Albury Wodonga Health

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1 March 2024

Ref: OUT24-0256

James Whyman
Law Clerk | Legal Services
Coroners Court of Victoria

Via email: team8@courts.vic.gov.au

Dear Mr Whyman,

Finding into death without inquest Mrs Mary Morrow - COR 2021 003682

We refer to your correspondence dated 20 September 2023 and provide a response to the findings of the Coroner's investigation into the death of Mrs Mary Morrow.

The Coroner recommended;

> *That Albury Wodonga Health continues to regularly review its systems of Venous Thromboembolism (VTE) prevention to ensure compliance with applicable standards, including any newly-released Victorian Guideline for the Prevention of Venous Thromboembolism (VTE) in Adult Hospitalised Patients (**the Victorian Guideline**).*

In response, we confirm that Albury Wodonga Health (AWH) will continue to regularly review its systems of VTE prevention to ensure compliance with applicable standards, including the newly-released Victorian Guideline for the Prevention of Venous Thromboembolism (VTE) in Adult Hospitalised Patients (the Victorian Guideline).

The Medication Safety Committee at AWH oversees the governance of medication related guidelines and is currently undertaking a gap analysis of the newly released Victorian Guideline to look for opportunities to enhance our current policies and procedure to ensure alignment with best practice. To this end, it was pleasing to note that in the newly released Victorian Guideline, the recommended Risk Assessment Tool is the New South Wales - Clinical Excellence Commission Tool, which has been in place at AWH since 2022.

We confirm that monitoring of compliance to the VTE procedure is in place at AWH and this includes auditing of clinical practice. Specifically, there are two audits which monitor VTE practice. The first audit includes the review of risk assessment for VTE and prescribing of prophylaxis appropriate to the level of assessed risk. The scope of this audit is currently being broadened to increase sample size and frequency of data captured to provide further assurance that the VTE procedure is embedded in clinical practice.

An audit in April 2023 of 75 patients, found 97% concordant prescribing of VTE prophylaxis and a follow up audit is currently underway. The results of this audit are reported to the Medication Safety

Committee, and if clinical variation in practice is found, the findings are also shared with clinicians to ensure quality improvements are implemented.

The second audit is specific to patients in a similar situation to Mrs Morrow who might be awaiting surgery in the community and is intended to assess compliance with the Orthopaedic Outpatient Follow Up Procedure. This audit has been included on the organisational wide schedule for 2024, and will be conducted quarterly. The audit will be monitored by the Perioperative and Surgical Divisional and Medication Safety Committee at AWH.

Further to these audits, the monitoring of adverse patient safety events through our incident management system and monitoring of hospital acquired complications such as DVT or pulmonary embolism in admitted patients is coordinated by the Clinical Safety and Quality Unit at AWH. Monthly and quarterly reports are provided to divisional clinical governance meetings where the Health Round Table National benchmarking reports and adverse event trends are reviewed. The benchmarking and adverse event trend reports provide assurance our systems for VTE prevention are in place and effective, but importantly will reveal if variation does exist and improvement is required.

We otherwise confirm that further education is provided by a Medication Safety Pharmacist and the clinical education team on induction of medical and nursing staff to ensure orientation to the VTE procedure. Further to initial induction, presentations at Grand Rounds are provided by the Medication Safety Pharmacist annually, along with other clinical education sessions held in the ward setting throughout the year.

In October each year, Albury Wodonga Health also promotes the “Stop The Clot, Spread The Word” campaign which is a global initiative to raise awareness for consumers and staff of the risks of DVT. This is promoted via the organisations *Pharmacy Phacts* newsletter and other communication mechanisms including social media.

On behalf of Albury Wodonga Health, I extend my deepest sympathies to the family of Mrs Morrow and hope that they can find some comfort in the measures put in place following her death.

Yours sincerely

Mr Bill Appleby

Chief Executive Officer

Albury Wodonga Health