26 September 2011

Mr James Whitton
Coroner's Registrar
Coroners Court of Victoria
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St. Vincent's Hospital
(Melbourne) Limited
Incorporating:
Caritas Christi Hospice Limited
St. George's Health Service Limit
Prague House Limited
ABN 22 052 110 755

Dear Mr Whitton

Court Reference: 4204/06

St Vincent's Mental Health response to Coroners recommendations regarding the death of Lionel Perry on 9th December 2008

The Coroner, Audrey Jamieson, found that Lionel Perry died from cardiomegaly on 9 December 2008.

Coroner's recommendation:

St Vincent's Hospital (STV) continues to implement all the matters actioned from the findings of the RCA with particular regard to:

1. *The provision of periodic education sessions for staff involved in mental health care with emphasis on the importance of timely, accurate, contemporaneous and comprehensive documentation in accordance with the Medical Record Documentation policy;*

STV Response:

a) The Coroner's recommendation has been implemented.

b) The Medical Record Documentation policy was updated in March 2010. Education sessions are run every 6 months across St Vincent's Mental Health and is incorporated into medical staff orientation annually. Mandatory Training days were established for the community settings in 2010 and are offered twice a year. The documentation presentations are provided by the Quality and Risk Coordinator in conjunction with staff from Health Information. An example of the mandatory training for all staff for 2011 is attached which outlines the documentation areas covered in training (refer to Attachment 1).
Training is provided by the Clinical Nurse Educator in collaboration with staff from Health Information in the Acute Inpatient Service. An example of the education session is attached (refer to Attachment 2). The documentation competency was developed in 2007/8 for the Acute Inpatient Unit (refer to attachment 3).

St Vincent's

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Coroner's recommendation:

2. *The provision of periodic education sessions on the roles and responsibilities of nurses who undertake the role of primary nurse or contact nurse as outlined in the Primary Nursing Manual;*

STV Response:

a) The Coroner's recommendation has been implemented.

b) Education is provided to inpatient nursing staff on an annual basis and is incorporated into the orientation of new staff and graduate nurses. The full day training is provided bi-annually by the Clinical Nurse Educator. The Primary Nurse Manual is currently under review as the Acute Inpatient Service adopts a recovery focus of care and will be supported by education as the new model is rolled out. The training material is attached (refer to attachment 4) and a copy of the Primary Nursing Manual is attached (refer to attachment 5).

Coroner's recommendation:

3. *The continuation of the annual file audits of clinical files from the mental health service for the purposes of monitoring and ensuring continued compliance with the Documentation Policy.*

STV Response:

a) The Coroner's recommendation has been implemented.

b) St Vincent's Mental Health undertakes file audits annually across all clinical areas. The results of these audits are reported to the Mental Health Clinical Quality and Risk Committee and used to identify areas for improvement and to implement action plans to address these areas. A copy of the audit tool for the Acute In-patient Service is attached –(refer to attachment 6)

The Acute Inpatient Service also audits 8 files per month of patients discharged from the Acute Inpatient Service. Results from these file audits are also tabled at the Mental Health Clinical Quality and Risk Committee for review and action.

I trust that you find the implementation of the Coroners recommendations satisfactory. If you require any further information, please contact Bridget Organ, Manager, Mental Health on 9288 4396.

Yours sincerely

Stephen Vale
Executive Director
Medical Services, Aged and Community Care