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

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Communication with women and their families

34. Before women agree to treatment, particularly radical gynaecological surgery, their options for care are to be discussed with them and documented in their clinical file.

35. Women are to be provided with written information concerning treatment options and, where possible, given sufficient time to review the information.

36. Interpreter services are to be used on a 24-hour basis to facilitate communication with women from non-English speaking backgrounds. This is especially important for obtaining consent.

37. It needs to be recognised that when a woman withholds consent for an important and medically indicated treatment, this may represent a communication breakdown. The responsible consultant is to be informed and he or she is to review the circumstances with the woman and her family.

38. When a baby dies, a plain English version of a post-mortem report is to be given to the woman and her family at the time when the findings of the post mortem are discussed with them.

Psychosocial concerns - generally

39. The Hospital is to take steps to enhance continuity of care for child-bearing women. One way this could be achieved is to make increased use of small teams of 6-8 midwives. Each team would take full responsibility for the care of an individual woman across each episode of care.

40. KEMH is to conduct regular workshops with medical, midwifery, nursing and allied health staff with particular emphasis on —

    (a) how to respond sensitively to women, including how to respond to their expression of subjective symptoms that do not match objective signs;

    (b) how to involve women in decision-making; and

    (c) how to respond to women who have had poor outcomes.

41. A woman is not to be discussed by clinicians in her presence or within her hearing without including the woman in the conversation.

42. KEMH is to develop and implement a method for eliciting women's experiences of care at KEMH together with a way of ensuring feedback to staff through newsletters and workshops.

Responses to poor outcomes

43. Midwives and healthcare professionals likely to be involved in identifying fetal death or abnormality are to be trained in how to discuss the circumstances sensitively with the woman and her family.

44. Whenever a poor outcome occurs for either a woman or her baby, then the woman should be offered at least one appointment with the consultant or senior registrar to discuss the outcome.

45. KEMH is to develop and implement guidelines for discussing poor outcomes with women and their families.

46. Where a woman's baby has died, her postnatal visit should not occur at the antenatal clinic. It should be conducted by someone who knows the woman and her circumstances.

47. A new position of Clinical Midwifery Consultant (for women whose pregnancies are at increased risk) is to be developed. This role should include continuity of care for selected women, a consultative service to women whose pregnancies are at higher risk and a supportive, educative function in relation to all midwives.

Involving women in decision-making

48. KEMH is to develop and implement a policy to ensure that a woman and her family is included in clinical decision-making related to her or her baby. Changes to clinical status, along with options for care, are to be discussed with the woman.

49. KEMH is to ensure that staff have the necessary communication skills to be able to develop assessment strategies collaboratively with the woman in a way that does not deny the women's subjective experiences.

R13.9 Performance management of consultants and directors

1. The Hospital is to develop and implement a performance evaluation and management policy and procedures for consultants and directors of clinical care units.

2. The Chief Executive and the clinical care unit directors are to be responsible for the timely conduct of performance evaluation and management for staff members for whom they are responsible.

R13.10 Performance management of registrars

1. The Hospital is to develop and implement a performance evaluation and management policy and procedures for registrars.

2. The process for the performance evaluation of registrars is to be coordinated by a full-time consultant who is not a director of a clinical care unit.

3. Feedback about a registrar's performance is to be sought from senior staff with whom that registrar has worked in the period under review.

4. Comments about a registrar's performance are to be collated by the coordinating full-time consultant who is to discuss the comments with the registrar before they are submitted to Medical Administration.

R13.11 Performance management of residents

1. The Hospital's performance appraisal and management process for residents is to ensure that performance appraisal forms are filled out and returned to residents before the residents complete their terms in each area.

2. The process is also to ensure that there is always a follow-up discussion between the registrar or consultant who completes the performance appraisal form and the resident.

R13.12 Performance management of midwives and nurses

1. The Hospital is to develop and implement a performance appraisal policy and process that is specific to the needs of nurses and midwives.

2. The standards of satisfactory clinical performance are to be the ANCI competencies for nurses and the AMCI competencies for midwives.

3. The roles and responsibilities of those involved in initiating, conducting and ensuring compliance with the process are to be clearly identified.

(Douglas et al, 2000 xxxi-xxxiv)