safety and quality indicators and data was evidenced in various forms and presented at relevant committee's such as, craft group Morbidity and Mortality (M&M) meetings. Quality Improvement Project Plans provide comprehensive review of the processes that make up the safety and quality systems specified in the NSQHS Standards.

MPH provides care in a planned way that is delivered in collaboration with the patients and their family and carer(s). Staff were able to describe the care practices and associated quality activities which they have implemented across the hospital.

There are established clinical systems that demonstrate reporting on safety and quality indicators and related actions from the wards and departments to the Quality Committee through to the Clinical Review Committee. At the ward and department level the annual quality action plans and activities are informed by analysis of data.

Evidence was provided to demonstrate that MPH meets the requirements of the standards and are continuing to initiate and be responsive to improving safety and quality of patient care. Actions/mechanisms are used to improve patient care. Processes are clear in regard to reporting, auditing, critical analysis and reflection.

RiskMan is the integrated risk management system that has been well established through a comprehensive collection and classification of risk rated data and analysis by management and staff. The risk register is used to monitor and reduce the level of risk for the hospital.

All risks have an identified owner and the tracking of risks is transparent with reporting against a range of Key Performance Indicators (KPIs) which includes a number of quality and safety indicators resulting from a comprehensive audit schedule. The process ensures that at the governance level there is regular reporting of operational, quality and safety KPIs.

The incident management system is easily accessible and understood by the staff. Automatic alerts to relevant managers, staff and executive are in place depending on the type of incident. The Quality/Infection Control Manager reviews all incidents. The executive has oversight of all incidents.

The Nurse Unit Managers (NUM) initiate investigations of incidents. Analysis of data is undertaken at the ward / department level and action plans generated where areas of improvement have been identified. Open disclosure is a section of the RiskMan reporting system for sentinel events. In addition, any critical incidents are followed up by the Quality & Infection Control Manager and the National Clinical Risk Manager. Reviews of all critical incidents are conducted by the Quality Committee, Clinical Review Committee and Medical Advisory Committee.

Open disclosure policies and processes are in place.

There are good mechanisms in place to identify patients at risk of harm and outlining early intervention strategies. Patient care plans and standardised observation and, assessment processes are managed well. Cultural Diversity is recognised in all aspects of care and services provided.

There are policies and procedures in place to assist with the requirements when recording activities and completing of the various clinical record documents. The electronic Medical Record, (eMR) introduced at Melbourne Private Hospital in August 2017, as the pilot site for Healthscope. The program continues to be developed with Telstra Health following feedback from all healthcare users. All staff provided positive feedback including the ease of use of the iPhone and iPad, being able to access patient information and the immediate access to a patient's clinical record for clinical care and audit purposes. There are systems in place for existing hard copy medical records to be managed and scanning of relevant documentation, with new admissions of previous patients into the system provides for currency of documentation.

The Clinical Documentation Improvement Program has demonstrated improvement in both documentation and communication. It has resulted in the hospital and clinicians ensuring the complexity of patients they are treating is captured in the medical record for continuity of care and has resulted in revenue maximisation (with improved documentation and reduced DRG changes).

Healthscope was an early adopter of the My Health Record initiative, with it being first introduced at MPH in 2016 with Event Summaries and Nursing Discharge Summaries uploaded to the system. Information is displayed throughout the Hospital for Patients with details to inform them on My Health Record.

Clinical performance and effectiveness

Action 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

MPH demonstrated effective orientation programs for front-line staff and managers in terms of their responsibilities and roles regarding safety, quality and clinical governance. This is supported by appropriate resources including the Healthscope orientation policy and ELMO eLearning modules. The program includes requirements for nursing fellowship students, agency staff, and contractors. There is also a supernumerary period in clinical areas which is tailored for the individual staff member. The visiting medical officers' responsibilities for safety and quality are defined in the By-Laws and recorded in the cGov credentialing system. In addition, the VMOs receive a welcome pack, as well as a structured introduction to their ward and surgical environments.

There was evidence that the organisation provides appropriate and effective ongoing education in safety, quality and clinical governance, in accordance with the Healthscope Mandatory Training and Education and Training policies. An education and training register in ELMO documents attendance at mandatory training sessions on a rolling 12-month program. Mandatory training requirements are periodically reviewed and have resulted in better targeted education for example in MedSafe eLearning.

Recent inclusions have been updated training for end-of-life care, cognitive impairment, bedside clinical handover and Aboriginal and Torres Strait Islander cultural awareness. Nurse educators provide opportunistic education as well as formal education sessions, based on feedback from performance development sessions and staff forums. There is a mature graduate nursing model of education and supervision which is highly regarded. A recent initiative provides a supervised workshop for patient assessment by the new graduate nurses. Feedback from staff, including VMO feedback regarding the effectiveness of education provides the basis for future improvements. A recent example relates to feedback from neurosurgeons regarding the deteriorating neurosurgical patient. The expertise of the nursing staff as a result of the formal and informal education provided at MPH is highly regarded by the specialist medical staff. Evaluation of the orientation program and mandatory training are reported to the Executive.

There are a number of strategies to improve the cultural awareness of the workforce to meet the needs of Aboriginal patients, with clear evidence of uptake by staff. These strategies include “asking the question” ELMO training for administrative staff, and the “share our pride” video. There is a dedicated culturally appropriate garden space for Aboriginal patients and visitors. Further initiatives underway include patient’s story videos from a recent Elder who was delighted with the culturally sensitive and empathic care delivered at MPH during a prolonged inpatient stay. Many staff are also attending an occasion celebrating ATSIC culture at Federation Square.

The Healthscope performance review and development policy requires staff to participate in review of their performance, and the performance development process at MPH. Participation is monitored by the department managers. Performance review identifies specific training needs and identifies skill gaps. Support for complex performance issues is provided by the Executive as well as Healthscope Human resources.

Each nursing educator undertakes a training needs analysis in their respective department and develops a calendar of appropriate development activities.

VMO performance is reviewed and monitored by the Executive in a variety of settings like clinical review meetings, morbidity and mortality meetings and MAC meetings. Any concerns regarding performance are escalated according to the requirements of the By-Laws.

There is a well-structured process for the credentialing of medical, nursing, pharmacy and allied health clinicians. Defining and monitoring their associated scope of practice is in place, within a well-defined policy framework, guidelines and governance structure. Credentialing of medical staff, including recredentialling for innovative technologies, is outlined in the By-Laws, and undertaken by MAC. Scope of practice is available hospital-wide via WebPAS and is a valuable tool for nursing staff. Regular auditing of compliance with VMO credentialing and scope of practice via the cGov system is undertaken, with regular reporting to Healthscope nationally.

The assessment team noted the efforts of the MAC to delineate conditional privileges of some visiting medical officers as the result of clinical incident review. The assessment team also noted that the requirements outlined in Advisory 18/12 for colonoscopy credentialing were met.

The organisation's performance development policy outlines safety and quality roles for all managers and clinicians. Position descriptions of all clinicians define responsibilities for safety and quality, as do the By-Laws for the VMO contracted staff.

There was evidence of appropriate supervision of the clinical workforce, including graduate nurses, as well as registrars and ICU fellows to ensure that they are able to provide safe, high quality care. Overnight ICU fellows are supervised by on-call specialists. In addition, increased supervision is provided on an individual basis as a result of performance review.

The health service supports the clinical workforce to provide safe, high-quality care with the provision of a range of best available evidence including guidelines, care pathways, screening and assessment tools, decision support tools and clinical care standards from the ACSQHC. All these tools are accessible via HINT. Clinical standards are distributed to medical staff by MAC, the relevant craft groups and at clinical review meetings.

Monitoring of the ACSQHC hospital acquired complications has demonstrated improvements better than peer hospitals in 2019, and the data is reported to the Healthscope Executive Board.
As part of a system to reduce variation in clinical practice, there was evidence that processes of care and health outcomes are regularly reviewed at morbidity and mortality meetings and clinical review meetings. In addition, performance is reviewed against other tertiary facilities, and selected clinical quality registries, like VCOR, ACOR, VASM, AOA joint registries and ANZICS adult. Mechanisms exist to detect, investigate and act on unwarranted clinical variation within the health service, and to record risks within the risk management system and credentialing systems.

Safe environment for the delivery of care

Action 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

A Business Continuity Plan and Emergency Management manual and Policy is in place for safe work practices and emergency situations. MPH co-location arrangements with the Royal Melbourne Hospital (Melbourne Health) space is at a premium and is challenging for the staff to manage particularly when the hospital is so busy, and demand is high. There is ongoing dialogue and commitment that any physical design of the environment will be part of the future redevelopment of the site. The current design of the facilities includes consideration of safety and quality surveillance, duress alarms, access to security services, and a secure environment after hours.

All external doors are on a Bi-Lock key system so one key will be used to lock all doors along Royal Parade and Grattan Street.

There is a kiosk in the foyer of the hospital, a good initiative for visitors to access information and find their way through the building and services.

A comprehensive preventative maintenance program is in place, developed and managed by the Facilities Manager who manages daily operation of various external contractors.

MPH has a Healthscope Acknowledgement of Country policy. Aboriginal artwork and a plaque describing the artwork are present in the MPH reception.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Community participation is led by the Healthscope Consumer Engagement Plan, and the strategic priorities embedded in the Strategic Plan specific are further supported by the MPH quality plans that have consumer opportunities identified and actioned.

The Healthscope Corporate Consumer Consultants Committee and Reconciliation Committee have good representation from the community. A focus since the last assessment has been on increasing engagement with Aboriginal and Torres Strait Islander people in partnership with the community was evident and sustainable governance processes that ensures consumer participation with their contribution at various levels of decision-making within the hospital.

There is evidence of a quality focus engagement of the diverse community. This provides opportunities for consumers to identify and discuss issues proactively leading to an enhanced range of quality improvements.

There is an ongoing process of continuous surveying to gain patient feedback with results validating the satisfaction of patients across the clinical areas with the services provided.

The assessors were fortunate to meet with a local elder and his partner who have both used the services of MPH and spoke highly of the care and cultural sensitivity of MPH to the needs of the Aboriginal and Torres Strait Islander people. They were both enthusiastic in supporting the Reconciliation Action Plan progression including contributing to storytelling.

Partnering with patients in their own care

Action 2.3	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.4	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.5	
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	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.6	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Rights and responsibilities are clearly displayed and patients well informed at the time of admission. There are systems in place to monitor compliance to informed consent and the engagement of patients in clinical decision-making, as well as identifying improvements in the documentation of consent and ensuring patients are provided with information to understand treatments and options.

Patients and families are included in the planning of their care and treatment and encouraged to provide feedback on the services provided.

There are systems in place to monitor compliance to informed consent and engagement of patients in clinical decision-making, improving documentation of consent and providing patients with information to understand treatments and options.

Patient confidentiality procedures and security systems are in place to ensure information privacy is maintained. Staff have clear and accurate understanding of their roles and responsibilities in this regard.

Patient and carer information is available at various points of contact and displayed in meaningful ways such as the patient whiteboards to provide patients and their families information relating to their specific care plans and opportunity to provide feedback.

Health literacy

Action 2.8	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.9	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Healthscope Corporate is committed to involving patients and carers in their own care, as well as partnering with consumers in service planning, designing care and service evaluation. MPH have adopted these principles as part of their patient-centred care approach.

Healthscope consumer approved publications are available for example, Falls Prevention and Infection Control. There is a corporate register of all Healthscope hospitals consumer information available as well as a list of Healthscope publications on the Intranet (HINT).

Interpreter Services, Consumer Approved Publications, Communication Cue Cards for Community Languages are available in 68 languages. Brochures for the Aboriginal and Torres Strait Islander peoples are available for staff to access on the Intranet.

The community is engaged in the various programs in targeted ways that encourages participation and contribution with feedback occurring.

Nursing Discharge Summaries are provided to patients on discharge with good engagement from the clinicians and craft groups. The Orthopaedic Pre-admission clinic provides relevant information for discharge for example rehabilitation options.

Partnering with consumers in organisational design and governance

Action 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is a clear commitment to engage with consumers at all levels from planning through to care delivery and evaluation. There is evidence of involvement with consumers and other agencies in the provision of focused programs that demonstrates the MPH plans and principles in operation.

There is evidence that demonstrates the consumer partnership in designing care including the engagement of consumers from various cultural backgrounds as well as the Aboriginal community to ensure that the target programs, including literature, meet the needs of these groups.

The Transcatheter Aortic Valve Implantation (TAVI) patient journey video is a prime example. In conjunction with a production partner and the treating interventional cardiologist, a patient journey video recording has been created to capture a patient's experience in the lead up to, during and following the procedure. The consumer (patient) was involved in the planning and production allowing him to tell of his life-changing experience in a manner that will likely resonate with other patients. At the time of the assessment the assessors were able to view the video which clearly acknowledged how grateful the patient and family were of the care and services offered at MPH and the outcome this procedure has had on the patient's quality of life. MPH intends to utilise this video to educate patients in the lead up to their procedure and will subsequently be valuable in facilitating patient consent.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action 3.1	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.4	
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Infection control systems have been implemented in accordance with Healthscope Corporate and local MPH policies and procedures and in line with Australian Guidelines for the Prevention and Control of Infections in Healthcare.

All Infection Control Policies are available on the Healthscope Intranet (HINT).

The Infection Control Committee Terms of Reference (TOR) are established. The TOR has a defined reporting structure which includes Healthscope Corporate Quality KPIs and HAC data.

The membership is well represented by all clinical departments and support services, as well as the Quality and Infection Control Manager and HICMR Consultant.

There is also an Infection Control (IPC) Management Plan which is reviewed annually by the Committee.

HICMR Infection Prevention and Control (IPC) Policy Manual, Toolkits, Risk Assessments are comprehensive and available through their e-portal which is easily accessible for staff to access.

The Antimicrobial Stewardship Program (AMS) is underpinned by Global and Therapeutic guidelines as well as policies and procedures specific to MPH.

It was evident at the time of the assessment that the hospital has engaged with patients and consumers in relation to infection control prevention. There is specific consumer information regarding hand hygiene, IV Access devices, VRE and MRSA which can be downloaded and given to the patient at any time. This ensures all publications are relevant and kept up-to-date.

Pre-admission information and assessment tools also provide patients with information regarding risk factors and the management of infectious diseases. Patients are well educated by the clinical Pharmacists. Patient communication boards are also used to help patients and families to understand the importance of infection control procedures. The hospital is encouraged to keep up the good work.

The Quality and Infection Control Manager is a member the National Infection Prevention and Control Webex Cluster whereby evaluation and benchmarking occur.

The risk management approach to infection prevention is highly impressive. RiskMan is the incident management system used and has defined descriptors regarding Infection Prevention Indicator sets.
Staff training commences at orientation which includes eLearning modules on ELMO, Healthscope's staff's training portal, as well as face-to-face sessions with the infection control team. Education is well managed, and staff are well educated in all aspects of infection control.

Infection control surveillance includes the Hospital Acquired Infections (HAIs) KPI Plan which is monitored through, pathology results, risk assessments and screening, incident reports and compliance audits.

Monthly reports form part of the agenda on the Infection Control Committee, the Clinical Review Committee (CCR), the Medical Advisory Committee (MAC), as well as at clinical and department meetings. Shared Learning's are published and available to all staff. The information is comprehensive and extremely valuable for MPH to access and review.

Infection prevention and control systems

Action 3.5	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.8	
The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.9	
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.10	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[18]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.11	
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.12	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.13	
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Standard precautions and transmission-based precautions, consistent with national guidelines are in use. Precaution signs are readily available and are colour coded and easily understood. Alerts are also captured on the electronic EMR, as well as validated screening tools. There are very good procedures in place to escalate a patient's infectious status to the appropriate qualified infection control clinical staff and Infectious diseases Physician for assistance if required.

The low infection rate is testament to the dedication and commitment by the medical workforce and all staff in this regard.

The MPH Infection Control Plan/Annual Surveillance plan is comprehensive, to enable infection control practices to be managed and monitored at the highest level of governance. Specialised designed departments and wards, such as the Intensive Care Unit (ICU) Operating theatres and Endoscopy Cardiac Suite, Neurology and cardiac wards. The assessors also noted the good infection control practices in the multidisciplinary ward, which accommodates a variety of medical and surgical specialties. Mobile PPE stations/trolleys are available if required.

Hand Hygiene is deemed a high priority and continues to be reviewed throughout all clinical and non-clinical areas in accordance with the hospitals Hand Hygiene Management Plan and National Hand Hygiene guidelines. Staff education commences at orientation and regular information sessions are conducted internally and externally. Results from audits remain consistently above 85% and are reported to the appropriate committees and service areas. Gold Standard Auditors have been trained and are involved in the 5 moment's observational audits in all clinical and non-clinical departments.

Hand hygiene Alcohol Based Hand Rub (ABHR)s are available at the point of care. The Quality and Infection Control Manager, with the assistance of the infection control champions monitor the availability of hand hygiene ABHR's throughout all departments especially the high-risk areas.

An Aseptic Technique Risk Assessment is in place and underpinned by the Healthscope Aseptic Policy and Mandatory training policy. The risk assessment outlines and describes what procedures are rated 'high risk' and who performs those procedures. Clinical departments and staff who work in high risk areas are trained in aseptic technique which includes eLearning education. Audits are detailed, showing compliance over 90% in all high-risk areas. Mandatory training is captured on ELMO the Healthscope education database.

There are policies and procedures in place regarding the insertion and management of invasive devices. The Invasive Devices Audit 2019 results show a 97% compliance which is to be congratulated.

The hospital is facing many challenges with the limited space they are dealing with particularly in the operating theatre, endoscopy and ICU. Efforts to de-clutter where possible is ongoing and the assessors encourage the staff to continue investigating ways to ensure equipment, supplies and general storage areas are able to be cleaned and ensure a clean environment is maintained. The introduction of stainless shelving in all storage rooms is to be congratulated.

HICMR Environmental Services policies and procedures are well established and well published.
Environmental Audits as well as the Maintenance/Engineering Services audit are regularly conducted and show over 91% compliance in 2019.

The Preventative Maintenance Schedule has recently been revised and includes matters in relation to infection control.

Cleaning schedules for environmental services are in use and staff well trained. Cleaning trolleys are well equipped with standard products and PPE's in place. Cleaning schedules for support/environmental staff are in place and clearly explain the procedure for cleaning rooms and equipment for infectious patients.

Material Safety Data Sheets (MSDS) were displayed in all dirty utility rooms and areas where chemicals are stored.

The segregation of waste is well managed by the staff and external contractors, from the point of generation through to disposal. As space is at a premium it may be worthwhile to work with the contractor to increase the pick-up times for waste collection.

Linen is also provided by an external contractor and managed well in relation to industry infection control guidelines. The Operating Theatre and Cardiac Suite use disposable linen and custom packs only.

Workforce Immunisation, staff screening and assessment against vaccine preventable diseases is a risk-based workforce immunisation program with clear guidelines and policies for all staff.

Vaccine Preventable Disease (VPD) Evidence Certification Form is used to ensure staff have been screened for Vaccine Preventable Diseases such as TB, Hep B and C, Rubella Whooping Cough, Chicken Pox and influenza a Panel Checklist is also used. Immunisation status records are required for all new employees and a database has been established. There has been significant work undertaken to increase the immunisation status compliance for all staff. Staff Health compliance rate is over 94%. The medical workforce is also providing immunisation records as part of the credentialing procedure.

Mandatory training regarding notifications of infectious diseases and injury management of Occupational Blood and Body Fluid Exposure Incidents (BBFEI) have been conducted.

Reprocessing of reusable medical devices

Action 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The design and layout of CSSD and Endoscopy services is challenging for MPH due to space constraints and the increasing high volume of work. The assessors congratulate the staff for their diligent management in all aspects to meet the Advisory AS18/07 as well as the GENCA guidelines for Endoscopy. Staff are well qualified and have met all education competencies. Observing the staff working in CSSD demonstrated a clear understanding of their roles and responsibilities. This included the management of loan sets.

A further gap analysis conducted in December 2019 and monthly water testing is in place and results monitored by maintenance. The installation of 2 (two) new sterilisers is planned for the end of March and will see further refurbishment of this area undertaken to improve sterilising practices.

Antimicrobial stewardship

Action 3.15	
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 includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.16	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Antimicrobial Stewardship Program is underpinned by Healthscope and MPH policies and procedures. The program has also incorporated the core elements, recommendations and principles of the current Antimicrobial Stewardship (AMS) Advisory AS18/08 and Clinical Care Standard.

There has been significant work undertaken by the recently convened AMS Committee. The committee membership has been strengthened by the inclusion of a dedicated infectious diseases physician and supported by the Internal Medicine Physician team, as well as the inclusion of a microbiologist.

A review of antibiotic prescribing and the appropriate use of prophylactic antibiotics is underway. The MAC members are involved and the stewardship program forms part of the MAC agenda.

Traffic light reports are generated by HPS pharmacists to report and flag exceptions. eTG Therapeutic guidelines are readily available on Hint.

The hospital is now contributing to the National Antimicrobial Prescribing Survey (NAPS). Audit results will be reported at the Infection Control Committee, MAC and craft groups meetings.

The collaboration and good relationship with Royal Melbourne Hospital's/ Melbourne Health AMS program is well established whereby policies, protocols result from audits can be shared and benchmarked internally and externally.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.4	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Governance of medication safety is provided by the MPH Medication Safety Committee as well as the Healthscope medication safety Webex. The local committee, which reports to the Quality Committee, is a multidisciplinary committee where hospital-wide pharmacy and medication issues are monitored, reported, and implemented in a systematic manner across the organisation to ensure safe medication practices. MPH also participates in the Medication Self-Assessment Audit (MSSA) every two (2) years. The MSSA audit comparison results 2017 to 2019 were discussed at the Medication Safety Committee in December 2019. An MSSA action plan has been developed and implemented to address actions from the audit. A suggestion has been made that the Medication Safety Committee review and monitor the action plan on a regular basis.

Policies and procedures support standardised medication management across the organisation. Policy direction is provided by Healthscope and there are clinical guidelines like the ICU drug policies developed locally which have been reviewed recently. The assessment team found consistency in understanding of and compliance with key aspects of medication policy across the organisation, for example high risk drugs, and signing of telephone orders within 24 hours.

Medication management audits are part of the Healthscope-wide schedule, and include Healthscope KPIs, the Medication Safety Self-Assessment, and the National Standard Medication Chart Audit as well as High Risk Medications and S8 audit. The Healthscope HACs relating to medication complications demonstrated best practice when compared against peers. A number of medication related risks are mitigated and monitored on the Risk Register. Medication-related incidents and adverse drug reactions are reported, reviewed and acted upon. The most serious incidents are reported and monitored at Quality Committee, Medication Safety Committee, MAC and Clinical Review Committee meeting.

At bedside handover the assessment team saw nurses and clinical pharmacists actively engaged with patients, providing information in a manner which met the patient's needs. A medication list is used by the Clinical Pharmacists to provide information to all patients at discharge.

Scope of practice relating to management of medications is well-defined and regularly reviewed. Credentialing occurs for medical staff, pharmacists and enrolled nurses. Graduate or inexperienced nurses and pharmacists are supervised and mentored appropriately. Nurses complete a range of mandatory medication safety modules, including drug calculation, as well as instructions for a best possible medication history and use of the medication chart. In addition, graduate nurses are provided with education to understand legislative requirements for valid prescriptions.

Suggestions for Improvement:

The Medication Safety Committee agenda includes the monitoring and progress of the MSSA Action Plans to ensure actions have been addressed and outcomes reported.

Documentation of patient information

Action 4.5	
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	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.6	
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	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.7	
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	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.8	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

A Best Possible Medication History (BPMH) is undertaken after checking at least two sources of information regarding medications on admission. Nursing staff and clinical pharmacists have specific education programs to understand the methodology of obtaining a best possible medication history. The clinical pharmacists are certified in BPMH as part of their credentialing processes.

High risk patients are identified where there are four positive parameters on the Cognitive Impairment Risk Assessment Tool CIRAT. Another high-risk scenario involves non-English speaking patients for whom the telephone interpreting system is used by clinical pharmacists and ward staff to communicatee appropriately with the patients.

High risk patients are referred to the ward-based clinical pharmacist for a medication management plan, and medication review.

There are processes for documenting a patient's history of allergies and adverse reactions relating to medicines, and also to food, latex, adhesives, and other substances. These checks occur at patient presentation, are repeated throughout the admission, including prior to medication administration, and appear well embedded. The RiskMan system is used to investigate suspected adverse reactions, including the causation and severity. Adverse drug reactions are added to the Alert screen on WebPAS and reported to the Therapeutic Goods Administration when required. Red identification bands are used for patients with allergy or ADR, consistent with policy.

Continuity of medication management

Action 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

High risk patients are identified where there are four positive parameters on the CIRAT comprehensive risk eMR screen. These patients are referred to the ward-based clinical pharmacist for a medication management plan, and medication review. Appropriate medication reconciliation occurs at transfers of care. Clinical pharmacists produce a medication profile for all discharge patients, which is discussed with the patient. Supplemental information includes the Consumer Medicine Information CMI, and brochures like the analgesic administration brochure. Medication review activities by the clinical pharmacists is highly valued and is monitored in the monthly report to the Executive.

Medication management processes

Action 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is good access to decision support tools for clinicians. The latest version of MIMS and the Australian Injectable Drug Handbook are available in each clinical area. There are medication information services available on HINT and on the pharmacy intranet.

The pharmacy, medication cupboards and trolleys were secure across the organisation and well organised despite space constraints. Controlled drugs are stored and accounted for in accordance with Victorian requirements and S8 and S11 Registers are audited. Improving the storage and handling of anaesthetic medications with the potential for drug addiction, like Propofol is a current focus in ICU. High risk drugs according to the APINCH acronym were well understood and could be extended to include neuro-muscular blocking agents. Clinical pharmacists ensure that medications are charted in accordance with approved abbreviations outlined in the ACSQHC terminology and abbreviations publication.

Drug refrigerators are monitored daily, and the opportunity exists to upgrade to a centralised monitoring system. There is good understanding of cold-chain management. The HPS Pharmacy manages the recycling of and disposal of medications.

High risk medicines are managed through an integrated system of policy, guidelines, forms, audits, education and tools. High risk medications are listed on the risk register, and medication incidents are monitored. Line labelling and syringe labelling is embedded at the hospital. Storage of Potassium ampoules is limited to ICU and is appropriate.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.4	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.5	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is governance oversight through the Quality and Clinical Review Committees on matters relating to the safe delivery of clinical care and services. Each craft group has dedicated Morbidity &Mortality (M&M) multidisciplinary meetings and all patient outcomes are discussed. Results are then provided to Senior Management the MAC and Healthscope Corporate office.

The DON of MPH is represented on the newly formed Nursing Governance Council their 1st inaugural meeting held in February 2020. The Terms of Reference (TOR) are to provide leadership and support to ensure there are evidence-based policies, forms and publications to guide and improve best practice care and outcomes, to ensure compliance with clinical care standards at all Healthscope hospitals in accordance with the Clinical Governance Framework and National and Clinical Care Standards as well as clinical issues that are unable to be resolved in other committees or teams.

It is planned to have at least three face-to-face meetings per year supported by teleconferencing at other times.

In 2018 Healthscope also established a Comprehensive Care Cluster to support hospitals to meet the Advisories and assist with identified gaps.

State, Corporate (Healthscope) and local policy and procedures are well structured, and accessible to staff electronically. Governance frameworks support the development and control of such documents. Observational audit and discussions with clinical staff during the assessment, demonstrated that staff understand and practice within established guidelines.

The assessors were able to verify that MPH has met the Advisories for this standard.

Quality improvement methodologies are utilised to mitigate risks associated with patient harm and to monitor, respond to and evaluate care. Extensive auditing schedules and performance indicators, measuring compliance and clinical outcomes are generated from a local, corporate and state level. Benchmarking occurs at a corporate and industry level.

Incident analysis, clinical reviews, mortality and morbidity reviews and patient feedback are also utilised to monitor and measure the effectiveness of the system. Feedback on performance is provided through a series of performance quality and safety reports to the Senior team, clinical staff and operational safety committees. Action is taken to reduce risks identified at department and organisation level.

Training is provided to the clinical workforce at point of entry into the health service and throughout the period of employment. Such training is provided through a range of formal and opportunistic learning opportunities and prioritised according to clinical risk. Attendance by staff is high and positively received. Training activities are currently being undertaken to support the provision of comprehensive care across acute services.

A person-centred approach to care is adopted and well demonstrated. Patients and their families are actively engaged in their care as evidenced by a range of innovative programs targeting the identification and communication of goals of care. Processes to encourage and support shared decision-making conversations have been introduced for the clinical workforce. Patient experience surveys rate their engagement and care delivery highly.

Systems to enable and support the delivery of comprehensive care to patients were evident. The electronic medical record (eMR) provides the platform by which clinical information, risk assessments are well documented and comprehensive care plans and progress notes communicated.

The assessors were impressed with how easy it was for staff to navigate and find relevant information in real-time. Auditing in real time is also a feature and has saved considerable time for NUMs to scroll through paper records retrospectively. Congratulations.

Processes are in place to ensure that patients are accommodated into the appropriate care setting that best meets their needs. Patient flow activities adopt a person-centred approach and are focused on placing patients in the right bed the first time and in a timely manner. The risk and associated harm minimisation controls have recently been reviewed and listed on the organisation risk register.

The referral system is supportive and responsive to the assessment process. The use of the eMR has improved the internal referral process for admitted patients. Referrals between services, clinicians and community support agencies has been streamlined. Individual service/programs have a suite of formal referral pathways and prioritisation matrices.

The clinician carrying the overall accountability for an individual patient's care is readily identifiable. Shared care arrangements are utilised where appropriate to do so.

Multidisciplinary collaboration and team work are actively supported and evidenced across the hospital. Activities such as staff safety huddles, structured clinical handovers, multidisciplinary meetings, case conferences, all collectively work together to build and strengthen a strong team approach to the provision of comprehensive shared care.

Developing the comprehensive care plan

Action 5.7	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.9	
Patients are supported to document clear advance care plans	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The clinical and psychosocial risk screening and assessment process commences prior to and at point of entry into the service. Reassessment occurs at predetermined intervals. Screening is undertaken utilising a suite of tools, (several of which are embedded within the eMR), and a positive response links to a secondary assessment. Assessments are structured, multidisciplinary and information generated from the assessment is communicated to members of the clinical workforce through a range of clinical handover points with good documentation to support the transfer of information. Elements of the process are individually evaluated utilising a series of quality assurance methodologies. The results of these are reported and actioned at a range of committees and working groups across the departments. These processes are established for falls, pressure injury, nutrition, delirium, cognitive impairment and aggression and violence.

Processes have been implemented to ensure all ATSI persons are identified at point of entry into the clinical and administrative datasets within the electronic systems. Persons identified are flagged in WebPAS and in the eMR.

Corporate and MPH processes describe how Advance Care Directives (ACD) and Health Care choices are to be managed and documented. Medical Power of Attorney/substitute decision makers nominated carers and ACPs are recorded in the electronic clinical and administrative systems.

Clinicians use processes for shared care decision-making, to develop and document a comprehensive and individualised care plan or pathway. Care planning is based upon the assessment of the patient and is recorded in a care plan, program of care, progress note, goals of care or specific care pathway. A case management approach is adopted for persons with complex needs or who have an extended length of stay. Throughout the assessment period it was noticeable that patients are actively engaged in their care.

Patient feedback indicates a high level of satisfaction and are involved in decisions made about treatment and care.

Discharge planning is commenced on admission and includes documentation of the patients expected length of stay, discharge destination and referral to additional discharge support services as required. Discharge is actively managed across the continuum of care.

Delivering comprehensive care

Action 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Care is delivered in accordance with the care plan or pathway. The recently developed Comprehensive Care Policy articulates the key components of an individualised care plan and staff responsibility to provide such care, in partnership with patients and their families. Both the eMR and paper based clinical records demonstrate changes to care plans in response to diagnosis therapeutic interventions and goals of care which are made in real time and communicated to the clinical workforce.

Bedside clinical handovers and Patient White Boards provide opportunities for interactive, contemporaneous conversations between patients and staff to ensure care goals are appropriate. Clinical reviews, death reviews and incident analysis monitor compliance with the system and clinical outcomes.

End-of-life processes are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Corporate, Policies and supportive clinical records are evidenced for the management of end of life, advance care directives, medical orders for sustaining Life (MOLST) and organ and tissue donation. MPH utilises the Clinical Excellence Commissions (CEC) 'Last days of life' toolkit if required. The staff attended an End-of-Life Workshop in November which was well received.

MPH medical and nursing staff are able to deliver palliative care services if requested by the patient and families. Medical and nursing staff are well trained and Pastoral Care services are readily accessible.

Advanced Care Plans and Not for Resuscitation (NFR) received from patients, are documented and recorded in WebPAS and eMR as an Alert.

The clinical workforce has access to supervision and support through peer support, mentoring, and access to external services for a formal debriefing or counselling if required.

Death reviews are conducted for all deceased persons and findings are referred to craft group mortality and morbidity meetings, and to the Clinical Review Committee.

Minimising patient harm

Action 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

MPH utilises the Healthscope Policy 'Pressure Injury – prevention, identification and management', which outlines the requirement to use the evidenced based Healthscope risk assessment tool for pressure injuries. Noting that the pressure injury risk assessment tool is incorporated into the eMR.

The comprehensive skin assessment commences on admission and risk rated accordingly. Skin assessments are communicated between staff at clinical handover, with a strong focus of pressure injury prevention.

The MPH pressure injury management policy identifies the importance of engaging with patients if they are diagnosed with a pressure injury on admission, or if they acquire one during their stay. Information for patients and their families begin with the website that is accessible to the public via the My Healthscope website, prior to admission. In addition, all booked patients at risk of pressure injury are provided with written information if required.

Care planning is completed in partnership with the patient. The family and /or carer is included in these discussions. The care plans are utilised at clinical handover to provide pressure injury information to the next staff, with the patient involved in this process. Patient boards in the rooms also identifying pressure injury concerns for staff and family. The risk assessment tool for pressure injuries also prompts the staff to provide more patient information if the patient's pressure injury condition deteriorates.

MPH is well resourced with a wide range of equipment for patients identified as a high risk of developing a pressure injury. Staff are aware of the equipment resources available for pressure injury management and how to use them with appropriate safety information available.

MPH has appropriate systems in place for the prevention and management of falls.

The Healthscope Policy 'Falls prevention and management - patient', which incorporates national best practice guidelines underpins the management of falls at MPH. RiskMan is the risk management system and all reported falls are reviewed by the Unit Manager and Quality and Infection Control Manager who report to the Quality Committee.

The patient falls history is incorporated into the eMR on admission or during the pre-admission booking process. The Falls Risk Assessment Tool (FRAT) is completed on admission.

The eMR will automatically generate a referral to Allied Health for patients at risk of falls, to ensure that comprehensive care planning includes physiotherapy consultation.

Patients assessed as a risk of fall, over 65 years of age will have preventative strategies identified and implemented by the staff, that could include more frequent rounding, adjustment of lighting and bed height, environmental checks for trip hazards and grip socks.

Care planning is completed in partnership with the patient; and the family or carer is included in these discussions. The care plans are utilised at clinical handover to provide risk of fall patient information to the next staff. On discharge, the discharge summary includes any inpatient fall and also a referral for a home assessment if required.

Post-fall management includes the documentation in the medical record and RiskMan, escalation to their treating Doctor, with a CT scan ordered if there is a suspicion of a head injury or fracture. MPH includes a review of the Healthscope `shared learnings' as part of their post falls management, which provides an overview of sentinel event falls across Healthscope hospitals, as well as any preventative strategies identified that could be utilised. The assessors observed the use of huddle boards and quality boards to display results.

A wide range of equipment for patients identified as a high risk of falls is available if the need arises.

Appropriate Healthscope policies, including Diet and Nutrition – are used to ensure patients nutritional needs are met. The management of nutrition commences with all patients being screened on admission with the Healthscope Malnutrition Screening Tool, which is integrated into the eMR and will generate a referral to the dietician if clinically indicated. The assessors noted that support of a dietician is available at all times.

The catering staff provide menus and collate the diet needs of each patient daily. This includes special diets and supplements if required. Information is captured on the Patient Management System (WebPAS) which communicates menus and diet needs to catering services at John Fawkner, a Healthscope hospital nearby who are contracted as the "production kitchen" to produce patient meals and dietary requirements for MPH. Meals are then transported to MPH's kitchen for serving and distribution.

The assessors when visiting the kitchen observed the collation of the menu, the range and choices and the food and beverage supplies to support those patients who may require a special meals or dietary requirements.

The groups of patients at MPH at risk of developing delirium include cerebral tumour patients, chronic pain patients, and post cardiac bypass patients. MPH has access to Healthscope policies on delirium and cognitive impairment prevention and management, as well as medication management policies. A cognitive impairment risk assessment is performed on all patient at admission using the electronic CIRAT tool. Family and carers are involved as required to identify triggers. Any reversible causes are addressed, and strategies for patient management are implemented, for example with single room, frequent reorientation, noise and light level adjustment. Clinical pharmacy involvement optimises medications. A cognitive impairment brochure is shared with at-risk patients and their carers which outlines strategies for managing their in-patient stay.

A post cardiac bypass delirium research project is underway in ICU in a formal, ethics approved and funded research project, aimed at verifying appropriate clinical management of this group of at-risk patients. In addition, RMH is collaborating with a Melbourne Health ICU observational study of patients “waking up” after anaesthetic.

Patients are screened pre-admission for self-harm traits or deterioration in their mental state. The MPH access policy defines criteria for elective admission to MPH which excludes this cohort of patient. Any at-risk patient is “specialled” until consultant psychiatrist review or transfer to an appropriate psychiatric facility, like the Melbourne Clinic, is arranged, or until the patient is transferred as an emergency to the collocated emergency department at Melbourne Health. MPH executive are always notified, which results in appropriate resource allocation for the patient’s needs prior to transfer out.

Healthscope policies outline prevention of workplace violence and aggression, as well as restrictive practices and patient restraint. A number of strategies to minimise violence and aggression episodes are in place including admission practices, communication and care planning, education, feedback mechanisms, and WebPAS alerts. Mandatory Workplace Aggression and Violence Education (WAVE) training and code grey calls provide additional protections for both staff and patients. Aggression and violence episodes are reported to the MPH executive a result in appropriate resources allocated for patient and staff safety.

Cognitive impairment patients are usually managed conservatively using nursing supervision, wanderer alert bracelets, bed alerts and other minimally restrictive practices. Mechanical restraint is not approved at MPH. Chemical restraint is used as a last resort at MPH in refractory cases of post-operative psychosis, for example in brain tumour patients and post cardiac bypass patients. Any incidents are recorded on RiskMan and reported to the executive.

There are no seclusion facilities at MPH. A patient requiring increased supervision will be specialled in a single room, or alternatively transferred to an appropriate facility like Melbourne Clinic or the emergency department at the collocated Melbourne Health.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

There is evidence of systems in place to ensure timely, effective communication that supports continuing, coordinated and safe patient care. These systems are supported by the VMOs and staff and a culture of patient-centred care was evident. Communication for patient safety is well embedded in the Clinical Governance Framework with a maturing culture of patient participation in care. This is visible during bedside handover, ward rounds and discharge planning. Electronic patient journey boards are used to map the patient journey effectively and are strategically located to mitigate privacy risks.

The effectiveness of communication for patient safety includes observational audits of bedside handovers, patient experience surveys using Qualtrics, complaints management and audit of handover tools. These are reported to the Quality Committee and CRC. The risk register includes matters relating to communication such as patient identification, consumer feedback, clinical handover and discharge planning. In addition, incidents relating to communication are logged on RiskMan.

Patient participation in care is visible during bedside handover, discharge planning, and in the ambulatory care environment. There is a determined intent to enable patients to be involved in communication about goals of care.

Regular huddles and ward rounds during each shift communicate critical information, including emerging clinical information. There is timely communication to the specialist medical staff whenever there is a deterioration or significant change in the patient's clinical status.

Correct identification and procedure matching

Action 6.5	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.6	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

MPH has a comprehensive policy framework for patient identification and procedure matching. This includes communication at transitions of care, including ward and inter-hospital transfers and discharges. Discharge documentation is forwarded electronically to caring community doctors and teams, and includes content from laboratories, radiology and pharmacy as well as discharge instructions.

Four identifiers are required at MPH to appropriately identify patients, and the assessment team confirmed that the checking of these identifiers and ID bands was embedded practice in all handovers and transition of care.

There are various team timeout processes to ensure that patient identification and procedure matching occurs. These timeout processes include surgical team timeout in the Cath Lab, Operating Theatre and Endoscopy. Monitoring and reporting have demonstrated compliance with these processes.

Communication at clinical handover

Action 6.7	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.8	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is a systematic approach to clinical handover. Clinical handover eLearning is mandatory for all staff. Clinical huddles and bedside handover were observed by the assessment team and these were found to enhance communication regarding risks, alerts and goals of care for each patient. Structured bedside handover also includes clinical progress, patient participation in reinforcing goals of care, as well as discharge planning and patient education. The patients were observed to be appreciative of the opportunity to ask questions and to participate.

Back to the Bedside patient-centred care program is well adopted at MPH. Feedback from patients about their participation in handover and overall care is rated as very good.

Communication of critical information

Action 6.9	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Critical information, alerts and risks are communicated in a timely way by the multidisciplinary teams. Specialist medical staff are primarily responsible for patient care and are notified whenever there is a change in the patient's condition. In addition, pharmacists use the MMP to convey any risks arising from medications, so that the risks can be mitigated. Remote technology assists the VMOs with communication of changes in a patient's condition. This functionality has been most welcomed from the medical staff. Other modalities include safety huddles, patient care boards, ward rounds, electric patient journey boards and family conferences.

Patients and carers can communicate and escalate their concerns via the "You call and we respond" message published for all patients. Patient care boards are also updated daily and provide a forum for any questions or concerns.

Documentation of information

Action 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Alerts and risks are contemporaneously documented both within the paper-based medical record, and the eMR. Care plans and risk assessments are revised and updated in real time. Also, third party providers like Pharmacy, Laboratories and Radiology contribute to the medical record in accordance with their agreement with MPH.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action 7.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The clinical governance and systems for blood and blood product prescribing and clinical use at MPH are safe and appropriate. MPH has representation on the expert Melbourne Health Blood management Sub-Committee as well as the expert Healthscope corporate transfusion committee. Healthscope policies direct the appropriate use of blood products at MPH. BloodSafe audits are included in the annual audit schedule and clinical indicator data is submitted nationally.

All clinicians credentialed for transfusion of blood and blood products have completed the BloodSafe eLearning packages, although the MPH mandatory training levels for blood and blood products are currently at 80% overall.

Consenting for the elective transfusion of blood and blood products is usually performed in the consultant's rooms prior to admission. Medical staff are responsible for providing information and obtaining informed consent from their patients. There is the opportunity to ensure that patients have been provided with additional brochures and information after admission as well as the opportunity to define the documentation required in the medical record. Brochures are available on HINT.

Prescribing and clinical use of blood and blood products

Action 7.4	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.6	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

All requests for packed cells are compliant with relevant standards and follow the “one unit then reassess” requirements of the Patient Blood Management guidelines. Massive transfusion requirements are released by direct request to Melbourne Health. The requirement for massive transfusion is low at MPH where all patients are elective and there is no obstetrics service. The reasons for transfusion are appropriate and in accordance with national guidelines, including Hb parameters. Iron infusions are used to optimise Hb levels preoperatively.

Adverse transfusion events are reported and investigated locally as well as by Melbourne Health. MPH staff contribute actively to the expert Melbourne Health Blood management sub-committee, which includes specialist staff and Red Cross representatives. Haematologists from Melbourne Health are available to assist with any relevant investigations. Haemovigilance activities are provided by the expert clinicians at Melbourne Health.

Managing the availability and safety of blood and blood products

Action 7.9	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Blood and blood products are supplied when required by the collocated tertiary facility, Melbourne Health. There are no blood storage facilities at MPH. Either the nursing staff or trained PSA's collect blood and blood products when needed, using an appropriate request form. Wastage is monitored and has been minimal as a result of good supply chain coordination. The level of unsuitable specimens or "specimen not valid" has increased to 6% overall in MPH, and a report provided by Melbourne Health identifies the MPH units where the opportunity exists to improve specimen collection practices.

The availability of blood and blood products is managed by Melbourne Health with alerts to MPH if required.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action 8.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

MPH meets the intent of the Recognising and responding to Acute deterioration standard. There has been a focus on recognising and responding to acute mental health deterioration using new delirium/confusion assessment tools with evaluation occurring.

Roles of staff attending MET and Code Blue calls in the hospital have been reviewed to ensure they are effective and know their designated responsibilities.

MPH Safety and Quality Plan includes Recognising and Responding to Acute Deterioration, demonstrating clinicians use of the safety and quality systems when implementing policies and procedures for recognising and responding to acute deterioration.

Staff can activate a Met Call, Code Blue or Code Stroke, via the campus wide rapid response activation system that is used at Royal Melbourne Hospital (Melbourne Health) which is the precinct partners, and the team who coordinate alerting staff of emergency situations at MPH.

There are prominent spaces on the patient whiteboards that has information on how to seek emergency assistance for patients and visitors and how to escalate concerns to clinical staff. This is also communicated to patients in the Patient Information Directory, which is a Consumer Approved Document. In the case of mental health deterioration MPH has access to the Royal Melbourne Hospital emergency department and private mental health facilities.

MPH collects and submits data on acute deterioration into the RiskMan system. Each incident is investigated and reviewed at the Deteriorating Patient Committee, with escalation to the Clinical Review Committee, Morbidity & Mortality committees and Medical Advisory Committee as indicated. Quarterly clinical quality KPI reports are submitted to the Healthscope quality team, which are benchmarked against other Healthscope hospitals.

MPH has standardised resuscitation trolleys with procedures for checking of bedside emergency equipment.

Improvement strategies relating to education and training are identified from incident investigation
Improvement programs include the implementation of a Cardiac Surgery Advanced Life Support (CALS) Course and Advanced Life Support Workshop. It was noteworthy that the ICU team at MPH are currently developing a protocol and an annual competency for CALS.

All incidents are reviewed by the Departmental Managers, Quality Manager and the Director of Nursing. All Met and Code Blue calls are discussed at the Deteriorating Patient Committee, and escalated to the Morbidity & Mortality Committees, Clinical Review Committee and the Medical Advisory Committee if deemed necessary.

MPH submits KPI outcomes and data and education compliance to Healthscope within the quarterly KPI. The data is benchmarked and communicated back to MPH for distribution within the MPH Quality and Risk Management Framework.

Consumers can access Recognising and Responding to Acute Deterioration data via the My Healthscope website. Patients at MPH contribute to the development of the patient care plan as well as ensuring MPH has a copy of any advance care directives that have been made. The Qualtrics patient experience survey provides MPH with data on patient's involvement in clinical decision-making with only the ALWAYS data recorded for review and benchmarking.

Alerts within the electronic medical record notify staff of the presence of an advance care directive or Not for Resuscitation (NFR) throughout the continuum of care.

Detecting and recognising acute deterioration, and escalating care

Action 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.5	
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	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.6	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Action 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.9	
The workforce uses the recognition and response systems to escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The use of the electronic medical record for recording of observations provides parameters to escalate care outside the desired ranges. With appropriate monitoring throughout the patient's day based on the care needs and during the clinical handover. MPH has risk assessment tools related to delirium and cognitive impairment (CIRAT) providing staff with the information to escalate care at any stage despite physiological observations not meeting escalation triggers on the observation chart which includes mental health issue.

There is 24 hours medical coverage for emergencies, and treating doctors are contactable via telephone, paging or SMS for non-emergency situations as well.

Individualised patient care plans/pathways and observation charts are a part of the quality and risk management system. Quarterly data on acute deterioration to Healthscope as part of the Healthscope Quality KPIs. Included in this reporting is a quality action plan if results are outside of the required benchmark. This data is benchmarked against other Healthscope Hospitals.

As part of the comprehensive approach to care the process commences prior to admission. All patients complete the Patient Health History and are assessed and screened for their clinical risk factors, mental health history and any psychosocial behaviour that may require additional care planning and/or referral to the multidisciplinary team. Patients, carers and or family are involved in the risk assessment process and in the development of comprehensive care plans.

There is a clear process for support and care for patients identified at risk of delirium and cognitive impairment. Cognitive information brochure is available for patients/ family/carer.

RiskMan notifications for incidents related to cognitive impairment are monitored with a dementia clinical extension available for additional detail and data analysis.

Responding to acute deterioration

Action 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is a standardised approach to recognising and responding to clinical deterioration, to ensure prompt and effective action is taken to minimise the occurrence of adverse events. Parameters and indicators for calling emergency assistance are built into the electronic medical record. There are audits on compliance with the track and trigger charts at least annually with results reported to Healthscope as part of the KPI reporting tool.

All Met Calls (clinical deterioration), Code Blue calls, Code Stroke are entered in the RiskMan system. All incidents are reviewed by the Deteriorating Patient Committee with sentinel events reported and investigated and reports submitted to relevant committees with details on reviews, actions and improvement strategies for sentinel events inclusive of events surrounding clinical deterioration.

Patients and visitors can activate an emergency call by pushing the red emergency assistance button, located in each room. This button alerts the clinical staff to the relevant area, with escalation to MET or Code Blue if indicated. Family/carers are provided with information on the process for escalating care on the patient whiteboards and forms part of the room orientation for patients. MPH also has a brochure available for patients, carers and families, detailing how to call for a Rapid Response team “You call and we respond” which is a Consumer Approved Publication.

Rapid referral systems and clinical expertise are in place and responsive to mental health deterioration or acute physical deterioration.

MPH also monitors staff response to patient pain through Qualtrics, the Patient Experience Survey by asking patients if they received the pain relief to meet their needs throughout admission.

All members of staff are given training on emergency procedures at the commencement of employment. Responsibility for compliance with mandatory training rests with the Department Heads.

Records of ALS accredited staff are maintained by the Clinical Development Coordinator and within the staff database. The processes that ensure appropriate skill level mix of staff is part of the governance system.

Recommendations from Current Assessment

Nil

Rating Summary

Melbourne Private Hospital

Health Service Facility ID: 101086

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met
1.3	Met
1.4	Met
1.5	Met
1.6	Met

Patient safety and quality systems

Action	Assessment Team Rating
1.7	Met
1.8	Met
1.9	Met
1.10	Met
1.11	Met
1.12	Met
1.13	Met
1.14	Met
1.15	Met
1.16	Met
1.17	Met
1.18	Met

Clinical performance and effectiveness

Action	Assessment Team Rating
1.19	Met
1.20	Met
1.21	Met
1.22	Met
1.23	Met
1.24	Met
1.25	Met
1.26	Met
1.27	Met

Action	Assessment Team Rating
1.28	Met

Safe environment for the delivery of care

Action	Assessment Team Rating
1.29	Met
1.30	Met
1.31	Met
1.32	Met
1.33	Met

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

Action	Assessment Team Rating
2.3	Met
2.4	Met
2.5	Met
2.6	Met
2.7	Met

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

Action	Assessment Team Rating
2.11	Met
2.12	Met
2.13	Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action	Assessment Team Rating
3.1	Met
3.2	Met
3.3	Met
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Met
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Met
4.2	Met
4.3	Met
4.4	Met

Documentation of patient information

Action	Assessment Team Rating
4.5	Met

Action	Assessment Team Rating
4.6	Met
4.7	Met
4.8	Met
4.9	Met

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action	Assessment Team Rating
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

Developing the comprehensive care plan

Action	Assessment Team Rating
5.7	Met
5.8	Met
5.9	Met
5.10	Met
5.11	Met
5.12	Met
5.13	Met

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met

Action	Assessment Team Rating
5.15	Met
5.16	Met
5.17	Met
5.18	Met
5.19	Met
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
6.3	Met
6.4	Met

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Met
7.5	Met
7.6	Met
7.7	Met
7.8	Met

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

Action	Assessment Team Rating
8.4	Met
8.5	Met
8.6	Met
8.7	Met
8.8	Met
8.9	Met

Responding to acute deterioration

Action	Assessment Team Rating
8.10	Met
8.11	Met
8.12	Met
8.13	Met

Recommendations from Previous Assessment

Nil