

18th April, 2016.

Coroners Court of Victoria
65 Kavanagh Street,
SOUTHBANK. Victoria. 3006.

cpuresponses@coronerscourt.vic.gov.au

Court Reference: COR 2013 003708
Recommendation 1.

The coroner's recommendation was implemented prior to receipt of the coroner's finding.

A Case Review was undertaken in July 2014 and presented to relevant organisational governance committees in September, 2014.

Changes arising from this review included:

- Extension of organisational Case Review program to include all inpatient transfers to higher level of care
- Revision of internal documentation
 - Nursing Care Plan & Clinical Documentation Policy
- Improved handover procedure to ensure matters requiring GP/VMO assessment are confirmed at each shift handover
- Introduced strategies to minimise the adverse effects of infection control isolation requirements.

Learnings arising from the Coroner's Prevention Unit Advice (received July, 2015) were summarised, de-identified and presented to nursing and medical practitioners in September, 2015.

I trust these initiatives satisfy the coroner's recommendation and will enhance the clinical management of patients suspected or confirmed as suffering from Clostridium difficile infection.

Sincerely,



Dr Peter Sloan,
Director of Medical Services.

CONTACT DETAILS

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