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15 November 2012

David Byrne
Coroners Registrar
Coroners Court of Victoria
Level 11
222 Exhibition Street
MELBOURNE VIC 3000

ref: COR2010003561

Dear Mr Byrne

I am writing in response to your letter of 24 August 2012 in relation to the investigation into the death of Dorothy E Plumb (Court ref: COR2010003561).

I record the coroner's recommendation arising from this investigation following:

> "I recommend that residential units and general medical practitioners establish and maintain medical records which sufficiently identify the diagnoses of baseline medical conditions in relation to people with intellectual disabilities"

The essence of this recommendation is already accommodated in the current edition of the RACGP *Standards for General Practices* (4th edition) (**Standards**). The Standards are a template for quality care and risk management in contemporary Australian general practices.

Whilst compliance is voluntary, currently approximately 80% of Australian general practices choose to be accredited against the Standards. Achieving independent accreditation against the Standards shows patients that a practice is serious about providing high quality, safe and effective care to standards of excellence determined by the general practice profession.

Included in the Standards are 41 Criteria which those practices who choose to undergo accreditation are required to meet.

Relevant to the coroner's recommendation, C*riterion 1.7.1: Patient Health Records, Indicator A* requires that:

> "There is evidence that each patient has a legible individual patient health record containing all health information held by our practice about that patient"

This point is further expanded in the explanatory notes for this Criterion, which state that:

> "practices need to have an effective system whereby a patient's health information is stored in a dedicated patient health record. Health records need to include: the patient's contact and other demographic information, medical history, consultation notes..."

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Also of relevance, *Criterion 1.7.2: Health Summaries, Indicator B* requires accredited practices to:

> "...demonstrate that at least 75% of our active patient health records contain a current health summary. A satisfactory health summary includes, where appropriate:
> - adverse drug reactions;
> - current medicines list;
> - current health problems;
> - relevant past health history;
> - health risk factors (eg. Smoking, nutrition, alcohol and physical activity);
> - immunisations;
> - relevant family history; and
> - relevant social history including cultural background where clinically relevant"

As such, a general practice that is accredited under the Standards is required to establish and maintain medical records which sufficiently identify the diagnoses of baseline medical conditions for patients.

I am happy to advise, therefore, that the intervention recommended by the coroner is already accommodated in the Standards, and has been since release of the 3rd edition in July 2007.

In addition to these requirements for accredited general practices, RACGP is in discussions to obtain funding for a project to develop guidelines for quality of health record information in primary care. These guidelines would detail the type of information that GPs should capture in a patient's health record, including baseline medical conditions, in order to ensure they are able to provide quality care to their patients. These would be made available to all GPs and other relevant health professionals such as practice managers.

I trust that this provides you with the relevant information that you require from RACGP.

Yours sincerely

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