Comments in response to the discussion paper *A review of hospital safety and quality assurance in Victoria*

These comments are by two steering committee members of the Emergency Care Clinical Network

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- ED does not have a Morbidity protocol. So we self-select patients we think are important. I worry that we aren't doing it right. Generally they are in response to a doctor or nurse saying care wasn't as good as it could be.
- A morbidity process for our size hospital and urgent care centres would be helpful. I had already had discussions with a nurse and doctor from Melbourne. They suggested NSW has a morbidity protocol that has a good format for me to look at .
- Mortality is done hospital wide and ED. Significant ones are done as a grand round.
- Could things be happening that shouldn't be?
- What about the 10 - 12 Urgent care centres we support?
- What is my role with them?
- CEO has mentioned of us taking a more active role with them in terms of quality.
- In our hospital medical risk has been discussing this.

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It would be great to see within this the importance of timely and effective clinical handover (and care provision) from and to emergency department settings and general practice as a central issue in patient quality care and safety.

The fact that this is exacerbated for those with complex and chronic problems and the vulnerable could also be included.

In particular some of the current barriers to this are:

- Lack of systematised/widespread eHealth systems for transfer of information to and from ED settings to doctors clinical systems

  Recommendation: Development of effective secure messaging b/w ED and GP developed

- Lack of performance indictors/reporting/standards of clinical handover b/w different health care provider systems (current hospital standards only address clinical handover within hospitals systems)

  Recommendation 1. Clinical handover accreditation standards should include clinical handover to and from GP in ED and other hospital settings

Recommendation 2. Min standard guidelines for clinical handover to and from GP and ED and other hospitals settings are developed by the Department/Hospital sector/PHNs in consultation with relevant stakeholders

- Patients with complex and chronic conditions frequently see multiple general practices and hospitals. This resulting fragmentation of care results in less safety (eg increased medicine errors); poorer communication and care planning across providers; greater inequity; inefficient care; greater cost and resource use of the system; less capacity in the system; more ineffective care; suboptimal whole person, preventative and self-management care; less accountability on providers; less ability to personalise care and measure outcomes/determine safety and effectiveness of care strategies

  Recommendation: DHHS work with hospitals, PHNs and the Australian government (in consultation with relevant stakeholders) to drive and champion a system whereby Patients with complex and chronic problems are registered to a single hospital and GP as their medical home hub

- Lack of real time prescribing systems resulting in medicine mismanagement across different prescribers (both Dr shopping and inadvertent). *Currently more people die in Victoria of prescription medicine than in the road toll* (In 2012 prescription drugs contributed to the deaths of 304 Victorians c.f 282 people died on Victoria's roads) and p*rescription drugs were involved in 82% of the 384 overdose deaths investigated by the Victorian coroner's court in 2014.*

  Recommendation: DHHS work with the Australian Government to urgently and jointly progress a real time prescribing system that works across hospitals, general practice and pharmacies