PORTLAND
DISTRICT HEALTH

RECEIVED AT
31 OCT 2019
CORONERS COURT OF VICTORIA

Court ref: COR 2015 005613

31/10/2019

Dear Ms Bebbington,

Investigation into the death of Allison J Allan

Thank you for providing Portland District Health with the opportunity to review and action learnings from this report and provide the formal response to the Coroner's recommendations as below.

Coroner's recommendations

1. Portland District Health (PDH) implement an operational change in their Urgent Care Centre in response to their review of Allison's death, whereby medical staff must make initial contact with Victorian Poisons Information Centre (VPIC). I recommend that this recent change in practice be reviewed by PDH, unless a doctor is available to consult with VPIC at the time of the patient presentation, it would be appropriate for the triage nurse to still seek early toxicology advice. The advice provided by VPIC may impact the allocated Australasian Triage Scale category as well as preliminary assessments and investigations prior to medical review. The treating doctor and/or medical team should re-contact VPIC for advice on patient management once they are available, and if appropriate, should also re-contact VPIC with further detailed information to confirm their management is correct.

PDH Response *- The Coroner's recommendation has been implemented*

PDH Guideline, Poisoning and Substance Abuse Emergencies, has been reviewed and now states;

If the Medical Officer is not available for phone consult, the triage nurse is to seek early toxicology advice. The advice provided by VPIC may impact the triage category as well as preliminary assessments and investigations prior to medical review. The treating doctor should re-contact VPIC for advice on patient management once they are available and if appropriate should also re-contact VPIC with further detailed information to confirm their management is correct, or whether the expected clinical course is not followed.

Evidence: Revised PDH Guideline, Poisoning and Substance Abuse Emergencies as attached

Portland District Health
Bentinck Street Portland VIC 3305 P 5521 0333 F 5521 0669 E pdh@swarh.vic.gov.au W www.pdh.net.au

2. PDH should review their current arrangements with existing pathology service/s, in relation to their capacity to provide optimal care for after-hours patient presentations to their Urgent Care Centre (UCC).

PDH Response - *The Coroner's recommendation has been implemented*

PDH continues to provide after hour pathology services to support the provision of optimal care for all patients.
In 2015 St John of God Pathology provided pathology services to PDH. PDH, as a smaller satellite site, safely and consistently provided a suite of onsite testing relative to equipment and staffing resources. The delay in reporting of valproate levels was due to the need for the specimen to be tested offsite at a larger facility with specialised equipment. It is unattainable for PDH to contract any pathology service to provide a full suite of onsite testing.
The current PDH pathology services contract expires in April 2020. PDH has commenced a review to determine the appropriate pathology service to provide PDH with the provision of optimal care for after-hours patient presentations to the UCC.

3. PDH should enter into an agreement with the nearest health service that provides a higher level of care, to develop a memorandum of understanding (MOU) regarding acute management of patients, such as toxicology patients, who have the potential to deteriorate post presentation. The purpose of the MOU – if such an arrangement does not already exist – would be to detail appropriate escalation of care in such circumstances, if required. Consultation between health services should be a phone conversation between consultant physicians, removing the reliance of junior doctors to appropriately refer or accept patient transfers.

PDH Response - *The Coroner's recommendation has been implemented.*

PDH has an agreement and shared understanding of an escalation pathway with Southwest Healthcare (SWH) (formally Warrnambool Base Hospital (WBH)) that facilitates the timely transfer of deteriorating patients requiring higher level care. In the instance of Allison Allan, once the transfer was deemed necessary, the consultant physician arranged transfer to WBH ICU.

Evidence: documented escalation of care pathway between PDH and SWH

4. Both PDH and Warrnambool Base Hospital (WBH) provide internal education to relevant medical staff regarding the importance of:

   a. Having a low threshold for utilising the VPIC service as a primary resource for the medical management of patients who present following overdose, envenomation or poisons exposure, when the treating practitioner does not have a clinical toxicology background or strong understanding of the expected clinical features and management required.
   b. Treating practitioners re-consulting the VPIC service for any ongoing medical management concerns in such patients, or when the expected clinical course is not followed.

PDH Response - *This Coroners recommendation has been implemented*

PDH Guideline, Poisoning and Substance Abuse Emergencies, require the utilisation of VPIC services to obtain advice on medical management following overdose and consulting when required. As demonstrated in this case, VPIC was contacted in a timely manner and the advice was actioned accordingly. As a rural facility supported by generalist clinicians, PDH staff have a strong reliance on specialist services such as VPIC.

The findings and recommendations of this report have been provided to the UCC staff as a learning opportunity. To date 54% of staff have read the Coroner's report which will continue to be available until all staff have reviewed. A further presentation of the Coroner's report, findings and recommendations has been scheduled for the PDH Journal Club on 12th November 2019.
The revised PDH Guideline, Poisoning and Substance Abuse Emergencies, as recommended in the Coroner's, report has been presented for discussion and endorsement at the UCC meeting on 29th October 2019

Evidence: UCC notice of mandatory requirement for staff to read Coroner's report and accompanying staff sign off list

Scheduled journal club presentations

c. Where applicable, include reference to the above recommendations in relevant health service policy or guidelines.

PDH Response - *This Coroners recommendation has been implemented*

The Coroners Case recommendations have been included to the PDH Guideline, Poisoning and Substance Abuse Emergencies as a reference document.

Evidence: Revised PDH Guideline, Poisoning and Substance Abuse Emergencies as attached

Please contact me with any additional follow up requirements or queries.

Regards

Loren Drought
Director Quality

POISONING AND SUBSTANCE ABUSE EMERGENCIES

PORTLAND DISTRICT HEALTH

Type	Guideline	**Approved by**	Urgent Care Centre
Department	Clinical	**Service**	Urgent Care Centre

Purpose

To provide timely and effective physiological support and management of the person presenting with a history or symptoms of intentional or unintentional poisoning.

Target Audience

Urgent Care Centre Medical Officers
Urgent Care Centre Registered Nurses/Enrolled nurses

Guideline

Equipment

- Vital signs monitoring including cardiac
- Defibrillator
- Resuscitation Cart
- Airway trolley

Management

1. *Resuscitation* (as per resuscitation guidelines)
   - Danger
   - Airway
   - Breathing
   - Circulation
   - Disability, Detect & Correct
     - Assess conscious state as per Glasgow Coma Scale
     - Hypoglycaemia; if bedside BSL ,4.0mmol give adults 50mL 50% Dextrose or 5mL/kg 10% Dextrose for children
     - Seizures; first line treatment is benzodiazepines. Phenytoin is contraindicated
     - Hyperthermia; if >38.5C need continuous core temperature monitoring. If greater than >39.5C intubate and ventilate and consider cooling techniques
     - Hypothermia; if patient has undetectable CVO's, aggressively rewarm and provide CPR. If mild hypothermia considering core warming techniques
   - Expose & Emergency antidote administration
     - Undress the patient and examine anterior and posterior surfaces for injuries and other information e.g. burns due to corrosives, bleeding in nose due to solvents, blisters due to barbiturates or organophosphates, bruising or puncture sites from IV drug usage
     - Removal of contaminated clothing is essential with dermally absorbed substances
     - The decision to administer antidote during resuscitation will depend if benefit is better than the possible side effect e.g. naloxone, atropine

2. *Risk Assessment:*
   - Agent(s)
   - Dose; noting if it is immediate or sustained release
   - Time since ingestion
   - Clinical Features and course
   - Patient Factors

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Obtain thorough history from a reliable witness if the patient is a poor historian. Once this information is collected, the Medical Officer is to contact the **Poison's Information Centre (13 11 26)** who will provide advice regarding treatment and management.

If the Medical Officer is not available for phone consult, the triage nurse is to seek early toxicology advice. The advice provided by VPIC may impact the triage category as well as preliminary assessments and investigations prior to medical review. The treating doctor should re-contact VPIC for advice on patient management once they are available and if appropriate should also re-contact VPIC with further detailed information to confirm their management is correct, or whether the expected clinical course is not followed

Be aware that contact may also need to be made with the **Toxacologist on-call** at the **Austin-Repatriation Medical Centre 03 9496 5000**.

The Poison's Information Centre may recommend transfer to a specialist hospital. If so, Adult Retrieval Victoria (ARV) should be contacted immediately.

3. Supportive Care & Monitoring:

- Airway
  - Basic Airway Manoeuvres
  - Intubation
- Breathing
  - Supplementary oxygen
  - Ventilation
- Circulation
  - Intravenous fluids
  - Inotropes
  - Control of hypertension
- Sedation
  - Titrate IV benzodiazepines
- Seizure control / prophylaxis
  - IV benzodiazepines
- Metabolic
  - Ensure normoglycaemia
  - Control of pH
- Fluid and Electrolytes
  - IV fluids
  - Hypo/ hyperkalaemia
  - Hypo/hypernatraemia
  - Hypo/hypercalcaemia
  - Hypo/hyperglycaemia etc.
- Renal function
  - Adequate hydration
- General
  - Nutrition
  - Respiratory care (suction, mouthcare etc.)
  - Bladder care (IDC with hourly measures)
  - Pressure area care

- Thrombo-embolism prevention (prophylaxis or mobilisation)

Treatment will depend on substance taken, advice from Toxicologist/Poisons Information and findings from Medical Officer Examination.

4. Investigations:

- Accurate Patient Weight
- 12 lead ECG (serial)
- Routine bloods (in the unwell patient)
- Paracetamol level, ETOH and specific agents if indicated
- Screening
- Arterial Blood Gases

Investigations should only be performed if they are likely to effect the management of the patient.

5. Decontamination

- Activated charcoal may be used within an hour of ingestion of the toxin **if** advised by the Poison's Centre

6. Antidotes

- Consider if an antidote is available for agent if benefits outweighs potential risks

7. Dispositions

- If poisoning is a result of significant deliberate self-harm, consideration of Mental Health Act must occur. Patient is to be assessed by medical officer as safe to travel then transported to a larger facility with mental health and emergency care services as soon as possible.

8. Documentation

- Ensure treatment, investigation, procedures, and plan is documented in the patient record

DEFINITIONS

ARV: Adult Retrieval Victoria
BSL: Blood Sugar Level
CPR: Cardiopulmonary Resuscitation
CVO's: Cardiovascular Observations
ECG: Echocardiograph
ETOH: Ethanol
IDC: Indwelling Catheter
IV: Intravenous
PDH: Portland District Health

Evaluation

This document will be reviewed in the event of any change in legislation, evidence based practice recommendations or within three years.

PORTLAND DISTRICT HEALTH

Type	Guideline	**Approved by**	Urgent Care Centre
Department	Clinical	**Service**	Urgent Care Centre

Key Aligned Documents

PDH Emergency Record – MR/120
PDH Fluid Balance Chart – MR/193
PDH policy: Advanced Life Support
PDH policy: Arterial Blood Gas
PDH policy: Neurological Assessment
PDH policy: Venepuncture
PDH policy: Medication Ordering

Key Legislation, Acts & Standards

EQuIP National Standards

References

- Murray, L., Daly, F., Little, M. & Cadogan, M. (2011). *Toxicology Handbook (2ed)*. Elsevier, Sydney.
- Royal Children's Hospital Melbourne, *Acute Poisoning - Guidelines for Initial Management*, accessed 22nd June 2016 from: http://www.rch.org.au/clinicalguide/guideline_index/Acute_Poisoning_Guidelines_For_Initial_Management/
- Coroners Recommendations from case COR 2015 005613. July 2019.

Authors / Contributors

Name	Position	Review date
Deb Tozer Loren Drought	NUM-UCC Director Quality	October 2019
Deb Tozer	NUM-UCC	January 2017
Deb Tozer	NUM- UCC	June 2016
Dennyel Smith	NUM-ED	June 2012

Policy established (1996)

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SOUTH WEST VIRTUAL ED SERVICE

WHAT IS THE VIRTUAL ED SERVICE?

The Virtual ED service (VEDS) is a consultant-led program to provide advice to clinicians (both doctors and nurses) in hospital-based emergency care facilities in South West Victoria. The system includes hospitals that refer some of their patients to South West Healthcare, Warrnambool (Hamilton, Portland, Heywood, Moyne, Terang, Timboon, Cobden, and Camperdown). Specialist emergency medicine physicians and senior rural generalists provide real-time support to sites via telephone and, if necessary, an integrated video conference network.

The purpose of the VEDS is to provide specialist advice to a local clinician or to help that clinician find subspecialist advice within the Victorian Health System (such as directing the caller to Adult Retrieval Victoria, the Poisons Information Service, or an appropriate inpatient unit). After the consult, a patient may go home, be admitted locally, or be transferred. The VEDS clinician will facilitate inter-hospital transport and may advocate for the caller with a third party, such as Ambulance Victoria or another Hospital. This is the role played by the senior staff member in all emergency departments. By expanding this service to include smaller services, the emergency services in South West Victoria become one large virtual ED.

When viewed as a region, the Southwest Area Virtual ED manages almost 50,000 per year (table 1)

Table 1. Emergency presentations to South West Victoria Feb 1st, 2017 to Jan 31st, 2018.

	Home	Admitted	Left before treatment complete	Transfer	Other	Total
Moyne	814	42	0	62	1	**919**
Portland	4,932	1,317	870	398	5	**7,522**
Camperdown	1,828	343	16	125	4	**2,316**
Timboon	1,447	80	4	84	2	**1,617**
Terang	2,780	157	7	72	2	**3,018**
Hamilton	5,277	1,810	224	134	4	**7,447**
Warrnambool	16,234	6,802	1,684	325	42	**25,087**
Total	**33,312**	**10,551**	**2,805**	**1,200**	**60**	**47,926**

Currently, 80 % of transfers from these hospitals are to Warrnambool.

Table 2. Transfers from South West Victorian emergency facilities Feb 1st 2017 to Jan 31st 2018

	South West Healthcare [Warrnambool]	University Hospital Geelong	Other	Total
Moyne	60	1	1	62
Portland	307	44	47	398
Camperdown	87	19	19	125
Timboon	75	4	5	84
Terang	69	1	2	72
Hamilton	97	14	20	131
Total	**695**	**83**	**94**	**872**

The goal of the VEDS is to have as many patients as possible treated safely in their town as this minimises double handling, leaves Ambulance Victoria vehicles and paramedics free to respond to pre-hospital emergencies, and is a definite preference of patients. Currently, more than 95% of patients in peripheral emergency facilities in South West Victoria have their treatment completed in their town. The VEDS supports this through several processes.

- Coordination of programs through the Barwon South West Emergency Care Forum
- Regional education supported by the Commonwealth-funded Emergency Education and Training Program, and the Deakin Rural Training Hub
- Benchmarking data using the Rural Acute Hospital Data Register (RAHDaR)
- Research, education and service planning by the Centre for Rural Emergency Medicine

HOW DOES THE SYSTEM WORK?

IF YOU HAVE A LOCAL DOCTOR

Your first point of call for medical assistance is ALWAYS your local GP or hospital specialist if they are available and employed to provide emergency on-call medical services for this type of patient at your hospital. The VEDS does not preclude any existing arrangements for medical services from your local medical staff.

If you have a doctor at your emergency facility, they are the medical practitioner primarily responsible for the patient. Escalation to the VEDS doctor should be for specialist advice and assistance in this case.

IF YOU NEED ADVICE

If a clinician at a peripheral hospital is unsure about the next step in patient management, and there is no local doctor to help, they can call the senior doctor at Warrnambool ED for advice. Sometimes your questions will be answered directly, and sometimes you will be referred to another specialty service or doctor. There is no inappropriate question: The Peripheral Hospital Clinician may ask about anything a junior ED doctor would ask a senior ED doctor.

The preferred method of contact is through completing the VED referral form (figure three) and faxing it to Warrnambool ED on 5563 1333). Filling out this form will help organise your thoughts prior to the referral and help record the interaction. After 9 PM and before 8 am, also ring the Warrnambool ED on 5563 1475 to notify them that the fax has been sent. The Warrnambool Senior ED Doctor should phone back on the number listed within one hour. If a call has not been received by then, please ring Warrnambool ED to remind them.

More urgent cases require an earlier discussion. For this service, an urgent patient;

- Has been given a triage category 1 or 2, or
- Is deteriorating, or
- Is agitated

For these patients, call as early as possible after you have performed the initial primary survey and stabilisation. If possible, fill and fax the referral form to clarify your clinical questions. When minutes matter, it is appropriate to call first and send the referral form later.

The referral form has been set out in an ISOBAR format. This format has the reason for your request included in an initial 10-second summary. It is essential to inform the Senior ED Doctor about what you are really asking about as early as possible, as it helps him or her listen to the most vital pieces of information (and it may stop them asking you to repeat things).

Usually, the consultation will be by telephone, but occasionally the Senior Warrnambool ED clinician will ask you to turn on the video conferencing system. The Peripheral Hospital Clinician needs to know how to turn on your video conferencing at his or her site, but the controls for moving and focussing the camera will be operated by Warrnambool.

Hospital logo with ED/UCC contact numbers SW telehealth referral form	UR Number: Surname: Given names: Date of birth: Sex: AFFIX PATIENT LABEL HERE

☐ URGENT ☐ Not urgent			
Identity	Your name:		
	Your role:		Mob:
	Date:		Time:
Situation	Presenting problem:		
	Most likely diagnosis:		
	I need to discuss (one or more)	☐ Investigations needed	
		☐ Treatment needed	
		☐ Need for admission or transfer	
		☐ Transfer to Warrnambool	
		☐ Other:	
Observations	Pulse: BP: RR: O_2 sat: Temp:		
Background	*(Relevant details of history, past illnesses, social factors, meds, allergies, and exam)*		
Assessment	***(Likely diagnosis, other possibilities, what are you worried might happen?)***		
Request	***(What is the most important question you want to discuss?)***		
Fax to Attending ED Specialist at 03 5563 1333			
Refer to Flowchart for clinicians at peripheral sites for details			
☐ **Documents attached? (such as ECG or specialist letter). Number ofpages:**			

Figure 1. Proposed referral form to be faxed

The consultation between the Senior Warrnambool ED Clinician and the Peripheral Hospital Clinician should be a discussion to arrive at an agreed plan. If either clinician is worried by an aspect of the plan, they should say so. The plan may be to discharge, observe, treat, admit, transfer, or ring another speciality clinician/service. If they plan works smoothly, no further contact may be needed. If the patient deteriorates or the process stalls,please ring Warrnambool again. 'Process stalls' includes situations when a call to a suggested speciality service is unhelpful or more than 2 hours have elapsed without an acceptable plan.

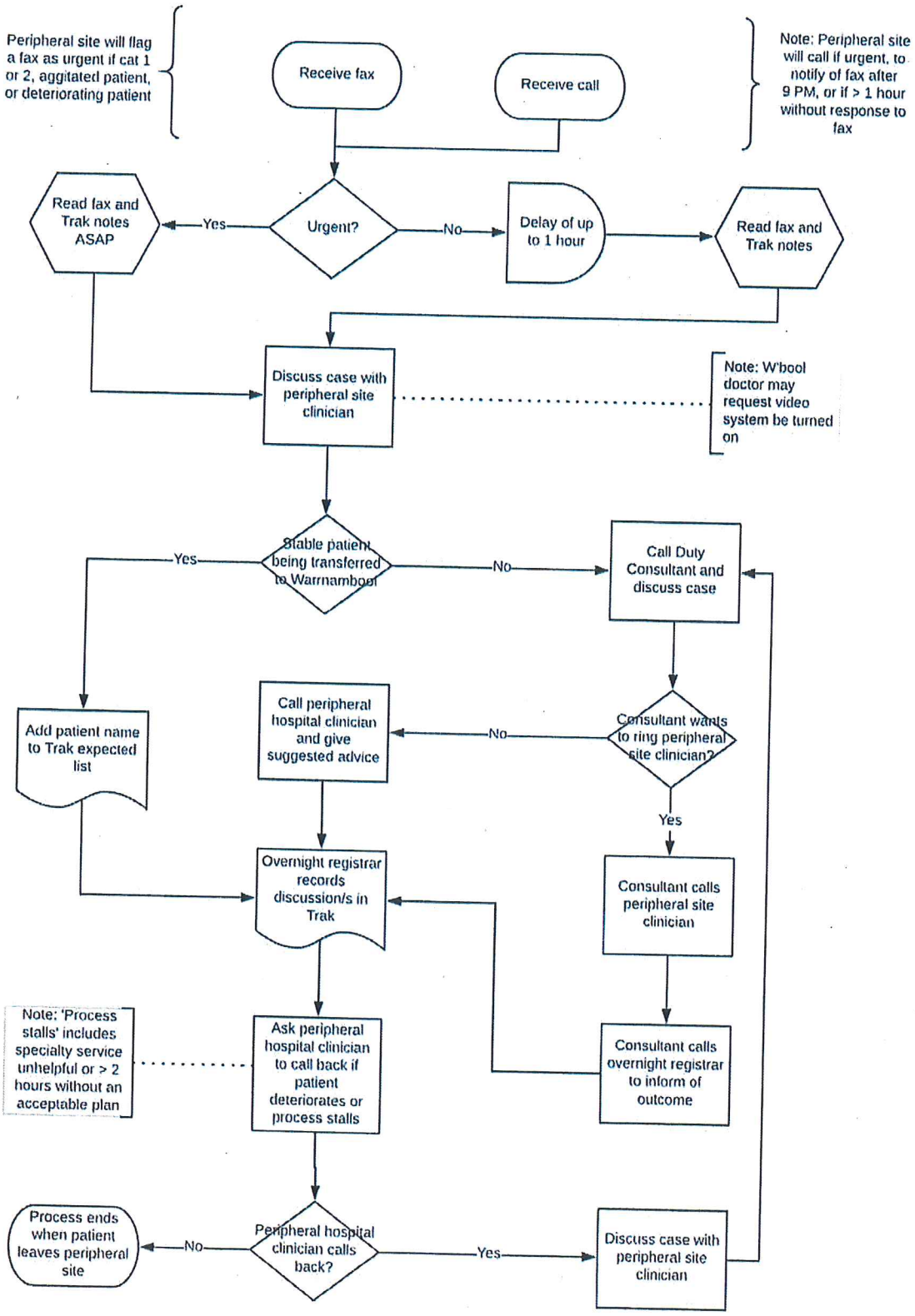

Figure 2. Pathway for Clinicians from Peripheral Sites

IF YOU RECEIVE A CALL FOR ADVICE

When possible the senior doctor in Warrnambool ED will provide advice. The doctor should read the fax and then read the notes the Peripheral Hospital Clinician has entered on Trakcare (if any). These notes can be accessed by logging on to the peripheral facility UD/UCC screen (if you have access) or searching for the patient using the UR number.

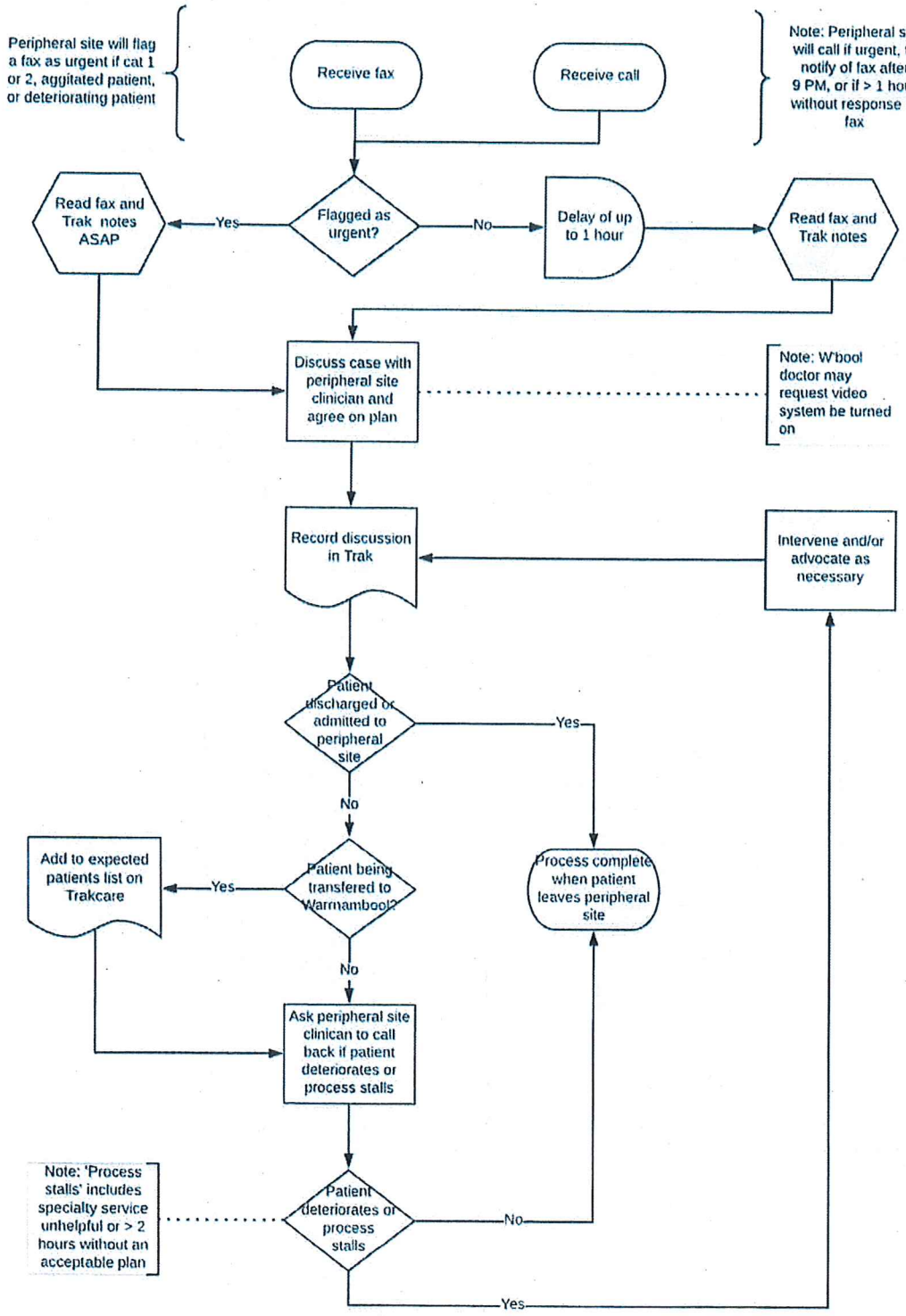

Figure 3. Pathway for Senior Emergency Department Doctor

When ready, ring the Peripheral Hospital Clinician. Remember that the call is to make an agreed plan. The Senior ED doctor will not be with the patient and will know less about the peripheral site, so remember to check that the Peripheral Hospital Clinician has no ongoing concerns.

At night, the ED consultant will usually have left the ED. The senior ED Doctor overnight will follow the same steps to sort out the clinical question and formulate an agreed response. Unless the patient is stable and being transferred to Warrnambool, the ED overnight doctor will ring the ED consultant for approval.

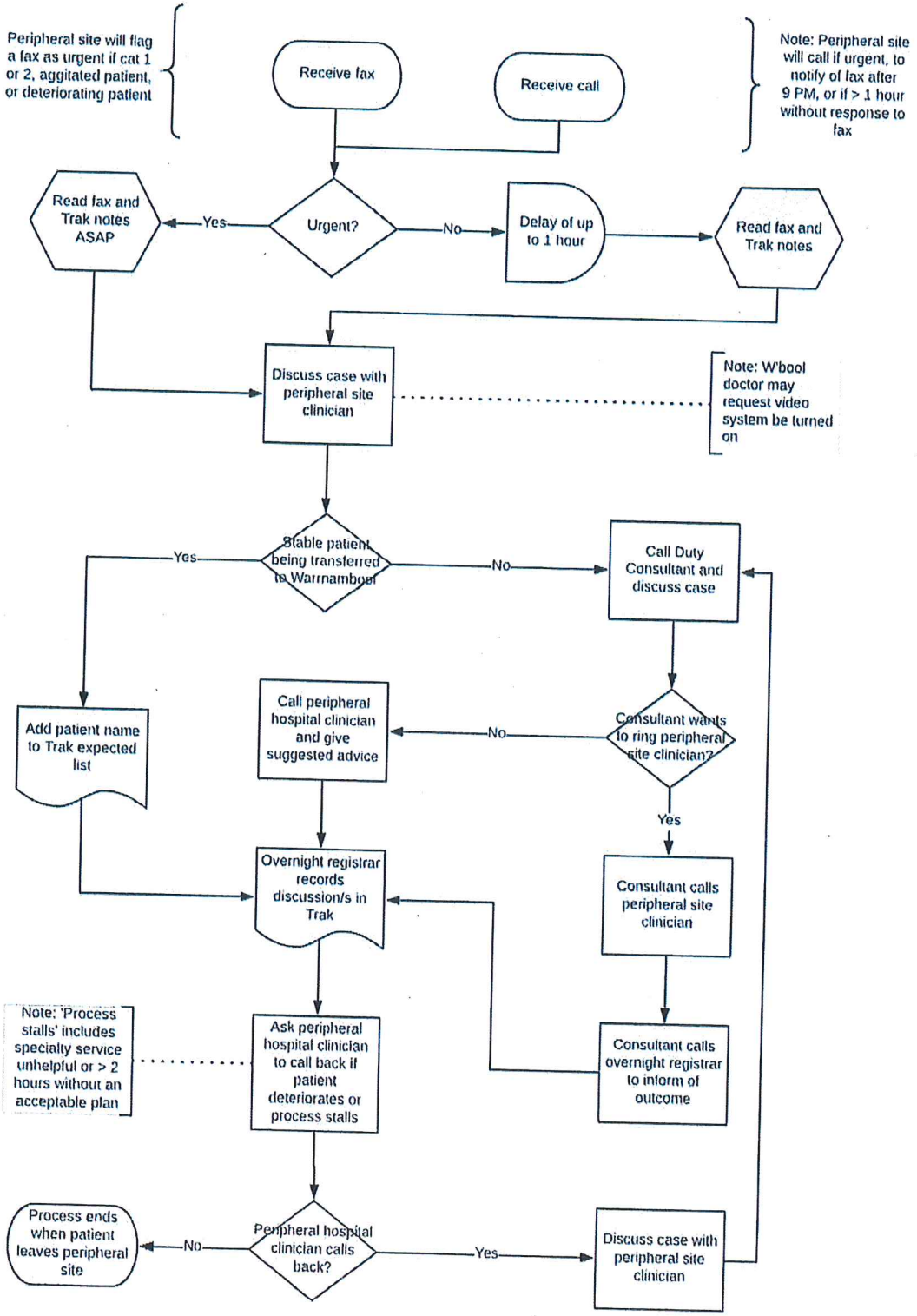

Figure 4. Pathway for Overnight Emergency Department Doctor

DOCUMENTATION AND AUDITING

All hospitals in this proposal use the Trackcare ED management software and are linked by common patient UR numbers. A patient's notes from any facility are located in the one linked file and can be found from any site by searching with the UR number.

The Australian *Quality Standards for Emergency Departments and other Hospital-based Emergency Care Facilities* suggests that both services involved in a consult need to record the discussion in the notes. The Peripheral Hospital Clinician will complete the patient notes and the referral fax (which will be scanned into the notes). The Warrnambool ED clinician will add their notes under the heading of telehealth consultation.

There are several developments to Trakcare under development

- Replacing the telehealth fax with a similarly formatted Trakcare referral form.
- Allowing all ED clinicians to access the ED/UCC floorplan from each site. This site lists the number of cubicles and the patients in each cubicle. Access can be granted to individual clinicians or groups of clinicians. ED clinicians can then directly click onto a Peripheral ED/UCC floorplan, or access the patients notes by searching with their UR number.
- Adding Telehealth consultation as a type of note (link medical note or nursing note). This will make auditing easier.
- Creating an audit tool that displays the relevant parameters for telehealth consultation audits

Activity and performance of the system will be tracked and benchmarked using the Rural Acute Hospital Data Register (RAHDaR).

SHARING COSTS

The Warrnambool ED consultants have agreed to trial this system as a second decision-maker (usually a GP or senior medical officer) has been added to the Warrnambool ED evening roster. This addresses the concern of senior ED staff that they will be distracted by a call/fax, and the junior staff at Warrnambool ED will stop processing patients as they wait for senior advice. Peripheral hospitals may be asked to contribute to employing a senior nurse to assist with the program (see below). A review of the initial VEDS used by each site may help weight each hospitals contributions. Contributions may become more necessary if hospitals wish to sign a memorandum of understanding where Warrnambool clinicians fax medication orders to a facility with no onsite prescriber. (Where this prescribing system is used elsewhere in Victoria, the central hospital has received a grant or charges for this service).

FURTHER DEVELOPMENTS

INPATIENT UNITS

Warrnambool ED is happy to receive calls from Peripheral Site Clinicians to refine their patient assessment and clinical questions before they contact inpatient registrars. There will have to be consultation through the Medial Directors Meeting as to whether inpatient units should be contacted before or after the patient comes to Warrnambool ED for further assessment.

NURSING

It has been proposed that the VED system employs a senior nurse or nurse practitioner as the frontline of the team between 1 PM and 9 PM daily. The VEDS nurse will review referrals and take the initial urgent calls during that time. They may directly involve the VEDS doctor, seek further clarification with peripheral hospital staff before contacting the VEDS doctor, or provide advice themselves (especially about appropriate pathways and other support services). This process will resemble the flowchart for overnight ED doctors (figure 4).

The VEDS nurse will have access to the Trakcare floorplan at each facility. He or she will review the screen to look for patients whose progress through the system appears to have stalled. In particular, the VEDS nurse will attempt to have a plan for all relevant patients in the peripheral facilities before 9 pm each night (when the VEDS doctor leaves South West Healthcare). The VEDS nurse may also assist with testing video conferencing equipment and modifying protocols.

SUPPORTING ONCALL GPS

Hospitals with difficulty maintaining GP coverage, and unable to recruit or train sufficient RIPERNs, may wish to have Warrnambool Clinicians fax a prescription for medications. In general, clinicians are reluctant to prescribe for patients that they cannot see and are worried about their medicolegal situation if an adverse outcome occurs. This could not occur without a Memorandum of Understanding between health services.

COMPLAINT RESOLUTION AND ONGOING DEVELOPMENT

Complaints will be addressed in the first instance between Directors of Medical Services (or similar Hospital Administrators) at the Peripheral sites and the Director of Emergency Medicine at Warrnambool. Ongoing discussions and developments can be made through the Barwon South West Emergency Care Forum.

ATTENTION UCC STAFF:

ATTACHED IS A REPORT THAT HAS JUST COME THROUGH FROM THE CORONER INVOLVING A CASE AT PDH IN 2015.

AS A RESULT OF RECOMMENDATIONS (AND TO ENSURE STAFF ARE AWARE OF THE PROCESS OF CORONERS CASES AND HOW LONG IT TAKES TO GET RESULTS), I AM ASKING ALL STAFF TO PLEASE READ THE ATTACHED CORONERS REPORT.

This is a detailed and long report, so I have made 3 copies for staff if you want to take it home to read. Once read please return copy for others and sign the attached signature form.

This is a **mandatory** recommendation from PDH Quality so please ensure you all read the document.

Thanks

Deb T

Mullen	Rebecca	
Jackson	Janina	
Stephenson	Anne	
Watson	Jacinta	
Lane	Angela	AL
Pitman	Ashley	
Bremner	Lindy	
Eichler	Casey	
Mibus	Bronwyn	
Griffith	Kate	
Pudlat	Angelique	
Bourke	Chloe	

Berry	Carolyn	
~~Fredericks~~	Emily	
Adams	Tania	
Halliwell	Sophie	
Mabbitt	Noelene	
Finck	Michelle	
Rowe	Kristen	
Starick	Marty	
Berry	Amelia	
Edgcumbe	Tim	
Silva	Kellie	
Lattin	Rosie	
Edwards	Daniel	

TAYLOR Nicola

Journal Club Schedule
Tuesdays 8am - 9am
Dr David Taylor Lounge

Date	Time	Presenter
1 January	**NO JOURNAL CLUB**	
8 January	8am – 9am	Britta Baade *Topic: Complex Paediatric Patients*
15 January	8am – 9am	Pratibha Ranjan *Topic: Ticking Bomb* Terry Cain *Topic: Internal Referral*
22 January	8am – 9am	Kaushik Banerjea *Topic: Case Studies*
29 January	8am – 9am	Pharmacy *Topic: SafeScript*
5 February	8am – 9am	Kushal Porwal *Topic: Heart Sounds and Murmurs*
12 February	8am – 9am	Terry Cain *Topic: Internal Referrals, Admission Note & Medical Apps*
19 February	8am – 9am	Lisa Johnson *Topic: Promoting Safe Blood & Blood Product Transfusion Practice*
26 February	8am – 9am	Pharmacy *Topic: SafeScript* *Theresa Cain* *Topic: Discharge Summaries/Emails/Workplace*
5 March	8am – 9am	Padmavati Venkatgiri *Topic: Evaluation and Management of Peripheral Vertigo*
12 March	8am – 9am	Karanvir Gill *Topic: Pulmonary Embolism*
19 March	8am – 9am	Zheng "Rodney" Yin *Topic: Safe Handover, Safe Patients: Guidance on Clinical Handover for Junior Medial Officer*
19 March	12.30pm – 1.30pm	HMO Expert Series *Topic: Acing the Interview and Buffing the CV*
26 March	8am – 9am	Clare Eldridge *Topic: Pharmacy Update* Vicki Barbary *Topic: Diabetes Update*
2 April	8am – 9am	Britta Baade/Pattie *Topic: Paediatrics*
9 April	8am – 9am	Jo Spurge *Topic: Advanced Care*
16 April	8am – 9am	Dieticians

Journal Club Schedule
Tuesdays 8am - 9am
Dr David Taylor Lounge

		Topic: Dietician Charting
23 April	8am – 9am	Ramana "Vijay" Kumar *Topic: Case Studies*
30 April	8am – 9am	Pratibha Ranjan *Topic:TBC*
30 April	12.30pm – 1.30pm	HMO Expert Series *Topic: Atrial Fibrillation*
7 May	8am – 9am	Terry Cain *Topic: General Catch Up re Systems*
14 May	8am – 9am	Marni Smith Topic: *Blanket referrals/appropriate referrals to Physiotherapy /Occupational Therapy* Fred Nittsjo (PMH) 8.30am Topic: Referral Pathways/After Hours etc.
21 May	8am – 9am	Ramya Nelakurthi *Topic: Approach to a Febrile Child*
28 May	8am – 9am	Kaushik Banerjea *Topic: Radiology Audit*
28 May	12.30pm – 1.30pm	HMO Expert Series *Topic: The Sick Cancer Patient*
4 June	8am – 9am	Pharmacy *Topic: Beers/PIMS/De prescribing*
11 June	8am – 9am	Joanna Spurge *Topic: Voluntary Assisted Dying*
11 June	12.30pm – 1.30pm	HMO Expert Series *Topic: The Agitated Patient*
18 June	8am – 9am	Padmavati Venkatgiri *Topic: Acute visual loss*
25 June	8am – 9am	Gaynor Denboer *Topic: Insulin and their profiles in action*
2 July	8am – 9am	Clare Eldridge *Topic: VTE Prophylaxis*
9 July	8am – 9am	Karanvir Gill *Topic: Headache*
16 July	8am – 9am	Terry Cain *Topic: Trak Happy Hour*
23 July	8am – 9am	Gaynor Denboer *Topic: Insulin*
30 July	8am – 9am	*Tim Baker* *Topic: High sensitivity troponins*
6 August	8am – 9am	Chris, Ros, Anne Miller *Topic: Patient Safety/Quality Activity* Kushal Porwal

Journal Club Schedule
Tuesdays 8am - 9am
Dr David Taylor Lounge

		Topic:
6 August	12.30pm – 1.30pm	HMO Expert Series *Topic: Diabetes: Practical management of blood sugar levels*
13 August	8am – 9am	*Mutaz Ferman* *Topic: Inflammatory Bowel Disease*
20 August	8am – 9am	*Clare Eldridge* *Topic: New requirements for VTE prophylaxis recording* *Kaushik Banerjea* *Topic: Case Reviews*
27 August	8am – 9am	Terry Cain *Topic: Radiology Logins & Trak Happy Hour* *Kaushik Banerjea* *Topic: Case Study*
3 September	8am – 9am	Brett Johnson *Topic: DKA*
10 September	8am – 9am	Terry Cain *Topic: TRAK Happy Hour*
17 September	8am – 9am	Naveen Sharma *Topic: Current guidelines for heart failure*
24 September	8am – 9am	Clare Eldridge *Topic: Insulin charting* Brett Johnson *Topic: Inpatient Diabetes Management Respiratory inhalers*
1 October	8am – 9am	Abdul Mannan *Topic: Pneumonia*
8 October	8am – 9am	Helen Roberts *Topic: Team Approach to Patient Radiation*
15 October	8am – 9am	Helen Roberts *Topic: Team Approach to Patient Radiation continued*
15 October	12.30pm – 1.30pm	HMO Expert Series *Topic: Running a MET call: How to step up when you want to freak out!*
22 October	8am – 9am	Padma Venkatgiri *Topic: Suturing – General Principles*
29 October	8am – 9am	Pharmacy *Topic: Drug Allergies*
29 October	12.30pm – 1.30pm	HMO Expert Series *Topic: Sepsis*
5 November	**NO JOURNAL CLUB**	
12 November	8am – 9am	Loren & Kaushik Coroners Case
12 November	12.30pm – 1.30pm	HMO Expert Series

Journal Club Schedule
Tuesdays 8am - 9am
Dr David Taylor Lounge

		Topic: Practical Radiology: will the scan change the plan?
19 November	8am – 9am	Brett Johnson *Topic: Respiratory Inhalers*
26 November	8am – 9am	Pharmacy *Topic: Antimicrobial overview*
26 November	12.30pm – 1.30pm	HMO Expert Series *Topic: Your Social and Legal Obligations: curly conundrums for healthcare workers*
3 December	8am – 9am	Shilpa Yeddula *Topic:*
10 December	8am – 9am	Pharmacy *Topic:*
17 December	8am – 9am	Rakesh Patel *Topic:*
24 December	**NO JOURNAL CLUB**	
31 December	**NO JOURNAL CLUB**	