Better patient safety

Improving outcomes in emergency and urgent care

The Victorian Government's insurer and risk adviser, Victorian Managed Insurance Authority (VMIA), has collaborated across government and the healthcare industry to improve outcomes and focus on harm prevention in emergency and urgent care.

The study

Building on its success with the ground- breaking harm prevention program for women and babies in the maternity and neonatal setting, VMIA has partnered with Safer Care Victoria and the Australasian College for Emergency Medicine to develop recommendations for harm prevention measures in the complex and challenging emergency setting.

Outstanding results for mothers and babies through the harm prevention program demonstrate the practical value of VMIA's data and insights when combined with industry expertise. It's a valuable foundation to inform our collective approach to improving outcomes in emergency departments.

With clinical leadership and insight from the Australasian College for Emergency Medicine and partnering with specialists from metropolitan and regional health services, the three-year program will be launched in mid 2022.

Who will benefit

Patients
with better health outcomes

Clinicians and hospital staff
with improved resources and support

The broader community
with enhanced hospital services and facilities from reduced claims

> **"Our shared objective is to reduce the risk of harm to patients in emergency settings."**
> Andrew Davies, CEO, Victorian Managed Insurance Authority

VMIA and patient safety

VMIA has a long history of investing in harm prevention initiatives.

Since introducing fetal surveillance training in 2004 and Practical Obstetric Multi- Professional Training in 2010, VMIA has seen a marked reduction in fetal death and obstetric claims.

Together with neonatal resuscitation, these initiatives are the foundation of VMIA's Incentivising Better Patient Safety Program. It rewards hospitals for training birth suite clinicians in key areas of risk mitigation, with almost $10 million in medical indemnity premium refunds to participating hospitals over the past 3 years.

vmia

Australasian College for Emergency Medicine

CENA

SCV Safer Care Victoria

VICTORIA State Government

Key themes + recommendations

Support clinical practitioners at the critical decision point, when they have limited information	Design and adopt new bundles of care for high-risk presentations to support rapid patient assessment, appropriate clinical pathways, and follow up care. Upgrade hospital electronic health record systems to integrate bundles of care into workflows.
	Simplify and standardise clinical guidance material and improve access at the point of care.
	Agree and adopt criteria to escalate patients making unplanned returns to the emergency department or urgent care centre to a senior practitioner to support decision making.
	Expand telehealth for decision support from senior and specialist practitioners for non-critical care.
Make patient information available to clinical practitioners and support staff at key points	Implement encrypted closed-loop messaging services within health services that comply with privacy and security standards, link to electronic medical records, and have robust governance.
	Trial expanded digital notification systems for abnormal laboratory and radiology results, with a direct phone call for urgent results.
Centralise state-wide system knowledge to mobilise resources and provide the right care	Expand critical patient transport co-ordination to include specific non-critical patients so practitioners can escalate for further care, identify health service capacity and coordinate transport.
Build practitioner knowledge so they're better prepared for likely events	Share lessons from adverse patient safety events, including patient stories, case studies, and best practice.
	Establish a forum for issues, emerging trends, best practice examples and learnings from adverse events.
	Establish a resource library to improve assessment and management of high-risk presentations, including case studies and evidence-based recommendations for ongoing training and education.
	Improve data presentation about adverse patient safety events to clinicians and managers to better identify opportunities to reduce risk and improve quality of care.

Read the full report and recommendations at
https://www.vmia.vic.gov.au/risk-advisory/harm-prevention/emergency-department

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