AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

D21-10761

Ms Caitlin English
Deputy State Coroner
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Deputy Coroner English

Coronial investigation into the death of Ian Fraser (Court Reference: COR 2019 6921)

Thank you for your correspondence of 2 March 2021 enclosing the report of the coronial investigation into the death of Mr Ian Fraser. The Australian Commission on Safety and Quality in Health Care (the Commission) confirms receipt of the report.

The Commission is committed to safety and quality initiatives that address the risks related to electronic medical records (EMR). As you reference in your report the Commission has developed the National Guidelines for On-Screen Display of Medicines Information. It welcomes the opportunity to work in collaboration with the Therapeutic Goods Administration to ensure these guidelines are more broadly adopted to guide local modifications of EMRs, which occur post registration on the Australian Register of Therapeutic Goods.

The Commission also has actions under the National Safety and Quality Health Service Standards, specifically action 6.11, which requires health service organisations to have processes to 'contemporaneously document information in the health care record including: critical information, alerts and risks; reassessment processes and outcomes; and changes to care plans'. The Commission has developed a number of resources to support health service organisations in relation to these actions and to assist them in maintaining relevant, accurate, complete and timely information about a patient's care.

Should you require any further assistance regarding this matter please contact:

Chris Leahy
Director of e-Health and Medication Safety
(02) 9126 3576 or christopher.leahy@safetyandquality.gov.au

Yours sincerely

Adjunct Professor Debora Picone AO
Chief Executive Officer

27 April 2021