IN THE MATTER of the Coroner's Act 2008

and

the death of **ANTONIOS MYRIANTHOPOULOS – COR 2020 001509**

RESPONSE BY WESTERN HEALTH

THE RECOMMENDATIONS

1. Pursuant to section 72(3) of the *Coroner's Act 2008* (Vic), Western Health hereby responds to the following recommendations made by Coroner Katherine Lorenz on 20 March 2024:

    a) Develop an anticoagulant stewardship program.

    b) Complete their review of administration practices at the time of registration of patients by clerical staff to ensure that they comply with the relevant procedures and policies.

    c) Review their policies and practice around the provision of timely discharge summaries and advice to general practitioners to ensure that essential information regarding ongoing management requirements is communicated in a clinically appropriate timeframe.

    d) Take steps to ensure that written advice is provided to patients and their carers regarding important medication, care, and follow-up plans.

    e) Review their VTE prevention guidelines against the suggested state-wide guideline from Safer Care Victoria and the facts of this case.

STATEMENT OF ACTION IN RELATION TO RECOMMENDATIONS

Recommendation 1: Develop an anticoagulant stewardship program

2. Western Health is in the process of developing an anticoagulant stewardship program. The anticoagulant stewardship program is anticipated to be implemented within the next 12 months.

3. The proposed model for anticoagulation stewardship at Western Health would support VTE prophylaxis management including:
    a. Conducting regular audits of VTE prophylaxis prescribing
    b. Review of VTE prophylaxis-related incidents
    c. Follow up of high-risk patients post-discharge via telehealth
    d. Daily review of VTE prophylaxis dashboards
    e. Education for ward pharmacists, nurses and junior doctors to enable appropriate advice for patients discharged on VTE prophylaxis medication
    f. Provide advice to inpatient medical units regarding VTE prophylaxis in complex patients
4. The anticoagulation stewardship team would not routinely be involved in decision-making about VTE prophylaxis at the time of patient discharge as this remains a clinical decision for the treating inpatient unit. However, they will be able to highlight the need for medical teams to provide a clear discharge plan for ongoing anticoagulation management, should it be required.
5. In the interim, whilst the anticoagulation stewardship program is being developed, a Western Health Anticoagulation Stewardship Working Group has been developed. This multidisciplinary Working Group was developed in July 2023 and continues to meet monthly. With the support of the Western Health Senior Pharmacist - Medication Safety, this Working Group:
    a. conducts an annual audit of VTE prophylaxis prescribing across Western Health;
    b. monitors Western Health trends in VTE-prophylaxis incidents;
    c. provides education to Western Health junior doctors on VTE risk assessment documentation and prescribing; and
    d. reports quarterly on findings and initiatives to the Western Health Medication Safety Committee.

Recommendation 2: Complete their review of administration practices at the time of registration of patients by clerical staff to ensure that they comply with the relevant procedures and policies.

6. The Coroner's recommendation has been implemented.

7. In June 2023 all Western Health clerks were contacted via email and reminded of the need to check patient details upon presentation to the Emergency Department and again on admission to the wards. At the same time an informal process was put in place whereby one of our clerical allocators performs random checks in our system to identify any patients who are missing General Practitioner details.
8. In addition, it is proposed that a more formal process be put in place to include:
    a. Conduct a thorough audit at least twice a year
    b. Random checks on different wards at least twice a week
    c. More thorough education to new and existing clerks
    d. A formal process for managing clerks who do not complete this requirement
9. The Electronic Medical Record team at Western Health is also working to include in our updated medical record the capability to capture and monitor when patient's details are checked and updated to facilitate monitoring and compliance.

Recommendation 3: Review their policies and practice around the provision of timely discharge summaries and advice to general practitioners to ensure that essential information regarding ongoing management requirements is communicated in a clinically appropriate timeframe.

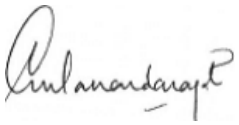
10. The Coroner's recommendation will be implemented.
11. Western Health is currently in the process of reviewing its process for providing discharge summaries to patients, families and other health professionals. We are in the process of transitioning to a new platform to enable greater efficiency and accuracy in the transmission of discharge summaries, particularly to general practitioners. It is anticipated that the new platform will be effective from July 2024.

Recommendation 4: Take steps to ensure that written advice is provided to patients and their carers regarding important medication, care, and follow-up plans.

12. The Coroner's recommendation will be implemented. Please otherwise see the response to Recommendation 3.

Recommendation 5: Review their VTE prevention guidelines against the suggested state-wide guideline from Safer Care Victoria and the facts of this case.

13. The Coroner's recommendation is in the process of being implemented. The anticoagulant stewardship program will include a review of all VTE prevention guidelines.



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