Health Service Investigation

Management, administration and delivery of public sector health services within the adult acute mental health inpatient units at The Prince Charles Hospital, Metro North Mental Health, Metro North Hospital and Health Service

August 2024

Metro North Health | Queensland Government

Executive Summary

On 14 May 2024, Metro North Health Acting Chief Executive appointed an external panel under section 190(2) of the *Hospital and Health Boards Act 2011* (Qld) (HHBA) to complete a Health Service Investigation. The panel was commissioned to investigate matters relating to the management, administration and delivery of public sector health services at the Adult Acute Mental Health Inpatient Unit, The Prince Charles Hospital, Metro North Hospital and Health Service.

An external panel was commissioned to review the delivery of care for people within the acute mental health inpatient wards at The Prince Charles Hospital following the deaths of three people who had died by suicide, and two people who had survived a suicide attempt in the inpatient wards from December 2022 to April 2024. The panel were asked to review and comment on the incident review processes, findings and recommendations, and any areas for improvement or suggested changes to existing improvement plans.

The review panel acknowledge the tragic nature of these events and acknowledge the significant loss for the families, carers, kin, support people and wider community networks known to the patients. The panel were extremely thankful and privileged to meet with four family members who felt able to share their story during the review process.

It is acknowledged that Metro North Mental Health (MNMH) has taken immediate steps to respond to the incidents and address recommendations that were made following the incident reviews. The panel found that sound incident review methodology was used and appropriate recommendations were made for the service. The panel concurred with the incident review findings and did not make any amendments to existing recommendations.

The panel noted a number of key themes during their review process that could reasonably be expected to impact on service delivery, patient care (inclusive of the experiences of family, carers, kin and support people), and staff wellbeing, these included:

1. Models of Care
2. Capacity and Demand
3. Governance and Structure
4. Workforce
5. Infrastructure and Environment

The panel agree that continuing to embed some of the quality improvement activities already commenced will support patient care, but also suggest that additional resources and adoption of alternative approaches, and models of care, would further improve patient flow, workload management and patient care (inclusive of the experiences of family, carers, kin and support people) within the acute inpatient wards at TPCH.

A number of specific recommendations are made within the report to address these key themes. The recommendations are based on information gleaned during the review process (i.e., finalised reports from the incident reviews, information provided by families, meetings with staff, on-site observations, documentation provided by MNMH), alongside insights and experience of the panel members.

The panel acknowledge the recommendations will take time and require additional resources to embed within the service. The panel anticipate that operationalising some of the initial recommendations will facilitate achievement of later recommendations and caution against trying to address all recommendations and improvement initiatives simultaneously, especially within the current organisational context and workforce shortages highlighted in the key themes. The panel note that some existing recommendations and safety risk concerns identified via the incident review processes need to be urgently addressed and acknowledge that additional resourcing may be required to support their implementation.

In summary, whilst noting areas for improvement and making recommendations based on learnings during the review process, the panel also note that MNMH-TPCH is already taking steps to address concerning safety risks that require immediate intervention. The panel acknowledge that some of the identified safety risks are not dissimilar to those experienced by other acute public mental health services. The panel found the staff and leadership of MNMH supportive of the review process and keen to implement improvement initiatives to support patient care and enhance staff wellbeing.

Table of Recommendations

Key Theme
Incident Reviews The panel determined that the service had used sound incident review methodology, including the use of external panel members during incident reviews, and appropriate recommendations were made for the service to improve consumer care. The panel concurred with the incident review findings and did not make any amendments to existing recommendations.
Recommendation 1. The panel recommend that MNMH-TPCH continue to implement the existing recommendations made following the individual incident reviews. However, the panel also acknowledge that MNMH-TPCH is experiencing some limitations that may impact on the ability of the service to achieve the recommendations.
Models of Care On review, the panel noted areas of the service where the existing models of care could be adjusted to facilitate greater efficiencies, maximise service delivery potential and improve care options for consumers (inclusive of the experiences of family, carers, kin and support people). ***Acute Care Services*** The panel acknowledge the current efforts being undertaken by MNMH-TPCH to review the Acute Care Team (ACT) model of service, the existing redesign process, and preparations for the new crisis stabilisation unit. The panel see benefit in expediting the current plan to centralise MH CALL (1300 MH CALL intake number), acknowledging that this will require additional temporary resources. The panel also noted that some of the current clinical governance processes within MNMH-TPCH were impacting on response times and unduly influencing the model of care. It is apparent that the existing structure and model of care do not optimise the workforce or facilitate the diversion of consumers from the Emergency Department (ED) and provide contemporary alternatives to inpatient admission. ***Older Persons Care*** Panel observations found that the current adult inpatient unit is not conducive to providing older persons with safe and holistic care, resulting in extended lengths of stay and reduced health outcomes. Critical observations included: 1a. A lack of timely access to specialised allied health care services for older persons (e.g., physiotherapy, incontinence support, dietitian), 1b. Accommodating different cohorts of consumers together potentially increases vulnerability for older persons both physically and psychologically, 1c. The Older Persons multidisciplinary team has accountability and governance for both inpatient and community consumers with limited resources to meet the demands and capacity. ***Inpatient services*** A lack of meaningful therapeutic programs was noted, with limited access to recreational and group activities, and few outdoor spaces, with further concerns noted regarding consumers smoking in those areas despite health facility restrictions. There did not appear to be structured processes to facilitate family inclusive practices or support their participation in care planning. The panel note that contemporary mental health care guidelines advise that service delivery should provide approaches that respect the person's choices, values and preferences and are sensitive and responsive to the diverse needs and experiences of people. This should include the provision of a holistic approach, incorporating physical health needs, considering complex multi-morbidity, and ensuring human rights and dignity.

Recommendations

Acute Care Services

2. MNMH-TCPH separate the functions of the Acute Care Team (ACT) into 3 constituent parts:
    a. 1300 MH Call - urgently establish centralised '1300 MH Call' model of care to safely and efficiently triage referrals
    b. Acute Care Team (including acute after-hours response) – redefine the ACT model of care to ensure the provision of acute and assertive community response, and provide support to consumers of Continuing Care Teams when required
    c. ACT Emergency Department response – refocus on relevant response time targets, consider the role responsibilities, capacity and utilisation of the ACT ED consultant psychiatrist (i.e., clinical capacity rather than bed flow coordination)

3. Review and ensure that the redesign incorporates appropriate consideration of accommodation requirements, digital health, QFleet cars and resourcing to enable successful transition. Consider how these changes will integrate with the newly established Crisis Stabilisation Facility.

4. Review the mental health workforce required for each component of acute care services to consider:
    a. Opportunities to review and include appropriate multidisciplinary roles to provide contemporary practice standards and support clinical governance, inclusive of Lived Experience and Aboriginal and Torres Strait Islander workforce roles.
    b. The specific clinical requirements of the ACT ED component to ensure the workforce is able to adequately address the acuity and complexity of presentations and facilitate timely, appropriate care. This may require senior level clinicians (e.g., Nurse Practitioner, senior Health Practitioners, Clinical Nurse Consultants).

Older Persons Care

5. Consider the Older Persons inpatient model of care and explore alternative inpatient unit bed stock to better attend to the specific needs and potential vulnerabilities of older persons. Consider the viability of potential options:
    a. Use the current Thoracic ward beds being utilised for mental health surge beds as a temporary ward for older persons
    b. Alternative ward locations (e.g., integrate or co-locate with Geriatric ward)

6. Enhance the multidisciplinary team to be inclusive of specialist disciplines required for older person's care.

7. Explore alternative models of care that could value add across the continuum of care (e.g., Hospital in the Home, sub-acute aged care beds).

Inpatient Services

8. Develop and implement a structured therapeutic inpatient multi-disciplinary service delivery model with a focus on engagement with people and their family, carers, kin and supports. This may require an education and training component for the multidisciplinary team to support the workforce, inclusive of Lived Experience and Aboriginal and Torres Strait Islander workforce roles, to upskill as required and embed the therapeutic program.

9. Develop a budget component to ensure the sustainability of a structured inpatient program, including; consumables, equipment, workforce roles and time (e.g., sensory modulation, diversional activities, skills development, group activities).

Capacity and Demand

The panel acknowledged that MNMH-TPCH has been significantly impacted by prolonged increases in demand across multiple service areas, and are unlikely to be able to address the impacts within their existing governance structure and workforce limitations. They noted that the increased demand, in the absence of increased resourcing, had resulted in impacts on clinical decision making, care provision and patient flow. However, they also recognised

that MNMH-TPCH leadership and workforce were strongly motivated to respond to the needs of people and increasing demands on the service, whilst operating within a stretched system.

Recommendations

10. MNMH Executive and MNMH-TPCH leadership establish clear guidelines regarding the total bed capacity for MNMH-TPCH.

11. Develop an escalation pathway with articulated activation points, accountability and expectation of roles within the service and wider organisation, inclusive of MNMH and MNH as required, to support the workforce when capacity is reached.

12. Develop (or utilise existing) analytics and dashboards to capture demand and capacity that is timely and accessible to accountable officers.

13. Review the practice of surge and outlier bed (i.e., SMHRU, CCU, medical wards) utilisation that is currently in place to manage demand, as this is not recommended for optimal consumer care and may contribute to poorer outcomes and a fragmented workforce response.

14. If continued demand dictates consistent use of 'surge' beds, this needs to be adequately staffed (inclusive of medical, nursing, allied health, Lived Experience and Aboriginal and Torres Strait Islander roles).

Governance and Structure

The panel found that current governance structures within MNMH-TPCH do not appear to support clear role delineation or facilitate understanding of roles, responsibilities or service accountability. The panel noted that role responsibilities and accountabilities were operationalised at higher than required levels, with a lack of appropriate delegation, resulting in procedural bottlenecks, delays and de-skilling of the leadership group.

Recommendations

15. Review and refine the leadership and management structure for MNMH-TPCH, supported by MNMH roles, to ensure clear accountability and delegation.

16. Review committee structures and the contribution of enabling roles where available (e.g., business finance teams, Mental Health Information Managers, Service Development Coordinators, Patient Safety Officers, MHA Delegates) to support the delivery of timely information to increase the capability of managerial leaders to fulfil their roles.

Workforce

The panel noted that the workforce was depleted in a number of areas within MNMH-TPCH. The vacancy rates of some roles, particularly inpatient nursing, acute care team multi-disciplinary positions and medical officers was concerning, and will require a comprehensive strategic approach to improve the current situation and deliver a sustainable plan for the future MNMH-TPCH workforce.

The panel recognised that the observed workforce shortages were likely to have resulted from a number of contributing contextual factors over time, and acknowledge there is current work underway with education partners, professional leads and other Hospital and Health Services to address these gaps.

Recommendations

17. MNMH develop a comprehensive strategic workforce plan inclusive of:
    a. Attraction, recruitment processes and retention
    b. Professional practice standards
    c. Multidisciplinary team (inclusive of all disciplines, Lived Experience workforce, Aboriginal and Torres Strait Islander roles)

    The plan should encompass education partnerships, professional development provisions, supervision requirements, professional lead contributions and consideration of other stakeholders (e.g., consumers, carers, families, kin and support people).

18. Inpatient workforce profiles should be informed by existing workforce benchmarking guidelines.

Infrastructure and Environment

The existing inpatient infrastructure at MNMH-TPCH was consistently identified as a key theme throughout the review process, including from feedback provided by families. The panel agreed that the inpatient facilities are no longer fit for purpose, not in keeping with contemporary guidelines for mental health facilities, not conducive to mental health recovery and wellbeing for consumers, and they pose a number of potential safety and ligature risks for both consumers and staff. The panel found evidence of regular safety and environmental audits completed by MNMH, identifying risk concerns, that were reported and escalated via appropriate governance processes to MNH, with documented action plans to address concerns.

Recommendations

19. MNMH-TPCH to continue, and expedite where possible, work already commenced to address identified safety risks with furniture, fixtures and equipment (i.e., bed frames, furniture, doors, rails, security cameras, duress alarms) to meet agreed mental health inpatient standards.

20. MNMH-TPCH to utilise temporarily vacant beds (i.e., following relocation of Older Persons designated beds to current surge bed or alternative ward) or establish additional temporary area for the relocation of approximately 8 to 10 patient beds, to expedite the required infrastructural changes.

21. Consider the reconfiguration and/or repurposing of mental health unit beds to facilitate improvements to the current layout of the mental health intensive care units (MHICU) to better meet the specific needs of MHICU for both consumer and staff safety. Consideration could be given to temporarily reducing the MHICU capacity to a singular 8 to 10 bed area while changes are made.

22. Enhance the inpatient ward environment to facilitate healing and recovery, ensuring appropriate contemporary mental health care standards are met to support the dignity of consumers and families accessing the service. The panel suggest a co-design process with stakeholders to consider feedback already obtained (e.g., removing the glass from inpatient ward nurse's stations, providing access to sensory rooms, outdoor spaces, exercise areas, activity rooms) and additional insights.