NS2.1 Short Notice Final Assessment

Final Assessment Report

The Melbourne Clinic

RICHMOND, VIC

Organisation Code: 220690
Health Service Facility ID: 101117
Assessment Date: 29 April 2025

Accreditation Cycle: 1

Contents

Introduction

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

ACHS is approved to accredit the following standards

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

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

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

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

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

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

The Commission works in four priority areas:

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

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

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

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

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

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

Rating scale definitions

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

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

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

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

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

Authority to act as an Accrediting Agency

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

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

Conflicts of Interest

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

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

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Lead Assessor	Ann Kelly OAM	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for The Melbourne Clinic. The accreditation decision was made on 06/05/2025 and The Melbourne Clinic was notified on 06/05/2025.

Executive Summary

On 29/04/2025, The Melbourne Clinic, underwent an NS2.1 Short Notice Final Assessment. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier	Delivery Type
The Melbourne Clinic	101117	On Site

Summary of Recommendations Subject to the Final Assessment

Facilities (HSF IDs)	Initial Assessment MwR	Initial Assessment NM
The Melbourne Clinic - 101117	1.10, 2.01, 2.14, 3.10, 4.15	

The final assessment was conducted for The Melbourne Clinic on 29/04/2025.
The following report outlines the assessment team's findings.

General Discussion

The Melbourne Clinic (TMC) has provided sufficient information and evidence showing compliance with the standards and converting the five Met with Recommendation ratings to Met.

Extensive information was provided including trended data, reports, dashboards, audits and education packages to verify the recommendations have been met.

Risk Management has undertaken a major review with a large number of risks being consolidated or archived with processes in place to ensure regular review of risks by managers and relevant committee.

The review of Peer support workers and Consumer Consultants has seen the review of position descriptions, the creation of onboarding packs and the review of the Consumer Engagement Pack.

Hand hygiene compliance has improved at the point of care with the installation of further dispensers in high traffic areas and the purchase of 600 portable antimicrobial hand rub to attach to staff lanyards or belts. Education and training of staff has occurred, and four staff have undertaken the National Hand Hygiene auditors' program.

Assessor Findings at Final Assessment

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

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

Initial Assessment Comments	**Initial Assessment Recommendation(s) / Risk Rating & Comment**
Healthscope uses the Enterprise Risk Management (ERM) Framework to support the management of the Risk Register. TMC staff are encouraged to register risks on the Risk Register. On review of the Risk Register, there was an extraordinarily large number of risks. Many seem to be similar, if not the same, risk registered more than once. Before a risk is registered, there should be a system to ensure that the risk or similar risk has not already been registered. As part of the review of registration and review of risks, there should be a review of mitigation strategies supported by associated monitoring system such as the review of audits, clinical incident, etc., and when appropriate, risk should be removed and archived from the risk report. The Assessment Team has recommended that a review of the current system to register and monitor a risk in the RiskMan database is completed as well as the process to review the risk register as per the ERM Framework.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Review the current systems for the registration and monitoring of risks on TMC Risk Register. **Risk Rating:** Moderate

Final Assessment Comments
The Risk Register at TMC has been completely revised with 151 risks consolidated to 53 risks, with 68 amalgamated and 30 archived. Staff education on the new register and processes has occurred. A risk register review has been placed on the agenda of relevant committees to ensure the sustainability of these processes. In addition, a national Healthscope approach to clinical risks for facilities with mental health clients is in process. A process is also in place for archived risks to be reviewed annually.

Final Assessment Rating	**Applicable**
Met	The Melbourne Clinic

ACTION	
2.01	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

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
There is limited clarity at organisational level about the role and function of the lived experience workforce in mental health services resulting in a single role or position description being in place for all Healthscope services, including TMC. There has been support for a change of name for workers, from consumer consultant to lived experience worker, without review of the position's roles and responsibilities, which does not support a structured approach to identifying training requirements for partnering with consumers.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** The organisation should develop an action plan to undertake a review of National and State guidance on the roles and functions of the lived experience workforce in mental health and to ensure appropriate role descriptions are in place to guide support, training, and development for workers. **Risk Rating:** Low

Final Assessment Comments
Documents regarding the review of the organisation structure and the position descriptions for Consumer Consultants and Peer Workers to be endorsed by the Healthscope National Mental Health Committee detailing onboarding packs and training requirements (Certificate 4 in Mental Health) were reviewed. Supervision plans have been completed for Consumer Consultants and the plans for Peer Workers are in progress. A corporate contract with Lived Experience Australia has recently commenced, providing staff education on the roles and responsibilities of Consumer Consultants and Peer Workers. The Consumer Engagement Plan was updated in December 2024; however, a further review has commenced to ensure relevant changes are reflected in the plan.

Final Assessment Rating	Applicable
Met	The Melbourne Clinic

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

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
The organisation has a range of processes to obtain information about the views and experiences of consumers and it was observed that informal opportunities exist for the workforce to capture these. However, a systematic approach to working in partnership with consumers to inform workforce training and education at TMC was not clearly presented during this assessment.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** That the organisation develops clear policy guidance and an action plan for involving consumers in the design and delivery of workforce training. **Risk Rating:** Low

Final Assessment Comments
TMC has developed a detailed action plan and policy regarding the involvement of consumers in the design and delivery of training. The recent partnership with Lived Experience Australia has assisted with the development of the position descriptions. The Consumer Consultant and Peer Worker position descriptions have been implemented, and the Senior Peer Worker and Peer Worker have been completed and are to be endorsed at the National meeting in May 2025.

Final Assessment Rating	Applicable
Met	The Melbourne Clinic

ACTION	
3.10	The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
On review of TMC's Hand Hygiene (HH) program based on the components outlined the National Hand Hygiene Initiative (NHHI) and the promotion of the use of alcohol-based hand rub, the point or care practice is not fully operational in general areas. It is identified that HH compliance cannot be achieved without available products for healthcare workers. It was observed during bedside handovers (Action 6.08) that hand gel was not available for use at the point of care nor applied following Moment 4 after touching the patients, an example is following routine verification of the patient identification. The workforce had been provided with 60 ml bottles of hand gel; however, the staff had indicated that these are heavy when attached to their lanyards. HH products have been attached to mobiles devices such as the Blood Pressure machines and located outside the patient sitting rooms. There may be some distance from the patients' rooms and point of care. Product placements should be consistent within locations across the facility and often act as visual cue to support good HH practice. HH signage is also limited.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Review the non-compliance with the requirements outlined in the National HH initiative for the availability of hand gel at the point of care. **Risk Rating:** Moderate

Final Assessment Comments
Compliance with hand hygiene has improved since the original assessment, with a recent spot audit showing 90% compliance. An additional 25 hand sanitiser dispensers have been installed in high traffic areas throughout the facility, and some of these have camera surveillance. The organisation has also purchased 600 60ml bottles of antimicrobial hand sanitiser, and staff were observed wearing these on their lanyards or belts. Hand hygiene is now a regular agenda item on the Infection Prevention and Control, Quality and Medical Advisory committees. An additional four (4) staff have completed the National Hand Hygiene Auditor Course and education has occurred for staff.

Final Assessment Rating	Applicable
Met	The Melbourne Clinic

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

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
On visiting the ECT unit, the Assessment Team reviewed the management of high-risk medications as Schedule 4 (S4) medications are used for the sedation for patients undergoing ECT. These are stored in a dedicated lockable cabinet that is kept unlocked during the full session then locked at the end. The medication cabinet maybe out of vision during the administration of ECT as it is located behind a wall partition, the treating team will often have their backs toward that end of the room. The room is empty during the retrieval and transfer to recovery of patients following their treatment. The Assessment Team witnessed the total number of S4 ampoules were taken out for the whole list with no record of the amount removed in the S4 record book at this point. These are all recorded into the Schedule 4 book at the end of the list. This record will be for the total amount used during the list with no reference to the patient, dose, time, or discard. The remaining amount of S4 medication returned to the cupboard is not reconciled or evaluated against patient records to the level of: • the name and address (or location) of the person to whom the Schedule 4 is supplied or administered. • the date of the transaction for each patient • the name, form, strength, and quantity of the medication given to each patient • the discard amount if any. The dispensing system is to be reviewed and routine auditing of the medication / ECT charts in line with best practice standards, the requirements by the Victorian Department of Health: Supply and administration and recording of S4 and S8 medication, Possession and Storage of S8 and S4 poisons. (Vic Govt.) and the Victorian Chief Psychiatrist who requires an evaluation of the medication documentation process for the management of ECT practice. The Assessment Team did not access audits results to demonstrate that the organisation had completed a risk assessment or evaluation of the sedation/s medication documentation for the management of ECT practice as required, during this review.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Review the process for the storage and recording of transactions of Schedule 4 medications for patients undergoing ECT. **Risk Rating:** Low

Final Assessment Comments
The process for storing and recording Propofol has been reviewed, and a stand-alone register is now used. Since the initial assessment, fortnightly audits have been conducted with 100% compliance, including checking ampules from the cupboard by two (2) registered nurses, and confirming the amount administered for each patient and the amount discarded, as well as the correct procedure for any recording errors (there were none). These audits will continue quarterly. The cupboard remains locked at all times except when drugs are removed. The medication room door now has a lock fitted. Education has been conducted regarding the Antimicrobials, Potassium, Insulin, Neuromuscular Blockers, Narcotics, Chemotherapy medications, Heparin and other anticoagulants (APINCH). A poster has been affixed to the medication cupboard and Six Minute Internal Training (SMIT) is taking place. Propofol management has been added to the Healthscope Electroconvulsive Therapy (ECT) policy, and has been tabled at the Medication, Quality, ECT and Medical Advisory committees.

Final Assessment Rating	Applicable
Met	The Melbourne Clinic

Summary of Accreditation Status

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

Health Service Facility Name	HSF Identifier	Accreditation Status
The Melbourne Clinic	101117	3 years Accreditation