DAVID YEHUDA WEISER

David Weiser, aged 70 years, died on 13 November 2013 from gastrointestinal bleeding after collapsing at home. Mr Weiser had presented to Peel Health Campus Emergency Department two days prior after passing black stools and feeling unwell; however, was diagnosed with gastroenteritis and discharged. The coroner reviewed the diagnostic decision making and explored access to, and sharing of, patient information given the deceased had a complex medical history.

The Department of Health’s Coronal Review Committee has reviewed these findings and has directed the recommendation to the appropriate stakeholders for review and response. The Committee endorsed the development of a fact sheet to be disseminated to all health services to provide a guide for the sharing of patient information.

Health Services have reported a number of existing health service-level policies and standard practices to address concerns raised about Emergency Department clinicians having timely access to patient health information, including but not limited to clinical documentation standards, patient transition clinical practice standards and clinical deterioration policy.

The South Metropolitan Health Service has been promoting sites’ adoption of the ‘Call And Respond Early (CARE) for Patient Safety’ program which provides a way for patients, their families and carers to raise concerns or call for rapid assistance when they feel that a patient’s changing condition may not have been recognised.

Work is currently being undertaken to improve access to the Psychiatric Services On Line Information System (PSOLIS) for Emergency Department consultants and clinical nurse specialists. Additionally the option of alerting a clinician of a recent entry in PSOLIS through the Emergency Department Information System (EDIS) is currently being investigated from a technical standpoint.

The WA Country Health Service is continuing to roll out the implementation of WebPAS (electronic patient administration system) which will facilitate the sharing of information across regional health care services. The use of the national
The recommendation made by the coroner is marked as ongoing at the time of this report. Progress for this recommendation will be updated in the next report.