AMA Victoria's response to the consultation on extending authorisation for rural isolated practice endorsed registered nurses (RIPERNs) to operate within their full scope of practice

16 June 2017

The Australian Medical Association (Victoria)

Introduction

AMA Victoria welcomes the opportunity to provide feedback to the consultation on extending authorisation for rural isolated practice endorsed registered nurses (RIPERNs) to operate within their full scope of practice.

Nurses whose registration is endorsed under the *Health Practitioner Regulation National Law* (s. 94), may be authorised to possess, supply, administer (and possibly prescribe) scheduled medicines in the lawful practice of their profession.

In Victoria, the *Drugs, Poisons and Controlled Substances Act 1981* (the Act) authorises any registered nurse whose registration is endorsed to supply and administer approved medicines:

s13(1)(bb) any registered nurse whose registration is endorsed under section 94 of the Health Practitioner Regulation National Law is hereby authorised to obtain and have in his or her possession and to use, sell or supply any Schedule 2, 3, 4 or 8 poison approved by the Minister in relation to the relevant category of nurse in the lawful practice of his or her profession as a registered nurse.

s14(A)(1) the Minister may, by notice published in the Government Gazette, approve any Schedule 1, 2, 3, 4 or 8 poison (as the case requires) for the purposes of an authorisation referred to in section 13(1)(ba), (bb), (c), (ca), (d) or (e).

Nurses in Victoria with Scheduled Medicines (rural and isolated practice) endorsement can currently possess and supply specified Schedule 2, 3 or 4 medicines under certain conditions, as outlined in the Primary Clinical Care Manual (PCCM). The PCCM was developed by the Queensland Government but is used by Victorian RIPERNs.

The PCCM is very broad and includes consideration of Schedule 2, 3, 4 and 8 medicines across a variety of clinical domains, service models, settings and care continua for that practice area.

Lists of medicines are approved by the Minister for Health in relation to different categories and scopes of practice for nurses and midwives. The list of nurse practitioner authorisations is outlined in the Victorian Government gazettal notice, last published in 2014. This gazettal notice does not include the Schedule 8 medicines included in the PCCM, specifically morphine and fentanyl.

The current proposal by the Department of Health and Human Services (DHHS) is to expand the medicines list to include morphine and fentanyl, to enable RIPERNs to administer and supply morphine and fentanyl in rural urgent care centres. This recommendation was supported by an independent review of the RIPERN framework carried out in 2014-2015.[1]

AMA Victoria is strongly opposed to this proposal to expand the medicines list to enable RIPERNs who practice within the full scope of their endorsement to supply Schedule 8 medicines as listed in the PCCM.

[1] MSPS Project Services and Inside Health Management, "Evaluation of the scheduled medicines administration and supply function of the Endorsed nurses operating within rural health services", 2015.

Proposal lacks solid supporting evidence base

In 2007, DHHS funded a collaborative practice model of care (CPM) pilot. The primary objective of the pilot was to improve the sustainability of care in rural Victoria and to test a new model of collaborative practice between general practitioners (GPs) and registered nurses who provide emergency care in rural hospitals and health services.

The outcomes of the pilot indicated that nurses operating within a CPM with an extended scope of practice improved the capacity of rural health services to deliver consistently high quality urgent care services.[2]

AMA Victoria supports the collaborative practice model and acknowledges the important role of RIPERNs to reduce the call on doctors for non-urgent, low risk patient presentations. In most rural and regional areas, GPs are on call to a specific health service to provide urgent care. AMA Victoria recognises that in some rural and regional centres, there is limited access to GPs.

DHHS proposes to expand the medicines list to allow RIPERNs to practice within the full scope of their endorsement. The Victorian RIPERN model was evaluated and AMA Victoria notes that the model was found to be successfully delivering safe, high quality care to the community.

It is not clear that there is a firm evidence base to support that the current model is not working, or needs to be changed significantly. The independent review of the RIPERN framework conducted in 2014-15 does not provide a solid evidence base to support expanding the medicines list to include Schedule 8 controlled drugs. No evidence has been presented, for instance, as to the number of avoidable fatalities that this expansion to the medicines list will prevent.

Patient safety and risk management

The AMA holds the position that only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in administration and supply of restricted and controlled drugs.[3]

The current proposal to expand the medicines list relates to the administration and supply of Schedule 8 controlled drugs, in accordance with the health management protocols within the PCCM. Where there is limited access to GPs, particularly in rural and regional settings, or the GP is not available to attend the urgent care centre, the current proposal would enable RIPERNs to supply and administer Schedule 8 drugs.

Schedule 8 medicines are controlled drugs and there is a reason why these medicines are classified as Schedule 8 - specifically these medicines are drugs with both therapeutic properties but also serious side effects and harms.

Schedule 8 controlled drugs are subject to a range of controls under the Act due to additional risks of drug dependence. Further, the (draft) *Drugs, Poisons and Controlled Substances Regulations 2017* (the Regulations) provide that medical practitioners in Victoria must apply for a *permit* to administer, supply or prescribe drugs of addiction. Doctors are also required to retain detailed clinical records to ensure that drug dependent patients are easily identified.

[2] Ibid.

[3] The AMA, "AMA Position Statement: Medicines", 2014.

For some individuals and in some circumstances, potential risks can include severe morbidity and even death.

Supply of Schedule 8 controlled drugs in the absence of a verbal or written instruction from a GP may also contravene an existing permit, and/or opiate contract in place.

AMA Victoria submits that a GP must always be consulted and issue verbal or written instructions before a RIPERN can supply Schedule 8 drugs. This is key to safety and risk management.

Risks and patient safety concerns with administration of fentanyl

Fentanyl is a drug with an extremely short half-life and is used in specific indications within healthcare. Fentanyl is mainly used in theatre by anaesthetists under careful supervision, or in a monitored patient situation in the emergency department for short duration procedures, all of which will be undertaken by a medical practitioner. The short duration of action renders fentanyl of little use in the rural and remote setting outside of the hospital or ambulance call-out setting.

Fentanyl citrate is a synthetic narcotic 100 times more powerful than morphine and 50 times stronger than heroin.[4] As a result, fentanyl carries a significant risk of serious side-effects that require the patient to be monitored when fentanyl is used.[5]

Fentanyl is characterised by a rapid onset of sedation and analgesia, a relatively short duration of action (approximately 30 to 40 minutes), and rapid reversal with opiate antagonists.

A recent Australian study revealed 136 fentanyl deaths between 2000 and 2011, with a staggering 62% having injected fentanyl at the time of death.[6]

AMA Victoria submits that fentanyl is a safe drug for use in an emergency department when appropriately prescribed and with appropriate monitoring and supervision. It requires careful dosing and titration, close patient monitoring, and the availability of naloxone hydrochloride and resuscitation equipment.

Patient safety is compromised by fentanyl theft and misuse and a recent Independent Broad-based Anti-Corruption Commission investigation resulted in 20 Geelong paramedics being suspended over the past six months over the illegal use of fentanyl.[7] This is an issue that must be considered in the context of a proposal to expand the scope of practice for RIPERNS.

AMA Victoria believes that it has no indication outside the hospital / ambulance setting. Further, it is not clear that there is any evidence to support that rural and remote nurses carrying this medication would improve patient outcomes.

Risks and patient safety concerns with administration of morphine

As with fentanyl, morphine is usually administered in emergency situations. However, morphine can also be administered in palliative care settings and post-op and post-procedure care.

[4] Narconon, "Fentanyl drug information", 2017.
[5] Chudnofsky, CR., et al, "The safety of fentanyl use in the emergency department", 1989.
[6] Roxburgh, A., et al, "Trends in fentanyl prescriptions and fentanyl-related mortality in Australia", 2013.
[7] Geelong Advertiser, "Ambulance Victoria drug probe: Anti-Corruption Commission uncovers shocking Fentanyl misuse", 2017.

Generally in these settings, the morphine required is prescribed by a GP, palliative care specialist or other medical practitioner. This allows all safety and regulatory protocols to be met prior to morphine being dispensed to an individual patient. If a nurse is attending a palliative care patient in their home, the nurse will be equipped with previous knowledge of the patient's history and specific advice from the GP on administering morphine.

Morphine has limited safe clinical use. It is not clinically safe to administer morphine to a wide variety of patient groups. The limited patient history available to RIPERNs further increases the risks associated with misuse of morphine.

A rural and remote GP reports that he carries an emergency box with 2 ampoules of morphine and has used it once in 25 years. Morphine is a Schedule 8 controlled drug to be used rarely and in a very limited range of clinical settings.

Further, nurses known to be carrying narcotics are at risk of experiencing assault and violence, including fatal violence, perpetrated by persons attempting to obtain this drug. Deputising services now travel with security to minimise this risk. Risks of occupational violence have only increased in recent years.

Safety of nurses in rural and regional settings is of particular concern. The tragic attack on South Australian nurse Gayle Woodford was perpetrated by a man known to have abused alcohol, cannabis and engaged in petrol sniffing.[8] Her attacker was reportedly high on ice at the time he attacked Ms Woodford. The attacker in this circumstance was not specifically seeking opioids however, AMA Victoria recognises that drug abuse is more common in rural and regional areas of Australia compared with urban centres. In particular, the use of pharmaceuticals not for medical purposes is higher in remote/very remote areas than in major cities at 5.2 percent, compared with 3.1 percent in major cities.[9] Aboriginal and Torres Strait Islander people, of whom 70 percent live in rural Australia, were 1.7 times more likely to have used illicit drugs recently compared to the general population.[10] As a result, nurses in rural and regional areas face specific risks to health and safety.

Morphine has limited usage when risk factors are taken into account and is currently being managed largely in emergency settings by trained, supervised and supported paramedics, or otherwise in controlled healthcare settings by a medical practitioner. There is no indication that rural and remote nurses with endorsement to supply Schedule 8 medicines including morphine would improve patient outcomes.

Administration and supply of Schedule 8 controlled drugs

AMA Victoria acknowledges that to work as a RIPERN in rural and regional Victoria, registered nurses must complete a study program that has been accredited by the Nursing and Midwifery Board of Australia.

Under the current RIPERN framework, and in line with the Gazetted list of medications, endorsed nurses are authorised to supply medicines for general, low-risk conditions.

[8] ABC News, "Gayle Woodford's killer Dudley Davey to spend 32 years behind bars", 2017.
[9] National Rural Health Alliance, "Illicit drug use in rural Australia", 2017.
[10] Ibid.

AMA Victoria commends this professional practice framework but submits that RIPERNs do not hold the training or the skills to administer and supply Schedule 8 drugs in treatment of patients with high-risk conditions.

RIPERNs lack in-depth knowledge of the patient's medical history, pharmaceutical interactions and allergies to date. Medical practitioners have superior knowledge of adverse events, doses, optimal routes, drug-drug and drug-food interactions, pharmacokinetics and pharmacodynamics.

As the practitioner with prescribing rights, doctors bear the duty of care and responsibility for decisions they make regarding medicines, including informing the patient and gaining consent.

Concerning urgent prescription arrangements, the 2009 AMA Victoria survey[11] reported that GPs prefer to review the patient's clinical condition before issuing an 'urgent' prescription. At the very least, GPs will review the patient's file before authorising a pharmacist or nurse to dispense a medication by telephone. Even in urgent care settings, AMA Victoria maintains that patient medication safety and efficacy depends on review by a registered medical practitioner.

Doctors place a high value on the professional role of RIPERNs and are committed to working with RIPERNs to improve the medication management and clinical outcomes of patients in rural urgent care centres.

To facilitate good communication and foster collaborative care, AMA Victoria endorses the *10 Minimum Standards of Communication between Health Services and General Practitioners and other Treating Doctors*, developed by the AMA Victoria Section of General Practice (refer ***Appendix 1***).

AMA Victoria submits that a medical practitioner must always be consulted and issue verbal or written instructions before a RIPERN can supply or administer a Schedule 8 controlled drug.

Medico-legal and ethical issues

Supplying a medicine contrary to prescription interferes with the therapeutic relationship between a doctor and a patient. Further, it raises serious medico-legal questions around who then bears the legal liability for the dispensing of Schedule 8 controlled drugs where a GP is not available.

AMA Victoria submits that doctors should not shoulder the responsibility for a decision in which they have not been involved. RIPERNs should never be able to supply a Schedule 8 controlled drug without further verbal or written instruction issued by a GP.

AMA Victoria supports adhering to the existing hierarchical tenets of patient management.

RIPERNs currently practice in non-remote rural hospitals. However, AMA Victoria acknowledges that Victorians in rural and remote regions do need better access to qualified medical practitioners who have already been trained for safe drug administration. Rather than expanding the scope of practice for RIPERNs to include administration of Schedule 8 drugs, the state government should invest in initiatives that address rural medical workforce shortages.

[11] AMA Victoria, "AMA Survey on Pharmacists' Request for Scripts", 2009.

The AMA and the Rural Doctors Association of Australia (RDAA) have developed a package of measures that recognises both the isolation of rural and remote practice and the need for the right skill mix in these areas. *Building a sustainable future for rural practice: the rural rescue package*, proposes two tiers of incentives:

- a rural isolation payment available to all rural doctors including GPs, locums, other specialists, salaried doctors and registrars, with the level of support provided increasing with rurality; and
- a rural procedural and emergency/on-call loading, aimed at boosting the number of doctors in rural areas with essential advanced skills in a range of areas such as obstetrics, surgery, anaesthesia, acute mental health, or emergency medicine.[12]

In the interests of patient safety and quality of care, supply of Schedule 8 controlled drugs should only occur with the verbal or written agreement of the patient's medical practitioner.

There is insufficient evidence to support the need to expand the medicines list to enable RIPERNs to practice within the full scope of their endorsement to supply Schedule 8 medicines as listed in the Primary Clinical Care Manual.

AMA Victoria submits that RIPERNs should never be able to administer or supply a Schedule 8 controlled drug without further verbal or written instructions issued by a GP.

[12] AMA, "A plan for better health care for regional, rural and remote Australia", 2016.

APPENDIX 1

10 Minimum Standards of Communication between Health Services and General Practitioners and other Treating Doctors

AMA Victoria's 10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors

February 2017

Introduction

This Standards document has been informed by the AMA Position paper General practice/hospitals transfer of care arrangements – 2013[i]. It has been developed by AMA Victoria's Section of General Practice and the AMA Victoria Policy Unit.

Purpose

AMA Victoria Section of General Practice has developed this **"10 Minimum Standards"** document to facilitate discussion with the Department of Health and Human Services Victoria, public and private hospitals, General Practitioners (GPs) and other treating doctors in order to drive key processes to enhance clinical safety, improve health outcomes, reduce avoidable hospital presentations, reduce risk, improve patient experience and improve resource efficiencies across our Victorian health system.

Context

For most patients who receive an episode of care from a health service, the episode comprises one part of their treatment, management, care or recovery journey. This is particularly the situation for people whose conditions are episodic, ongoing or 'chronic'.

For most patients in Australia, their General Practitioner is the main provider of ongoing health care. A person's General Practitioner plays a critical role in co-ordinating responses to their patient's health care needs, including making relevant referrals to specialist non-admitted care, admitted care, allied health care services and social support. They also continue the patient's health care after any medical event or change that has resulted in a care episode in hospital. General Practitioners also work in tandem with medical specialists who medically manage and treat the patient in non-admitted care settings, such as health service specialist outpatient clinics and other health practitioners that work in outpatient health care services. This role of the patient's general practice to function as a health care home is important at many levels, well evidenced to improve health outcomes and supported by the Australian Medical Association.

In order that a patient's care is safe, effective and efficient, adequate and timely communication of information between all medical and health professionals, who provide care to the patient, is required. This needs to occur between all treating health practitioners at all stages of the patient journey; starting from the community setting, through to acute or sub-acute care, and on subsequent 'return' to the community and clinical handover back to a person's General Practitioner.

When appropriate and effective transfer of care practices between General Practitioners other treating doctors and health services and are undertaken, re-admissions are reduced and adverse events minimised. There is also an improvement in satisfaction and experience for patients, carers, families, doctors and other health practitioners.

Stakeholders

The most important stakeholder are patients, their carers and families as improved communication leads to better health outcomes and improved patient experience.

Practical examples include reducing the frequent need for patients to repeat fundamental information or undergo repeat investigations and preventing medicine mismanagement due to poor communication between providers.

The other major stakeholders of these requirements include General Practitioners/ other treating doctors, health services and health professionals.

For both health services, and General Practitioners, adherence to these Standards will help achieve and demonstrate performance against their respective Quality Standards by demonstrating the policies and systems required for good communication.

Government is also an important stakeholder as the outcomes of improved communication between General Practice and Health Services will improve efficiency and sustainability, increase patient and carer satisfaction and strengthen service performance.

Who do these Standards apply to?

These standards are principally concerned with health services, General Practitioner and other medical professionals. Health Services may be public or private. These Standards scope emergency care, admitted care and non-admitted care episodes[13]

[13] See Glossary at end of this document.

THE 10 STANDARDS IN SUMMARY

Standard 1: Referral information from a practitioner to a health service

A referral to a health service from a General Practitioner includes information for an assessment of the need for care in their setting, triage, and the requirements for the patient's access to the health service.

Standard 2: General Practitioner Details

The name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.

Standard 3: Supported Access to a General Practitioner

When patients do not have a regular General Practitioner, the health service has a process to support patients to locate a General Practitioner and/or practice and to attend for follow-up care.

Standard 4: Timely Communication

The health service has a system for timely communication directly to a patient's General Practitioner and other treating doctor(s) on the conclusion of every episode of care, after sentinel events and periodically during ongoing care.

Standard 5: Handover back to a General Practitioner

The health service provides General Practitioners with clear and appropriate information to support safe and meaningful clinical handover of patient care.

Standard 6: Information Transmission

The health service has secure and reliable electronic systems to send and receive information to and from the Health Service and General Practitioners and other treating doctor(s).

Standard 7: Outpatient services intake and appointment systems

Specialist Outpatient Services have transparent intake and appointment systems that provide appropriate information and notifications to patients, General Practitioners and other treating doctor(s).

Standard 8: Outpatient Services Communication

There is a system for ongoing and timely clinical communication about patient care between a health care service's Specialist Outpatient Services, other ambulatory and day services and the patient's General Practitioners and other treating doctor(s).

Standard 9: Discharge Planning Processes

The health service has discharge care planning processes for patients with complex needs that involves their General Practitioner and other treating doctor(s).

Standard 10: Managing Quality

These standards are incorporated into the Policies and Quality Systems of General Practices and Health Services.

THE 10 STANDARDS IN DETAIL

Standard 1: Referral information from a practitioner to a health service

A referral to a health service includes information for an assessment of the need for care in their setting, triage, and the requirements for the patient's access to the health service.

Elements of this information include, where appropriate to the needs and circumstance of the patient:

- demographic and contact information.
- reason for referral to the health service.
- findings, investigations; medical summary, medicines and allergies.
- an Advance Health Care Plan (when appropriate).
- the person's need for interpreter and cultural support.
- any disability support needs, including advocates and/or alternative decision makers.

Supporting standards and corroborating guidelines for this Standard are:

- The RACGP Standards for general practices (4th edition) Criterion 1.5.2 Clinical handover[ii].
- The RACGP Standards for general practices (4th edition) Criterion 1.6.2 Referral documents[2].

Standard 2: General Practitioner Details

The name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.

The preferred criteria is the name of the General Practitioner, while the minimum criteria is the name of the practice.

Standard 3: Supported Access to a General Practitioner

When patients do not have a regular General Practitioner, the health service has a process to support patients to locate a General Practitioner and/or practice and to attend for follow-up care.

Minimum criteria for the process includes:

- Relevant staff have access to up to date contact details for General Practitioners for their catchment area.
- Assistance is available for the patient to choose a General Practice and to make a follow up appointment.

Standard 4: Timely Communication

The health service has a system for timely communication directly to a patient's General Practitioner and other treating doctor(s) on the conclusion of every episode of care, after sentinel events and periodically during ongoing care.

Criteria for timely formal communication:

Circumstances	Timing
• Unplanned inpatient admission • Discharge from an inpatient admission • After attendance at an emergency department or short-stay setting • On patient death or other sentinel events	Within 24 hours

• Initial Specialist outpatient consultation • Changes in health status or medication at a specialist outpatient service • Discharge from Specialist outpatient clinic	Within 7 days

Standard 5: Handover back to a General Practitioner

The health service provides General Practitioners with clear and appropriate information to support safe and meaningful clinical handover of patient care.

Supporting standards and corroborating guidelines for this Standard are:
- National Safety and Quality Health Service Standards Standard 6 – Clinical[iii].
- AMA Position Statement - General Practice/Hospitals Transfer of Care Arrangements – 2013[1].

Standard 6: Information Transmission

The health service has secure and reliable electronic systems to send and receive information to and from the health service and General Practitioners and other treating doctor(s).

These should interface with patient information management systems commonly used by General Practitioners and other treating doctors in private or community clinic settings.

Standard 7: Outpatient services intake and appointment systems

Specialist Outpatient Services have transparent intake and appointment systems that provide appropriate information and notifications to patients, General Practitioners and other treating doctor(s).

Minimum criteria include:
- a single point for referral to all specialist outpatient services.
- a publically available system that informs patients and referring doctors of the expected wait for various outpatient specialist services.
- a tracking system to enable patients and referring doctors to determine the prioritisation and status of a given specialist outpatient referral.
- clear, timely and responsive administrative and clinical processes, triggered by notification from a General Practitioner/referring doctor to review the scheduling of a patient's appointment according to clinical circumstances.
- referral from doctor acknowledged within 3 working days of being received.
- a patient's non-attendance of an appointment is notified to referring doctor within 3 working days.
- re-scheduling or cancellation of an appointment initiated by the patient or the health service is notified to a referring doctor within 7 working days.

Standard 8: Outpatient Services Communication

There is a system for ongoing and timely clinical communication about patient care between a health care service's Specialist Outpatient Services, other ambulatory and day services and the patient's General Practitioners and other treating doctor(s).

Minimum criteria include systems:
- for the receipt of updating advice from the General Practitioner or referring doctor about the patient's progress, changes in management, clinical condition or care requirements.

- to enable scheduled secondary consultation with or without the patient directly present at the health care service or general practice.
- to enable telehealth outpatient consultations from the General Practitioner's Clinic when the patient resides in a rural or aged care residential setting.

Standard 9: Discharge Planning Processes

The health service has discharge care planning processes for patients with complex needs that involves their General Practitioner and other treating doctor(s).

Minimum systems for discharge planning processes for patients with complex needs include:

- the ability to undertake telephone, video conference or face-to-face case conferencing prior to discharge that includes the General Practitioner and/or referring doctor.
- outpatients appointment date (if required) scheduled prior to discharge.
- the ability for expedited re-assessment in the Emergency Department if the patient's medical condition deteriorates and warrants the patient's re-presentation within 72 hours following inpatient discharge.
- a documented plan of care and support to be provided to the General Practitioner in addition to discharge summary if Post-Acute Care services are put in place.

Standard 10: Managing Quality

These standards are incorporated into the Policies and Quality Systems of General Practices and Health Services.

Minimum requirements include incorporation of requirements for:

- documentation of policies, procedures, systems and processes that support the attainment of these Standards.
- appropriate Quality Indicators for these requirements are developed, which enable performance monitoring and the measurement of performance improvement initiatives.

Glossary

Emergency Care:
Care provided in an emergency department or emergency treatment/care area

Admitted Care:
This includes hospital wards, hospital in the home, acute psychiatry, short stay units, day procedure units, day oncology, bed-based rehabilitation, bed-based Transition Care and other subacute care such as Geriatric Evaluation and Management and bed-based palliative care.

Non-admitted Care:
This includes Specialist Outpatient Services, rehabilitation services, community-based Transition Care Packages, community based Specialist Palliative Care and other recovery programs such as cardiac rehabilitation and respiratory rehabilitation programs.

References

[i] Australian Medical Association. 2013. AMA Position Statement. General Practice/Hospitals Transfer of Care Arrangements – 2013

[ii] Royal Australian College of General Practitioners. 2010. Standards for general practices. 4th edition. Published October 2010 Updated May 2013, updated March 2015, updated July 2015

[iii] Australian Commission on Safety and Quality in Health Care. 2012 National Safety and Quality Health Service Standards Standard 6 – Clinical Handover Safety and Quality Improvement Guide. https://safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf

[4] Specialist clinics in Victorian public hospitals: Access policy. August 2013 https://www2.health.vic.gov.au/getfile//?sc_itemid=%7BE6447CD4-2AD8-48B3-8760-08A028FC788E%7D

[5] Victorian public hospital specialist clinics. Discharge Guidelines. August 2010 https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Discharge%20guidelines

[6] Victorian Auditor – General's Report. Managing Acute Patient Flows. December 2008 http://www.audit.vic.gov.au/publications/2008-09/20081112-Managing-Acute-Patient-Flows.pdf

[7] Victorian Auditor – General's Report. Clinical ICT Systems in the Victorian Public Health Sector. October 2013 http://www.parliament.vic.gov.au/file_uploads/20131030-Clinical-ICT-Systems_ftGBLy2B.pdf