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The influence of health inquiries on clinical governance systems: A case study of the Douglas Inquiry

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

The following recommendations have been made following an in depth review of the Obstetric and Gynaecological services at King Edward Memorial Hospital for Women in Perth, Western Australia. Semi structured interviews were conducted with 41 people during a 5 day period from 20 – 24 March 2000. Confidential submissions were also received and considered. There were eight terms of reference that were addressed.

Recommendation 1

The current clinical cases that have resulted in adverse outcomes are dealt with in accordance with legal parameters. This should include an evaluation of the particular cases where the Director of Obstetrics has been involved to determine whether there are any issues of personal clinical competence

Recommendation 2

An indepth review of the current medical and midwifery practices of the delivery suite be conducted.

Recommendation 3

A clear policy related to the management of clinical cases with adverse outcomes in obstetrics and gynaecology be written and implemented as a matter of priority. This will include specific information about reporting and managing such cases.

Recommendation 4

The reviewers endorse in principle the report by Ernst and Young dated 25 October 1999 and suggest that the recommended actions of this report be implemented as a matter of priority

Recommendation 5

The appointment documents for all medical and midwifery/nursing staff in the Obstetrics and Gynaecological Clinical Care Units be reviewed to ensure that they are current and working within the legal parameters of their appointment

Recommendation 6

Review the responsibilities of all medical and midwifery/nursing staff in the Obstetrics and Gynaecological Clinical Care Units and make changes where necessary to ensure that the incumbents are fulfilling the responsibilities of the position.

Recommendation 7

Review the composition, terms of reference and the conduct of all current committees in Obstetrics and Gynaecology to ascertain their function and effectiveness

Recommendation 8

Review the reporting relationships of the new devolved structure (Unit Directors and the CE) and how the management of KEMH will demonstrate an integrated service that reflects safety, quality and cost effectiveness.

Recommendation 9

Review the outcomes of the Birth Centre with a view to providing obstetric cover and considering its use for low risk Aboriginal women.

Recommendation 10

Rewrite the protocols and manuals for perineal repair and CTG monitoring professional development according to the latest evidence and best practice.

Recommendation 11

Develop a register of perineal repair and CTG monitoring competence of each member of the delivery suite staff (midwives, residents and registrars).

Recommendation 12

Develop and implement a process of peer review for all levels of staff in the Obstetric and Gynaecological Clinical Care Units

Recommendation 13

KEMH formally adopt the ACMI Competency Standards for Midwives (1998) as a benchmark for midwifery practice and ensure that every midwife employed has their own personal copy of these competencies

Recommendation 14

The directors of each of the units and the CE develop a corporate Quality Vianagement plan. The need for quality to be driven as a top down initiative and to be primarily patient focussed should be emphasised.

Recommendation 15

The Medical and Nursing Directors of Obstetrics and the Medical and Nursing Directors of Gynaecology develop a Quality Management plan for their respective areas that meet the principles of the corporate Quality Management plan.

Recommendation 16

A position be created in the short term (to be reviewed) to take a lead role in the development, implementation and evaluation of a Quality Management plan for KEMH.

Recommendation 17

KEMH seeks accreditation by a nationally recognised body by 2001.

Recommendation 18

A formal program for credentialling house staff be developed.

Recommendation 19

The hospital keep records of the 6 monthly training assessments of the registrars

Recommendation 20

The hospital urgently review the registrar rostering to ensure safe levels of cover out of hours with appropriate provisions for consultant attendance.

Recommendation 21

Clearly identify 'patient complaint' and then review the position description of the Patient Advocate and develop a method whereby all patient complaints (as defined) can be effectively dealt with

Recommendation 22

A staffing review of the mix and numbers of midwives in delivery suite needs to be undertaken

Recommendation 23

A review of all sessional work of all consultant medical staff needs to be undertaken

(Child & Glove, 2000 3-5)