SUBMISSION

A review of hospital safety and quality assurance in Victoria

North Western Melbourne PHN

Background

At the request of the Minister for Health, the Department of Health and Human Services (DHHS) has commissioned a review of hospital quality and safety assurance in Victoria. This was prompted by the avoidable deaths of seven babies at Djerriwarrh health service in 2013 and 2014, and concerns that the failure of the health system to respond appropriately to the safety breaches and concerns raised about this hospital may be indicative of wider system failures.

An expert panel has been commissioned to undertake a broad consultation with the clinical community and the public, and to make recommendations to improve the quality and safety of all Victorian hospitals, with a particular focus on the role of the DHHS as the system reglator. The panel has released a *Discussion Paper: A review of hospital safety and quality assurance in Victoria.* This is accessible at https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review

The review is examining four key themes:

1: Fostering continuous improvement and clinical excellence

2: Improving hospital governance

3: Strengthening oversight of safety and clinical governance

4: Advancing transparency

This submission, by the North Western Melbourne PHN, is not intended to be a comprehensive consideration of all the themes and questions posed in the *Discussion Paper* but is instead focused on highlighting three key points relating to the important area of the interface between primary care and hospitals, and how these impact on the quality and safety of care.

1. The importance of timely and effective clinical handover

Timely and effective clinical handover and continuity of care between hospitals and general practice are central issues in patient quality care and safety. This includes clinical handover from and to emergency department settings, as well as inpatient and outpatient care. Inadequate clinical handover creates major discontinuity of care issues for patients, and often relies on the patient's recall of clinical advice and follow-up. These issues are exacerbated for those with complex and chronic conditions, and for vulnerable populations (e.g. people whose first language is not English, new migrants, elderly, people experiencing homelessness, people experiencing mental illness).

Current barriers to effective clinical handover include:

- the lack of systematised electronic referral and communication systems for transfer of information to and from hospital settings;

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- the lack of performance indictors/reporting/standards for clinical handover between different health care provider systems (current hospital accreditation standards only address clinical handover within hospitals systems).

Recommendations re clinical handover:

- Effective secure messaging referral and communication systems between primary care and hospitals be developed;
- Minimum standard guidelines for clinicalhandover between primary care and hospital settings should be developed by the DHHS/hospital sector/PHNs in consultation with relevantstakeholders;
- Clinical handover accreditation standards should include clinical handover to and from general practice and hospital settings, including emergency departments.

2. Patients with complex and chronic conditions seeing multiple providers

Patients with complex and chronic conditions frequently engage with multiple general practices, hospitals, and allied health providers. This results in fragmentation of care, poor communication and care planning between providers, increased risk of clinical errors and medication errors, reduced capacity and efficiency within the system, reduced accountability for care, and difficulties in monitoring the safety andeffectiveness of care.

Recommendations re management of patients with complex and chronic conditions:

- DHHS works with hospitals, PHNs, the Australian Government and relevant stakeholders to drive and champion a system whereby patients with complex and chronic conditions are registered to one general practice as their *Health Care Home;*
- Hospitals (LHNs) develop formal, enduring relationships with their local general practices and community health services, with clear standards and accountabiliites for clinical care, rapid access and discharge protocols, health records and communication.

3. Medication mismanagement

The lack of real time prescribing systems with the ability to monitor prescribing and dispensing of medications across multiple providers is a major cause of medicine mismanagement. Currently more people die in Victoria from a range of issues related to prescription medicine than on Victoria's roads. In 2012, prescription drugs contributed to the deaths of 304 Victorians; in 2014, prescription drugs were involved in 82% of the 384 overdose deaths investigated by the Victorian Coroner.

Poor and untimely communication between health care settings are significant barriers to improved medication management, as described in the points above. In addition, patient confusion and lack of understanding regarding the availability and consistency of prescriptions dispensed as generic rather than trade-named drugs (patients may take both not realising they are the same drug), and low levels of health literacy (particularly for vulnerable populations) can contribute to medication errors.

Recommendation re medication mismanagement:

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