

David Yehuda WEISER

David Weiser, aged 70 years, died on 13 November 2013 from gastrointestinal bleeding after collapsing at home. Mr Weiser had presented to Peel Health Campus Emergency Department two days prior after passing black stools and feeling unwell; however, was diagnosed with gastroenteritis and discharged. The coroner reviewed the diagnostic decision making and explored access to, and sharing of, patient information given the deceased had a complex medical history.

The Department of Health's Coronial Review Committee reviewed these findings and directed the recommendation to the appropriate stakeholders for review and response. The Committee endorsed the development of a fact sheet to be disseminated to all health services to provide a guide for the sharing of patient information. This will take recent legislative changes relevant to information sharing between health entities into consideration.

Health Services have reported a number of existing health service-level policies and standard practices to address concerns raised about Emergency Department clinicians having timely access to patient health information, including but not limited to clinical documentation standards, patient transition clinical practice standards and clinical deterioration policy.

The South Metropolitan Health service has been promoting sites' adoption of the 'Call And Respond Early (CARE) for Patient Safety's program which provides a way for patients, their families and carers to raise concerns or call for rapid assistance when they feel that a patient's changing condition may not have been recognised.

The Child and Adolescent Health Service use a number of strategies to facilitate the sharing of information, including: the access of results via the public Picture Archiving and Communication System for services (PACS); monitoring the EDIS Expect Module to identify expected patients arriving from another service (thereby enabling the timely request of patient information); the use of The Electronic Discharge summary (TEDS) in conjunction with strategies to ensure timely completion of discharge summaries; and, other processes to obtain the medical history of a patient treated within the Child and Adolescent Health Service.

NMHS have systems in place to ensure that information is communicated to their GP. This information is automatically generated from the Emergency Department Information System (EDIS) and includes triage details (for example, investigations performed, consultations made, and the final diagnosis for the patient).

The recommendation made by the coroner is marked as ongoing at the time of this report. Progress for this recommendation will be updated in the next report.