IN THE CORONER'S COURT OF VICTORIA AT GEELONG

CASE No. COR 2010 4286

INQUEST INTO THE DEATH OF JUNE OLIVE PEGG

RESPONSE OF BARWON HEALTH TO CORONER'S RECOMMENDATIONS PURSUANT TO SECTION 72(2) *Coroners Act 2008* (Vic)

The following recommendations relate to Barwon Health.

1. Recommendation One: ***To improve safety of patients I recommend that Barwon Health undertake action to raise awareness of their practitioners and clinicians to their obligations to provide quality documentation of patient care, including documentation of clinical handover between shifts*.**

Barwon Health Response:

1.1 All clinical staff have access to the Barwon Health "Documentation Standards for Clinical Records" procedure. This procedure has been updated in February 2015 and is consistent with the requirements of the *Health Records Act 2001* (Vic), and Australian Standards for both paper-based health records (AS 2828.1:2012) and digitized health record system requirements (AS 2828.2:2012). Reference to this procedure is made in documentation in-services throughout the organisation and as a key aligned document in relevant policies and procedures.

1.2 Documentation in-services have been developed and presented within a multidisciplinary study day which is held annually.

1.3 Stand-alone documentation presentations/in-services are provided to various clinical staff groups throughout the year and this education will continue in 2015.

1.4 Documentation requirements are included in the orientation of medical officers and are incorporated in the Barwon Health Medical Officer's handbook that is available to all clinical staff.

1.5 A memo from Barwon Health's Chief Medical Officer has been prepared and will be distributed to all Barwon Health medical staff. This document refers to:

- the Coroner's recommendations;
- the standard of clinical documentation required by medical practitioners, in accordance with their registration requirements with the Medical Board of Australia and its Code of Conduct ("Good Medical Practice Guide: A Code of Conduct for Doctors in Australia", March 2014); and
- the requirement of Barwon Health staff to comply with the Barwon Health "Documentation Standards for Clinical Records" procedure.

1.6 Barwon Health is accredited by SAI Global to the National Safety and Quality Health Service (NSQHS) Standards and must demonstrate compliance and continual improvement to all the Standards' criteria. This includes Standard 1.9 which requires use of "*an integrated patient clinical record that identifies all aspects of the patients care*". Barwon Health was accredited and has satisfied the requirements of Standard 1.9 in February 2015. The accreditation cycle is continuous.

1.7 Documentation of handover is being addressed by the Barwon Health Patient Identification and Handover Committee. The Coroner's recommendations will be tabled at the next committee meeting. This committee's activities include audit of shift to shift handover processes across the organisation. It has identified the following improvement activities for shift to shift handover to be actioned in 2015:

- standardisation of junior medical officer shift to shift handover; and
- a redesign of the rehabilitation care plan to enable documentation of multi-disciplinary handover.

2. Recommendation Two: ***I recommend that Barwon Health, as part of their process for a patient whose death may be regarded as a coronial case, in that it appears to fulfil the criteria for "reportable death" in section 4 Coroners Act 2008, encourage staff at the first opportunity, to commit to writing a record of their involvement in the management of that patient that they can refer to throughout any internal and/or external investigation.***

Barwon Health Response:

2.1 Documentation in-services have been developed and presented within a multidisciplinary study day. This study day was held in 2014 and will be held annually. The presentations include information regarding the Coroner's process, collecting statements, the requirement that detailed, accurate and timely documentation of events leading up to a patient's death must be recorded within the hospital medical record, and that the record is not only a record of events, but can be accessed as an aide memoir by the authors if a statement is required.

2.2 All patient deaths at Barwon Health that occur during a medical procedure or following a medical procedure where the death is or may be causally related to the medical procedure, and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death, and patient deaths that involve high risk adverse events, are identified through the Barwon Health incident reporting system, medico-legal department and mortality committees. As part of these processes, relevant staff involved in the management of the patient will be requested to document their involvement and recollection of events leading up to the death.