Limited Adverse Occurrence Screening (LAOS)

Annual report for 2008–09
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Accessibility

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Foreword

I feel privileged to have been asked to write the foreword for the third annual report of the LAOS program.

Originating in rural Victoria at Wimmera Base Hospital in Horsham, LAOS has been designed, implemented and improved by the input of rural GPs in a small hospital setting. Clinical risk management improves the practice of our craft, and improves outcomes for our patients. As a late starter to this program, I have been impressed from day one with the valuable learning experience for all concerned. True GP peer review – for GPs, by GPs – of real cases familiar to us all in our daily work schedule covering clinical management outcomes, and common controversies/frustrations, results in a quality process that is unparalleled in my experience. There is no ‘blame game’, and feedback is sought from the treating doctor on our reviews. Positive suggestions and comments, rather than negative criticism, results from this peer review process.

We are the experts, pooling a vast range of experience in the field to discuss each history. Constructive comments, aimed at improving care and identifying (all too common) barriers to effective therapy, are offered to both the treating GP and the institution. Situations of concern are identified at the local, regional, and metropolitan hospital levels. Transport issues and bed availability commonly impact on clinical management issues.

A program such as LAOS relies heavily on the organisational strength of the staff who run it. History gathering and liaising with hospital clinicians and health information networks is no easy task – rather like ‘herding cats’. The results, however, are to be seen in this comprehensive report. When the panel discusses clinical cases I often say to myself, ‘There, but for the grace of God, go I.’

The fear that some GPs may have of criticism dissolves when you are involved with the process of the reference panels. In our Murray Plains Division of General Practice, membership of the review panel continues to grow. The ‘bush telegraph’ has spread the word, and I commend both this report and the LAOS program to you.

Dr John Quayle
MBBS DCH DRACOG FACRRM
Chair
Murray Plains Division of General Practice Board
Acknowledgements

A special acknowledgement is extended to all rural and regional general practitioners and staff in small rural hospitals for their ongoing support and contribution to the LAOS program. The Department of Health also acknowledges the contribution made by staff of rural divisions of general practice, General Practice Victoria, the patients who have experienced adverse outcomes and their carers.
LAOS patient safety checklist

This checklist may be used to ensure strategies are in place for minimising the risk of adverse events. It is designed to be used in conjunction with the LAOS patient safety checklist published in the 2007–08 LAOS annual report. See http://www.health.vic.gov.au/clinrisk/downloads/laos-prog-report.pdf

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<th>No</th>
<th>WIP*</th>
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* WIP Work in progress
^ N/A Not applicable
Introduction

The Limited Adverse Occurrence Screening (LAOS) program provides Victoria’s small rural hospitals with a simple, cost-effective method of improving systems and quality of care. It does this by providing an anonymous, non-confrontational, general practitioner (GP) peer review of selected patient records with the involvement of the treating GP. This independent medical review may be otherwise difficult to obtain in the small hospital of a rural community.

The Department of Health (the Department) formerly the Department of Human Services, funds the LAOS program as part of its overarching clinical governance policy framework. The department has provided funding on a triennial basis since 2001 when the LAOS program was rolled out; it is currently funded until 2012.

The divisions of general practice deliver the LAOS program by assisting small rural hospitals to maintain an independent ‘arms-length’ medical review process. The divisions of general practice are ideally placed to understand the needs of rural GPs and hospitals, while linking in with other general practice divisions and health providers.

Beneficial support structures are provided for all participants, which fosters a culture of safety, evaluation and cooperation between the hospital and its visiting medical officers (VMOs). LAOS is designed to complement a hospital’s own internal review of patient records. Many small rural hospitals conduct both an internal (usually nursing) review and send records that meet the LAOS selection criteria for an external medical review.

LAOS aims to identify and prevent adverse events in Victoria’s small rural hospitals by retrospectively examining patient files for adverse events and educational opportunities. This also detects any previously unnoticed or unreported adverse incidents and helps highlight systematic problems. Reviewed records with identified adverse events or a possible educational opportunity are sent to the treating VMO for comment. The reviewed, de-identified records are then taken to a divisional reference panel of at least four trained reviewing GPs who issue recommendations for system improvement or educational opportunities. The LAOS coordinator attaches references, templates and any other useful resources to the recommendations. All recommendations are de-identified to protect the privacy of the patient, the doctor and the hospital. It is recognised that what has occurred in one small rural hospital may occur at another hospital unless there is system change. Many GP reviewers have commented ‘That could have been me!’, hence the recommendations are issued to all small rural hospitals and GPs in the division and are pooled for statewide analysis.

LAOS recommendations are discussed at hospital quality forums that ideally involve both hospital staff and GPs. It is through the support of the LAOS coordinator that some GPs are now involved in the quality forums of small rural hospitals. Some regional quality forums also discuss the LAOS recommendations and initiate regional responses to identified system issues. LAOS coordinators are happy to be involved with all quality forums and to offer their division and statewide expertise and resources. GPs also discuss the recommendations with colleagues and feed back their system responses to the LAOS coordinator. Discussing LAOS recommendations at all levels aids the understanding of why events occur and what action may be required. Feedback from the quality meetings is sought to show what system changes or educational programs have been implemented to support the recommendations or if there are any obstacles.

Recommendations from all divisions are pooled. Although each small rural hospital may have only a few acute care beds, hence few adverse events, the statewide analysis of records submitted from all of Victoria’s small rural hospitals and the feedback received in response to recommendations can
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reveal trends. The LAOS coordinators can then present these trends to general practice divisions and/or the department for attention. Common themes are presented at the Sentinel Event Review Subcommittee of the Clinical Risk Management Reference Group to inform the department about any statewide issues where it may provide statewide direction.

Another benefit of being involved in LAOS is that it gives immediate GP-peer and divisional support. This is especially useful for GPs new to the area and for international medical graduates who have yet to fully understand the Australian and Victorian health system processes.

**GP comments about LAOS involvement:**

‘I enjoy the involvement I have, I believe [LAOS] is an invaluable process to improve patient care in small rural hospitals. It engages GPs. From the [department’s] perspective it now closes the loop for improved outcomes, not just a GP academic process – and it is geared to be a peer support, not a punitive process. We are all human, we all make mistakes and could do better. To learn without public criticism is a golden opportunity that educated members of a professional body must surely cherish.’

‘It is always interesting to hear what others are doing or their opinions.’

‘A very worthy program.’

‘Extremely useful program. Record review is most interesting and certainly makes us aware of our own shortcomings.’

‘Thanks. Helpful to reflect on real rural cases’.

‘The LAOS program is a way of getting doctors together to discuss common problems and suggest solutions to them. It fosters a supporting environment in which to practice and identifies issues that need attention, either at the practice level, the divisional level or at the state level.’

**Feedback from a hospital information manager working in a hospital that has its own internal review program, and is now also participating in LAOS:**

‘I think it’s a great opportunity to participate in the LAOS program, with not only GPs but hospitals benefiting from the outcome. Hospitals are always looking at ways to improve patient care and treatment; facilitated by receiving (LAOS) reports with recommendations we can discuss at our quality committee. Outcomes may include improved processes, better communication between clinical staff and GPs, or further education.

From a health information manager point of view recommendations regarding documentation are usually a favourite. Good documentation is very important to clinical coders as we are always looking to extract the most out of the record to ensure correct coding, diagnosis related group (DRG) assignment and therefore appropriate funding for the hospital.

Any program that results in reducing risk, improving patient care and clinical practices can only be a win–win for the patient, GP and hospital.’
A division board member’s thoughts about LAOS:

‘An enormously successful program that is going from strength to strength and ... a program like that is one of the better programs as I get a lot more out of it than I put in.

It’s a program where we review cases, actual real cases from hospitals, and there’s the opportunity for the treating doctor to comment if there’s adverse comments made, so it’s a quality measure that’s done. The comments are, like the reviewers, anonymous ... but at the end of it recommendations are made, some of which are really important to all in the way we practice because we are in such a little box ... so it’s a really good quality tool that we use.

It’s non-inquisitorial, probably its best advantage, there’s no: “You did that bad, you did that good”, it’s just: “What can we learn?” It’s really good.’

Comment from a hospital about LAOS involvement:

‘This is a really good program and an excellent way to get our GPs involved in quality activities.’
LAOS review process

Patient records are sent in batches by the small rural hospitals, so some records may already be one to three or even up to six months old when received by the LAOS coordinator. The LAOS coordinator sends small batches of records to available peer-reviewing GPs; this review process takes an average of six to eight weeks due to the many time demands on our busy rural and remote GPs. It is to their credit that they commit themselves to the LAOS process. The records with possible adverse events noted are then returned to the treating GP for comment – while they too are committed to the process, they also have many demands on their time, and so records may be delayed here by an average of six to eight weeks.

Reference panels are held when there are sufficient reviewed records, usually between two and four times a year, adding another delay to the process.

Thus, the recommendations and case histories that are examined and presented in this annual report include records from hospital stays not only in this financial year but also from earlier inpatient stays.
LAOS medical record flow chart

Health information manager identifies records that meet LAOS screening criteria

Copy sent to division LAOS coordinator

Record reviewed by peer-reviewing GP

LAOS coordinator

Does this record contain an adverse event/education opportunity?

Yes

Listed on agenda of reference panel meeting as ‘not for discussion’

Reference panel meeting: recommendations made

Recommendations developed, researched by LAOS coordinator, approved by reference panel chair

Recommendations sent to all GPs and chief executive officers/quality managers in general practice division

Recommendations discussed at local quality forum

Feedback to LAOS coordinator

No

Record returned to treating GP for comment

Reference panel chair examines the review and other comments. Does record need further discussion?

Yes

No

Copied record shredded

Recommendations posted onto secure LAOS website

Accessed by peer-reviewing GPs, hospitals and LAOS co-ordinators
Adverse events identified by LAOS

LAOS is a large clinical risk management program. While each of the 75 small rural hospitals involved in LAOS may have only a few acute care beds, there is a combined total of more than 1,200 acute care beds (figures are not available for all hospitals). This combined coverage enables identification of not only local issues, but also statewide system problems that may otherwise be missed due to low local prevalence.

A GP involved with the statewide implementation of LAOS:

‘Being statewide the program has the cumulative force of numbers. The problems faced by rural GPs are similar to other GPs; with these identified, they provide strong drivers for change at individual, local and government levels. Already, LAOS cases have demonstrated a need for improvement in the transfer of patients from one facility to another and the state government is preparing solutions for this through the Quality Council. Other common issues involve mental health services, critical care and palliative care.’

A total of 102 peer-reviewing GPs have reviewed records this year and 91 VMOs have responded to the findings of the peer-reviewing GPs. Some VMOs are worried about the implications of commenting on reviewed records. We remind VMOs that the LAOS review process is a no-blame process; that the comments from the VMO adds greatly to the understanding of what happened and why. The LAOS process aims to improve the system so that what happened to the patient is unlikely to occur again. The reviewing GPs and reference panel members are also VMOs who are dedicated to improving the system; they make factual, non-personal comments on the records that they review and discuss. No GP, VMO, patient or hospital is identified during this process.

A reference panel chair and educator in LAOS explains:

‘Health care is a complex system, so when something untoward occurs it is likely that a number of factors were involved in its causation. When correcting such clinical adverse events it is essential that all parties involved are given the chance to have input. With the LAOS program this occurs in a setting of mutual respect and the issue can be analysed with attention to the causes of the adverse event. This allows the identification of the factors involved and removes the blaming of an individual for the adverse event. After all, a health care worker is unlikely to get out of bed in the morning with the intent of harming someone, so why blame them for errors?’

A peer-reviewing GP:

‘Currently I am a panel member for LAOS and when reviewing cases I try to put myself in the position of the doctor involved in each particular case. It also makes me reflect on how I would have managed in a similar situation. Sometimes the issues are many; other times there are only a few, but they all provide opportunity to improve patient care.’
There were 916 records received for review from small rural hospitals in 2008–09, which is a 16 per cent decrease* from the previous year.

Figure 1: Number of records received 2004–05 to 2008–09

*LAOS selection criteria changed on 1 July 2007 to narrower definitions (see separate section on selection criteria). Because records can take some weeks to be sent to the LAOS coordinator after the patient has been discharged, there is a flow-on effect of reduced numbers from 2007–08 to 2008–09.

Apart from the change in selection criteria, it is difficult to compare figures with previous years because the LAOS selection criteria do not select all records that may contain an adverse event. LAOS is only a “taster”, designed to select a wide range of possible adverse events from a wide range of records.
Table 1: Number of records positive for each of the selection criteria

<table>
<thead>
<tr>
<th>Selection criteria</th>
<th>Number of records*</th>
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<tbody>
<tr>
<td>Unexpected transfer to another health service</td>
<td>430</td>
</tr>
<tr>
<td>Unplanned readmission within 28 days of discharge</td>
<td>349</td>
</tr>
<tr>
<td>Unexpected patient death</td>
<td>107</td>
</tr>
<tr>
<td>Patient’s length of stay greater than 35 days</td>
<td>70</td>
</tr>
<tr>
<td>Unplanned return to theatre within seven days</td>
<td>6</td>
</tr>
<tr>
<td>Unknown; no criteria selected</td>
<td>6</td>
</tr>
<tr>
<td>Any record that has been recommended by a doctor or other health professional for review</td>
<td>5</td>
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*The total number is 973, as some records are positive for two or more selection criteria

Because it takes a number of steps and weeks for records to be fully reviewed, there were records received in previous years that had their review completed this year and some of this year’s records that are not yet complete. Of this year’s 916 records received, 530 have had their review completed, but including previous years’ outstanding records, 809 records have had their review completed in 2008–09.

Of the 809 completed, 90 records (11 per cent) were found to contain an adverse event; 130 (16 per cent) an educational opportunity and 539 (73 per cent) had no adverse event or educational opportunity found. The 220 ‘positive’ records were discussed over 14 reference panel meetings across Victoria. This resulted in 83 recommendations. If multiple records are presented at a reference panel meeting with similar adverse events, there may be just one recommendation issued to cover all the situations. Likewise, if the adverse event has already had a recent recommendation made, then another recommendation may not be issued. Thus, the total number of recommendations made will be smaller than the total number of adverse events.

Figure 2: Themes of the 83 recommendations:
Table 2: Examination of recommendations by sub-theme

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Number of recommendations</th>
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<tbody>
<tr>
<td>Medical management</td>
<td>Medication orders – appropriate and timely</td>
<td>14</td>
</tr>
<tr>
<td>Medical management</td>
<td>Treatment plan – development and documentation</td>
<td>7</td>
</tr>
<tr>
<td>Patient factors</td>
<td>Case complexity or complication</td>
<td>6</td>
</tr>
<tr>
<td>Organisational/environment</td>
<td>Access to other acute facilities or treatment options</td>
<td>6</td>
</tr>
<tr>
<td>Medical management</td>
<td>Diagnostic tests – choice and timeliness</td>
<td>5</td>
</tr>
<tr>
<td>Medical management</td>
<td>Initial medical assessment and history</td>
<td>5</td>
</tr>
<tr>
<td>Organisational/environment</td>
<td>Resource or equipment constraints</td>
<td>5</td>
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<tr>
<td>Medical management</td>
<td>Treatment, monitoring, transfer – appropriate and timely</td>
<td>5</td>
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<tr>
<td>Task factors</td>
<td>Protocols or guidelines – availability and/or use</td>
<td>4</td>
</tr>
<tr>
<td>Organisational/environment</td>
<td>Staffing levels, workload and skill mix</td>
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<td>Communication</td>
<td>Communication between clinicians/handover</td>
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<td>Medical management</td>
<td>Clinical guidelines – appropriate use</td>
<td>3</td>
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<tr>
<td>Communication</td>
<td>Content of medical record</td>
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<tr>
<td>Communication</td>
<td>Communication to/from other agencies</td>
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<td>Patient factors</td>
<td>Social factors</td>
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<td>Medical management</td>
<td>Diagnosis – appropriate and timely</td>
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<tr>
<td>Communication</td>
<td>Discharge arrangements and plan developed</td>
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<tr>
<td>Task factors</td>
<td>Treatment plan – implementation</td>
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<tr>
<td>Task factors</td>
<td>Education, training and credentialing</td>
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<tr>
<td>Communication</td>
<td>Information provided to patient/carer</td>
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The majority of recommendations (41 out of 83) relate to medical management; most (31) of these related to:

- appropriate and timely medication orders (14)
- the development and documentation of a treatment plan (7)
- the choice and timeliness of diagnostic tests (5)
- the initial medical assessment and history (5).
Documentation – or the lack of it – is a recurring theme in LAOS. Twenty-four of the above 83 themes and sub-themes relate to documentation:

• development and documentation of a treatment plan (7)
• initial medical assessment and history (5)
• communication between clinicians/handover (4)
• content of medical record (3)
• communication to/from other agencies (3)
• discharge arrangements and plan developed (2).

The patient safety checklist in this annual report contains some resources to assist both GPs and small rural hospitals with expected standards in medical management, communication and handover.

Other resources that may assist include the patient safety checklist from the LAOS annual report 07-08:


the patient safety checklist in the Sentinel Events annual reports: www.health.vic.gov.au/clinrisk/sentinel/ser.htm#08

and a more extensive list of resources on the GPV website: www.gpv.org.au/content.asp?cid=12,30&wid=410&t=Resources

Recommendations issued by the LAOS reference panels are available from the LAOS website of recommendations; the address and password are available to LAOS participants from the divisional LAOS coordinators.

**The usefulness of recommendations is demonstrated by these GP comments:**

‘The information has become part of our emergency protocols. Helpful to know what will happen in the emergency department once the patient is transferred.’

‘I will be more proactive in monitoring (biochemical) levels.’

‘An ongoing problem of significant proportions with case used for training of GP registrars and students.’

**Hospitals discuss recommendations at quality forums and take action in response:**

‘Agenda item and copy of case provided at [staff] meeting. Information given to VMOs.’

‘New nomogram distributed. Changed patient procedure.’

‘All cases discussed at clinical review committee meeting (Ten GPs in attendance) … Action [taken] to review current chemical induction of labour procedure.’

‘Hospital has procedures in place to prevent seven of the nine recommendations occurring. GPs agree that consultant medical staff should be contacted for advice rather than registrars.’

‘Nursing clinical education planned regarding case numbers (1–5).’
A regional hospital looked at participating in LAOS:

‘Thank you so much for visiting us recently to discuss in detail our possibilities of participating in the LAOS program. The meeting was very informative and it was clear that ... it was a successful program. Since our meeting we have researched and found we do not have GP bed card admitted patients and only on a very rare occasion in our Hospital in the Home service. So with this information in hand we would be unable to participate. We do however appreciate any information that our GP liaison officer may be able to distribute to assist in any promotion with GPs.’

Directors of medical services’ comments:

‘Hospitals appreciate the quality improvement framework that the LAOS program provides.’

‘The issues raised reflect the same issues raised at state, national and international levels.’

‘I consider this program to be of inestimable value, both in the region and across the state, because of the critical mass of reported incidents.’
Reference panel meetings

Reference panel meetings are held regularly among peer-reviewing GPs to discuss the adverse events and educational opportunities that arise as a result of the LAOS review process. These meetings are also used as a peer-support mechanism by the attending GPs. Meetings may be held within one general practice division or inter-divisionally. Inter-divisional/cross-border reference panels are useful if there are not enough reviewed files from one division to justify a reference panel meeting, or if there are GPs who wish to gain additional experience or mentoring from other peer-reviewing GPs.

The LAOS coordinators distribute copies of Risk Watch, relevant coroner’s reports, Coronial Communiqué and any other material that may be of assistance to our rural GPs. Items from these reports are sometimes discussed along with the de-identified reviewed case histories.

The reference panel chair attaches any appropriate documentation and references, then submits the recommendations for approval. Once approved, the recommendations are circulated to the small rural hospitals and GPs in the local division. If the recommendations are from a cross-border reference panel discussion they are distributed across both divisions.

It is strongly recommended that the LAOS-issued recommendations are discussed at both the hospital quality meetings – which ideally include GP representation – and at local GP practices. Questions are now added to the recommendations to help provide a starting point for discussion. Feedback is encouraged about the actions taken in response to each recommendation to help close the quality loop.

Recommendations are pooled statewide and examined for trends, which are then taken to divisions and/or the department for further action. One statewide issue that has been actioned in 2008–09 is inter-hospital patient transfer. Barwon-South Western region is undertaking a patient transfer project and the Victorian Quality Council (VQC) has a working group looking at this issue in response to LAOS recommendations. (See next section for details of these initiatives.)

Anticoagulation therapy has featured in a number of LAOS reference panel recommendations. As a result the Murray Plains Division of General Practice hosted a National Prescribing Service event called Antiplatelet and Anticoagulant Therapy in Stroke Prevention across multiple locations during 2009, which was well attended.

In West Vic Division of General Practice, LAOS identified areas where international medical graduates (IMGs) required further support. These areas were confirmed by the experience of division workforce managers. After presentation to the division’s board, an investment was made in a set of resources to assist the IMGs to deliver quality services in the Australian setting. These resources include therapeutic and general practice guidelines and resources to assist with communication with patients. This resourcing has become a permanent divisional assistance to the IMGs.

Similarly, the issues of managing palliative care and using advance care plans have been highlighted as a result of LAOS recommendations.

Many divisions now offer ongoing education activities in these areas. Please contact your local division or General Practice Victoria (GPV) for more details about these activities.
Cross-border reference panel meeting

During 2007–08 the LAOS program added cross-border reviewing of medical records between the six lead divisions. The divisions identified that sharing the workload would help sustain the program because each division has varying numbers of peer-reviewing GPs and hospitals submitting records. Following on from that initiative, this year the Otway Division of General Practice and West Vic Division of General Practice came together to hold the first cross-border reference panel where patient records from both divisions were discussed.

GPs identified several positives from cross-border reviewing and reference panels:

- program sustainability
- sharing the workload across a greater number of GP reviewers
- ‘fresh eyes’ reviewing the records
- identifying common themes
- timeliness of records being reviewed
- the department being supportive of cross-border reviewing.

Further cross-border reference panel meetings will be held as required.

Feedback from peer-reviewing GPs attending the cross-border reference panel meeting:

‘A chance to network with GPs who we do not often see.’

‘This was a successful meeting and we would be keen to have a combined reference panel again.’

Feedback in response to a journal article and a coroner’s report circulated at a reference panel meeting:

‘Thanks for sending this along; a fascinating, informative and educational read.’

‘I’ll store this for reference with students.’

Some GP responses to reference panel recommendations:

‘Communication is a problem particularly if a shift changes and if there is no documentation. It needs to be written clearly in the notes what action is to be taken so that the next shift covering doctor understands what is to be done.’

‘Reference websites on the recommendations are excellent.’

‘Recommendations are useful and helpful.’

‘The process has no relevance for me as there are excellent internal review processes at [this] hospital.’

‘These cases were, I feel, badly managed.’
Hospital responses to recommendations issued by reference panels:

‘Policy updated.’

‘Policy to be developed that requires doctors to sign all pathology slips prior to filing.’

‘Policy reviewed to ensure criteria of reportable death is included – is now in place.’

An IMG’s reflections on practising in Australia:

‘About three years after I arrived in Australia I joined the LAOS program. One of the things I noticed about practising in rural Australia is that GPs work in silos, as individuals, with little opportunity to discuss medical issues with other doctors around the coffee table. Participating in the LAOS program provides a forum for this type of non-threatening discussion. The retrospective, no-fault nature of the program means that doctors can discuss anything. I find it valuable to meet with other GPs for such discussion and it is a valuable way of learning from mistakes made – your own and others.’
Barwon-South Western Region Patient Transfer Project

The LAOS program has highlighted that patient transfers are often compromised. This can be most evident when patients are transferred between organisations where there are less effective methodologies for handing over information. The problem is compounded when there is a lack of understanding about the capacity of a small rural hospital to meet the patient’s needs. This can be medical, nursing, medication management or other specialist needs not available at a small rural hospital.

‘Handover’ is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. ‘Patient transfer’ refers to transferring all necessary information and clearly identifying professional accountabilities and responsibilities of the individuals involved in the transfer process. There is evidence that patient care can be compromised by ineffective handover between clinical teams. Inter-hospital issues (issues with transfer of a patient from one health service provider to another) have been identified as one of the categories of system failures that regularly contribute to sentinel events in health care.

A project aiming to improve the outcomes of patients who are transferred between health care facilities in the Barwon-South Western region has been piloted. The project uses a structured patient transfer tool to standardise the approach to patient transfer. This required implementing an improved patient transfer care system across a broad range of health care provider organisations within the Barwon-South Western region. The successful rollout of a wider project across all organisations in the region will deliver safer, more consistent transfer of critical information regarding continuing patient care between clinical teams. The overall goal of the project is to ensure patients are transferred between organisations in a safe and timely way. That is, patients are transferred between organisations with an appropriate clinical handover, into an environment capable of undertaking their care with all the relevant resources necessary.

The project will introduce a standardised ‘transfer envelope’ and transfer form for inter-organisation patient transfers. This will include transfers from: acute to subacute; acute to lesser acuity facilities; aged care to acute transfers; and acute to aged care transfers. It will address emergency, semi-urgent and elective transfers. The project will involve all health care agencies (public, not-for-profit and private) in the Barwon-South Western region. It is restricted to these recognised participant health care organisations and, as such, will not address transfers from institutional care to the home environment.

The transfer envelope includes crucial patient information, contact details for the staff who have been advised of the transfer/handover, and other essential information (for example, discharge letter, tests, X-rays and medications). In order to ensure staff planning a transfer understand the capacity of the receiving organisation, a set of laminated ‘flip charts’ has been developed that includes critical information regarding each organisation’s scope of operations and details of the person responsible for accepting patient transfers.

There is a strong commitment from Barwon-South Western hospital chief executive officers, directors of nursing, quality managers group, clinical risk groups within the facilities and the Otway Division of General Practice to address the issues surrounding patient transfers.
Victorian Quality Council Patient Transfer Working Group

Critically ill patients benefit from transfers coordinated at a statewide level but, for non-critical hospital transfers, hospitals organise patient transfers directly with each other.

Many rural GPs have expressed frustration with delays in transferring non-critical patients from small rural hospitals to regional hospitals. There have been several recommendations issued that have noted unacceptable delays in the transfer of non-critical patients who have exceeded the capacity of the small rural hospital to manage their needs. Similarly, there are problems with patients being transferred from regional or metropolitan hospitals to small rural hospitals where the doctors at the larger hospital have no understanding of the lack of resources – such as cardiac or stroke care units or even an on-site pharmacy. There is also limited availability of allied health services such as physiotherapy and speech therapy at small rural hospitals, which can result in patients being transferred to small rural hospitals that cannot support the ongoing care needs of these patients.

The VQC held a workshop in March 2008 on inter-hospital transfer that attracted wide interest from a diverse group of stakeholders. The top three priority actions identified through this consultation were:

1. standardise the information transfer process (communication and documentation)
2. establish statewide, centralised service/s for adult patient transfer
3. standardise the transfer process.

In May 2008 the VQC convened a limited-term expert panel with representatives from public and private hospitals, ambulance services, GPV and specialist retrieval service to review the issues identified at the workshop and determine a framework for future work.

The panel endorsed a draft project brief focusing on standardising patient transfer processes across the state. As the council’s second term drew to a close in June 2008, the project was suspended until such time as the new council had determined alignment of this work with the council’s new terms of reference and the 2008–2012 strategic plan. The council subsequently endorsed the project and work commenced early in 2009.

In a letter to the VQC in April 2009, the LAOS program expressed concern over ongoing problems with inter-hospital patient transfer, particularly for small rural hospitals. As a result a representative from GPV is part of the new Inter-hospital Patient Working Group. The key focus of the group is to develop:

- generic information/guidelines for inter-hospital transfer of non-critical patients that:
  - standardises terminology
  - identifies requirements for feedback to appropriate stakeholders such as GPs
- standardised electronic inter-hospital patient transfer form/s that link to appropriate decision support processes.

Feedback from GPs about patient transfer issues statewide:

‘Must continue to pressure larger hospitals for change by constant reminder of system failure.’
‘Tertiary hospital discharge has improved over the last few years.’
**GP education**

**Continuing professional education**

**Royal Australian College of General Practitioners (RACGP)**

Continuing professional development points are available for GP participation in LAOS.

RACGP category one points are available for GPs who undertake the full LAOS process.

Category two points are available for GPs who complete any one part of the process.

**Australian College of Rural and Remote Medicine (ACRRM)**

Clinical audit points are available for GPs who participate in the LAOS program.

Please notify your LAOS coordinator if you wish to apply for continuing education points with RACGP or ACRRM.

**Feedback from GPs about LAOS providing continuing education:**

‘LAOS provides interesting real case scenarios … and some expert references are made.’

‘Will discuss in our own doctors’ meeting.’

‘Relevant discussion outside the cases also of great value.’

‘LAOS could be an important part of registrar training and registrars should be encouraged to participate in this non-punitive peer review process and it should form part of the continuing medical education ethos of future doctors. Registrars should be encouraged to take part in review panels. Perhaps the RACGP training module could be used as a training module for registrars. LAOS has so many positive outcomes in terms of participation with the hospital, improving patient outcomes, risk reduction. This is all part of where medicine is heading and should not be an optional extra tack on, but more of a fundamental process in training registrars.’

‘A GP’s life is cluttered with much bureaucratic paperwork these days, but of all the things that cross my desk, LAOS is important to me and I make sure that I read it.’

**A director of medical services:**

‘GPs can feel that the presented cases couldn’t happen to them; however, with accreditation of general practices now driving standards, the LAOS program will become more validated and accepted. Best practice will become more important in the future as the public will demand higher standards of patient care at a time when there will be increasing workforce shortages for all health force professionals.’
LAOS reports to reference groups and conferences

The following reports have been presented to the Sentinel Event Review Subcommittee of the Clinical Risk Management Reference Group:

- June 2009: follow up from previous reports
- December 2008: small rural hospitals and patient transfer issues
- October 2008: palliative care advance care planning.

GPV is represented on the new Inter-hospital Patient Working Group which was established by VQC in 2009.

A poster describing the LAOS process and its achievements was presented at the 2008 School of Rural Health Research Conference held at the University of Melbourne, School of Rural Health, Shepparton on 16 October 2008. This attracted a lot of attention, many handouts were issued and we were able to directly address queries from involved hospitals and those interested in the program.

Feedback from reference panel chairs about the value of LAOS reports to reference groups:

‘This is [an] aspect of how LAOS can be promoted to young rural GPs: Some of the things [GPs] all complain about is the fact that we effectively have very little impact in the corridors of power. When we come across something that’s a recurrent clinical issue it is incredibly gratifying to think that we as mere GPs can be involved in a review panel process through the LAOS report to the Sentinel Event Review Subcommittee process. We, from the grassroots level, can influence policy makers and educational centres of excellence, so that there are changes visible in our own life time, as to how people are taught or things are funded or policies are rolled out. That really gives you the feeling that things you do and say matter. They really count and they change things. I think that is an incredibly empowering concept to feed into training doctors to say if you are involved in this project, that what you say changes the way all your colleagues will think and behave in as little time as one year. I can’t think of anything else I can do that does that.’

‘I think this is part of the feedback loop that we previously hadn’t thought about. We have been keen to close the loop between GPs reviewing things and getting the information back to hospitals so that it actually results in reduced adverse events in the hospital. The idea that the educational side can go back to GPs is proof that your input makes a difference. I think that’s important to let doctors know.’
Case Study Reports

To illustrate the diversity of issues dealt with by the LAOS program, six case studies are presented that were discussed by reference panels during 2008-09.

Case study 1: Managing renal obstruction

This case relates to medical management issues and communication between clinicians. It presents the issue of a patient who has exceeded the capacity of a small rural hospital’s services.

Screening criteria:
Unplanned readmission within 28 days; transfer to another acute care facility

Case summary:
Patient admitted with renal colic.
Pain eased after 48 hours to a dull discomfort.
Given home leave, but readmitted four days later with acute pain and mild fever.
CAT scan two days after admission showed mid ureteric calculus and hydronephrosis (kidney stone and distension of kidney with urine).
Cause discussed with urology registrar from an urban hospital. Conservative management and outpatient review initiated. Further pain 31 days after second admission. Acute transfer five days later to urban hospital.

Summary of issues raised by GP reviewer:
High obstruction with moderate stone and hydronephrosis one week after onset of pain and advised to try conservative management by urology registrar.
GP not supported well by referral hospital.
Patient’s kidney put at risk due to non-transfer, probably due to reluctance by urban hospital.

Summary of treating GP comments:
Argue that this patient required definite treatment earlier. Urban hospitals are in most cases very supportive of small rural centres.

Summary of reference panel discussion:
Advice from urology registrar does not seem to address the severity of the clinical situation.
Hospitals that provide support to small rural hospitals may not be aware of the limitations small rural hospitals work within.

Recommendations:
1. The treatment of an obstructed kidney should be as an organ at risk of failure. Delayed treatment can result in irreversible loss of renal function.
2. VMOs need to actively transfer patients to the support hospital when they believe their hospital is unable to provide appropriate care and service.
3. VMOs could consider adopting a lower threshold of transferring patients to support hospitals if the rural hospital cannot provide appropriate care.

4. VMOs should deal with consultant specialists if they are unhappy with the advice of junior doctors or registrars.

**Case study 2: Managing warfarin**

This case relates to medical management and presents the difficulties of managing warfarinised patients, especially during surgery. There have been five recent cases relating to warfarin in three different divisions, illustrating an emerging issue across Victoria.

**Screening criteria:**

Unexpected patient death

**Case summary:**

Patient with history of atrial fibrillation. On warfarin. Admitted for elective hip surgery. Suffered a cerebrovascular accident (CVA – a stroke) intra-operatively and died five days later. Warfarin was ceased one week prior to surgery. Blood pressure (BP) went up to 200/130 briefly during anaesthetic.

**Summary of issues raised by GP reviewer:**

Management of anticoagulation pre-operatively in atrial fibrillation.
Query risk of CVA when off warfarin for one week.
Query indications for Clexane® pre-op.
Management of hypertension during anaesthesia in elderly patients.

**Summary of treating GP comments:**

It is my understanding that cessation of warfarin carries an increased risk of CVA; however I have not seen a recommendation that patients ceasing warfarin prescribed for atrial fibrillation prior to surgery should have Clexane® cover (unlike for heart valves, for instance, in which heparin or Clexane® is indicated).

The patient had brief episodes of significant hypertension intra-operatively, most of the time the blood pressure was at the moderately elevated level including at pre-op assessment and before induction. I avoided anti-hypertensives intra-operatively and focused on analgesia and muscle relaxation for fear of causing hypotension (blood pressure was labile and the patient was briefly hypotensive also).

The patient was booked as a hip revision although the surgery turned out to be different and quite long. I had misgivings about conducting the surgery at the local hospital and wondered if a tertiary centre may have been better. The patient may well have had a stroke where ever it was done.
Summary of reference panel discussion:

Difficulty in managing warfarin.
In surgical cases the anaesthetist should have the last say in management.
Arrange a professional development course on the subject.

Recommendations:
1. GPs review their practice of managing patients treated with warfarin.
2. Health services review/develop their procedures in collaboration with their GP VMOs on managing warfarin and/or international normalised ratio (INR); especially during the course of anaesthesia.
3. Local divisions arrange an education program on warfarin management including intra-operative use.

Case study 3: Frequency of medical visits and writing of notes for acute patients

This case relates to medical management and communication, visiting inpatients and recording notes. Documentation is an ongoing issue. All participants in LAOS are reminded that the Medico-legal guidelines published by the Medical Practitioners Board of Victoria in March 2006 (see checklist for website) requires medical practitioners to maintain accurate contemporaneous records of treatment provided to their patients.

Screening criteria:
Unexpected transfer to another health facility

Case summary:
Elderly patient admitted for rehabilitation after a fractured humorous +/- pneumonia.
Nursing notes frequently documented increasing shortness of breath (SOB) on exertion and at rest.
Little medical attention paid to the SOB until patient became seriously short of breath requiring transfer.

Summary of issues raised by GP reviewer:
2. Nursing notes documented SOB. Was this communicated to medical staff?
3. Nurofen™ ‘increased to three times daily (tds)’. May have aggravated or precipitated congestive cardiac failure (CCF).
4. No investigation results in file. Don’t know what ultimate cause of SOB was.
5. I wonder if more timely medical review plus investigation would have allowed earlier management and prevented this outcome.
Summary of treating GP comments:
This patient has a history of congenital brain injury, extensive mental disorders such as panic attacks, bipolar affective disorder and depression, CCF, recurrent chest infections, osteoporosis, increasing falls in care and arthritis.
I examined the patient briefly on admission but didn’t have adequate time to write a detailed note as there was only a half-hour to visit the nursing home, hostel and acute unit on that day.
On the second day when I visited, nurses told me the patient was in the toilet and I couldn’t review progress. The nurses also told me the patient was fine and no complaints but is always short of breath which may be due to resistant cardiac failure, panic attacks and/or poor lung capacity. The other clinical parameters were normal during these days. Nurofen™ tds might have caused precipitation of CCF but there are no other causes we can consider before Nurofen™. We avoided unnecessary investigations. Even in hospital you can’t prevent this type of CCF exacerbation.

Summary of reference panel discussion:
Frequency of medical officer visits when treating acute patients.
Frequency of written notes when treating acute patients.

Recommendations:
1. If a patient is occupying an acute bed the panel members recommend a patient deserves to be seen at least daily and notes recorded by the treating GP in the patient record.
2. Health services establish standards in line with published standards and guidelines (some standards are included in the checklist contained in this annual report and there are resources relating to handover in the 2007–08 annual report’s checklist).
3. If nursing staff express concern about a patient to the treating GP, the treating GP should visit the patient.

Case study 4: End-of-life directives
This case presents issues around medical management, communication, task factors and patient factors.

Screening criteria:
Transfer to another acute care facility

Case summary:
Elderly patient admitted for respite care.
Developed acute myocardial infarction (AMI, heart attack) with severe bradycardia and hypotension.
IV normal saline given: 100 ml bolus and 1000 ml over eight hours.
An electrocardiograph (ECG) (done later) showed an idioventricular rhythm.
No attempt to stabilise heart rate and blood pressure before transfer to regional hospital. Not for resuscitation (NFR) noted.
Summary of issues raised by GP reviewer:

Patient possibly developed an AMI. The severe bradycardia and hypotension would warrant an ECG. Normal saline was running only at 1,000 ml eight-hourly after 100 ml bolus, which is probably inadequate to raise the blood pressure significantly.

If transfer to another hospital is decided, some effort to increase the blood pressure and pulse rate should be attempted. Atropine may be considered to try to raise the heart rate before transferring.

I note this patient was NFR.

Summary of treating GP comments:

The doctor on duty that night had left the practice, comments were made by a colleague.

As mentioned, the patient was NFR and was admitted to improve the congestive cardiac failure symptoms – if at all possible (this was not mentioned by the reviewer in the case summary). If I was on duty, a more palliative treatment approach rather than transfer would have occurred as per the patient and family’s wishes – perhaps this should have been better documented. I cannot comment on the treatment given, other than to note that aggressive fluid replacement may not have helped the patient’s already brittle congestive cardiac failure.

Summary of reference panel discussion:

Lack of end-of-life directives and documentation of directives.
Lack of continuity of care and the implications for NFR orders.
No clear plan on how best to manage this patient.

The fluid replacement appeared inadequate for resuscitation.

Recommendations:

1. Try to contact the patient’s usual GP if faced with a NFR situation
2. Consider a patient held case summary with documented NFR status, or formalise documentation in the patient file indicating end of life plans
3. Education for health workers on end-of-life issues

Resources:

• Some divisions of general practice have facilitated advanced care planning at aged care facilities across their region. All of the facilities which have implemented the program have consultants who have been trained by the divisions, and have transferred this knowledge across to the acute section of their health services.

• Education is also provided to GPs of facilities where the program has been implemented.

• Health services are encouraged to participate in advanced care planning training. There are trainers who can deliver education to health professionals.
Case study 5: Bradycardia and transfer

This case relates to medical management of a complex case and organisational/environmental and transfer issues with the regional hospital.

Screening criteria:
Transfer to another acute care facility

Case summary:
Elderly patient. Discharge diagnoses: bradycardia/hypotension/falls, acute gout, chronic renal failure (CRF)/prostatism, rectal bleeding, frailty/dementia.
Documented severe bradycardia and frequent falls. Not ambulating well.
Moderate to severe renal impairment. Incontinence of urine and faeces. Multiple problems and medications that need coordination.
Transferred to regional hospital by private car at the patient and family’s request (with continence pad/pants).

Summary of issues raised by GP reviewer:
Severe bradycardia was clearly documented on ECG. Suggest arrangement for pacing should be done earlier. It may not be advisable to transport patient who has severe bradycardia, hypotension and incontinence of urine and faeces in a private car over a long distance.
Medication given may aggravate already moderate to severe renal impairment. There was also epigastric pain and rectal bleeding. The cause of the rectal bleeding was not investigated (for example, fissure, piles or bleeding higher up). Prednisolone may be better for treating gout in this situation. There seems to be little indication for starting antibiotics.
Arrangements should be made for further investigations of rectal bleeding and the cardiologist informed of what’s been done instead of mentioning patient may need a colonoscopy. The managing doctor should coordinate this.

Summary of treating GP comments:
Day 1: Elderly patient with mild dementia/gout referred by district nurse for investigation. Patient was reluctant to attend clinic or be admitted (but was persuaded to come into hospital). On examination temperature 37.9, tender epigastrium, low blood pressure, slight postural drop. At hospital, heart rate (HR) decreased from 65 to 44 (on ECG). Medications changed.
Day 3: Occasional drop to HR of 23–29 but remains asymptomatic with low blood pressure but no postural drop. Continued monitoring discussed with cardiologist re: pacing and change of medication.
Day 4: Complaining of painful feet/difficulty walking/incontinence of urine; unable to weight-bear because of pain in feet.
Day 5: HR now 60+ but not walking, now complaining of abdomen pain/constipation. Mini-mental state examination (MMSE) 16/30; for referral to geriatrician.

Day 6: Increased pain in abdomen, ultrasound: biliary calculus ++ but common bile duct normal. Also pain in left elbow, uric acid .51, renal function improved, given another medication.

Day 7: Tender ++ left elbow, spiking low-grade temperature ?sepsis. C-reactive protein increased to 277 (from 30) erythrocyte sedimentation rate increased to 131 (from 61), neutrophilia noted therefore blood cultures taken and patient commenced on antibiotics. Decreased pain/less hot left elbow. Seen by geriatrician who agrees with proposed referral for pacing at base hospital (still without bed availability).

Day 10: Ambulation improving, no pain, still no bed available at regional hospital.

Day 11: Episode of slight per rectum bleeding. Abdomen soft/no masses. Digital rectal examination: smallish prostate, soft faeces, no masses, piles or fissure.

Day 12: Referral written detailing multiple problems, including episode of per rectum bleeding and need for colonoscopy.

Day 13: Still no bed available. Transferred to regional hospital by private car at patient and family’s request (with continence pad/pants).

Issues worthy of discussion:
Asymptomatic bradycardia per se does not of itself warrant immediate treatment and it is worthwhile to see if there is any cause for it (medication or otherwise).
A short course of diclofenac may provide rapid relief of gout without necessarily compromising renal function (as long as it is monitored). Although I agree it may aggravate chronic renal failure.
Antibiotics were started on good clinical and laboratory ground.
Whilst attempts may be made to get a patient attended to in a regional hospital for two separate conditions in my experience it is rarely successful, if ever!

Summary of reference panel discussion:
Reviewer probably did not have the full details/picture of the case.
Elderly patient with bradycardia – could stop medication and watch.
Prednisolone is good for treatment of gout.
Not able to transfer patient to regional hospital – GP was looking for assistance and was unable to get help. Timely transfer and gastrointestinal re-evaluation is desirable as patient had gastrointestinal bleeding.
Regional hospitals should automatically accept medically complex cases that would place the unsupported rural practitioner at risk.
Recommendations:
1. To encourage regional hospitals to be part of a team effort in treating a patient and accept transfers from small rural hospitals.
2. Regional hospitals need to be more sympathetic to transfers from small rural hospitals and acknowledge that they have doctors on site to treat the patients in an emergency department and can transfer patients to the metropolitan hospitals if necessary.

Case study 6: Clinical guidelines for stroke and TIA management
This case study relates to changes in the management guidelines of stroke and transient ischaemic attacks (TIA) and the need for small rural hospitals to ensure all clinical guidelines are current. It also illustrates where treating GP comments would have aided the discussion.

Screening criteria:
Patient death

Case summary:
Elderly patient with multiple comorbidities was admitted with lethargy, nausea and vomiting, shortness of breath and a suspected CVA. The patient had ceased to take their normal medications over the previous month. The patient’s condition deteriorated and four days after admission they became unconscious and died.

Summary of issues raised by GP reviewer:
There was a delay in organising a CT or MRI which may have influenced the patients’ outcome. The approach to CVA now is more aggressive

Summary of treating GP comments:
Record returned from treating GP with no comment

Summary of panel discussion:
1. No mention of CT, result would possibly not have changed what happened
2. Not a very acute presentation
3. Not obvious from day one, was becoming obvious over the admission
4. A problem is trying to obtain a CT appointment

Recommendations:
1. Protocols for the treatment of CVA have changed significantly over two years therefore small rural hospitals are encouraged to ensure that they update protocols regularly in-line with current best practice.
2. If there is any doubt contact the regional hospital’s stroke unit.
Divisions of general practice

GPs and small rural hospitals are assigned to a local division of general practice. There are six lead divisions of general practice involved in LAOS, which also represent Victoria’s other rural divisions of general practice.

The general practice divisions are listed below.

- General Practice Alliance South Gippsland (www.gpasouthgippsland.com.au) is the lead division also representing East Gippsland Division of General Practice and occasionally GPs from the Eastern Ranges Division of General Practice and Dandenong Casey General Practice Association Inc., who practice as VMOs in Gippsland's small rural hospitals.
- Goulburn Valley Division of General Practice (www.gvgp.com.au) is the lead division also representing Central Highlands Division of General Practice and Central Victoria General Practice Network.
- Murray Plains Division of General Practice (www.mpdgp.com.au) is the lead division also representing part of the Mallee Division of General Practice.
- North East Victorian Division of General Practice (www.nevicdgp.org.au) is the lead division also representing part of Albury Wodonga General Practice Network.
- Otway Division of General Practice (www.otway.asn.au)
- West Vic Division of General Practice (www.westvicdiv.asn.au) is the lead division also representing Ballarat Division of General Practice.
- Statewide coordination is managed by GPV (www.gpv.org.au). Further information relating to clinical risk management and the LAOS program may be found at http://www.gpv.org.au/content.asp?cid=12,30&t=Clinical%20Risk%20Management

Appendices

Divisions of general practice

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## LAOS partnerships

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<th>Partners</th>
<th>Role in LAOS</th>
<th>Details</th>
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| Department of Health (formerly the Department of Human Services) Quality and Safety Branch | Funding body  
Strategic statewide direction  
Clinical Risk Management Reference Group | Funding on a triennial basis; 2001 to 2012. |
| GPV | Statewide coordination  
Presentation of pooled recommendations at the Sentinel Events Review Subcommittee of the Clinical Risk Management Reference Group | | |
| Divisions of general practice | Local coordination  
Develop local initiatives in response to recommendations  
Support local GPs  
Work with lead divisions  
Develop local programs in response to recommendations | Twelve rural divisions involved; managed by six lead divisions |
| Peer-reviewing GPs | Review patient records from small rural hospitals  
Attend reference panel meetings  
Develop recommendations  
Act upon recommendations | 102 GPs reviewed records  
83 recommendations made |
| Rural GPs | May be appointed as a VMO in a small rural hospital  
Comment on their own patient’s reviewed records  
Attend hospital quality forums  
Discuss, act upon and give feedback on recommendations  
Participate in division programs | 1,371 GPs in the rural divisions covered by LAOS; all receive LAOS recommendations (not all are VMOs) |
| Small rural hospitals | Provide medical services to local patients  
Screen records and send for LAOS review  
Hold quality forums with local VMOs  
Discuss, act upon and give feedback on recommendations  
Participate in division programs | 75 small rural hospitals receive recommendations. |
| Department of Health's rural regions | Auspice regional quality forums  
Assist in developing regional programs/trials in response to recommendations | Five rural regions |
| RACGP ACRRM | Provide continuing education/professional development points that are required for GP registration | Several modules available |
LAOS selection criteria from 1 July 2007 – 30 June 2009

The six selection criteria used from 1 July 2007 to 30 June 2009 and covered by this annual report are:

• unexpected patient death
• unplanned return to theatre within seven days
• unplanned readmission within 28 days
• unexpected transfer to another health service
• patient’s length of stay greater than 35 days
• any record that has been recommended by a doctor or other health professional for review.

Definitions

1. Unexpected patient death – All patient deaths that are not clearly documented in the initial clinical management plan as an expected or likely progression of the current admission. This will often be noted as palliative care, and may include an NFR form. It should be clear from the documentation that notes such as these are not a consequence of unforeseen patient deterioration during the course of management. Cases should be counted where a classification of palliative care occurs after a more thorough assessment several days after admission. It should be noted that a classification of palliative care after a period of assessment is an entirely appropriate clinical decision in many cases, and in and of itself does not represent an issue.

2. Unplanned return to theatre within seven days – If it was necessary for further operation for complication(s) related to a previous operation/procedure in the operating room.

3. Unplanned readmission within 28 days of discharge – Refers to a readmission of the patient within 28 days of discharge. All readmissions within 28 days are counted unless clearly proposed as part of the documentation of the previous admission. With this criterion the reviewer is looking to see whether an adverse event occurred in the first admission resulting in readmission to hospital. When health information managers are completing the analysis form for this criterion, the code of the treating GP during the first admission should be recorded. The admission and discharge dates recorded on the analysis form will also be those of the first admission.

4. Unexpected transfer to another health service – Any situation where transfer was not anticipated in clinical documentation of the initial presentation. Not to be counted if planned transfer was documented as part of the initial management plan. Any delay or disruption to a planned transfer should be reviewed. To be counted if the initial management plan was for observation and/or stabilisation for a period of time and, subsequently, it was decided to transfer. It should be noted that observation for a period of time to allow a better decision on the need for transfer is an entirely appropriate clinical decision in many cases, and in and of itself does not represent an issue.

5. Patient’s length of stay greater than 35 days – If from the time of admission to the time of discharge of the patient, their stay was greater than 35 days. This conforms with the current acute/nursing home type (NHT) classifications.
6. Any record that has been recommended by a doctor or other health professional for review
   - If a GP or other health professional requests that the patient’s medical record of a particular admission be sent for peer review. Why the health professional wanted the particular medical record reviewed should be noted. Particular note should be made of obstetric cases. Apart from cases that are flagged under other criteria, some health services have sent a sample of their obstetric cases to the program as part of a regular quality review. There are a range of GP/obstetricians in programs across the state who are available for review of these cases.

There have been a few records finalised during 2008–09 from inpatient stays before 1 July 2007. These records were selected using the original selection criteria in use until 30 June 2007:

**LAOS screening criteria to 30 June 2007**

- Patient death
- Return to theatre within seven days
- Unplanned readmission within 28 days
- Transfer to another acute care facility
- Patient length of stay greater than 21 days
- Any record that has been recommended by a GP or other staff for peer review

**Reflections from an educator:**

‘Perhaps in the future the LAOS program could be incorporated into other clinical settings, such as the practice or aged care facilities. Case audit is an effective tool in analysing risk and working towards change.’
Glossary

ACRRM  Australian College of Rural and Remote Medicine
Adverse event  An incident in which harm resulted to a person receiving health care.
Blame  To hold at fault (implies culpability).
CPD points  Continuing professional development/education points, required to maintain professional competence and registration.
CRM  Clinical Risk Management; an approach to improving quality in health care that places special emphasis on identifying circumstances that put patients at risk of harm, and then acting to prevent or control those risks.
Clinical Risk Management Reference Group  Provides expert advice to the Department of Health to support the identification, management and minimisation of risk in the clinical setting.
(The) department  The Department of Health, formerly the Department of Human Services
Division of general practice  An organisation of local general practitioners established to encourage GPs to work together with other health professionals to improve local health service delivery. Across Victoria there are six lead rural divisions of general practice involved in LAOS, representing a total of 12 rural divisions.
Educational opportunity  Many system or clinical issues do not lead to an adverse event, but in other circumstances they may have, and thus represent an educational opportunity.
GP  General practitioner
GP reviewer/peer reviewing GP  A rural general practitioner who reviews the selected medical record looking for any adverse event or educational opportunity in a no-blame manner.
IMG (international medical graduate)  A doctor who has obtained their basic medical degree outside Australia.
LAOS  Limited Adverse Occurrence Screening. A retrospective examination of small rural hospital patient records looking for adverse events and educational opportunities.
LAOS coordinator  Person employed by the division of general practice to administer the LAOS program.
Medical record  A manual or electronic record containing a patient’s health or personal information, status and treatment.
RACGP  Royal Australian College of General Practitioners
Reference panel  Meeting of peer-reviewing GPs who discuss the adverse events and educational opportunities found in reviewed patient records and issue recommendations for system improvement.
Safety  Freedom from hazard
Sentinel Events Review Subcommittee  A subcommittee of the Clinical Risk Management Reference Group; reviews sentinel events and root cause analysis reports.
Victorian Quality Council (VQC)  The group that leads and influences the quality and safety agenda to achieve safer, better health care for all Victorians.
VMO  Visiting medical officer (In this document, refers specifically to a GP employed in this role in a small rural hospital.)

‘The thing about an adverse event is that even though it may not have occurred in your own practice, it could. So what are you doing about preventing it from happening to you? That’s the value of the (LAOS) program in my own clinical practice.’