Safer Care Victoria

2 May 2019

Emergency Care Clinical Network

Forum 2019

Twitter
#ECCN2019
@SaferCareVic

VICTORIA State Government

Emergency Care Clinical Network Forum

Welcome

Acknowledgement of country

Michael Ben-Meir
Chair, ECCN Governance committee

HOUSEKEEPING

Phones

Exits & bathrooms

Breaks – morning tea 11.20am, lunch 12.55pm, close 3.25pm

Questions & microphone use

Sign in at your table

Tweet #ECCN2019 @SaferCareVic

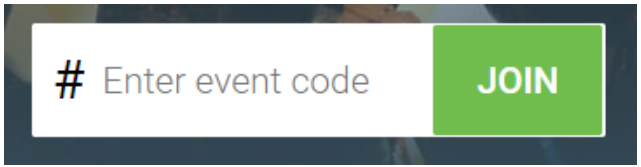
Sli.do

Sli.do can be found following the link - https://www.sli.do/

Or

You can go to the appropriate app store on your device and search for Sli.do

Enter event code #ECCN



Sli.do Practise

Sli.do event code : #ECCN

How did you get here today?

- Public transport
- Car (own car, taxi or uber)
- Walk
- Cycle
- Online participant

Session 1 – ECCN update

Chair: Michael Ben-Meir

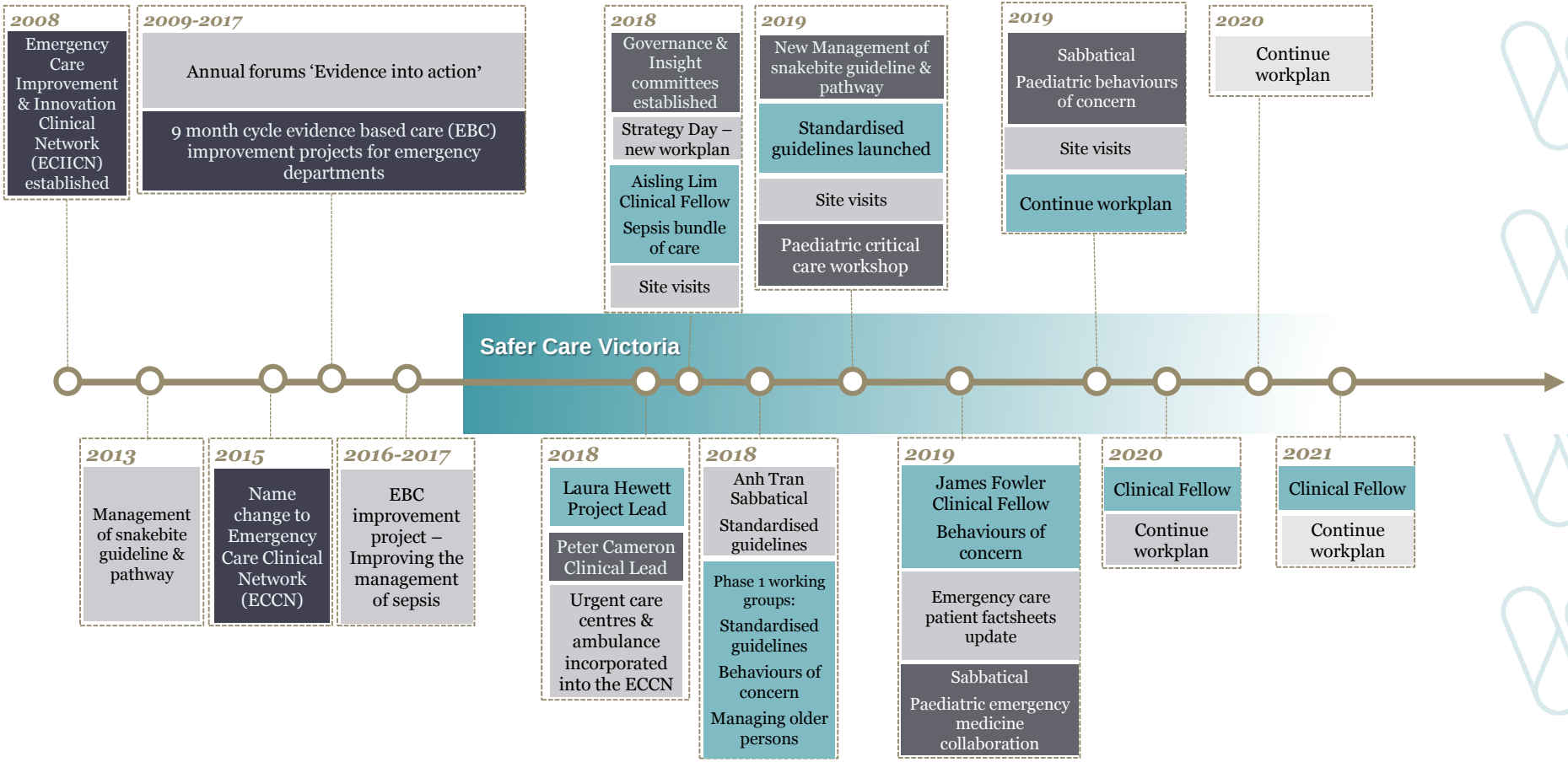
Chair, ECCN Governance committee

Emergency Care Clinical Network Forum

Reflection on ECCN

Peter Cameron
ECCN Clinical lead

The path so far…..



Strategy day – your priorities

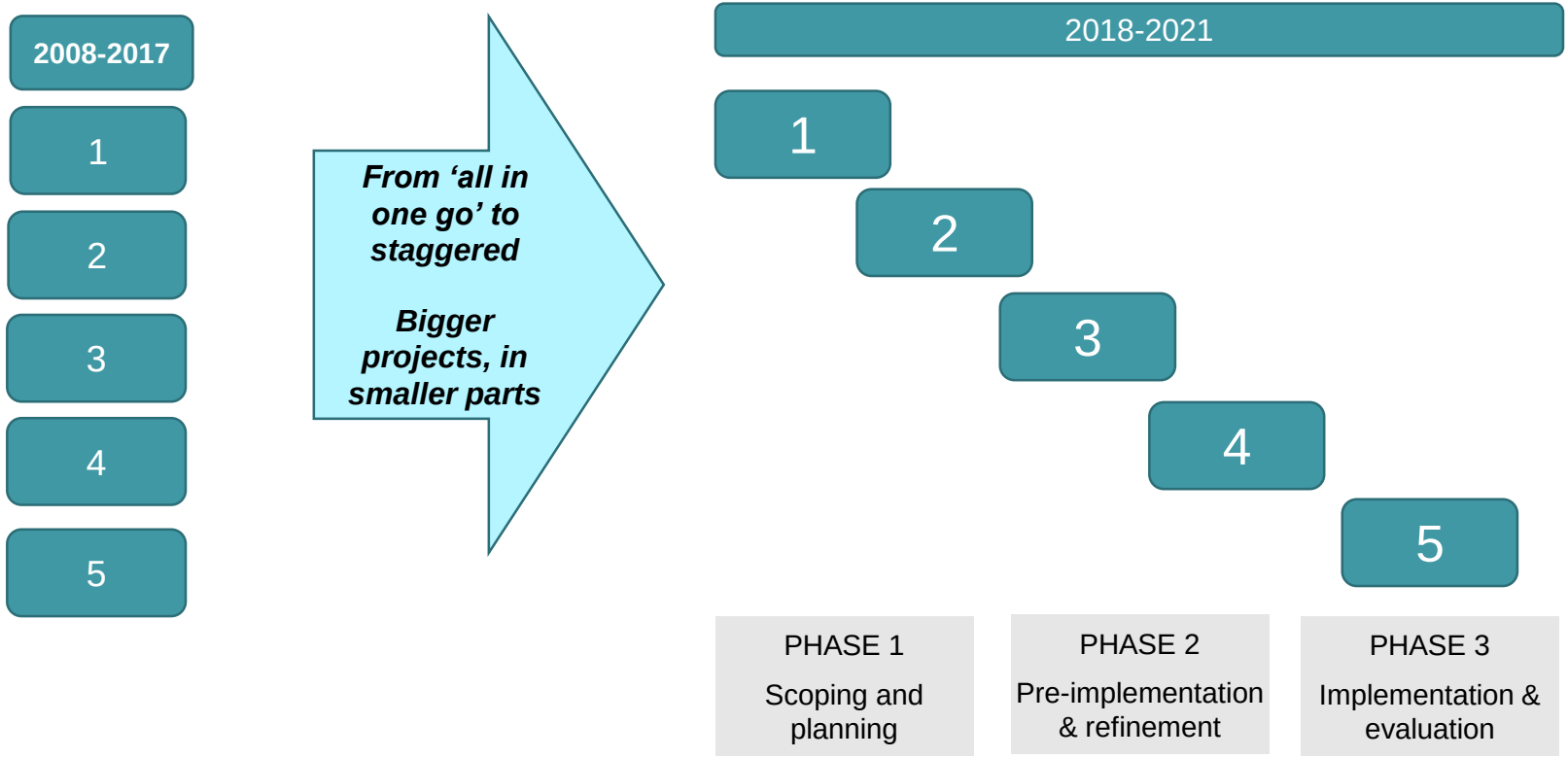
Lead and collaborate

- Guidelines and patient handouts
- Managing behaviours of concern
- Managing presentations of the older person
- Data

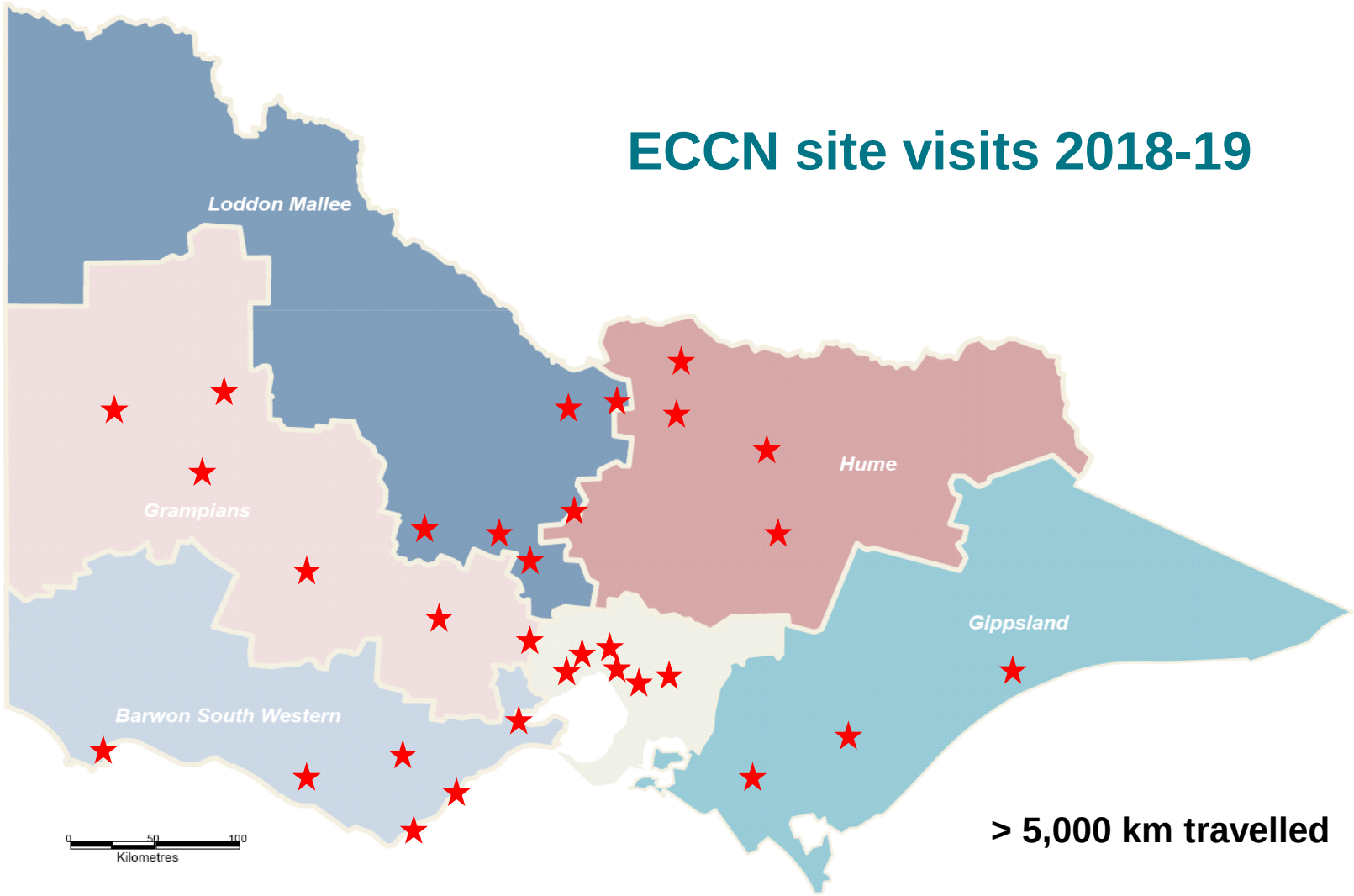
Connect to, communicate, conduit

- Referral pathways
- Demand and access
- IT
- Telehealth

New ways of working



ECCN site visits 2018-19



> 5,000 km travelled

Connect with us

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info@safercare.vic.gov.au

@safercarevic

Safer Care Victoria

Subscribe to our e-news at www.bettersafercare.vic.gov.au

Emergency Care Clinical Network Forum

ECCN priority area: Managing presentations of the older person

Peter Cameron

ECCN Clinical lead

Chair, Managing presentations of the older person expert working group

Phase One – Planning and scoping

Expert working group formed in August 2018

21 multidisciplinary clinicians and consumers representing 13 public and private health services across metropolitan, rural and regional areas

Tasked with making recommendations to guide our workplan for optimal emergency care for older persons

Phase One – Planning and scoping

The working group:

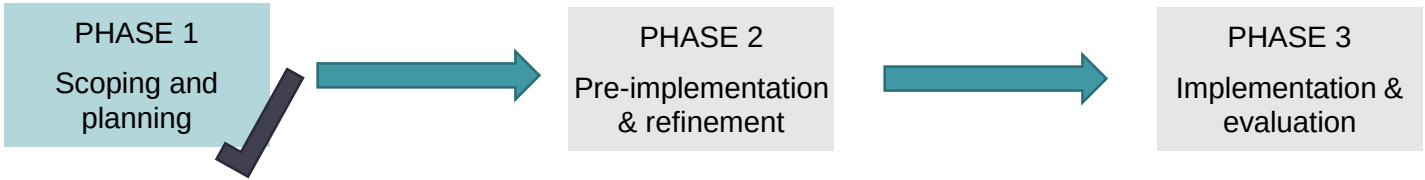
- Identified issues regarding the management of emergency care presentations of older persons
- Reviewed national and international experience with improving models of emergency care for older people
- Liaised with areas of the Department of Health and Human Services and Safer Care Victoria, such as Residential care policy and Care for the Older People Clinical Network, who were working on initiatives or policy related to the older person to identify gaps, opportunities and synergies
- Reviewed data from sources such as Ambulance Victoria, Victorian Emergency Minimum Dataset and the Rural Acute Hospital Data Register to highlight gaps and opportunities

Phase One – Planning and scoping

The working group made recommendations for the ECCN to pursue to implement best practice management of emergency presentations of the older person in regards to:

- Clinical pathways/protocols/guidelines
- Facility design
- Staffing and training
- Models of care
- Community integration and follow up services

Next steps



- Recommendations to go to the ECCN Governance committee for review and endorsement at the end of May 2019
- Work plan to be formulated
- Phase 2 expected to commence later in the year
- Be subscribed to our Clinical Network Newsletter for opportunities to be involved

Emergency Care Clinical Network Forum

ECCN sepsis project: Overview and patient story

Aisling Lim
Clinical fellow
ECCN

Damian Holden
Nurse unit manager
Heathcote Health

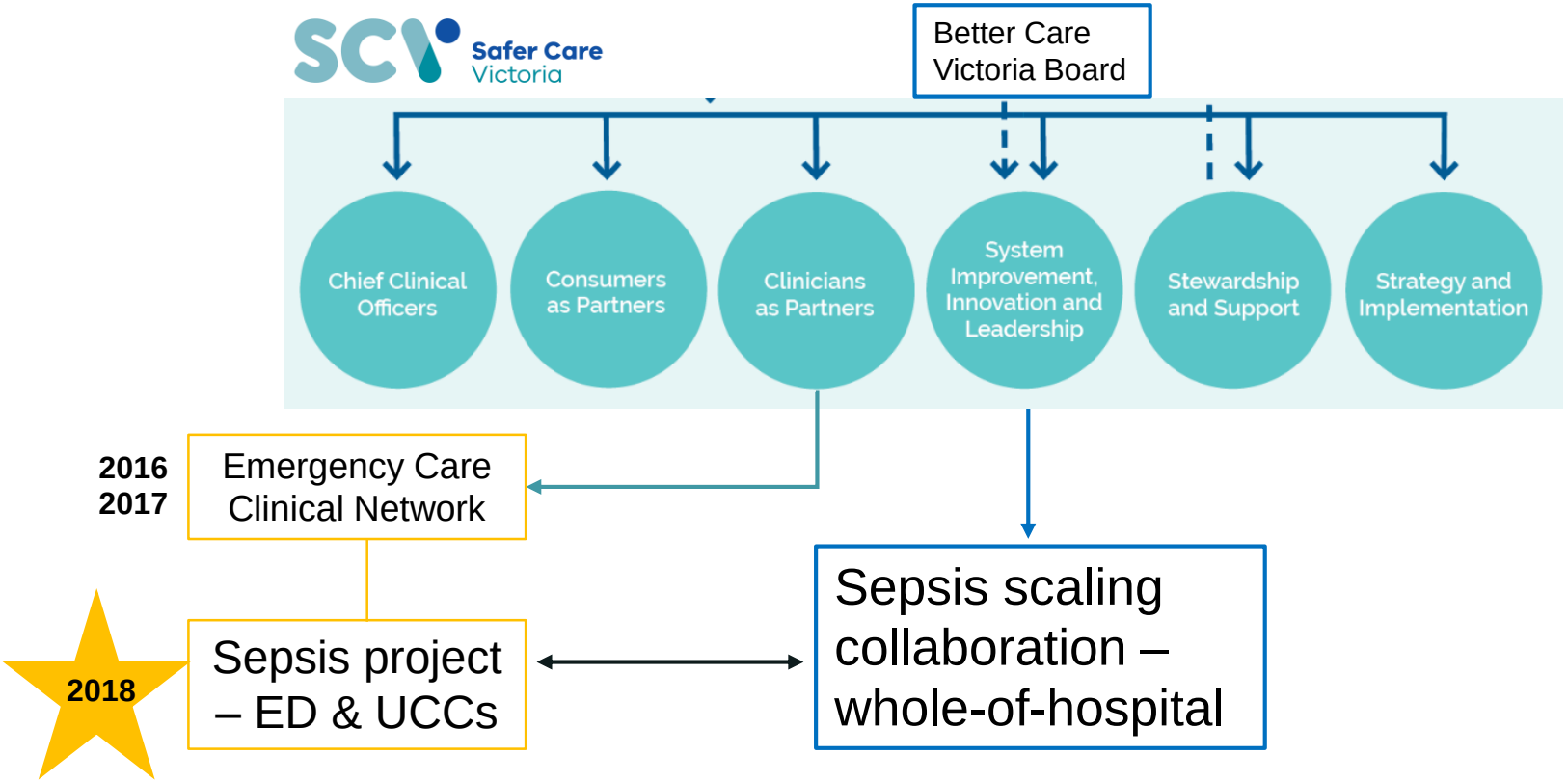
Simone O’Brien
Nurse practitioner
Heathcote Health

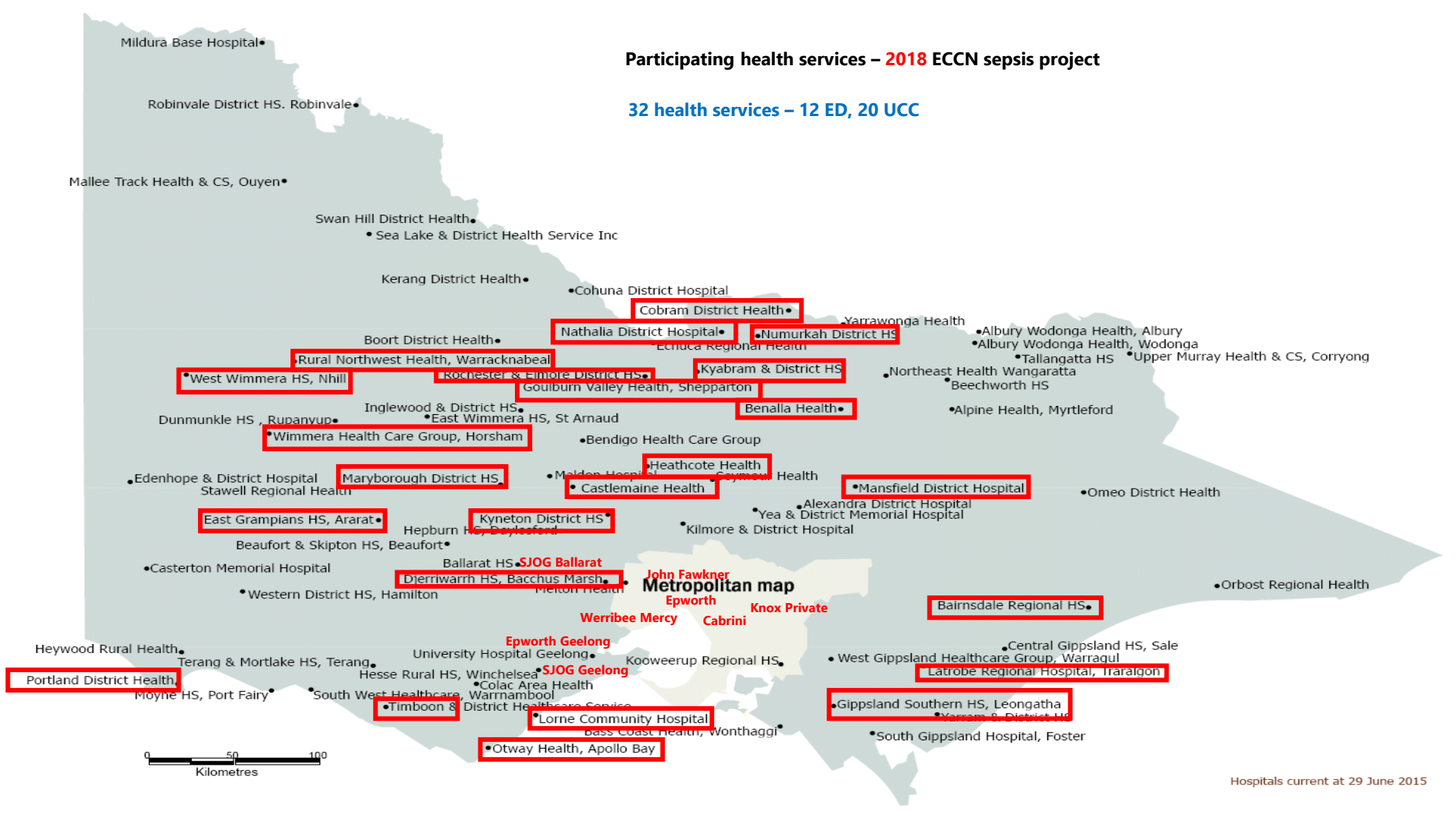
Implementing a sepsis bundle of care in emergency departments and urgent care centres

Aisling Lim

ECCN Clinical fellow

SCV sepsis projects



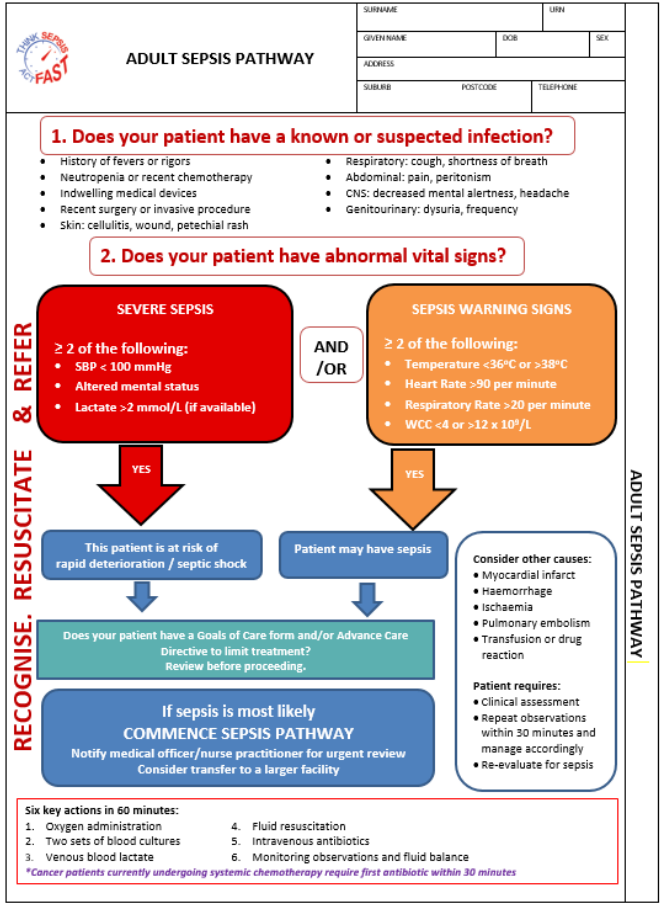

Participating health services – 2018 ECCN sepsis project
32 health services – 12 ED, 20 UCC
Mildura Base Hospital
Robinvale District HS. Robinvale
Mallee Track Health & CS, Ouyen
Swan Hill District Health
Sea Lake & District Health Service Inc
Kerang District Health
Cohuna District Hospital
Cobram District Health
Yarrawonga Health
Nathalia District Hospital
Numurkah District HS
Albury Wodonga Health, Albury
Albury Wodonga Health, Wodonga
Boort District Health
Echuca Regional Health
Tallangatta HS
Upper Murray Health & CS, Corryong
Rural Northwest Health, Warracknabeal
Rochester & Elmore District HS
Kyabram & District HS
Northeast Health Wangaratta
West Wimmera HS, Nhill
Goulburn Valley Health, Shepparton
Beechworth HS
Inglewood & District HS
Benalla Health
Alpine Health, Myrtleford
Dunmunkle HS , Rupanyup
East Wimmera HS, St Arnaud
Wimmera Health Care Group, Horsham
Bendigo Health Care Group
Heathcote Health
Edenhope & District Hospital
Maryborough District HS
Stawell Regional Health
Castlemaine Health
Mansfield District Hospital
Omeo District Health
Alexandra District Hospital
Yea & District Memorial Hospital
East Grampians HS, Ararat
Kyneton District HS
Kilmore & District Hospital
Beaufort & Skipton HS, Beaufort
Casterton Memorial Hospital
Ballarat HS
SJOG Ballarat
John Fawkner
Djerriwarrh HS, Bacchus Marsh
Metropolitan map
Orbost Regional Health
Western District HS, Hamilton
Epworth
Knox Private
Werribee Mercy
Cabrini
Bairnsdale Regional HS
Epworth Geelong
Heywood Rural Health
University Hospital Geelong
Central Gippsland HS, Sale
Terang & Mortlake HS, Terang
Kooweerup Regional HS
West Gippsland Healthcare Group, Warragul
SJOG Geelong
Hesse Rural HS, Winchelsea
Latrobe Regional Hospital, Traralgon
Portland District Health
Colac Area Health
Moyne HS, Port Fairy
South West Healthcare, Warrnambool
Gippsland Southern HS, Leongatha
Timboon & District Healthcare Service
Lorne Community Hospital
Bass Coast Health, Wonthaggi
South Gippsland Hospital, Foster
Otway Health, Apollo Bay
0
50
100
Kilometres
Hospitals current at 29 June 2015

Sepsis pathway

Six key actions in 60 minutes:

1. Oxygen administration
2. Two sets of blood cultures
3. Venous blood lactate
4. Fluid resuscitation
5. Intravenous antibiotics
6. Monitoring observations and fluid balance

+ Empiric antibiotic guide (TG)



Implementation

Education and awareness campaigns

Blood culture sampling and intravenous cannulation training

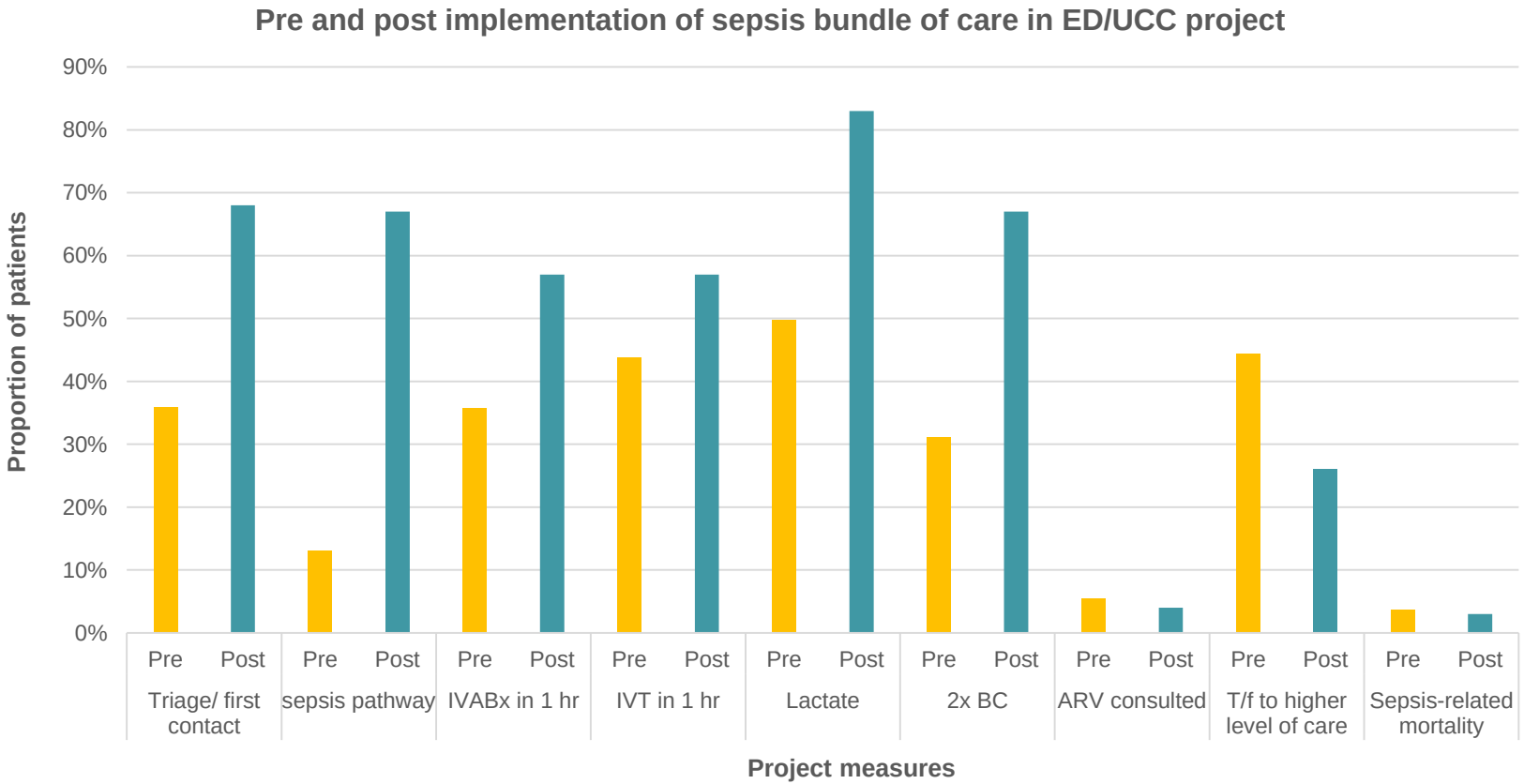
Engaged local ambulance, local pathology

Updated observation chart to align with sepsis criteria

Developed standing orders

Collaborated with referral hospitals (in whole-of-hospital sepsis project)

Results


Pre and post implementation of sepsis bundle of care in ED/UCC project
Proportion of patients
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Pre
Post
Triage/ first contact
sepsis pathway
IVABx in 1 hr
IVT in 1 hr
Lactate
2x BC
ARV consulted
T/f to higher level of care
Sepsis-related mortality
Project measures

Sepsis project summary

Travelled 4873 km, visited 28 health services

30 ED/UCC implemented a standardised sepsis pathway

Successes – increased awareness, improved staff confidence, nurse empowerment

Challenges – resource allocation, low numbers of presentations, governance approval, obtaining feedback from referral hospitals

Next steps

Finalise the evaluation

Finalise change package to guide future health services to implement the sepsis pathway

Networking opportunity 22 May – ECCN and whole-of-hospital sepsis project sites to connect and share their work

Opportunities to collaborate with SCV on sepsis projects – guided by the Infection Clinical Network

Thank you

Participating ED and UCC in the 2018 project

ECCN sepsis project subcommittee

ECCN/SCV team

Sepsis in the UCC

A Patient Story

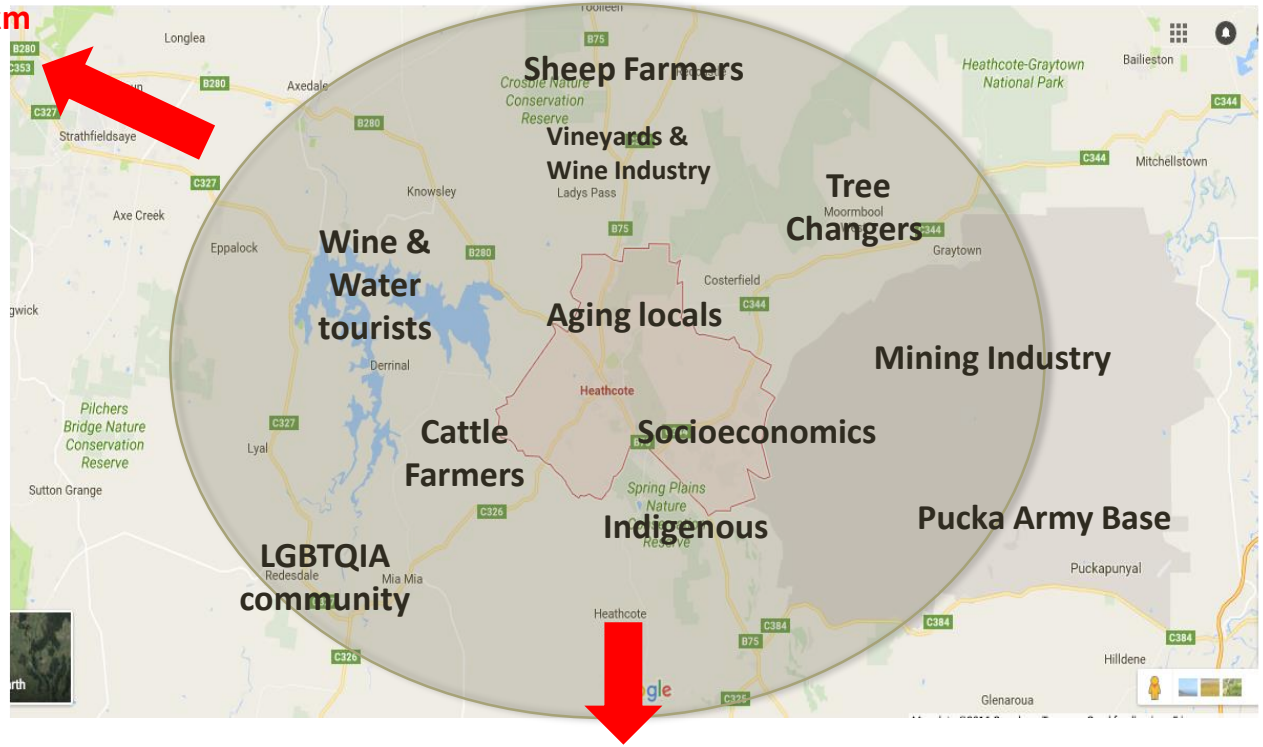
Heathcote Health

Damian Holden (NUM Acute, UCC and Community)
Simone O'Brien (Nurse Practitioner)

HEATHCOTE Health

Who are we?

Bendigo 50km



Melbourne 135km

HEATHCOTE Health

Mr R

- 67 year old male
- PHx:
  - Craniopharyngioma
  - Hypoandrogenism
  - Diabetes Insipidus
  - Hypopituitarism
  - Ca Prostate w prostatectomy
  - HLD & HPT
  - Hypothyroidism
  - OA
  - L shoulder enchondroma

Allergies: [redacted]
CANT TAKE LOSEC BECAUSE OF THE CRANIOPHARYNGIOMA

Current Medications:

Drug Name	Strength	Dosage	Reason	Last script
ALLOPURINOL Tablet (Allopurinol)	300mg	1 daily		25/09/2018
ATACAND Tablet (Candesartan cilexetil)	8mg	1 daily		01/11/2018
BUDAMAX AQUEOUS Nasal Spray (Budesonide)	64mcg/dose	1 daily both sides		01/11/2018
CARTIA EC Tablet (Aspirin)	100mg	1 daily		01/11/2018
CIRCADIN SR Tablet (Melatonin)	2mg	1 nocte p.r.n.		01/11/2018
CLARATYNE Tablet (Loratadine)	10mg	1 daily p.r.n.		01/11/2018
DVA DAA - 6 MONTH SUPPLY 99647N				25/09/2018
GABAPENTIN Capsule (Gabapentin)	300mg	1 t.i.d.		25/09/2018
GLUCOSAMINE SULFATE Sachet (Glucosamine sulfate. Crystalline non-hydroscopic)	1,500mg	1 daily		27/03/2018
HYSONE Tablet (Hydrocortisone)	4mg	2 b.d.		01/11/2018
LIPITOR Tablet (Atorvastatin (as calcium))	20mg	1 nocte	Hypercholesterolaemia	25/09/2018
MINIRIN TABLET Tablet (Desmopressin acetate)	200mcg	1/2 t.i.d.		21/03/2018
NUTROPIN AQ Liquid (Somatropin (rbe))	10mg (30 units)	1 daily		08/04/2011
OROXINE Tablet (Levothyroxine sodium)	100mcg	2 daily		22/08/2018
PANADOL OSTEO SR Tablet (Paracetamol)	665mg	2 t.i.d.		01/11/2018
PROCTOSEDYL Ointment (Hydrocortisone/Cinchocaine hydrochloride)	0.5%/0.5%	p.r.n.	Proctitis	28/07/2017
RANI 2 Tablet (Ranitidine (as hydrochloride))	150mg	1 b.d.	Gastritis	25/09/2018
REANDRON 1000 Injection (Testosterone undecanoate)	1,000mg/4mL	1 10 weeks	Hypoandrogenism	16/11/2018

"Thank you for seeing Mr R, age 67yrs with rigours and dysuria for further assessment and management.

This gentleman with a history of hypopituitarism has presented with an abrupt onset of rigours, dysuria and lower abdominal pain.

He's unwell on exam with tachycardia and tachypnoea with central cyanosis."

Triage Assessment: Time of Arrival 0935 Triage Category

Clinical Description: presenting from GP (+ [redacted]
↓ abdo pain (LLQ)
fevers / rigors. Mottled appearance

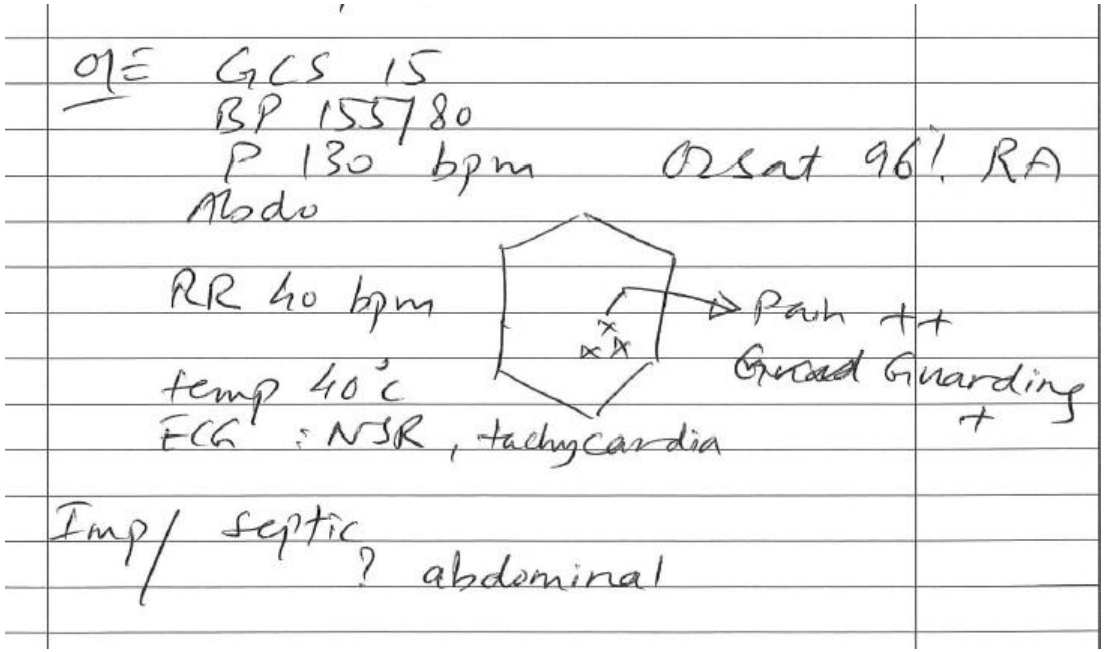
Signature. [redacted]

- [ ] 1 - immediate
- [ ] 2 - <10 minutes
- [x] 3 - <30 minutes
- [ ] 4 - <60 minutes
- [ ] 5 - <120 minutes
- [ ] GP Clinic

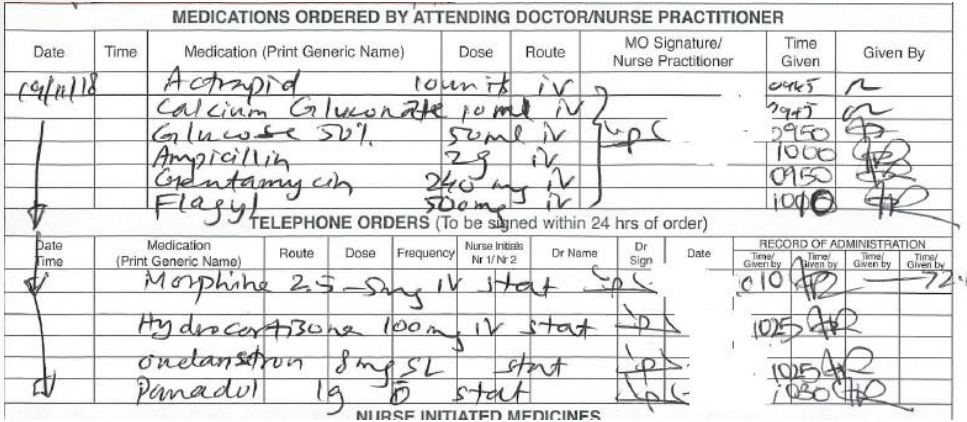
Signs/ Symptoms	1. Does your patient have two or more SIRS criteria, hypotension or altered mental state?	2. Does your patients also have any of the following risk factors, signs or symptoms of infection?
	☑ Temperature <36°C or >38°C	☑ History of fever or rigor
	☑ Heart Rate >90 bpm	☐ Neutropenia or recent chemotherapy
	☑ Resp Rate >20/min	☐ Indwelling medical device
	☐ WCC <4 or > 12 x 10^9/L	☐ Recent surgery/invasive procedure
	☐ Systolic BP <100mmHg	☐ Skin: cellulitis, wound, petechial rash
	☐ Altered mental state	☐ Respiratory: cough, shortness of breath
	3. Does your patient have clinical signs of hypoperfusion?	☑ Abdominal: pain, peritonism
	☑ Cool peripheries (hands and feet)	☐ CNS: decreased mental alertness, headache
	☐ Decreased/no urine output (for >8 hrs)	☐ Genitourinary: dysuria, frequency

Date 19/11	Time	0850	0920 0940	1000	1025										
Respiratory Rate (breaths / min)	Write ≥ 31	44													
	25-30		38	30	59	30									
	21-24														
	15-20														
	11-14														
	5-10														
	Write ≤ 4														

Initial VMO Assessment



	Dr	In Attendance
P/	2 iv lines 1L iv fluid D/W BH-ED-AO ↳ K+ 9	Blds taken with B. cultures → 1. Ca++ gluconate 2. insulin + 50% Dextrose
↻)		



MEDICATIONS ORDERED BY ATTENDING DOCTOR/NURSE PRACTITIONER

Date	Time	Medication (Print Generic Name)	Dose	Route	MO Signature/ Nurse Practitioner	Time Given	Given By
19/11/18		Actrapid	10 units	iV		0945	
		Calcium Gluconate	10ml	iV		0945	
		Glucose 50%	50ml	iV		0950	
		Ampicillin	2g	iV		1000	
		Gentamycin	240mg	iV		0950	
		Flagyl	500mg	iV		1000	

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1/ Nr 2	Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given By
	Morphine	2.5-5mg	IV	stat					0910			72.5mg.
	Hydrocortisone	100mg	iV	stat					1025			
	ondansetron	8mg	SL	stat					1025			
	Panadol	1g	PO	stat					1030			

NURSE INITIATED MEDICINES

FULL BLOOD EXAMINATION

					(x109/L)	
HB :	170 g/L	(130-180)		WHITE CELL COUNT:	7.1	(4.0-11.0)
PCV:	0.51 L/L	(0.40-0.54)		Neutrophils: 60%	4.3	(2.0-8.0)
RCC:	5.53 x1012/L	(4.50-6.50)		Lymphocytes: 26%	1.8	(1.0-4.0)
MCV:	92 fL	(80-96)		Monocytes : 2%	0.1	(0.0-1.0)
MCH:	31 pg	(27-32)		Eosinophils: 0%	0.0	(0.0-0.5)
MCHC	335 g/L	(320-360)		Basophils : 0%	0.0	(0.0-0.2)
RDW:	13.3 %	(11.0-16.0)	*	Band Forms : 12%	**0.9**	(0.0-0.6)
				PLATELETS :	182	(150-450)

FILM: White cells: Band forms are increased.
Red cells and platelets show normal morphology.

COMMENT: The white cell changes are suggestive of infection or inflammation.

Patient Story

- Link to video

Emergency Care Clinical Network Forum

ECCN priority area: Standardised guidelines

Anh Tran

ECCN sabbatical

Chair, Standardised guidelines expert Working group

Standardised guidelines – work plan

Scope out and consolidate current available guidelines. Consider those within state and interstate that could be endorsed.

Establish gaps and prioritise the areas where new guidelines are required

Develop a work plan to develop these guidelines

Liaise and collaborate with content experts and other clinical networks (as appropriate, pending guideline topics)

Consider accessibility such as the website, apps, search engines etc.

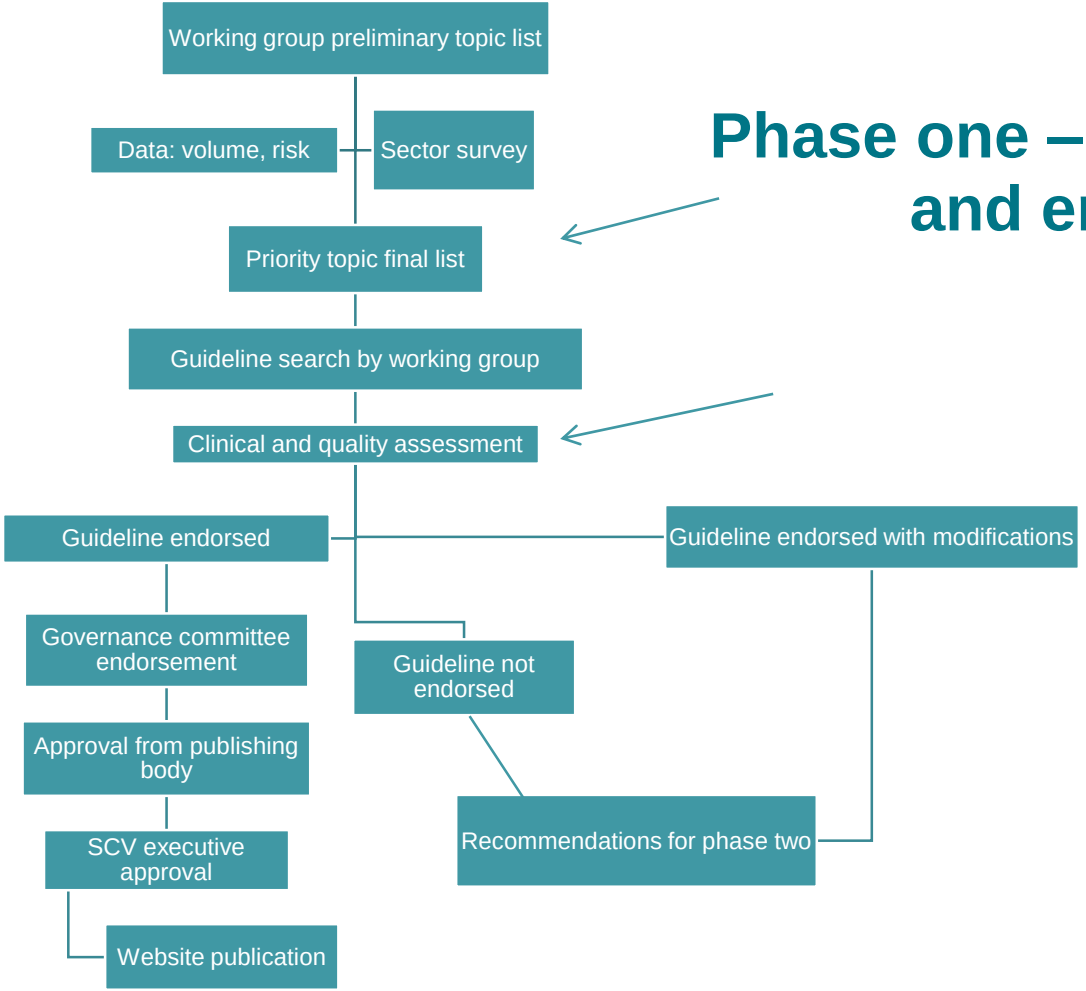
With input from the Insight committee, identify key performance indicators/quality indicators associated with each guideline (as appropriate)

Phase One

Expert working group formed in August 2018

16 multidisciplinary clinicians and consumers representing 13 public health services across metropolitan, rural and regional areas

Phase one – process of review and endorsement



Expert working group high priority list

High Risk

- Stroke
- Behaviours of concern (BOC)
- Paediatrics
- Chest Pain (ACS)
- Trauma
  - C spine*
  - Spinal Cord Injury*
  - Referral guidelines
  - Burns*
- Falls
- DKA*
- Maternity*
- Difficult airway management*
- Endometriosis
- Women's Health
- Asthma
- Sepsis
- Drug and alcohol
- Toxicology

High Volume

- Cellulitis*
- Flu*
- Abdominal pain
- Low Back Pain*
- Fractures
- Vertebral fracture*
- Soft tissue injury *

High impact

- NPEP*
- Gastroenteritis*
- Thunderstorm asthma
- Communication
  - Difficult conversation
  - Breaking bad news
- Nursing guidelines
  - RIPERN*
- Infection/ Isolation*
- Procedural sedation

Expert working group high priority topic list

High Risk

- Stroke
- Behaviours of concern (BOC)
- Paediatrics
- Chest Pain (ACS)
- Trauma
  - C spine
  - Spinal Cord Injury
  - Referral guidelines
  - Burns
- Falls
- Stroke
- DKA
- Maternity
- Difficult airway management
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- Women's Health
- Asthma
- Sepsis
- Drug and alcohol
- Anaphylaxis
- Toxicology

High Volume

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High impact

- NPEP
- Gastroenteritis
- Thunderstorm asthma
- Communication
  - Difficult conversation
  - Breaking bad news
- Nursing guidelines
  - RIPERN
- Infection/ Isolation
- Procedural sedation

Additions

- Acute Pain Management
- Pulmonary Embolism
- COPD
- Mental Health
- Renal colic
- Head Injury
- Eyes (eye injury)
- Pneumonia
- Headache/ migraine
- AF
- Syncope/ collapse
- ACP/ end of life
- Febrile neutropenia
- DVT
- Vertigo
- Hyperkalemia
- Hypovolemia
- Family violence
- Paracetomol OD
- UTI
- epistaxis
- Tonsillitis
- First trimester bleeding
- seizure

Not in VEMD top 30. Not a priority according to sector survey responses

Sources

- Victoria (SCV)
- Interstate (Emergency Care Institute, NSW)
- National
- International
  - Emergency medicine
  - Expert professional bodies

Safer Care Victoria | Emergency Care Clinical Network

Existing guidelines assessment tool

Name of guideline:

Source:

1. RELEVANT

Applicability: The guideline is applicable to the emergency care[1] setting. Clinical management options, clinical risks and benefits are mentioned. This guideline is not covered in other areas.

Strongly disagree* ☐	Disagree ☐	Neutral ☐	Agree ☐	Strongly agree ☐

* no further assessment required

Comments:

2. RELIABLE

Guideline Creation: The guidelines were created in consultation with individuals from all relevant professional groups. This was clearly mentioned as were potential conflicts of interest.

Strongly disagree ☐	Disagree ☐	Neutral ☐	Agree ☐	Strongly agree ☐

Comments:

3. VALID

Use of evidence: Systematic methods[2] were used to search for evidence. The quality of evidence was assessed and graded[3]. Good quality evidence was used to support the key recommendations.

Strongly disagree ☐	Disagree ☐	Neutral ☐	Agree ☐	Strongly agree ☐

Comments:

Currency: The guideline was developed in the last five years or is not due to expire in the next year. There is a planned review date or process which is clearly stated.

Strongly disagree ☐	Disagree ☐	Neutral ☐	Agree ☐	Strongly agree ☐

Comments:

4. USABLE

Presentation: The key recommendations are:

- summarised in a flow chart or algorithm
- easily identified e.g. summarised in a box, highlighted in bold
- easy to read (unambiguous, specific) e.g. antibiotics should be prescribed in adults with consolidation on chest x-ray for 10 days
- actionable (available in the emergency care context)

Strongly disagree ☐	Disagree ☐	Neutral ☐	Agree ☐	Strongly agree ☐

Comments:

Findings

- 50 guideline topics were identified as high priority topics
- 12 existing guidelines were endorsed as fit for purpose
- 13 existing guidelines were endorsed pending minor modification
- 7 existing guidelines were reviewed but not endorsed
- Suitable guidelines were not found for 14 topics.

Endorsed guidelines

National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand: Australian Clinical Guidelines for the Management of Acute Coronary Syndromes 2016

Trauma Victoria Major Trauma Guidelines

Victorian Adult Burns Service

- Initial Management of Severe Burns
- Initial Management of Small Burn Injuries
- Victorian State Burns Service Transfer Criteria

Australian Asthma Handbook – Managing Acute Asthma in Clinical Settings

Endorsed guidelines

Therapeutic Guidelines – Antibiotic

- Acute gastroenteritis
- Community-acquired pneumonia

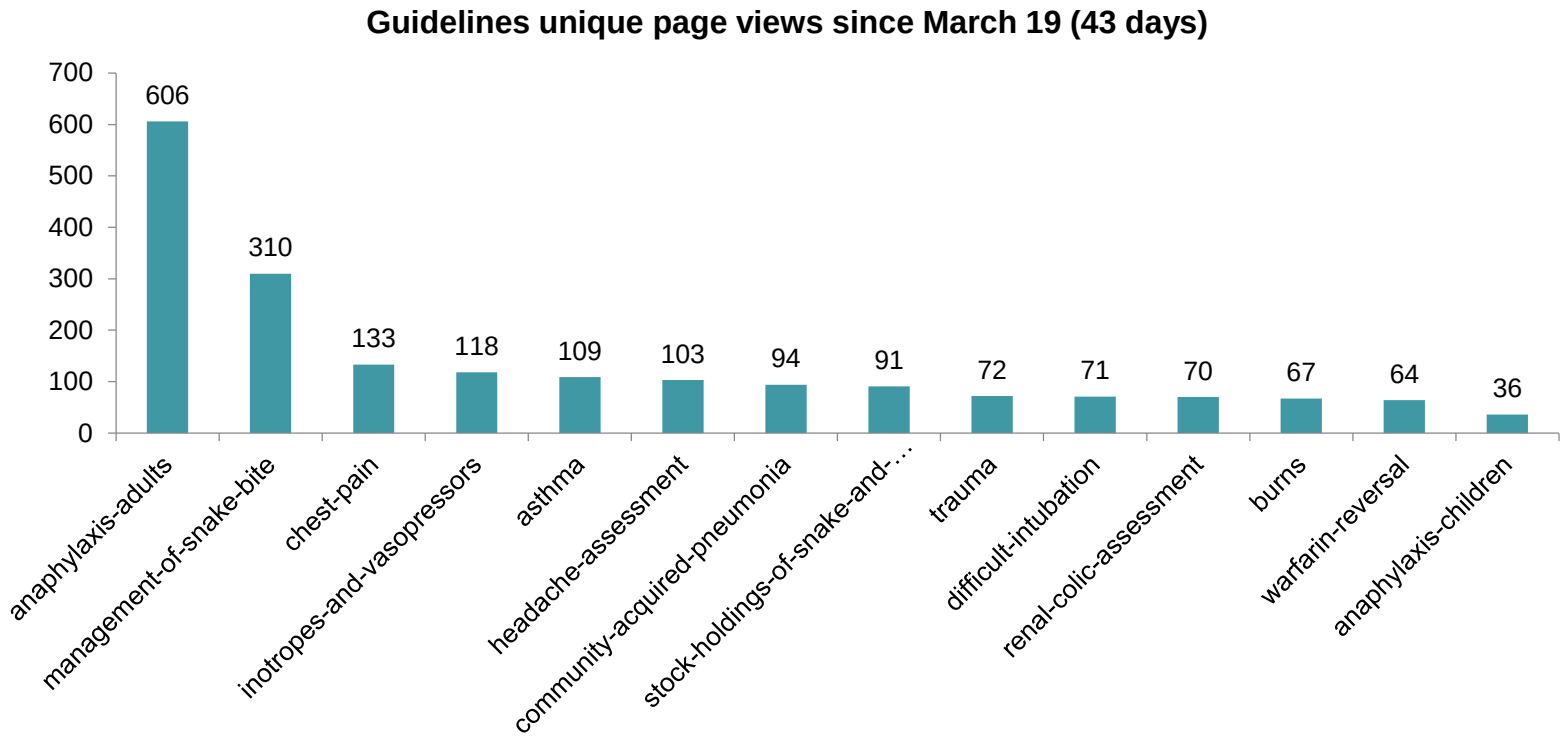
Difficult Airway Society 2015 guidelines for management of unanticipated difficult intubation in adults

Government of Western Australia Diagnostic Imaging Pathways

- Loin pain (Renal colic)
- Headache (Adult)

Australasian Society of Thrombosis and Haemostasis: An Update of Consensus Guidelines for Warfarin Reversal

Website analytics



Phase one recommendations

Maintenance

Evaluation

Work plan, possible options:

- Developing new guidelines ie. Where no appropriate existing guidance is available
- Adapting/adopting existing guidelines ie. Modify existing guidance where it is available
- Implementation pilot project to test and embed a guideline into practice
- Develop key performance indicators to monitor use and translate guideline into clinical practice

Acknowledgements

SCV ECCN leadership team:

- Peter Cameron, Michael Ben-Meir, Thomas Chan, Laura Hewett, Monica Holdsworth

Expert working group

SCV clinician as partners branch

SCV team

Sli.do question

Before today were you aware of the ECCN standardised guidelines for emergency care?

Yes 58%

No 42%

Sli.do question

How did you find out about the ECCN standardised guidelines?

Safer Care Victoria newsletter 14%

Social media, i.e. Twitter, LinkedIn 0%

Email from the ECCN 19%

Via a friend or colleague 22%

Other 4%

I didn't know about them before today 42%

Sli.do question

In progressing work on standardised guidelines, the ECCN should invest in:

Developing new guidelines, i.e. where no appropriate existing guideline is available 43%

Adapting or adopting existing guidelines, i.e. modify existing guidance where it is available 26%

Implementation pilot project to test and embed a guideline into practice 31%

Develop key performance indicators to monitor use and translate guideline into clinical practice 0%

Question time

Chair: Michael Ben-Meir

- Peter Cameron
- Aisling Lim
- Simone O’Brien
- Damian Holden
- Anh Tran

Emergency Care Clinical Network Forum

ECCN priority area: Managing behaviours of concern

Thomas Chan

Chair, Managing behaviours of concern expert working group

Phase One – Planning and scoping

Expert working group formed in August 2018

16 multidisciplinary clinicians and consumers representing 8 public health services across metropolitan, rural and regional areas

Tasked with making recommendations to guide our workplan for optimal emergency care for managing behaviours of concern

Phase One – Planning and scoping

The working group:

- Identified issues regarding the management of behaviours of concern in emergency care
- Reviewed national and international experience with improving models of emergency care for managing behaviours of concern
- Liaised with areas of the Department of Health and Human Services and Safer Care Victoria, such as Drug Policy and the Mental Health Clinical Network, who were working on initiatives or policy related to managing behaviours of concern to identify gaps, opportunities and synergies
- Conducted a sector survey to help in understanding service access for alcohol and other drugs and training requirements for emergency departments and urgent care centres

Phase One – Planning and scoping

The working group:

- Held a consumer focus group to further elicit the consumer perspectives in how to improve the management of behaviours of concern in emergency care
- Made recommendations for the ECCN to pursue to implement best practice management of emergency presentations of the managing behaviours of concern in regards to:
  - Clinical pathways/protocols/guidelines
  - Facility design
  - Staffing and training
  - Referral pathways, access to specialised care and consultations

Phase One – Planning and scoping

The working group:

- Defined behaviours of concern as “patients exhibiting behaviours of concern, or an acute behavioural disturbance, display agitated and/or aggressive behaviour. This puts them at risk of causing harm to themselves or other patients, relatives/visitors or staff.”
- Excluded dementia and delirium in the scope.

Phase One – Recommendations

- The development of a statewide management of acute behavioural disturbance guideline
- Bringing together management of aggression training and facility design resources on the SCV website
- The development of a clinical pathway for patients presenting with behaviours of concern which includes access to specialised referrals and consultations
- The development of guidance around the use of physical restraint in emergency care which aligns the management of duty of care patients with those under the Mental Health Act

Phase Two – Clinical Fellow

James Fowler

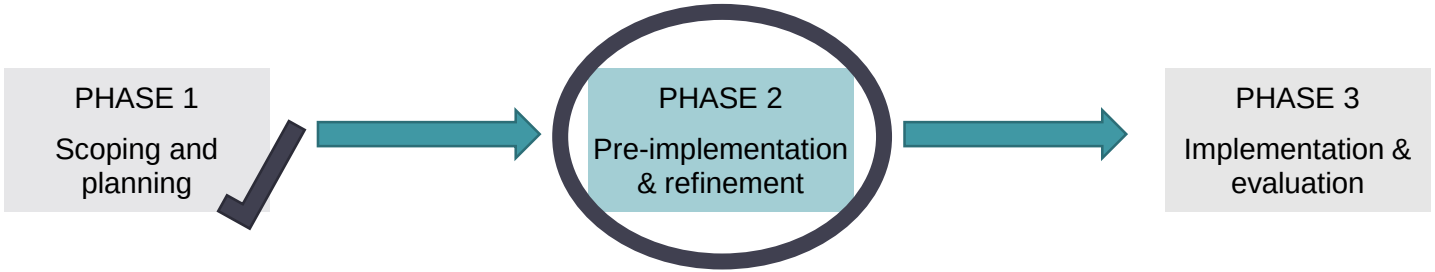
Emergency Nurse / Paramedic from Royal Children's Hospital

12 month clinical fellowship (secondment) to Safer Care Victoria

Will progress the first two recommendations (guideline and website resources)

Commences next Monday

Next steps



- Phase 2 commencing Monday
- Clinical Fellow to lead the project with direction from a working group
- Expressions of interest to be part of the Phase 2 working group to open this month
- Be subscribed to our Clinical Network Newsletter for opportunities to be involved

Emergency Care Clinical Network Forum

Update from Insight committee

Thomas Chan
Chair, ECCN Insight committee

Purpose of Insight

1. Provide expert to governance committee and to health department and other agencies
2. Build network collaborations with consumers, clinical networks, professional associations
3. Act as conduit to allow members to access and engage with data
4. Build partnership between Clinical network and Victorian Agency for Health Information

1. Expert advisory group
2. Collaboration
3. Conduit of Information
4. Build partnership with VAHI

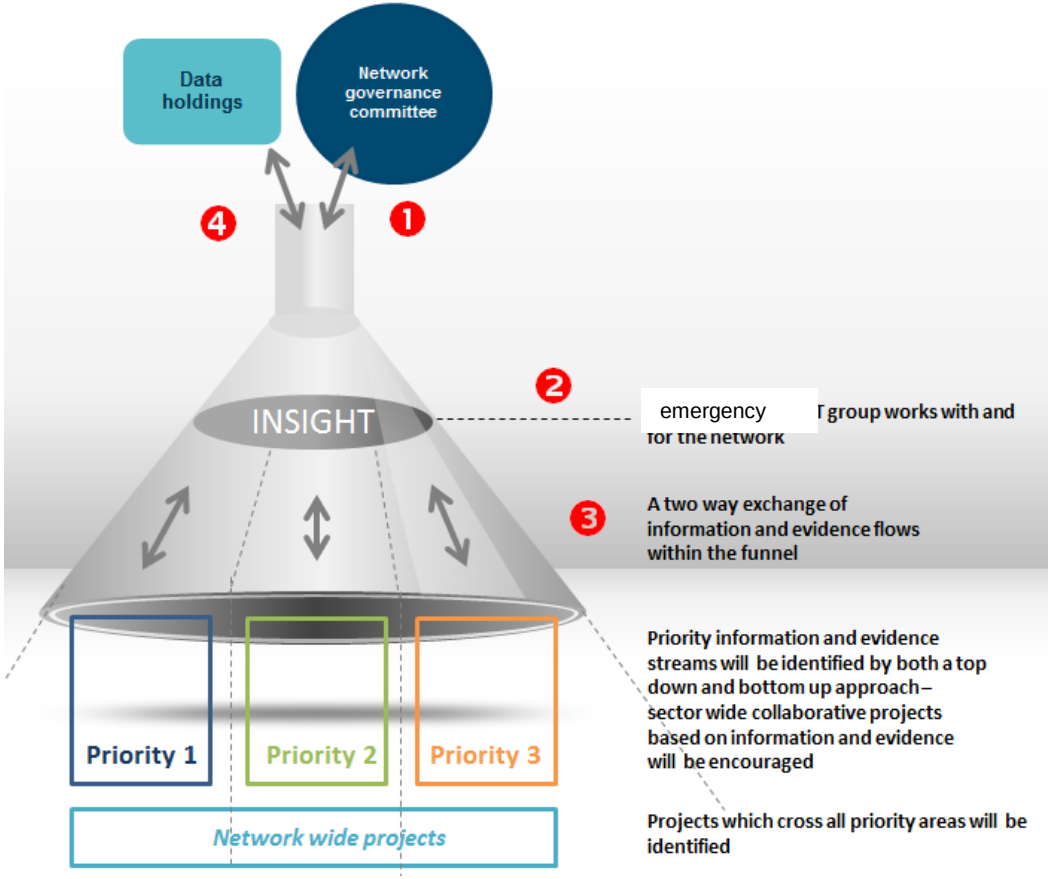


Figure 1: Schematic representation of the four main purposes of the Emergency Care INSIGHT group

Key Domains of Work

- Access and Monitor Range of data sources to provide recommendations regarding improvement projects
- Define and evaluate key set of quality and safety outcome measures for sector*
- Survey to identify capability*
- Work with VAHI and Department to develop an accessible dashboard for members

Quality Indicator Working Group

Analgesia

Diagnostic Error

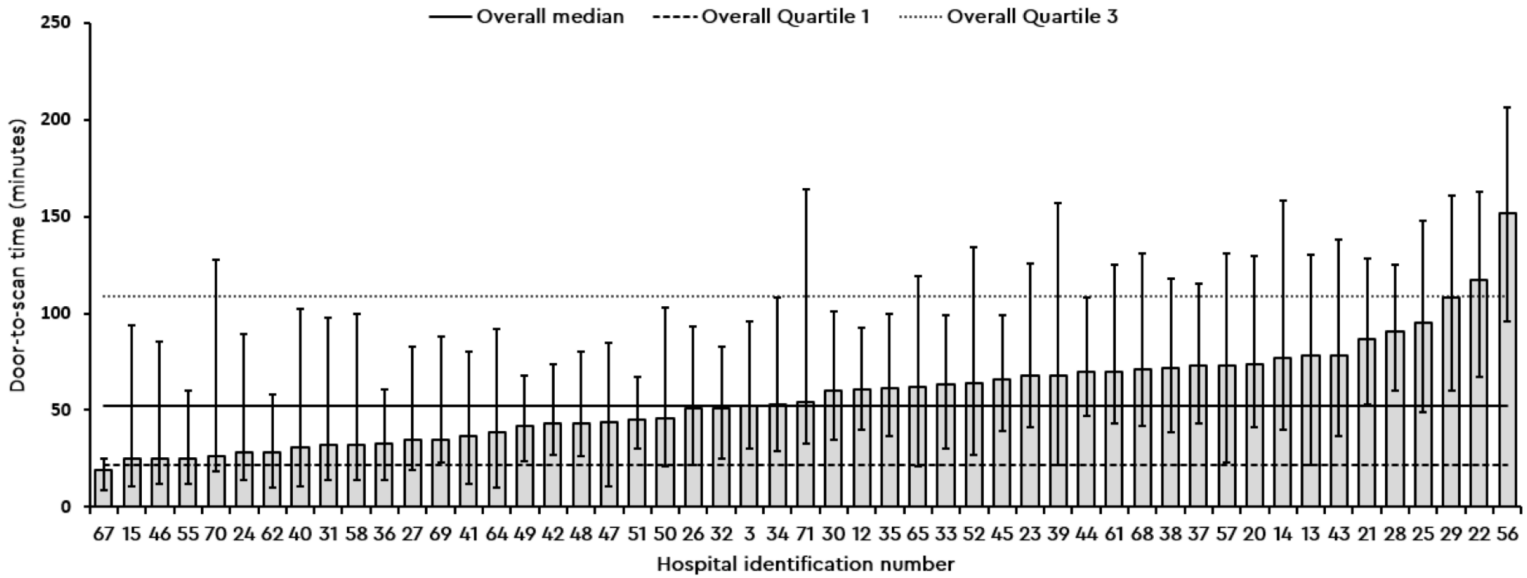
STEMI (Victorian Cardiac Outcome Registry)

Stroke (Australian Stroke Clinical Registry)

Sepsis

AuSCR- MEDIAN DOOR TO SCAN

FIGURE 9: MEDIAN DOOR-TO-SCAN TIME, BY HOSPITAL



Data for cases where a scan was provided after 270 minutes of arrival are excluded

Hospitals with fewer than 10 cases with door-to-scan times are excluded

Number of cases with door-to-scan times by hospital range from 14 to 648

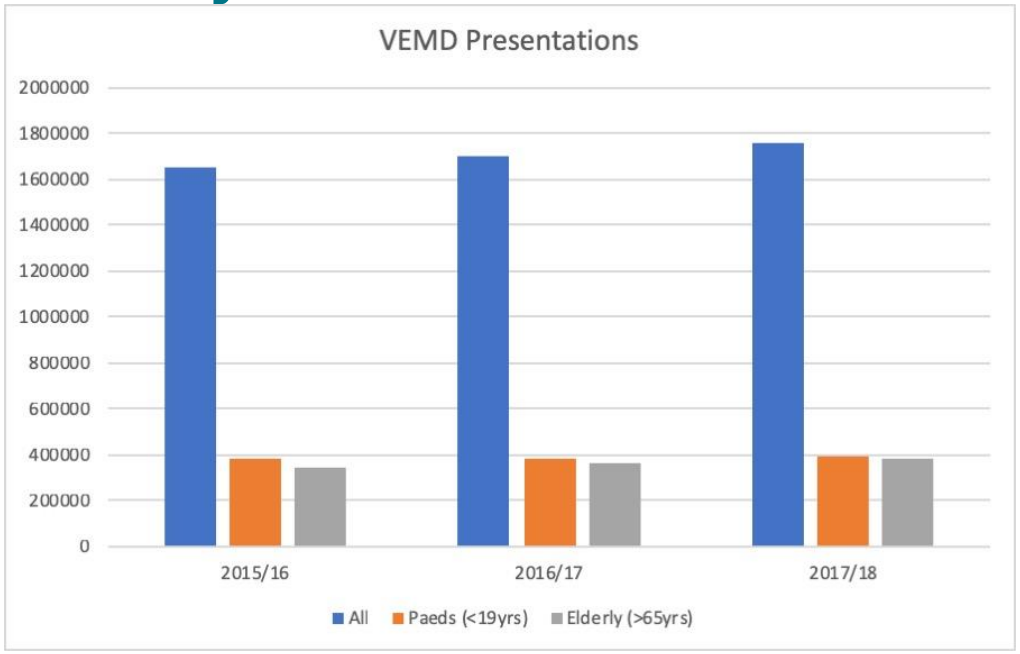
MONITORING ACROSS QUALITY DOMAINS

SAFETY	PATIENT EXPERIENCE ENGAGEMENT	CLINICAL CARE	ACTIVITY	ACCESS	STAFF EXPERIENCE ENGAGEMENT
MORTALITY	PREM	KEY INDICATORS	AV	ACCESS TARGET	PEOPLE MATTERS SURVEY
CRITICAL INCIDENTS	PROM	CLINICAL PROJECTS Eg SEPSIS	PRESENTATIONS	TIME TO ADMISSION	STAFF TRAINING
UNPLANNED READMISSIONS		ANTIBIOTIC STEWARDSHIP	ADMISSIONS	OCCUPANCY	
			PAED/ ADULT/ ELDERLY	EXIT BLOCK	
			DIAGNOSTIC GROUPS	AV OFFLOAD	

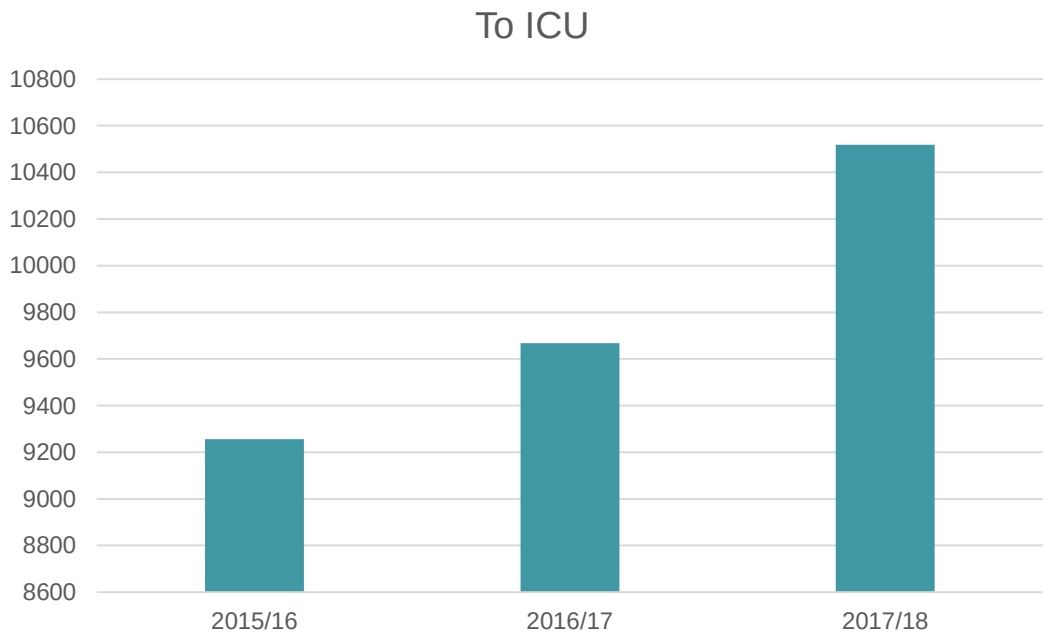
USING and INTEGRATING CURRENT DATA SOURCES

SAFETY	PATIENT EXPERIENCE ENGAGEMENT	CLINICAL CARE	ACTIVITY	ACCESS	STAFF EXPERIENCE ENGAGEMENT
Coroners Incident Monitoring (VHIMS) -Critical Incidents Victorian Admitted Episode Dataset (VAED) Victorian Managed Insurance Authority (VMIA)	Victorian Health Experience Survey (VHES)	Cardiac Outcome Registry (VCOR) Australian Stroke Registry (AuSCR) Audits Eg SEPSIS	Victorian Emergency Minimum Dataset (VEMD) PRISM REPORT AV Victorian State Trauma Registry (VSTR)	Integrated Service Monitoring (PRISM) Victorian Admitted Episode Dataset (VAED)	People Matters Survey

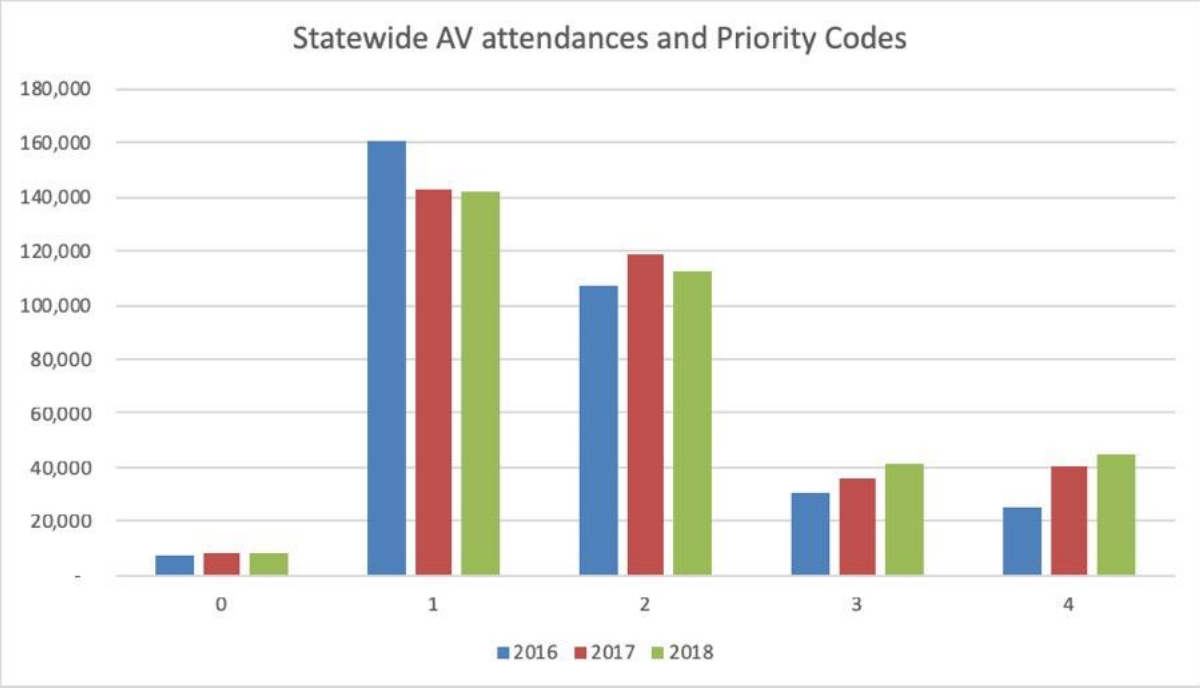
VEMD Presentations Aggregate
All/ Paed/ Elderly



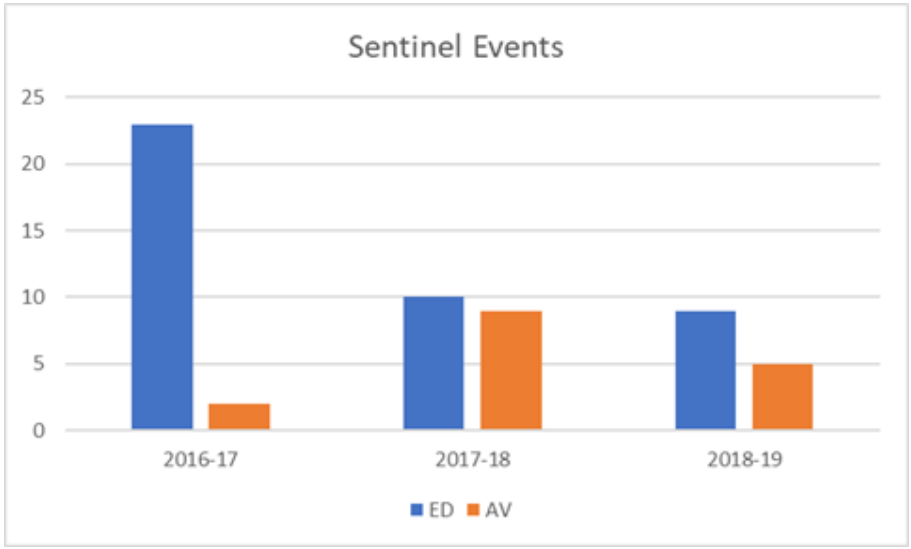
VAED ICU admissions Aggregate



AV- Priority Codes

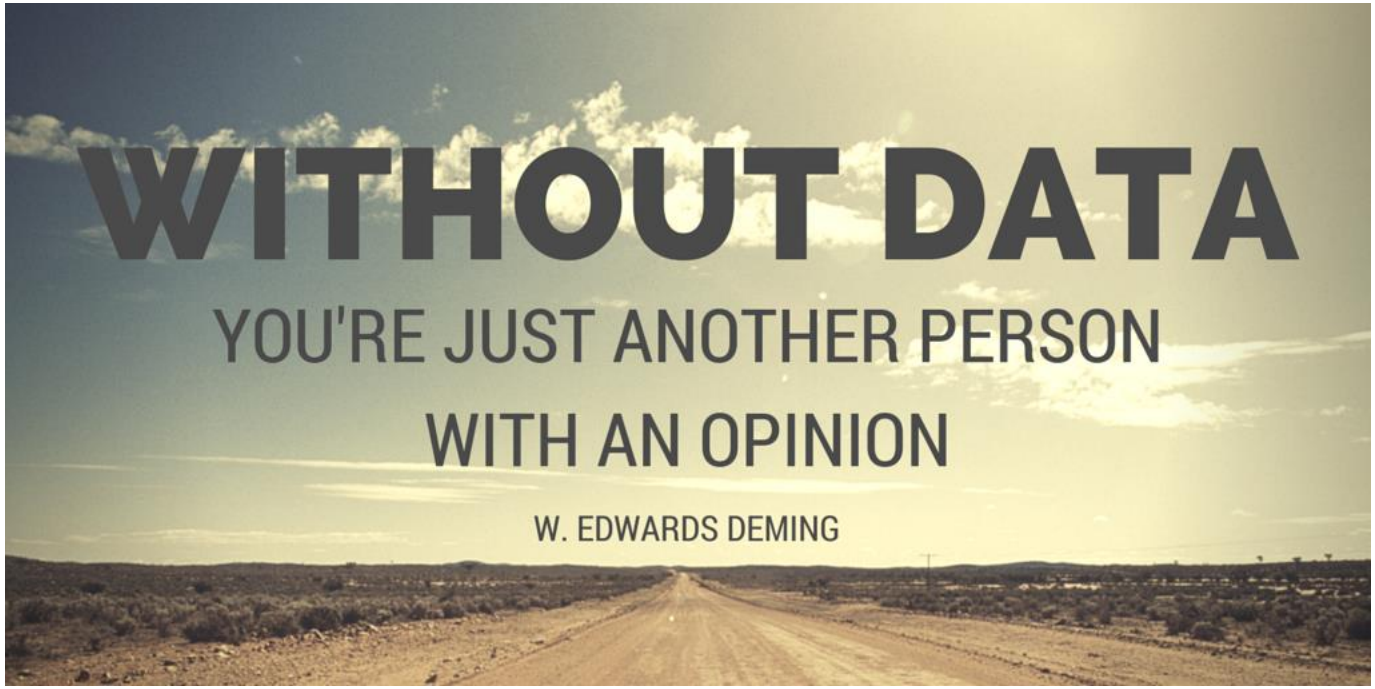


Sentinel Event Data- ED/UCC and AV



5 due to Medication error

27 due to Other


WITHOUT DATA
YOU'RE JUST ANOTHER PERSON
WITH AN OPINION
W. EDWARDS DEMING

Acknowledgements

Members of Insight Committee and Working groups

Laura Hewett

Monica Holdsworth

Aisling Lim

VAHI and Data Agencies

Emergency Care Clinical Network Forum

Emergency care survey

Understanding Emergency and Urgent Care in Victoria

Mark Putland

ECCN Insight committee member

Why?

Devolved governance of Victorian Health Services

Lack of understanding of what capacity exists

Need to understand the sector in order to serve it

What?

What services?

- Emergency departments of all sizes, urgent care centres, ambulance

What info?

- Physical size, equipment, staffing, workload, governance
- What’s behind it?

How?

Prefill as much as possible with “what we think we know about your service”

Depends on data sharing and privacy considerations

Start small

Let survey respondents guide iterations of the survey

URGENT CARE CENTRES

Contact details of person completing this survey

Name:	
Email:	
Contact number:	

PART 1

Hospital name:	Prefill
Hospital DMS name and email:	
Hospital DON name and email:	
UCC NUM name and email:	

Casemix

If this data is not available at your site, mark N/A in the appropriate box

	Total	Adults	Paediatrics (≤15yo)
Patient attendances			
ATS 1 attendances			
ATS 2 attendances			
ATS 3 attendances			
ATS 4 attendances			
ATS 5 attendances			
Number of ambulance arrivals			
Inpatient admissions to your hospital from the UCC			
Did not wait			
Dead on arrival			
Died in UCC			
Transferred to another health service			

Prefill from AIMs/RAHDaR for UCCs where available

Infrastructure

	Number		Number
Total UCC beds/bays		Specific: Short stay beds	
Specific: Resuscitation beds/bays		Specific: Paediatric beds/bays	
Specific: Monitored beds/bays			

Specialty services (including GP specialists)

	Onsite: Y/N	If available, when?
Anaesthetics		
Obstetrics		
Other (specify):		

PART 2

Other services

	Equipment Y/N:	Radiographer working hours	On call working hours
Diagnostic ultrasound availability on site			
X-ray availability on site			
CT scan availability on site			

	Y/N:		Y/N:
Point of care ultrasound available		Clinician radiography available (ie. Nurse or doctor)	

	Y/N:		
Laboratory pathology availability off site		Turn around time for results	
Laboratory pathology availability on site		Working hours	

	Y/N:		Y/N:
Point of care testing available for troponin		Point of care testing available for lactate	
Point of care testing available for haemoglobin		Point of care testing available for blood gas	

Workforce

Medical

	Y/N:	Comments ie. Specific model, variations to service, frequency of gaps in the roster
GP available M-F in hours		
GP available (on call) M-F after hours		
GP available weekends in hours		
GP available (on call) weekends after hours		
Other medical staffing ie. Junior doctors, FACEMs. FACEM trainees (specify model/positions M-F, weekends, in hours and after hours)		

Nursing

	EFT	Comments
Nurse practitioners		
Nurses with emergency or critical care certificates		
RIPERN		
Registered nurses		

	Y/N:		Y/N:
The nurses are based in the UCC		The nurses attend to the UCC from the ward as required	

Allied health/pharmacy

Do you have access to allied health or pharmacy in the UCC?	
Which disciplines?	
How often?	

Paramedicine

Is the ambulance station co-located?	

Security

	Y/N:		
Available onsite		Working hours	
Available offsite		Working hours	
Other model (please specify) ie local police:			

Clinical governance

Do you hold an M&M?		Is it held at a hospital level or regional level? (specify)	
How often?		Do you have UCC representation on a hospital or region quality and safety committee? (specify)	
Are minutes taken and distributed to staff?			

Telehealth

			Y/N:
Do you receive a telehealth support service from another health service (or equivalent)?			
Service (specify):			
Patient cohort(s):		Frequency of use*:	
Service (specify):			
Patient cohort(s):		Frequency of use*:	
Service (specify):			
Patient cohort(s):		Frequency of use*:	
Service (specify):			
Patient cohort(s):		Frequency of use*:	
Service (specify):			
Patient cohort(s):		Frequency of use*:	
Service (specify):			
Patient cohort(s):		Frequency of use*:	

*Daily, weekly, monthly, rarely or never

Policy/pathway/procedure

	Y/N:
Do you have an UCC sepsis pathway?	
Do you use a medication book (or similar) for paediatric medication dosing?	
Do you use the VicTOR UCC observation charts?	

What will we do with it?

Hoard it centrally?

Make your own data available to you?

Make anonymised data available for benchmarking (health round table style)?

Make all the data available to all services?

Data for researchers?

How will it help?

Development of referral networks

Resourcing

Policy

Why not? Is it just adding burden?

Accreditors

Australian College of Emergency Medicine

Royal Australian College of Surgeons

Own executive

Victorian Emergency Minimum Dataset (VEMD)

Victorian Admitted Episodes Dataset (VAED)

Proposed ECCN survey

Emergency Departments (per service)	Urgent Care Centres (per service)	Ambulance Victoria (per region)
Casemix (ie. Attendances, disposition, adults and paediatrics)	**Casemix** (ie. Attendances, disposition, adults and paediatrics)	**Casemix** (ie. Road incidents, adults and paediatrics, transfers, retrivals)
Infrastructure (ie. Beds, chairs)	**Infrastructure** (ie. Beds)	**Infrastructure** (ie. Branches, ambulances)
Specialty services (ie. Onsite versus visiting)	**Specialty services** (ie. GP specialists)	**Workforce** (ie. Paramedic, first responders, bush nursing)
Other services (ie. Radiology, pathology)	**Other services** (ie. Ultrasound, X-ray, CT scan, pathology, point of care testing)	**Clinical governance**
Workforce (ie. Medical, nursing, allied health/pharmacy, mental health, alcohol & other drugs, security)	**Workforce** (ie. Medical, nursing, allied health/pharmacy, security)	
Clinical governance	**Clinical governance**	
Policy/procedure	**Policy/procedure**	
Telehealth	**Telehealth**	

Session 2 – Emergency care system

Chair: Kellie Vivekanantham

ECCN Governance committee member

Emergency Care Clinical Network Forum

Managing the emergency care system

Ryan Heath

Acting Director of Commissioning, Performance and Regulation
Department of Health & Human Services

Improving Ambulance Patient Transfer Performance

May 2019

Ryan Heath – A/Director, Commissioning, Performance and Regulation

Health and Wellbeing Division

VICTORIA State Government | Health and Human Services

Ambulance arrivals and growth in ED presentations

This year there has been 1.35 million emergency department presentations, this is up 2.3% on last year (30,122 more patients).

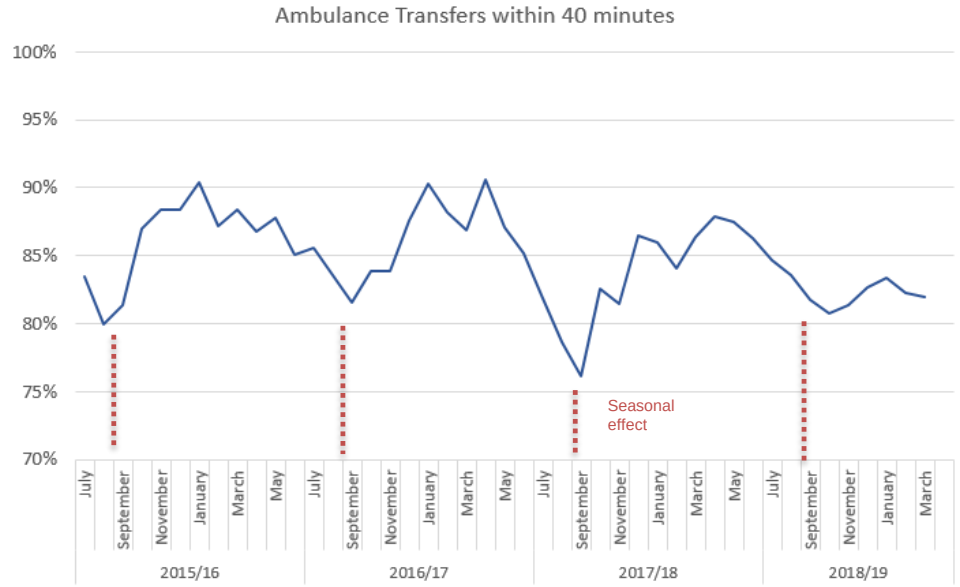
- 83% of this growth are ambulance arrivals (up 7.6% (24,940 more patients)
- 63% of ambulance arrivals go on to be admitted, 75% are CAT1-3.

Arrival Method	Admitted	Did Not Wait	Non-admitted
Ambulance	63%	3%	34%
Other	28%	6%	66%

- Admitted patients on average spend 2 hours longer within the ED
- CAT1-3 patients on average spend 1.5 hours longer within the ED

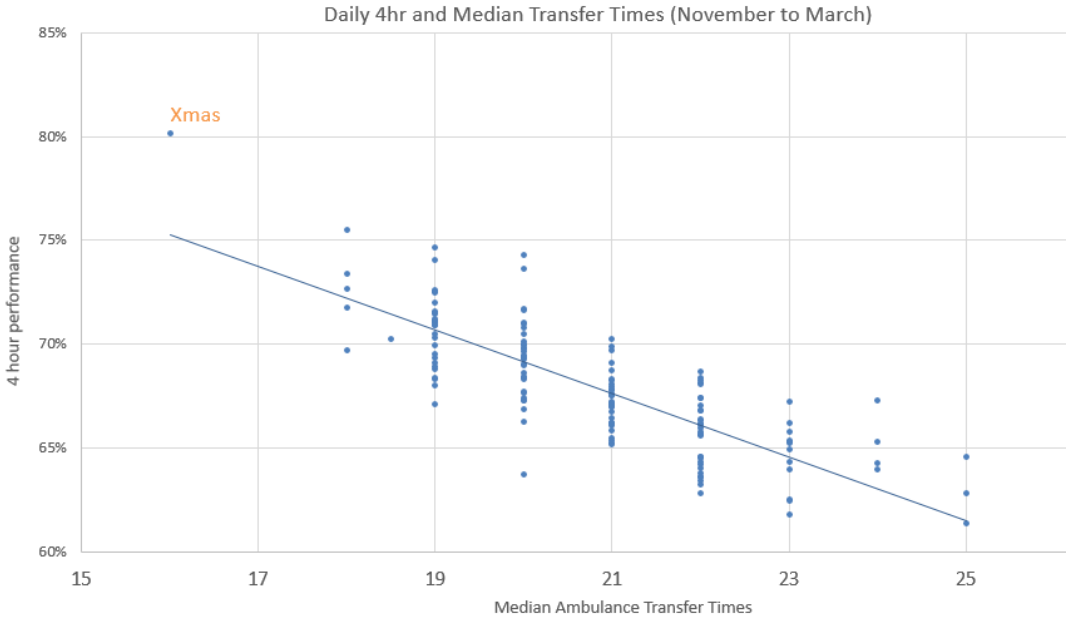
Ambulance patient transfer performance

Percentage of ambulance transfers within 40 min (YTD March)				
2015/16	2016/17	2017/18	2018/19	Target
86.0%	85.7%	82.6%	82.5%	90%



ED demand & ambulance transfer times correlate

- A patient stays in the ED is determined early in the patient journey.
- Short transfer times are accompanied by short ED lengths of stay



Improving Ambulance Patient Transfer Roundtable

Aim:

Develop an improvement plan for ambulance patient transfer performance

Outcomes:

1. Re-focus recommendations from the 2013 Ambulance Transfer Taskforce
2. Transparency of real time diversion status data
3. Discussion at Council of Board Chairs
4. Establish Departmental Ambulance Patient Transfer Taskforce

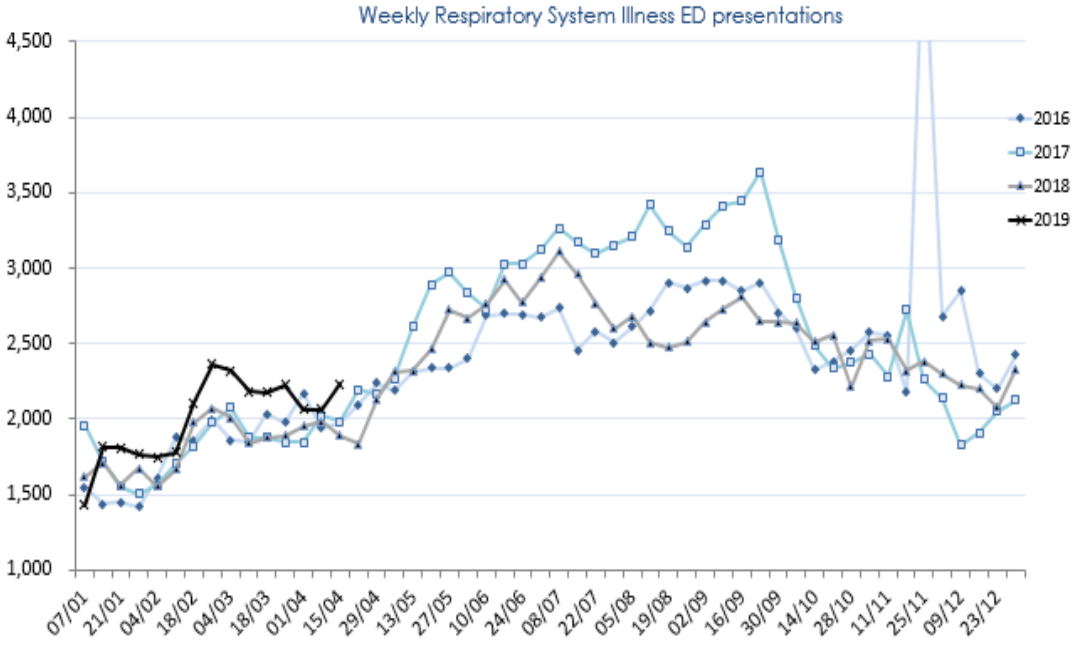
Proposed system actions

- **Refreshed transfer standards and expectation setting**
- **Health services /Better Care Victoria partnership on patient flow**
- **Locally driven improvements**
- **Progression of Care Maturity index**

- Performance improvement plans for campuses falling below a threshold, e.g. 80%
- Focus on flow – greater emphasis on whole of hospital solutions and reducing known bottlenecks (eg Mondays)
- Guidelines /sharing of best practice on nursing workforce roles
- Improvement network – linking health services and supporting peer review

Winter 2019

- Presentations for respiratory illness (flu) in quarter 3 are the highest since 2011.



Discussion:

Sli.do

Are you aware of the department's guidelines on

- **Ambulance presentations to the ED**

Yes 39% No 61%

- **Annual winter guidelines?**

Yes 19% No 81%

Discussion:

Sli.do

Are you aware of your hospitals winter plan? Are you a part of any winter oversight structure?

I am aware of our winter plan 28%

I am aware of our winter plan and I am part of my hospital's oversight structure 10%

I am not aware of the winter plan or any oversight structures 62%

Discussion:

Sli.do

What are some immediate priorities for the department in terms of strategies to support hospitals?

Support sector collaboration and engagement, e.g. set up a sector forum 24%

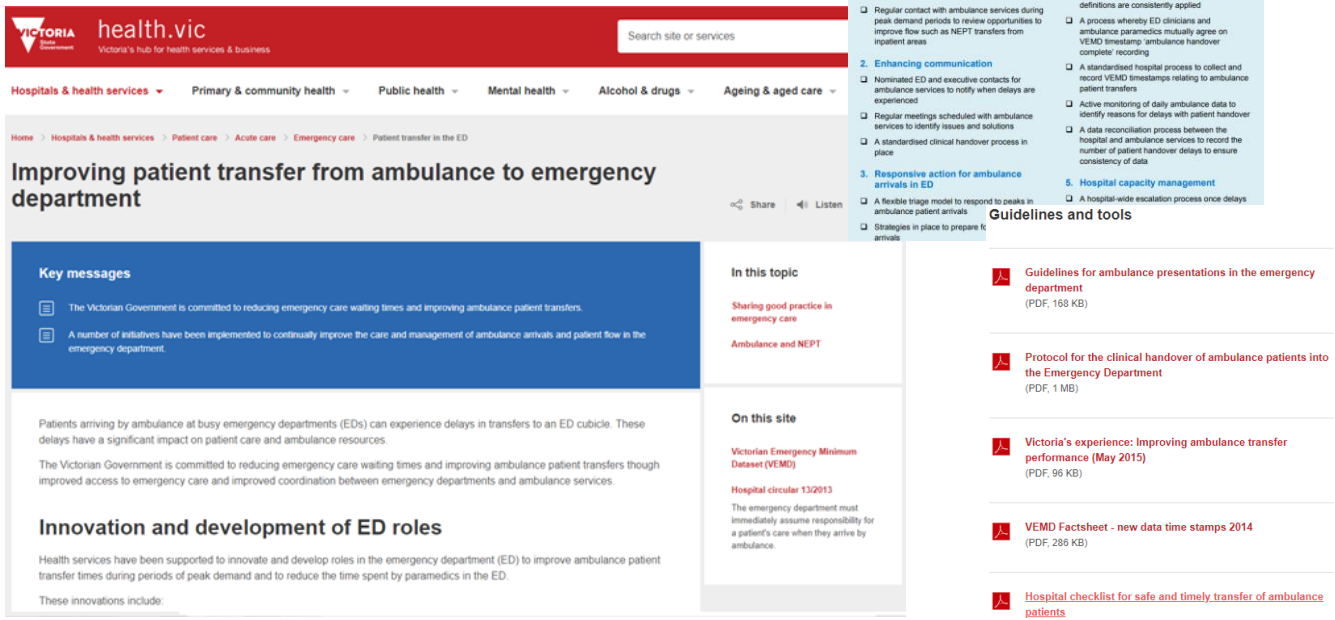
Develop and disseminate best practice information 51%

Provide greater direction on key priorities 18%

Increased reporting and oversight 7%

Resources

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/emergency-care/patient-transfer



Guidelines and tools

- Guidelines for ambulance presentations in the emergency department (PDF, 168 KB)
- Protocol for the clinical handover of ambulance patients into the Emergency Department (PDF, 1 MB)
- Victoria's experience: Improving ambulance transfer performance (May 2015) (PDF, 96 KB)
- VEMD Factsheet - new data time stamps 2014 (PDF, 286 KB)
- Hospital checklist for safe and timely transfer of ambulance patients (PDF, 188 KB)

Emergency Care Clinical Network Forum

Emergency care capability framework

Katy Fielding
Assistant Director, Health Services Policy
Department of Health and Human Services

Sli.do question

Have you seen the latest draft of the urgent, emergency and trauma care capability framework?

Yes 26%

No 74%

Urgent, emergency and trauma care capability framework

ECCN Forum
2 May 2019

VICTORIA State Government | Health and Human Services

Capability frameworks

Drafts of:

- Cardiac care
- Renal care
- Surgical and procedural care
- **Urgent, emergency and trauma care**

System planning

Statewide Service and Infrastructure Plan for the Victorian health system:

A series of supporting design, service and infrastructure plans for the major service streams within the health system, such as cardiac, emergency care, stroke and surgery services.

Targeting Zero (Recommendation 2.12.2)

Within three years, the department has expanded its capability frameworks to cover all major areas of hospital clinical practice, be monitoring adherence to them (across public and private hospitals) and sharing information on adherence with hospitals and boards

Capability frameworks

Primarily system planning tools but also contribute to a system of good governance to support the quality and safety of health care. They:

- support a transparent approach to planning and service development at local, regional and system levels
- provide a common language and understanding of clinical services capability for the community and for health service providers, and
- facilitate improved service alignment and linkages between healthcare providers.

Capability frameworks

In Victoria, capability frameworks describe what **should be** in place (not what is currently in place). They comprise:

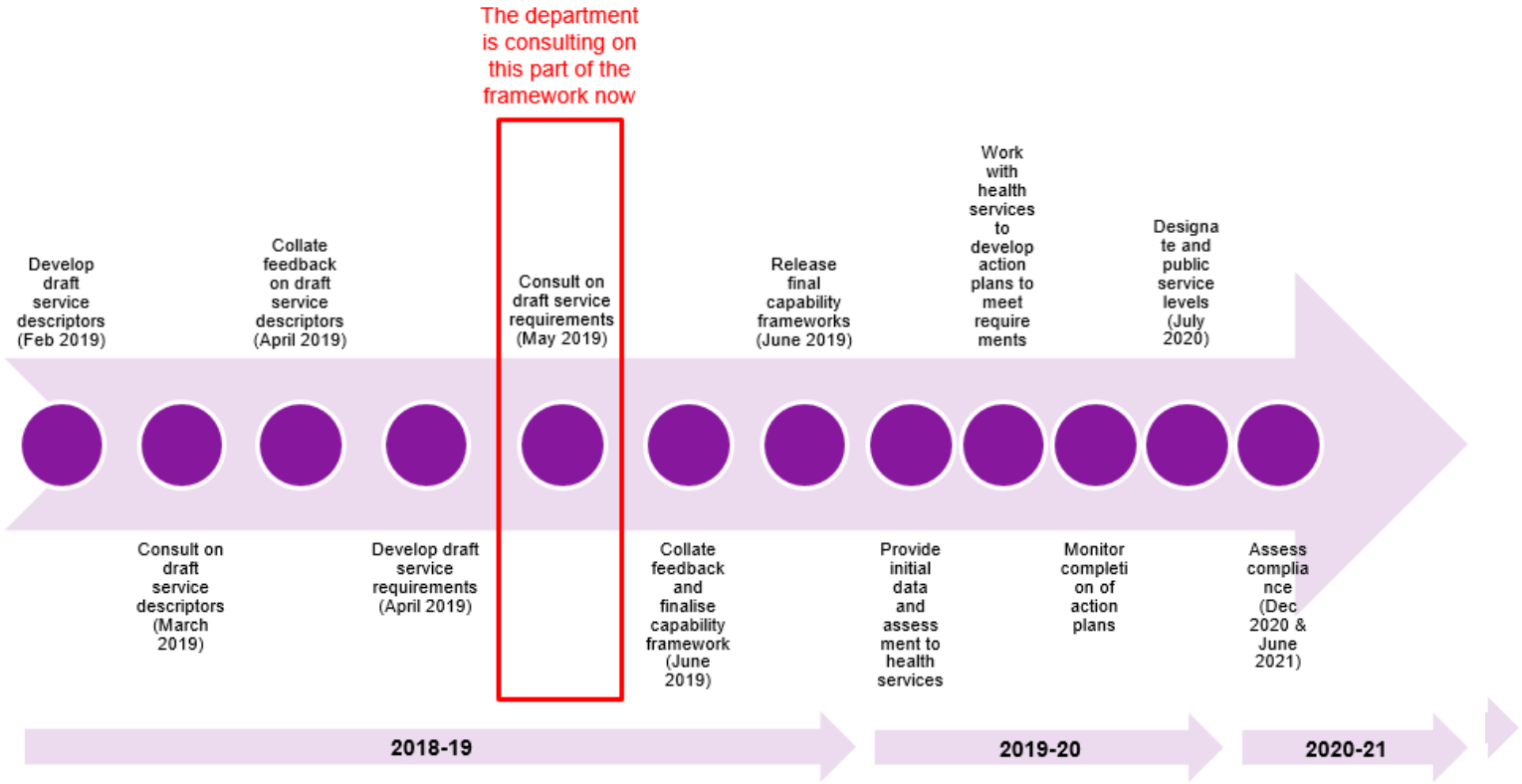
1. service level descriptors – what a health service does
2. service requirements – what it needs to do that

Using the principle of ***form follows function:***

- First develop service level descriptors – that is, broad statements that describe the scope of services and complexity that health services will provide at each of the six levels of service complexity
- Then work on the detail of the service requirements – the underpinning skills, equipment, clinical supports and clinical governance needed.

Scope: Public and privates, direct clinical aspects, continuum of care and of the service system.

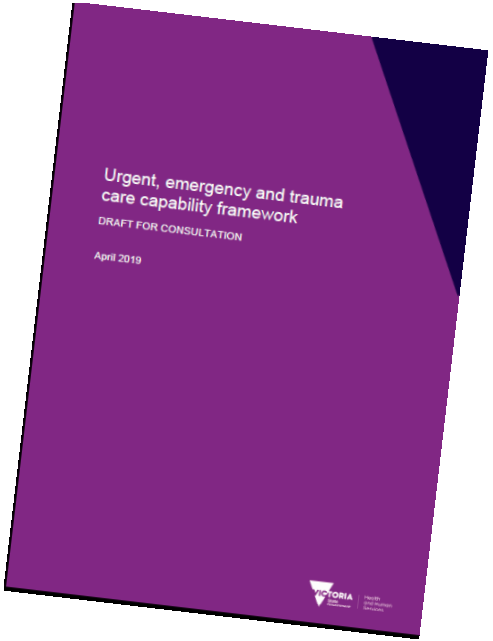
Development and implementation process



Where are we now?

Consultation is open until **20 May 2019**.

Send feedback to:
emergencyandtrauma@dhhs.vic.gov.au



Question time

Chair: Kellie Vivekanantham

- Ryan Heath
- Katy Fielding

Emergency Care Clinical Network Forum

My Health Record

Andrew Hugman

Clinical lead, My Health Record in emergency departments project
Australian Commission on Safety and Quality in Health Care

Sli.do question

For clinicians who work in an urgent care centre or emergency department, have you accessed the My Health Record for any of your patients?

Yes 9%

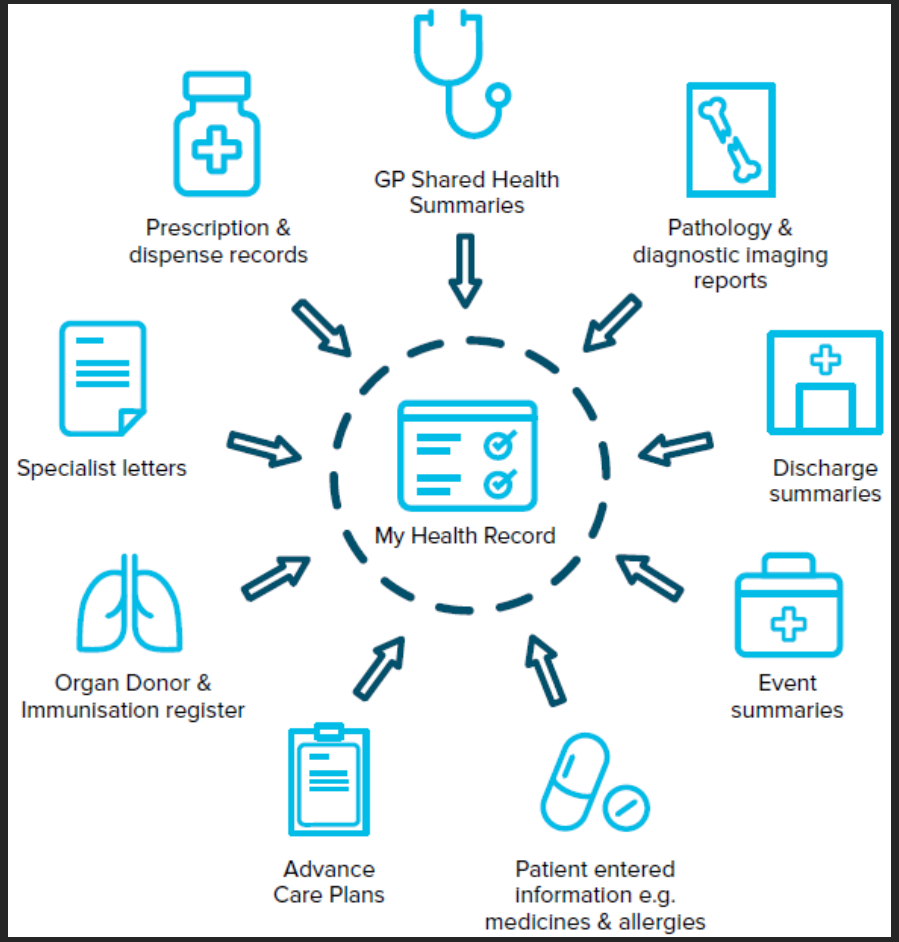
No 91%

My Health Record in Emergency Departments

Emergency Care Clinical Network Forum | 2 May 2019

My Health Record

is a secure, online collection of information from different health care providers and settings



Specialist Letter
25 Aug 2012

Frank **HARDING** DoB 4 Oct 1949 (64y) SEX Male IHI 8003 6086 6670 1594

START OF DOCUMENT

Bay Hill Hospital

Author Dr Jane Anderson (General Medical Practitioner)
Phone (07) 45754566

Response Details

Response Narrative

Thank you for referring Mr Harding, a 64 year old male to me for consideration of a cholecystectomy due to RUQ pain, reported gall stones, abnormal LFTs. I have placed his name on the waiting list at the Bay Hill Hospital and will send a report once the procedures are done.

Response Details

Procedures	Diagnoses	Other Diagnoses
	• Calculus of gallbladder without mention of cholecystitis	

Recommendations

Recommendations

Time frame	Recommendation	Addressee	Address / Contact
25 Aug 2012 - 8 Sep 2012	Determined hospitalisation is needed.		Residential:1 Australia lane, North Adelaide, SA, 5006, Australia Phone: (07)30238400

Medications

Reviewed Medications - Medications

Medication	Directions	Clinical Indication	Change Type	Change or Recommendation?	Change Description	Change Reason
Tritace 10mg, capsule, 30 capsules	Take 2 tablet daily, oral	Hypertension	Changed	The change has been made.	Increase dosage from one tablet daily to two tablets daily	Worsening symptoms

Diagnostic Investigations

This section may contain the following subsections Pathology Test Result, Imaging Examination Result and Requested Service(s).

Imaging Examination Result (Diagnostic Investigations > **Imaging Examination Result**)

Imaging Examination Result Date Time

13 Sep 2011 07:33+1000

Anatomical Site(s)

Australian Government

Australian Digital Health Agency

My Health Record

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Records

Connections

Application

Records

Connections

Application

Single sign-on

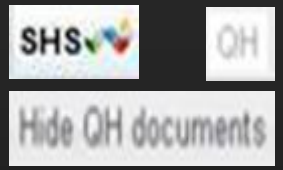
Seamless access between ED CIS and MHR

Flags / visual cues

Icons on the ‘patient list’ (main EMR screen)

Source markers

Show / hide MHR docs. in that are in the EMR

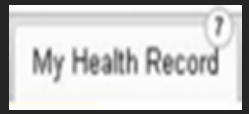


Inconsistent titles

PCEHRs, eHealth Records

Document badge

Display total number of documents, per type



Browser version

Interface display affected by browser compatibility

PROJECTS

- My Health Record in Emergency Departments
- Awareness (Guide & Roadshows)
- Transitions of Care

PROJECTS

My Health Record in Emergency Departments

Awareness (Guide & Roadshows)

Transitions of Care

PROJECTS

My Health Record in Emergency Departments

Awareness (Guide & Roadshows)

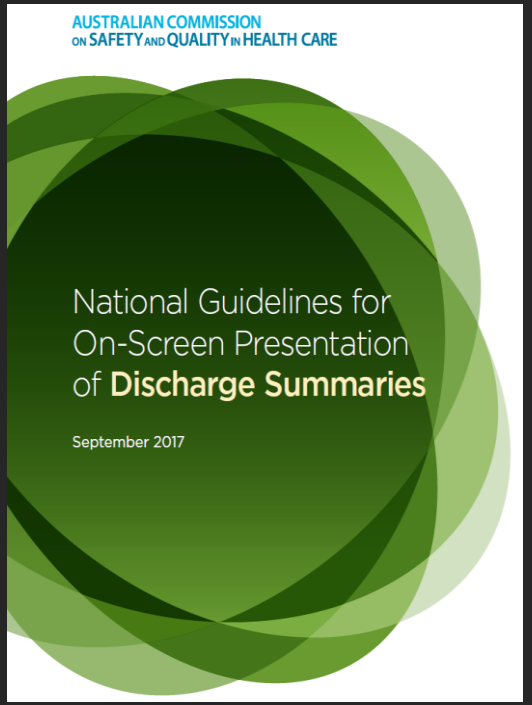
Transitions of Care

PROJECTS

My Health Record in Emergency Departments

Awareness (Guide & Roadshows)

Transitions of Care



My Health Record in EDs

- Workflows
- High-yielding patients
- EMR features that supports use
- Effects on ED KPIs
- Role of patients & carers

3 Points of View

Questionnair

Surveys & Use-Cases

ED & MHR Data

Pilot Sites

Orion

HealtheNet

Cerner FirstNet

The Viewer

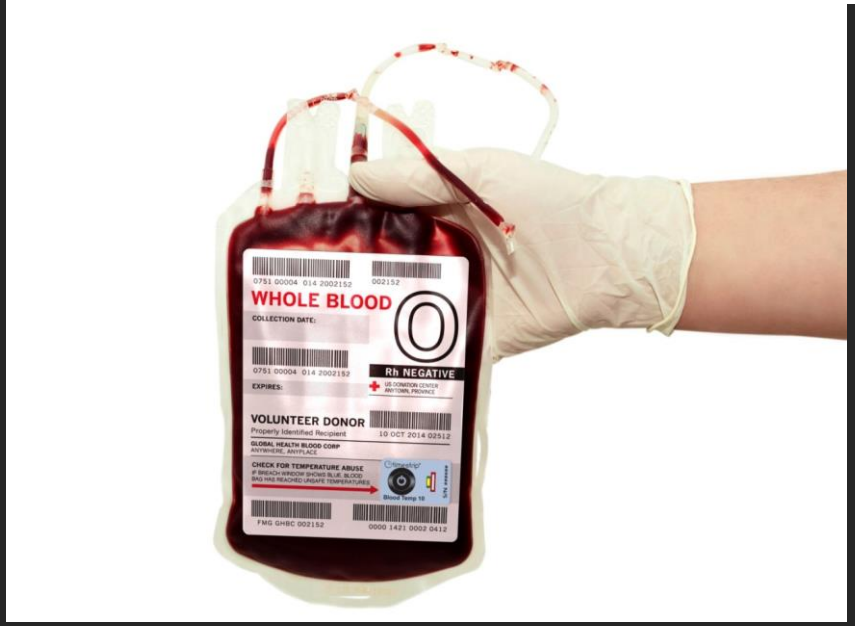
Epic

Epic

EDIS

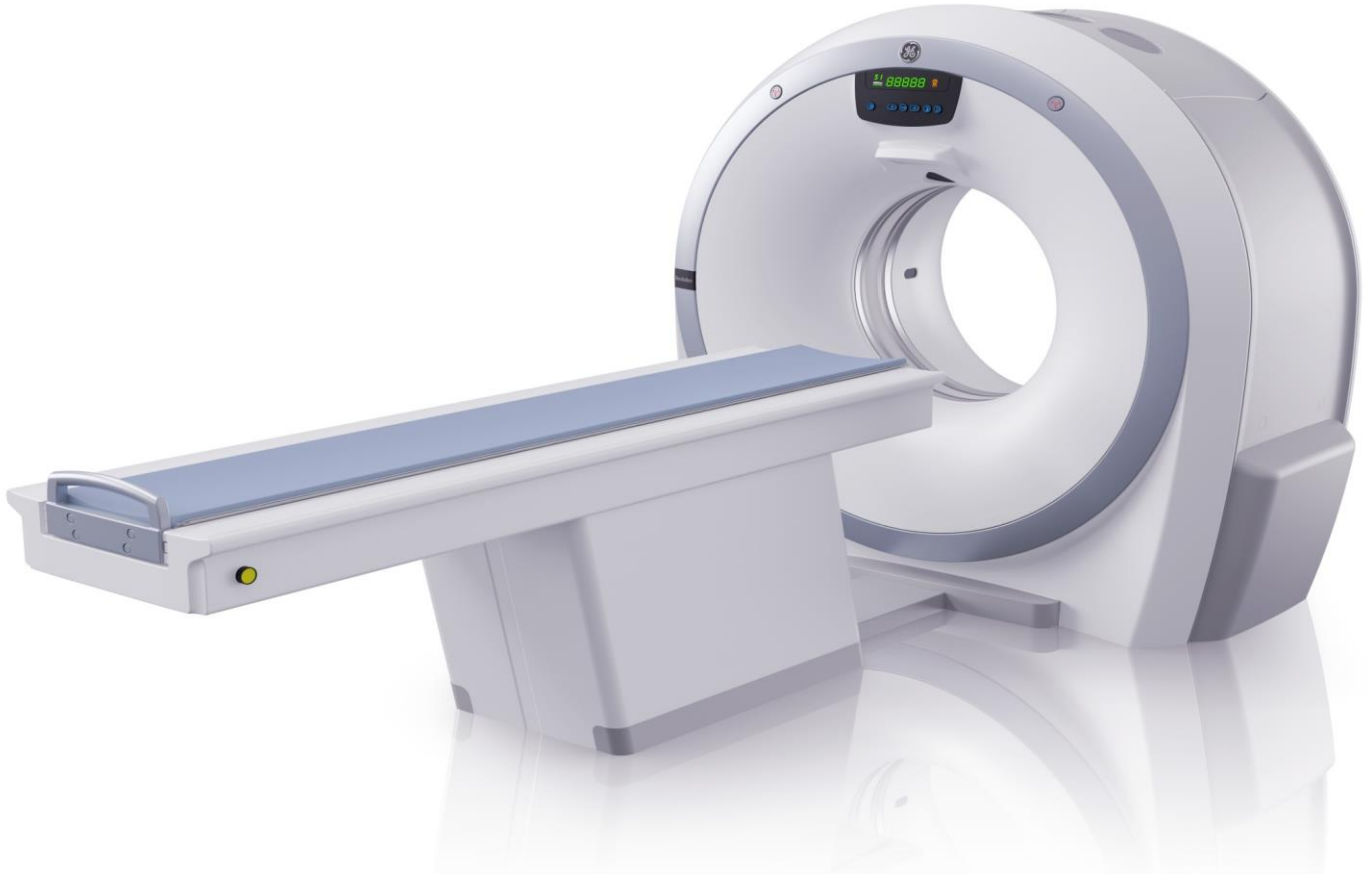
HIPS

Access to patient history



Improved medication management

Avoid duplication of tests



As a clinician

As a patient or carer

MJA

LOGIN

ONLINE FIRST CURRENT ISSUE ARCHIVE PODCASTS CAREERS ARTICLE TYPES FOR AUTHORS SEARCH

EXPANDING THE EVIDENCE BASE IN DIGITAL HEALTH

VOLUME 210 / ISSUE 6 SUPPL

Towards routine use of national electronic health records in Australian emergency departments

Paul Miles, Andrew Hugman, Angela Ryan, Fiona Landgren and Grace Liong

Med J Aust 2019; 210 (6): S7-S9. || doi: 10.5694/mja2.50033

Published online: 31 March 2019

andrew.hugman@safetyandquality.gov.au

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Emergency Care Clinical Network Forum

Safewards

Marisol Corrales
Project manager
Safewards

Ashleigh Ryan
Project officer
Safewards

Kate Bendall
Project officer
Safewards

Safewards Victoria

Can Safewards do for ED what it has done for Mental Health inpatient units?

Marisol Corrales, Office of the Chief Mental Health Nurse, DHHS
Ashleigh Ryan, Peninsula Health
Kate Bendall, Peninsula Health

vmia Risk Management and Insurance
VICTORIA State Government | Health and Human Services

Safewards background

What is Safewards?

- Developed in the UK
- Research-based
- 6 Originating domains, 10 interventions

Why Safewards?

- Service interest
- VMIA interest
- 14.6% reduction in conflict
- 23.6% reduction in containment events
- 36% reduction in seclusion events (Vic)

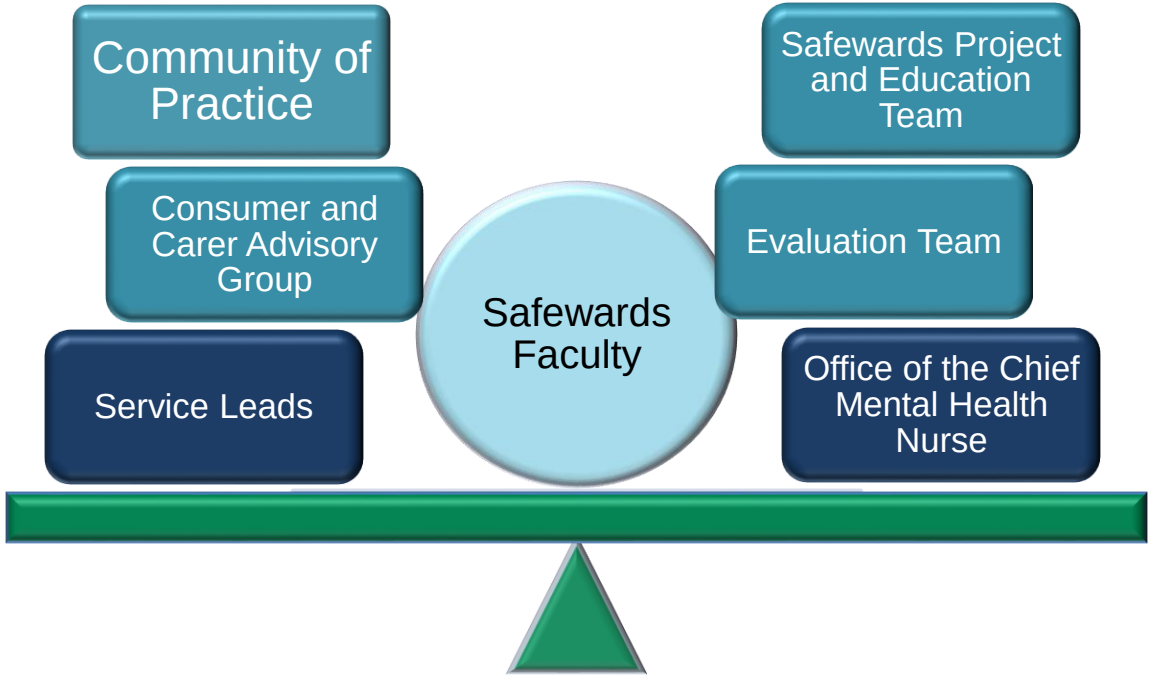
Safewards Implementation

2016-2018 - Stage 1 - Mental Health

2019 - Stage 2 - ED

2020 - Stage 3 - General

Collaborative approach

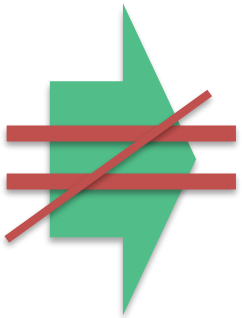


Safewards in the ED

- 18 month pilot
- Dedicated project lead at service
- Adaptation of resources

Conflict and Containment

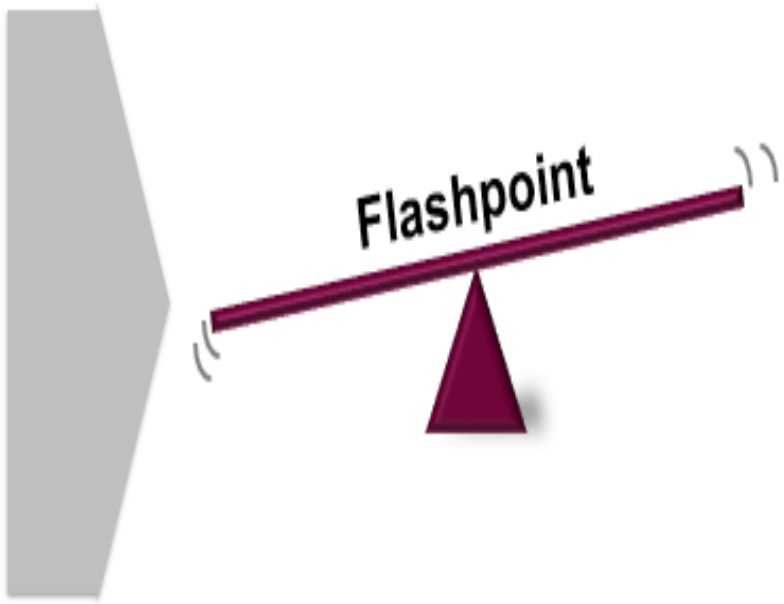
Conflict
anything that could lead to harm for the patient, others or staff



Containment
what staff do to prevent conflict events or minimise harmful outcomes

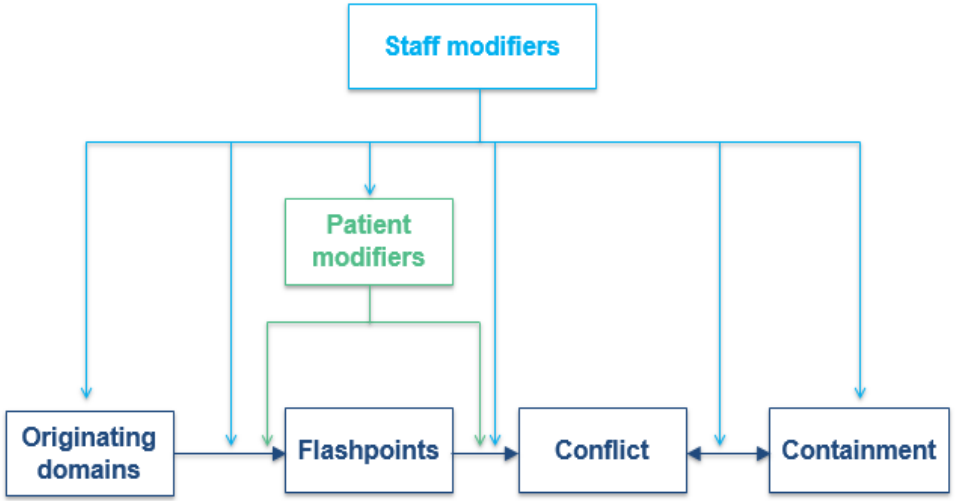
The originating domains

1. The patient community
2. Patient characteristics
3. Regulatory framework
4. Staff team
5. Physical environment
6. Outside hospital

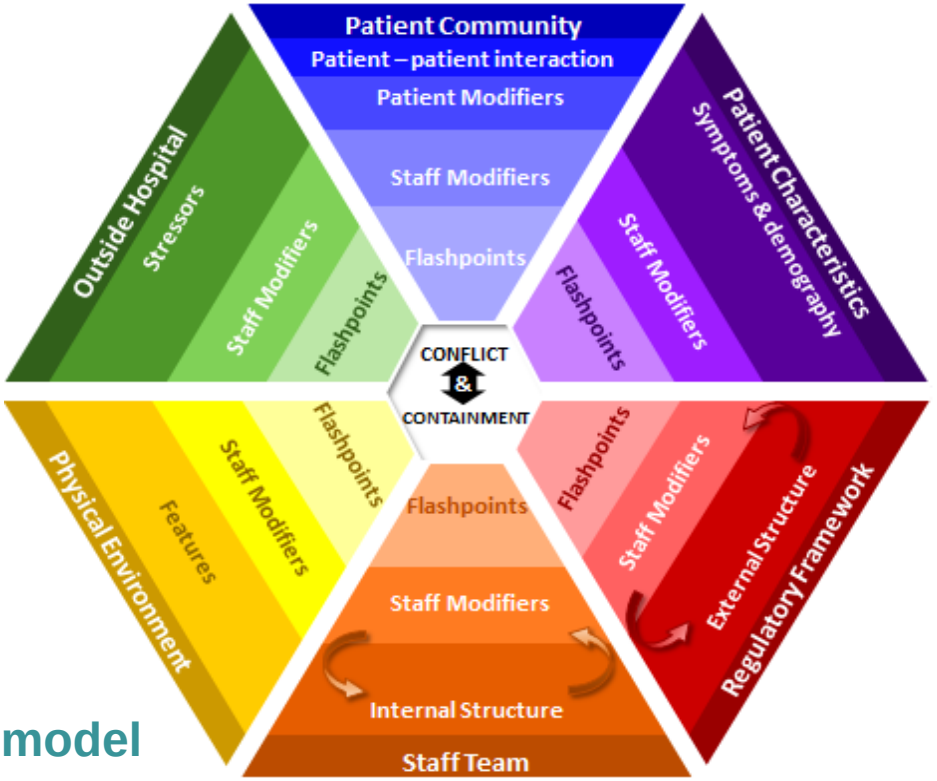


The Simple Model

Simple model



The Safewards model



Technical model

The Interventions in ED

Know Each Other

Respectful Limits

Senior Safety Round

Clear Mutual Expectations

Talk Through

Positive Words

Calming Methods

Perception and Awareness

Reassurance

Delivering Bad News

Question time

Chair: Kellie Vivekanantham

- Andrew Hugman
- Angela Ryan
- Marisol Corrales
- Ashleigh Ryan
- Kate Bendall

Lunch break

12.55 – 1.40pm

Twitter
#ECCN2019
@SaferCareVic

Session 3 – Voluntary assisted dying & Innovation

Chair: Jeff Robinson

ECCN Governance committee member

Emergency Care Clinical Network Forum

Voluntary assisted dying: Implications for clinicians

Peter Hunter

Voluntary assisted dying implementation taskforce

Voluntary Assisted Dying Act 2017

Introduction and overview

ECCN forum

2nd May 2019

VICTORIA State Government | Health and Human Services

Introduction

- The Voluntary Assisted Dying Act 2017 was passed by the Victorian Parliament on 29 November 2017.
- The Act will commence operation on 19 June 2019.
- The Act followed two years of consultation and development, and reflects a balance between giving people choices at the end of their life and ensuring community safety.
- The policy in the Act is now settled and the focus has shifted to implementation of the Act.

Guiding Principles

- Every human life has equal value.
- A person’s autonomy should be respected.
- Informed decision making.
- Quality care that minimises suffering and maximises quality of life.
- Therapeutic relationships be supported and maintained.
- Open discussions about death and dying.
- Conversations about treatment and care preferences.
- Genuine choice balanced with safeguards.
- All people have the right to be shown respect for their culture, beliefs, values and personal characteristics.

Voluntary Assisted Dying Act 2017

The Act sets out the legal requirements of voluntary assisted dying. Like any other clinical intervention, there are other considerations that will need to be addressed in practice.

The Act provides for and regulates access to voluntary assisted dying in Victoria. It:

- establishes clear eligibility criteria
- steps through a detailed request and assessment process, including requirements for medical practitioners
- sets up a voluntary assisted dying permit process which authorises the prescribing and dispensing of voluntary assisted dying medications
- establishes the Voluntary Assisted Dying Review Board (Review Board)
- provides for a range of additional safeguards including medication monitoring, practitioner protections, offences, and a five year review.

Eligibility Criteria

To access voluntary assisted dying, a person must meet **all** of the following eligibility criteria:

- be aged 18 years or more; and
- be an Australian citizen or permanent resident; and be ordinarily resident in Victoria for at least 12 months; and
- have decision-making capacity in relation to voluntary assisted dying; and
- be diagnosed with a disease, illness or medical condition that:
  - is incurable; and
  - is advanced, progressive and will cause death; and
  - is expected to cause death within weeks or months, not exceeding 6 months (12 months for people with a neurodegenerative condition); and
  - is causing suffering that cannot be relieved in a manner the person considers tolerable.

Request and assessment

A person must make **three** separate requests.

The formal process for requesting voluntary assisted dying is as follows:

- The person makes their **first request** to a medical practitioner (who becomes the co-ordinating medical practitioner if they accept).
  - The person undergoes a first assessment by the co-ordinating medical practitioner.
  - The person undergoes a consulting assessment by a consulting medical practitioner.
- The person makes a **written request**, which is signed by two independent witnesses.
- The person makes a **final request** to the co-ordinating medical practitioner.
- The person's final request must be made at least 9 days after the day on which they made their first request (exception if they are likely to die within that time).

If the person is eligible

- The co-ordinating medical practitioner applies for a **voluntary assisted dying permit** from DHHS to prescribe the voluntary assisted dying medications. This is an opportunity to ensure compliance with the request and assessment process.
- If the person is physically able to self-administer and digest the medication, the practitioner must apply for a **self-administration permit**.
- If the person is not physically able to self-administer or digest the medication, the practitioner must apply for a **practitioner administration permit**.
- Administration by a medical practitioner will only occur in very limited circumstances and will ensure those who are physically unable to self-administer are not discriminated against.

Information for health practitioners

- A health practitioner is not required to participate.
- A health practitioner must not initiate the discussion about voluntary assisted dying with a patient while providing a health service.
- There are protections for health practitioners and paramedics who act in good faith and in accordance with the Act.
  - This includes not providing life-sustaining treatment that has not been requested if they believe the person has accessed voluntary assisted dying.
- There are a range of offences, including offences to induce a request or self-administration, falsify records or make a false statement, and to provide or administer voluntary assisted dying medications without a permit.

Roles of medical practitioners

- The roles of the two assessing medical practitioners are clearly defined as the co-ordinating medical practitioner and the consulting medical practitioner.
- The **co-ordinating medical practitioner** supports the person, undertakes the first assessment, receives the requests, and is responsible for reporting.
- The **consulting medical practitioner** provides a consulting assessment.
- Both practitioners must ensure the person is properly informed of all treatment and care options and likely outcomes.
- Both practitioners must undertake independent assessments to form a view as to whether:
  - the person meets the eligibility criteria;
  - the person understands the information provided;
  - the person is acting voluntarily and without coercion; and
  - the person’s request is enduring.

Which medical practitioners can participate?

- Only specialist medical practitioners (includes GPs) can conduct the assessment process and prescribe the medications.
- Between them, the co-ordinating and consulting medical practitioners must have:
  - at least five years post-fellowship experience; and
  - expertise and experience in the person's disease, illness or medical condition.
- Both medical practitioners must complete compulsory voluntary assisted dying training before conducting an assessment.
- Only co-ordinating and consulting medical practitioners are required to complete this training.

Medications and statewide pharmacy service

- A range of suitable medications are secured for use in Victoria.
- Medication protocols have been developed and will be made available to medical practitioners who have completed the voluntary assisted dying training.
- Permit applications and prescription will be required to occur in accordance with the medication protocols.
- The government has established a single statewide pharmacy service to dispense medications for voluntary assisted dying across Victoria.
- The statewide pharmacy service will assist co-ordinating medical practitioners in prescribing the voluntary assisted dying medications. It will also provide information and support to patients and contact persons about the use and return of medications.

Reporting requirements

- Mandatory reporting to the Review Board following the:
  - first assessment (co-ordinating medical practitioner);
  - consulting assessment (consulting medical practitioner);
  - final review, following third request (co-ordinating medical practitioner);
  - dispensing of the medication (pharmacist);
  - disposal of the medication (pharmacist); and
  - administration of the medications by a co-ordinating medical practitioner.

- Reporting forms are detailed in the Schedule to the Act.

Role of health services

- Health services must decide their level of participation in voluntary assisted dying.
- Regardless of whether a health service provides voluntary assisted dying it must be prepared for the commencement of the Act.
- Things to consider include:
  - how will staff respond to questions and requests for information?
  - how will staff be supported in managing these requests?
  - if voluntary assisted dying will not be provided, will patients be referred?
  - how will staff be educated and supported if voluntary assisted dying will be provided at a health service?

Resources

- Model of care pathways and other health service resources
- Guidance for health practitioners
- Community and consumer information
- Voluntary assisted dying training
- Statewide pharmacy service
- Medication protocol
- Care navigator support service
- Taskforce monthly newsletter

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying

Emergency Care Clinical Network Forum

My Emergency Doctor

Jocelyn Howell
Emergency Physician
My Emergency Dr

MY EMERGENCY DR

Introducing My Emergency Dr

Contents

MED Background

How it works

MY EMERGENCY DR

Contact us

https://www.myemergencydr.com/

admin@myemergencydr.com.au

1800123633

MED Background

My Emergency Dr (MED) has provided **more than 19,500 telehealth consultations** with patients across Australia since 2016.

Our innovative model allows us to provide high quality emergency care to people at home and reduce the burden on Australian emergency departments as well as emergency ambulance call-outs.

Our aim is to get the right patient to the right place at the right time.

How it works

24/7 service

1. Patient / carer / clinician calls us via free app or 1800 freecall.
2. MED patient support officer takes details
3. MED specialist emergency doctor assesses patient, makes diagnosis, provides expert advice on disposition and timing (e.g. ED now / GP tomorrow).
4. Plus prescription / imaging / pathology request where appropriate.

MED doctors

More than 60 Fellows of the Australasian College for Emergency Medicine (FACEMs), based across Australia and overseas, providing 24/7 cover.

FACEMs

Specialists in emergency medicine

Recognize the limitations of telehealth

ACEM Standards Committee has confirmed that MED is compliant with college standards, in particular, “Guidelines for inter-professional collaboration between general practitioners and other medical specialist providing video consultations: Emergency Medicine Appendix” and the “ACEM Statement (S27) on Rural Emergency Medicine”.

Current clients & partners

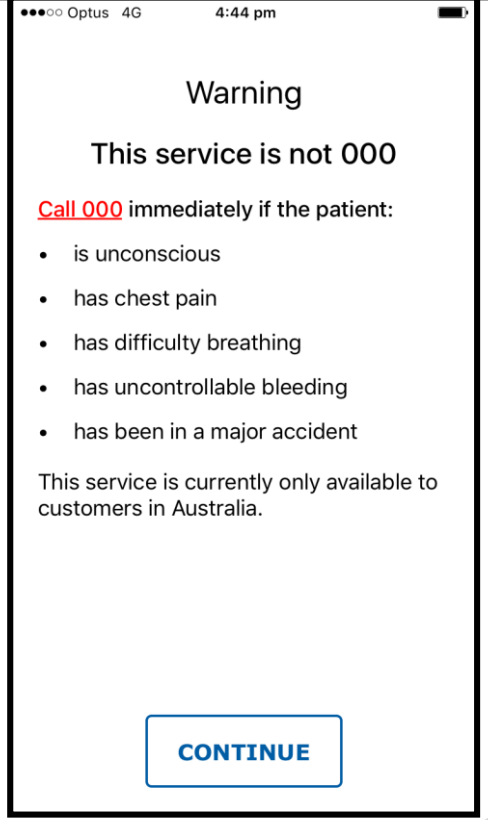
- Ambulance Victoria
- Eastern Melbourne Primary Health Network
- Royal Flying Dr Service- South East region
- Mid North Coast LHD and North Coast PHN (joint project)
- Chris O'Brien Lifehouse
- Urgent care centres
- Residential Aged Care Facilities
- Schools

References available on request

Progress to date

MED doctors have managed more than 19,000 cases by voice and video call since 2016.

- Overall we have managed 65% at home without recourse to ED.
- Residential aged care nurse calls: we have managed 83% of cases in situ.
- Calls from the public: we have managed 87% of cases in situ.



Limitations

Not a hands-on service

Not intended to provide chronic / ongoing care

Diagnostic ability limited to conditions that can be diagnosed without physical assessment

For this reason:

We employ only specialist EM physicians

We encourage followup with usual GP

Emergency Care Clinical Network Forum

Alternative medical support in UCC

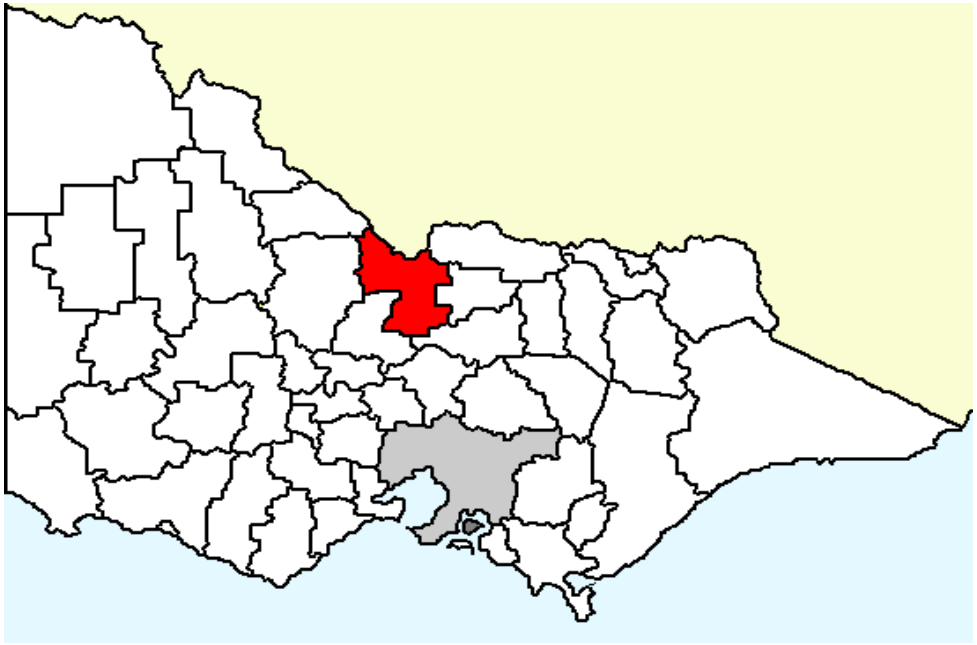
Bernadette Wardle
Director of Clinical Services
Kyabram District Health Service

KYABRAM DISTRICT
HEALTH SERVICE

Medical Support Models in UCC 2300–0700hrs

10/7/2018 – 31/12/2018

Where is Kyabram?



Background

- 4600 presentations per annum (all hours)
- GP VMO workforce ~ 8-10 doctors of varying levels of emergency skills and experience
- GP proceduralists providing surgery & anaesthetics to KDHS as well as on call responsibility
- Loss of GPs due to after hours UCC on call commitment
- Increasing variances in quality of care provided
- Clinical nursing workforce reliance on phone contact with local GPs for advise and medication orders for many cases
- No dedicated UCC staff
- Imaging including Xray, ultrasound and CT available overnight
- Pathology – FBE, U&E, Troponin and blood gases utilising point of care testing (Nurse managed)

Model

4 Tier

1. Nurse managed Cat 4 & 5
2. Web-link telehealth consult to GVH ED Senior MO using Health Direct Cat 3 & 4
3. My Emergency Doctor video link to FACEM via web portal Cat 3 & 4
4. ARV video & phone support for walk in Cat 1 & 2

Goulburn Valley Health ED support

- MOU for services when a Senior MO is on duty.
- GVH provide a senior MO roster to KDHS nominating nights that a service is available. Where a senior MO is not available to the roster, the service is not provided.
- The care is provided inline with the ATS Triage guidelines and waiting times.
- KDHS clinical staff have real time visibility of GVH activity through their demand management portal.
- Services are delivered using the Health Direct portal.
- Pts are treated as GVH pts and included in GV ESIS data.
- There is no cost to KDHS or the pt for this service.
- Where GVH cannot provide a timely response within triage guidelines; or do not have a senior MO available, the pt is escalated to the MyEmergencyDr pathway.

FAXED

Goulburn Valley Health

Emergency Department Tele-Health Medical Consult Record

[redacted]

AD

Sex: F
Age: 84
Ward: ANE
PN:
FC:ST
MO [redacted]

REL: R/C [redacted]

FUND: NO:

EN: 05818348

Consult commencement time: 05:45 hrs Medical Officer Mirni Abu ... (Print Name)

GVH Triage Category: 2 Consult completion time: .... hrs

Final diagnosis: chest pain for evaluation Follow up call planned [ ] Yes [ ] No

This sheet scanned and emailed to referring organisation at .... hrs

Outcome: [ ] GVH transfer [ ] LMO next day [ ] LMO PRN

TELE-HEALTH PROGRESS NOTES

Notes:

awoken by chest pain at 03:00, sharp
no radiation associated w̶ ~~shortness of breath~~ no sweating no shortness of
breath pain last for about 15-20 min
before it subsided by GTN she was

presented to GV health on 21 Jul for
similar complain c [illegible] discharged w̄
GP follow-up.

Never been diagnosed as IHD before
(no angio [illegible] last angio [illegible] yr ago [illegible]
normal)

O/E: pain free
looks well, not distressed
radial pulses are synchronous w̄
equal volume w̄ no radio-femoral delay

lungs: good equal breath sounds
few fine basal crackles

ED TELE-HEALTH MEDICAL CONSULT RECORD MR790

Version No: / Date

Patient name: [redacted] DOB: [redacted] UR number [redacted]

Notes:

the plan -
1. connect to cardiac monitor
2. hourly ECG
3. to repeat trop I at 09:00
4. if develops ECG changes at any time to be transferred to GVH immediately
5. to be reviewed in the morning by the on call doctor
6. chest x-ray PA view to evaluate for wide mediastinum.

Dr. Mirni

Phone orders provided

Date	Medication	Route	Time	Dose	RN name receiving

IV fluid orders

Date	Medication	Route	Time	Dose	RN name receiving

Medical Officer signature: [signature]

Communicated to: ....

Name: Mirni Signature: [signature] Designation: SHMO

MR790

My Emergency Doctor support

- MoU provides authority to admit, provide Medication orders, treatment orders, scripts, radiography and pathology requests.
- Consultations with FACEMs via dedicated web based portal within 15 minutes guaranteed.
- Australian Based Company. With AHPRA Registered FACEMs.
- Credentialing aligned to the company as a regional service provider. Covers all clinicians appointed to the service.
- Cost $160 per consult, includes overnight contact for care. Borne by KDHS, funded through UCC grant with no fee levied to the pt.

My Emergency Doctor experience

- Wait time – experienced average of 5 minutes.
- Email / Fax scripts to patients, pharmacy or KDHS – original are received by pharmacy in 5 days.
- Provide Imaging and Pathology requests as required.
- Provide a comprehensive patient clinical summary soon after consultation.
- Admitted patients to KDHS. Care taken over by GP in morning.
- Recontact FACEM if condition changes or further medication is required overnight. No extra cost.
- GP receives copy of the Clinical summary.

Example

MY EMERGENCY DR

My Emergency Dr
Suite 8, Level 2
14-16 Suakin Street
Pymble NSW 2073
Ph: 1800 123 633
Email: admin@myemergencydr.com.au

CONFIDENTIAL CLINICAL REPORT

Date: 11/07/2018

To: [redacted]

Re: [redacted] 22/08/1942

This patient contacted our online service today and Dr [redacted] one of our Emergency Specialists (Fellows of the Australasian College for Emergency Medicine), took the call.

Reason for consultation: unwell, abdominal pain

Clinical Notes: app call from Kyabram health service

75yo [redacted] known to the hospital.

presented with severe abdo pain around 5am at the hospital. the onset of the pain was around midnight. associated with lightheadedness, nausea, feeling generally unwell.

took stemetil 5mg orally at home, no relief for the nausea; pt think the dinner last evening could have caused it. husband had the same but no sx. no recent illness. no haematemesis or melena. no weight loss. LBO - ?yesterday. no diarrhoea; has had urinary frequency but apparently this has happened before in the absence of an UTI (?)

on arrival to the hospital, patient was alert, orientated. PAF on ECG with LBBB (old); AF is known/chronic, currently only on aspirin, 5 yrs ago had ablation. no longer on any rate control; used to have flecainide.

other Pmhx - T2DM; had anaphylaxis last year > cardiac arrest. left nephrectomy, cholecystectomy;

aspirin, irbestartan, nifedipin, metformin, diamicron, rosuvastatin\\

allergic - naproxen, azithromycin, digoxin.

on examination by senior nurse:

airway intact;

sats 97 on 3l NP; was 89 on air. not SOB, not tachypnoeic. chest sounds clear.

BP 104/52 at the beginning of the app call, was 140/100 just before, and another measurement showed 130/110 after few minutes - please check cuff size, repeat on both sides +/- manually.
CRT is <2sec, well perfused peripheries. good colour, good mentation, good urine output so far, HR 140-150 on monitor now, AF as above.

GCS 15/15; orientated, good historian. BSL 10.

temp 36. no rashes; weight 85kg.

AP resolved now. was not tender on palpation on arrival. pain poorly localised, mostly central and upper abdomen. no abdo distension; bowel sounds? - to be confirmed

POC investigations so far:
urine dip - nad;

trop 0.01 - neg

U&E - all normal exc urea 13; Hb 15.6 on istat - to be confirmed with formal bloods.

ECG not seen, interpreted by senior nurse as PAF, rate as above, old LBBB (old notes available and patient known to staff).

Impression - abdominal pain ?cause, likely triggering PAF on background of chronic AF;

low sats ?consolidation ?early APO- to be ruled out. apparently quite positional/check trace

Prescribed by us:

Management Plan: 1L CSL over 8hrs if BP remains stable. if any hypotension or shock signs give fluid bolus stat and seek medical advice stat. consider IDC, monitor u.o closely.

10mmol Mgso4 in 100ml nacl over 1hr, keep monitored.

ondansetron 4mg iv or sl if further nausea. [redacted]

not for rate control medication at this point, until further ix of abdominal pain/nausea. pathology form sent for all tests discussed. repeat troponin too.

[redacted]

CXR, CT abdomen. (has had cholecystectomy, consider also US later if AP persist and nil found on CT/bloods etc.)

do VBG please - ?pH, ?lactate; note patient also diabetic, on metformin etc.

repeat ECG please; keep monitored.

urine MCS; abx if any evidence of developing sepsis; noted allergy and previous anaphylaxis with cardiac arrest.

local doctor due to arrive shortly. if any concerns or worsening please call us back and/or arrange transfer to usual referral hospital, as per local guidelines.

Should you have any questions about this consultation, please don't hesitate in contacting our practice on 1800 123633 or email admin@myemergencydr.com.au however please note that this is normally a paid service and callers seeking follow-up medical advice will be asked to provide their payment details prior to consultation.

Yours sincerely

Dr Eugen Salahoru
298390X

CC:

Signed not Sighted

UCC Model 2300-0700
6 month review (10/7/2018 – 31/12/2018)

- 157 Total Presentations
- 85 Category 4 and 5 assessed and managed by nursing staff only and discharged for GP follow up
- 23 Direct transfers to GVH for higher level of care – Category 2 or complex category 3 (no telehealth)
- 14 Telehealth with GVH Senior MO
  - 5 admitted to KDHS under GVH supervision
  - 7 treated and discharge home for follow up by own GP
  - 1 treated but did not improved escalated transfer to GVH
- 28 Telehealth used with my emergency doctor
  - 2 transferred to GVH for higher level care
  - 4 treated and discharged home for follow up with own GP
  - 18 received medication and discharged home
  - 4 admitted to KDHS under MED supervision

6 month pre & post model comparison

2300-0700	July to December 2017 Pre model	July to December 2018 Post model
Presentations	157	157
Admitted to KDHS	34	9
No of Cat 1 Cat 2	1 5	0 9
Local GP attendance at site	18	0
Transfers to higher facilities for care from UCC	10	26

Clinical Governance

- Daily reporting by Nursing staff re overnight activity and outcomes to CEO, DCS, Project Lead and NUM.
- All Urgent Care Charts are review by the NUM and Project Lead, and referred to Director Medical Services as required.
- Model of care and case review outcomes are presented to the multidisciplinary clinical quality & safety review committee.
- LMRCGC Emergency/UCC working group.
- Board reporting through clinical dashboard.

Keys to success

- Partnering with the GP.
- Supporting and developing our nurses through education and skills development.
- Effective marketing of the model to the community.
- Real time monitoring of case presentations and barriers to timely care.
- Having a backup plan for when technology fails.
- Regular meetings with the partners, including AV, GVH, MED,GPs & DHHS/SCV.

Challenges

- Technology
- Reliance of private enterprise (MED)
- Scalability
- Transferability
- Collecting the right data
- Loss of local services
- Maintenance of admitted WIES

KYABRAM DISTRICT
HEALTH SERVICE

Emergency Care Clinical Network Forum

Choose well, feel better

Sarah Finlayson
Quality Systems Manager
Nurmurkah District Health Service

Choose Well, Feel Better
A Rural Urgent Care Project

SARAH FINLAYSON, PROJECT LEAD

Heart of the problem

What are addressable reasons that so many people are presenting at our regional emergency department with lower complexity conditions?

Overall Marketing and Communications Strategy

Phase 1: Testing

DEC17 - FEB18

- Strategic planning with project team
- Setup digital data gathering processes
- Testing of audience, messaging and channels
- Content ideation

Phase 2: Traction

MAR18 - MAY18

- Asset creation (e.g. website)
- Launch of Facebook Page
- Design of branding assets around Choose well, Feel better campaign
- Testing across Facebook ads

Phase 3: Scale

JUN18 - NOV18

- Optimisation of campaigns
- Update on creative ad assets
- Increased intensity of paid campaigns and content

1

Targeting future consumers/patients

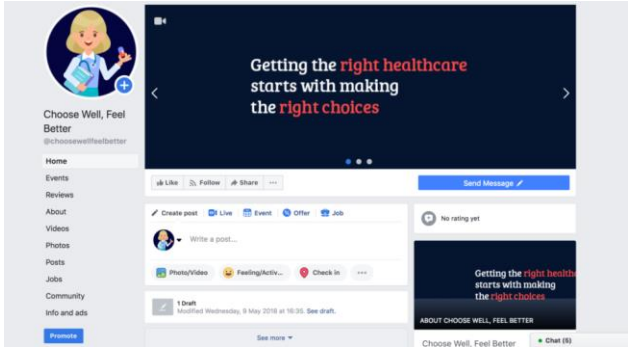
1. EDUCATE COMMUNITY ON COURSE OF ACTION

Goal was to educate the community on course of action, if/when an incident takes place in the future come in first

Implementation through:

- Developing a Facebook page and community to share information and engage the group with targeted messages

- Distribution through Facebook Advertising and other media



Total cost	Reach	Impressions	Post Engagements
$12,048.23	68,079	876,720	72,634

2

Targeting immediate incidents

2. TARGETING IMMEDIATE CUSTOMERS

Goal was to target patients who had just had an incident happen and were immediately looking for a solution.

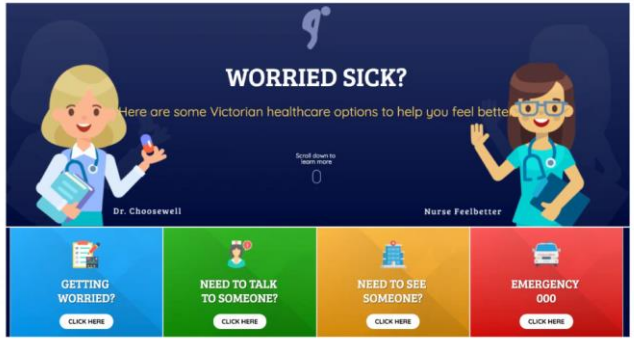
The implementation of this was done through Google Ad words which were targeted across specific keywords such as:

'Emergency Department'
'Who should I see for...'
'Symptom checker'
'24hr Clinic near me'

Driving this traffic to the ChoosewellFeelbetter.com website

Google Ads

Website design



Costs	Clicks	Avg. CTR	Impressions
$3056.48	2,156	4.49%	47,988.88

3

Educating people through offline tactics

3. OFFLINE TACTICS

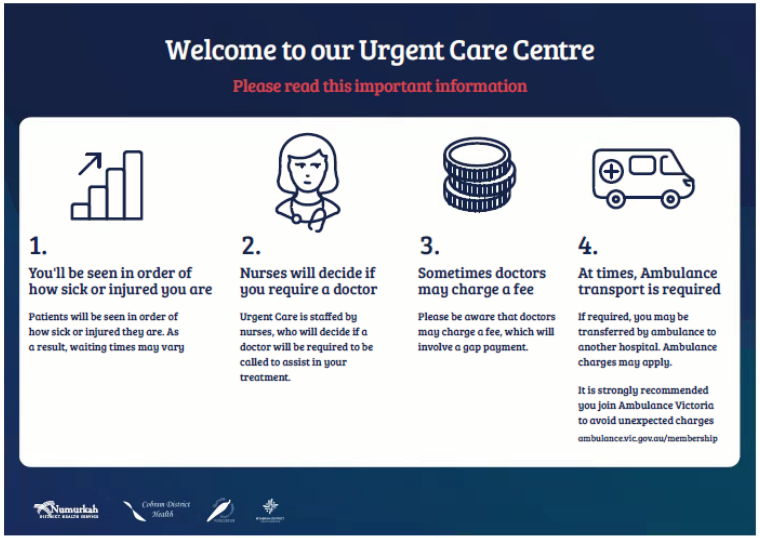
The implementation of this was done through:

- Creating offline creative assets such as posters and magnets to be shared throughout the community
- Attending live community events
- Traditional media – press releases, e-mail campaign
- Engaging local business/organisations – sporting, schools, supermarkets, pharmacies, GP practices

Poster 1: For GPs and Local Businesses

Poster 2: For Collateral / Fridge Magnets

Posters


Welcome to our Urgent Care Centre
Please read this important information
1.
You'll be seen in order of how sick or injured you are
Patients will be seen in order of how sick or injured they are. As a result, waiting times may vary
2.
Nurses will decide if you require a doctor
Urgent Care is staffed by nurses, who will decide if a doctor will be required to be called to assist in your treatment.
3.
Sometimes doctors may charge a fee
Please be aware that doctors may charge a fee, which will involve a gap payment.
4.
At times, Ambulance transport is required
If required, you may be transferred by ambulance to another hospital. Ambulance charges may apply.
It is strongly recommended you join Ambulance Victoria to avoid unexpected charges
ambulance.vic.gov.au/membership


Client feedback for Urgent Care Centres
1st March 2018 — 30th September 2018
463 patients responded
85% rated their urgent care experience as excellent
86% said they knew that there was an Urgent Care Centre close by
85% said that the Health Facility was fantastic
1 in 7 people gave recommendations on how to improve the health care provided
112 patients made comments on how the nurses were friendly and welcoming
You said it, we listened...
"It's a disappointment that we have a great facility and doctors are not readily available."
While doctors are not on site in the Urgent Care Centre, they will see patients when required and are also using Health Direct video call
Some of your feedback
"Great service, I did not have to wait long at all. Thank you."
"The nurses were terrific, very thorough and professional in their treatment of me. I would highly recommend the Urgent Care to everyone."
"Fortunate to have such a wonderful facility."

Key project learning's

- **There is positive evidence of changing trends through the monitoring of presentation numbers from project postcodes.**

- **SMS Patient Experience Monitor showing evidence that people are finding out about Urgent Care Centres via Facebook**

- **Driving behavioural change will take some time to establish - key is consistency in messaging and activity**

- **Large appetite for engaging content (especially video)**

- **Appetite for the community to better understand the system and people behind it - highest engagement when sharing stories of community members**

- **Community co-design and community health literacy expertise is a critical area for future sustainability, effectiveness and replication of the strategy**

- **This model of community engagement is highly scalable across primary health care services**

- **Require a pillar source of resources to direct people to and build community around (e.g. website & Facebook page)**

Acknowledgements

Emergency Care Clinical Network Forum

Scribes in ED

Katie Walker
Emergency Physician
Cabrini Health

Should we use scribes in Australian healthcare?

Cabrini Foundation, Equity Trustees, Phyllis Connor Memorial Fund

Cabrini, Austin, Dandenong, Bendigo, Monash Paediatric EDs
Cabrini Institute, Monash University DEPM, ACEM

Katie Walker, William Dunlop, Michael Ben-Meir, Margaret Staples
David Taylor, Thomas Chan, Gabrielle O'Connor
Rachel Rosler, Adam West
Diana Badcock, Mark Putland
Danny Liew, Kim Hansen, Carmel Crock

Cabrini

Research

Impact of scribes on emergency medicine doctors' productivity and patient throughput: multicentre randomised trial

BMJ 2019 ; 364 doi: https://doi.org/10.1136/bmj.l121 (Published 30 January 2019)
Cite this as: *BMJ* 2019;364:l121

Opinion

It's time to think hard about how clinicians work in a digital age

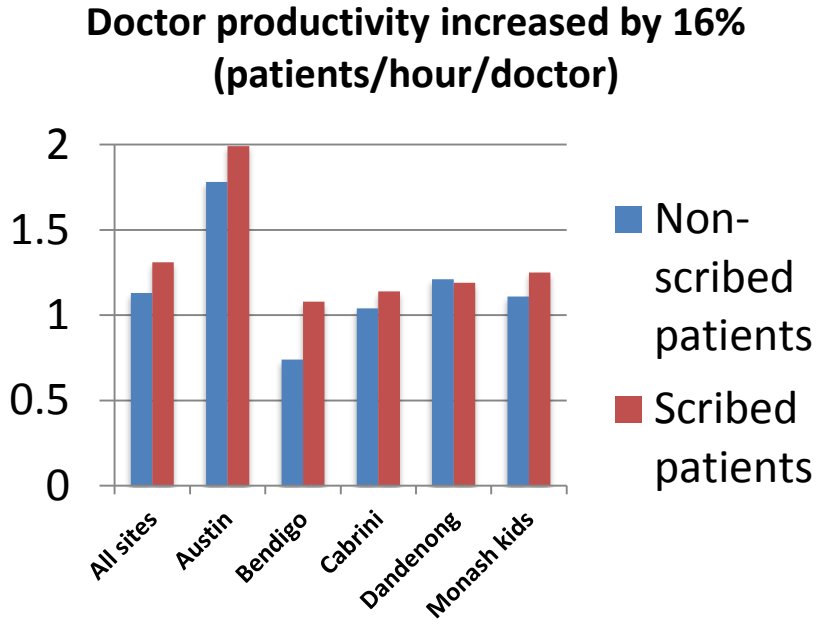
Should we use scribes?

Multi-centre randomised study: FACEM patients/hr, time-based metrics, risk

5	12	88	2	589
sites	scribes	doctors	years	scribed shifts

Physician productivity (patients/hour/doc)

- Total Increased (95%CI)
  - From 1.13 (1.11,1.16)
  - To 1.31 (1.25,1.38)
  - 0.18 patient per hour gain (15.9%)
- Primary patient rate increased (95%CI)
  - From 0.83 (0.81,0.85)
  - To 1.04 (0.98,1.11)
  - 0.21 patient per hour gain (25.6%)



Physician productivity by ED region

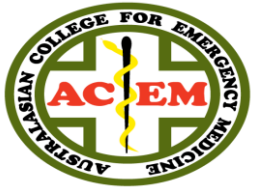
- Senior doc at triage
  - +0.53 (95%CI 0.14,0.93)
- Acute area
  - +0.09 (95%CI 0.03,0.15)
- Sub-acute (short stay)
  - -0.05 (95%CI -0.14,0.24)
  - Issues with counting
- Paediatric regions
  - +0.13 (95%CI 0.04,0.22)

ED Time-based metrics

- Door-to-doc unchanged
- Door-to-discharge reduced (IQR)
  - From 192 mins (108,311)
  - To 173 mins (96,208)
  - 19 mins less (p<0.001)

Risk: Self-reported patient and scribe safety events

- We used Emergency Medicine Events Registry (EMER) to record events
- Self-reporting – scribe trainers, physicians, scribes
- 16 incidents, all minor, mainly near misses
- 1 in 300 consultations
- Often involved wrong patient selection in the electronic record 7/16
- Often, scribe noticed and rectified an issue before an incident occurred (not caused by scribe) 8/16
- Like all of us, scribes are vulnerable to assault, infectious diseases and emotional responses to ED scenarios
- Self-reporting methodology has issues



Summary

- Emergency physicians who use scribes see 0.21 more patients per hour
- Patient length of stay is decreased by 19 minutes per patient
- Door-to-doc time is unchanged
- Self-reported patient safety incidents (adverse event or near miss) occur in 1:300 patients
  - Mainly incorrect patient identification or test ordering
  - Most events were captured by the scribe prior to adverse event
  - Scribes prevented several other ED events (observing and intervening)

Questions?

- How can we train scribes?
- Costs of training scribes
- How to set up a scribe program
- Patient experience
- FACEM experience
- Scribe work quality
- What tasks can a scribe perform?
- Cost-benefit analysis
- Why aren't there scribe programs here already?
- Further information

Back to questions

Feasibility Evaluation of a pilot scribe-training program
in an Australian Emergency Department
Australian Health Review, DOI: 10.1071/AH16188

How can we train scribes in Australia?

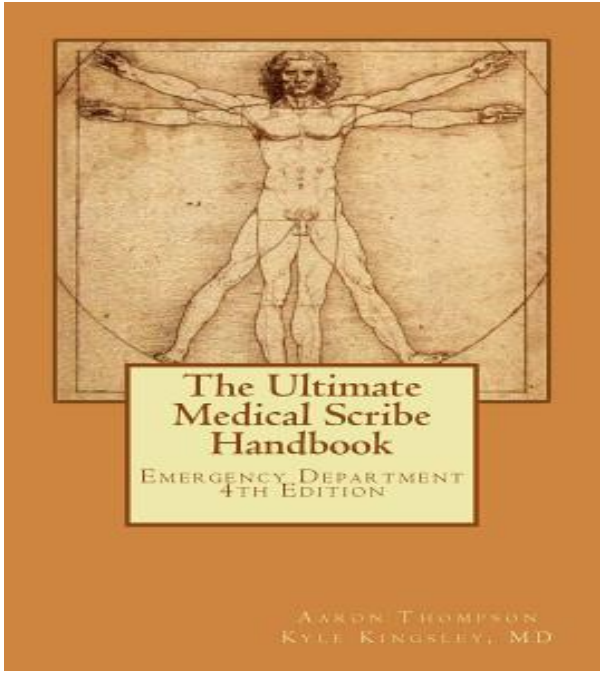
Pre-clinical
30-40 hours online

↓

Simulation
One Day

↓

Clinical
Up to 20 shifts



Back to questions

An economic evaluation of the costs of training a medical scribe to work in Emergency Medicine
Emergency Medicine Journal, DOI: 10.1136/emermed-2016-205934

Costs: start-up and training scribes

Task	Total Costs	Cost per competent scribe
Role Development	$6,915	$1,383
3 Computers + Trolleys	$9,598	$1,920
Education program (including courses)	$9,075	$1,816
Recruitment of 10 trainees	$5,955	$1,191
Administration cost of training program	$6,253	$1,251
Salary cost of trainees	$8,213	$1,642
Overall costs (including start-up and training)	$46,009	$9,203

Back to questions

Feasibility evaluation of a pilot scribe-training program in an Australian emergency department, Australian Health Review, DOI: 10.1071/AH16188

How to set up a scribe program

- Description of how to implement a scribe program outside the USA
- Recruitment
- HR
- Training
- Equipment
- Certification of skills

Back to questions

Medical scribes have no impact on the patient experience of an ED
Emergency Medicine Australasia, DOI: 10.1111/1724-6723.12818

What do patients think about scribes?

- Interviews
  - Purposive recruitment
  - 10 interviews
  - All positive
- Blinded survey
  - 82% response rate
  - 95 scribe:115 no scribe
    - Press Ganey
    - Net Promoter Score
    - Crowding/inhibition/autonomy all same

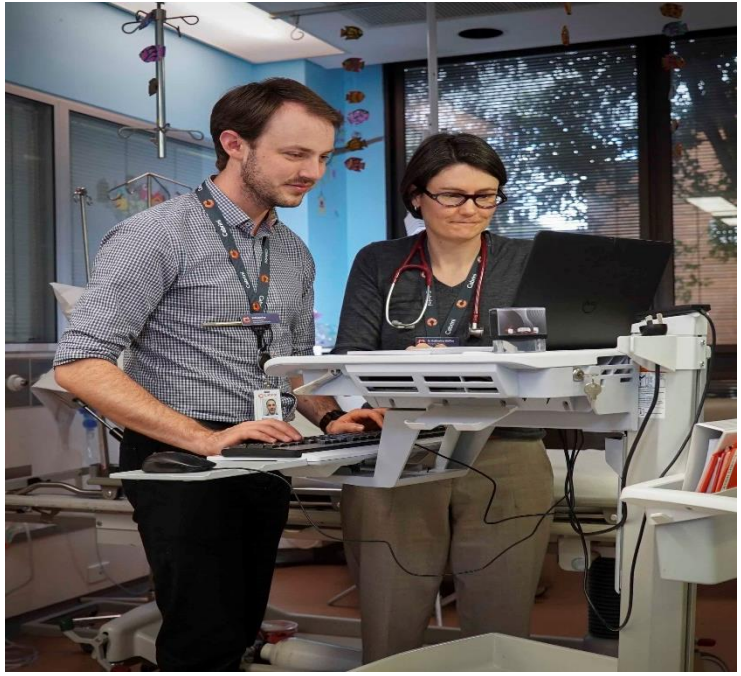
Back to questions

Emergency consultants value scribes and most prefer to work with them, a few would rather not

Emergency Medicine Journal, DOI: 10.1136/emermed-2017-206637

What do FACEMs think about scribes?

- 85% like scribes
- 15% are happier without

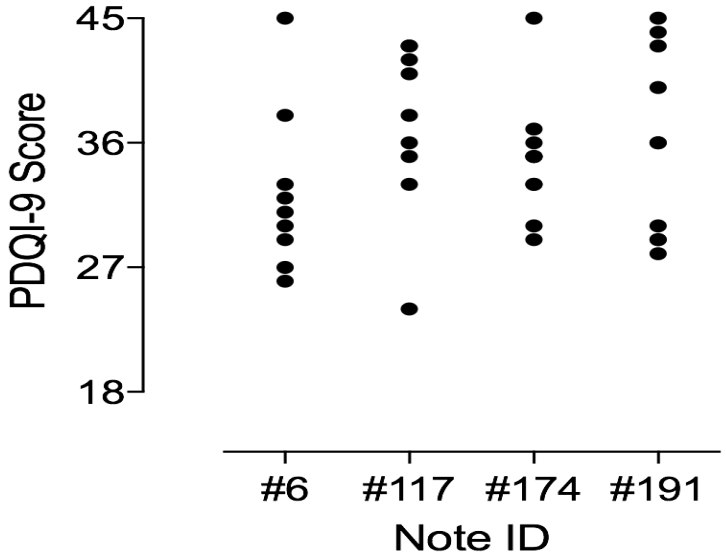


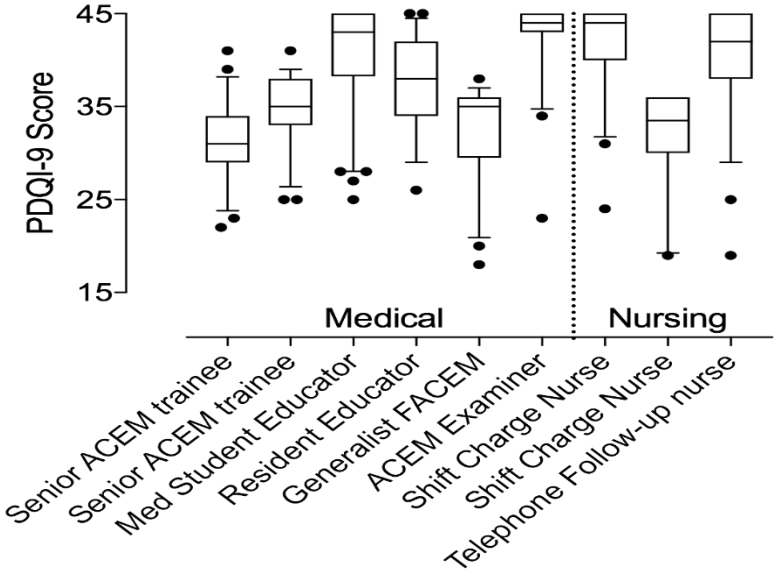
Back to questions

The PDQI-9 score is not useful in evaluating EMR scribe note quality in Emergency Medicine

Applied Clinical Informatics, DOI: 10.4338/ACI2017050080

Is scribe work quality ok?





Back to questions

Tasks a scribe can perform

- Electronic physician allocation
- Locating nurses notes
- In-room documentation of:
  - History
  - Physical examination
  - Medical plan
  - Investigation results/interpretations
  - Progress in ED
  - Diagnosis
  - Disposition plan
  - Safety net information
- Information retrieval:
  - Primary care letters
  - Clinic/specialist letters
  - Previous hospital records
  - Previous investigations
- Facilitation of investigations:
  - Adding clerical details to requests
  - Faxing investigation requests
  - Calling in radiology staff
  - Coordinating with porters
  - Confirming bookings and times
  - Communicating plans to nurses
  - Troubleshooting investigation delays
- Post Initial consultation tasks:
  - Booking beds
  - Conveying written requests to nurses/allied health staff
  - Paging registrars/residents
  - Locating specialists
  - Obtaining specialists on the telephone
  - Documenting specialist phone opinions
  - Documenting specialist consultations
  - Time-based data entry
  - Mandatory registry data entry
- Discharge preparation:
  - Printing sick certificates
  - Making review appointments
  - Printing referral letters
  - Making out-patient test appointments
  - Printing advice sheets

Back to questions

Cost-benefit analysis – Cabrini data example

Assumptions

- Training cost per scribe $USD 5015
- Physician productivity gain/hour: 15%
- Time in ED per patient reduced by 19 minutes
- Scribe works 1000 hrs total in career after training
- Mean scribe wage $USD 20.51/hr
- Physician wage $USD 165/hr
- 25% on-costs included above
- Costs per cubicle hour USD $64.20
- Revenue per patient is unchanged
- There is continuous patient supply

Calculations

Costs or savings in USD per scribed hour	With training absorbed by site	50% training absorbed by site 50% by scribe	100% training absorbed by scribe
Scribe costs	(20.51)	(20.51)	(20.51)
Training cost	(5.00)	(2.50)	0
Cubicle costs saved	26.91	26.91	26.91
Physician costs saved	24.75 (15% of US $165)	24.75	24.75
Total USD costs saved per scribed hour	**+26.15**	**+28.65**	**+31.15**

Back to questions

Why haven't scribes been implemented yet? What are the barriers?

- Upfront investment
  - Political/organisational commitment
  - Personnel (FACEM to run scribe program)
  - Start-up cost $50K
- Corporate knowledge/skills
- Lack of fee-for-service environment
- Lack of a pool of trained scribes to hire

Back to questions

Further Australian scribe research information

- Pilot: EMA: DOI: 10.1111/1742-6723.12314
- Extended Pilot: EMA: DOI: 10.1111/1742-6723.12562
- How to start-up: AHR: DOI: 10.1071/AH16188
- Cost of training: EMJ: DOI: 10.1136/emermed-2016-205934
- Patient experience: EMA: DOI: 10.1111/1742-6723.12818
- FACEM experience: EMJ: DOI: 10.1136/emermed-2017-206637
- Quality of notes: ACI: DOI: 10.4338/ACI2017050080
- Multicentre economic and safety study: BMJ: 10.1136/bmj.l121

- Contact: Katie Walker, Cabrini ED; +61 431 272 262, katie_walker01@yahoo.com.au

Question time

Chair: Jeff Robinson

- Jocelyn Howell
- Bernadette Wardle
- Sarah Finlayson
- Katie Walker
- Laura Parker-Stebbing

Emergency Care Clinical Network Forum

AWARDS

Judy McCahon

Consumer, ECCN Insight committee

Implementing a sepsis bundle of care project

Award category

Implementing a sepsis bundle of care project awards

Most improved health service – **Mansfield District Hospital**

Most innovative improvement idea – **Benalla Health**

Outstanding project leads:

- **Valerie Coleman**, Castlemaine Health
- **Catherine Salita**, Cabrini Health
- **Nerida Patterson**, Wimmera Health Care Group

Highly commended for contribution to a network working group

Award category

Contribution to a network working group awards

Managing presentations of the older person expert working group

Simonne Collins
Northern Health

Claire Doherty
St Vincent's Hospital

Mazdak Mansoury
Bendigo Health

Andrew Underhill
Alfred Health

Managing behaviours of concern expert working group

Shaun Baxter
Alfred Health

John Hambly
Bairnsdale Regional Health Service

Danny Zorzi Ambulance Victoria

Stuart Lewena
Royal Children's Hospital

Standardised guidelines expert working group

James Hayes
Northern Health

Leonie Frick
Barwon Health

Contribution to the network

Award category

Contribution to the network

Outstanding clinician contribution – **Anh Tran**, Mercy Health

Outstanding consumer contribution – **Elizabeth Flemming-Judge**

Abstract and e-poster submissions

Award category

Abstract and e-poster awards

Best forum abstract – **GoodSAM app**

Laura Parker-Stebbing, Mike Ray, Resmi Nair, Karen Smith, Tony Walker, Kylie Dyson, Ambulance Victoria

Best forum e-poster – **Care coordination consumer information pamphlets in the emergency department**

Phillipa Stewart, Sarah Miller, Karl Lincke, Jane carlin

Congratulations to award recipients

Thank you to everyone who participated and contributed to the network

Emergency Care Clinical Network Forum

Session close

Peter Cameron
ECCN Clinical Lead
Safer Care Victoria

Thank you to ECCN forum planning group

Michael Ben-Meir

Simon Craig

Elizabeth Flemming-Judge

Christopher Gartside

Laura Hewett

Monica Holdsworth

Simon Jemmett

Paul Jennings

Natalie Ladner

Aisling Lim

Jodie Mills

Jeff Robinson

Mark Santamaria

Anh Tran

Kellie Vivekanantham

Safer Care Victoria

Thank you for your attendance

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#ECCN2019

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