KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
1.	R1.5	**Referral of cases to the Medical Board** The conduct of the doctors in the cases referred to in the confidential attachment to this Report should be referred to the Medical Board.
2.	R2.2	**Legislative Framework** The *Hospitals and Health Services Act* and the *Public Sector Management Act* should be amended to ensure that where an inquiry is conducted under either or both of those Acts - a) witnesses and counsel have the same protections that are available under the *Royal Commissions Act;* b) those assisting the inquiry (including the inquiry's staff, consultants and those providing information to the inquiry) have clear and adequate statutory protections from personal liability; c) the inquiry has the power to refer any matter arising out of its investigation to a State or Commonwealth authority that has power under a law to investigate or take action in relation to a matter of that kind; d) the inquiry has the power to protect from publication any information given to it in confidence by a person who does not appear as a formal witness; and e) confidential information and evidence given to or obtained by the inquiry is protected from publication and access after the completion of the inquiry.
3.	R3.3.1	**Internal structure, role and management** A review of the management structure at the Hospital is to be undertaken to assess whether the current devolved management structure is the most appropriate structure for the Hospital.
4.	R3.3.2	A review of the organisation of the Delivery Suite, and in particular the function of the Observation Ward, is to be undertaken to assess whether it is the most appropriate structure for the provision of timely and safe patient care.
5.	R5.20.1	**Supervision and cover in the Delivery Suite** There is to be a senior obstetric cover on-site 24 hours a day (see recommendations R9.2, 1-3).
6.	R5.20.2	If the Delivery Suite consultant or registrar is performing an emergency Caesarean section, another senior doctor is to be readily available to the Delivery Suite. Close call at home is not appropriate cover.
7.	R5.20.3	The morning and evening ward rounds in the Delivery Suite are to be attended by the on-call consultant, an anaesthetist (or registrar) and neonatologist (or registrar) in addition to the Delivery Suite Midwife Co-ordinator, Delivery Suite registrar and resident.
8.	R5.20.4	KEMH is to develop and implement clinical practice guidelines that define the boundaries that are acceptable for progress of spontaneous or induced labour, or attempted vaginal birth after Caesarean. Whenever these boundaries are exceeded, the circumstances are to be reviewed by a consultant.
9.	R5.20.5	KEMH is to ensure that, where possible, a consultant is to be present for all vaginal breech deliveries.
10.	R5.20.6	A consultant is to review all women with rare presentations of the fetus (eg brow) in labour.
11.	R5.20.7	The on-call consultant is to attend after a failed attempt to achieve instrumental vaginal delivery.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
12.	R5.20.8	**Caesarean sections** For some emergency Caesarean sections, rapid induction of anaesthesia may be essential (for example where there is a prolonged fetal bradycardia). In those cases, general anaesthesia or spinal are to be given priority over epidural block. Anaesthetic staff are to be rostered to ensure that the registrars on night and weekend duty are sufficiently skilled to provide general anaesthesia for urgent emergency Caesarean sections.
13.	R5.20.9	KEMH is to develop and implement a policy to manage the situation where an emergency Caesarean section is needed and the theatres are busy.
14.	R5.20.10	The decision-to-delivery interval is to be recorded for each non-elective Caesarean section. It should be less than 45 minutes. There is to be a regular audit of these intervals.
15.	R5.20.11	**CTG interpretation** The midwifery and medical staff involved in the care of pregnant women are to attend mandatory training in CTG interpretation that is comprehensive enough to allow them to be safe practitioners in the interpretations of CTGs (see recommendation R12.7, 1-4).
16.	R5.20.12	Staff attending training in CTG interpretation are not to be rostered to any other duties at the same time.
17.	R5.20.13	The Hospital is to organise the training in CTG interpretation and, as this is to be a safety requirement, there is to be no fee charged to staff members for this training.
18.	R5.20.14	If there is uncertainty about a trace, the consultant is to review the trace (and preferably the woman) as soon as possible.
19.	R5.20.15	The Hospital is to maintain a record of staff who attend training in CTG interpretation.
20.	R5.20.16	**Medical and Obstetric emergencies** KEMH is to develop and implement a program of mock emergencies, ‘fire drills’, of common or serious emergencies that are likely to occur in a tertiary maternity unit. The program should include, but not be confined to – a) collapsed or fitting adult; b) large antepartum haemorrhage; c) cord prolapse; d) prolonged fetal bradycardia; e) shoulder dystocia; f) very preterm birth; g) emergency Caesarean section when rostered staff are busy; h) postpartum haemorrhage; and i) baby requiring resuscitation.
21.	R5.20.17	Major postpartum haemorrhage is an obstetric emergency. The on-call consultant and the on-call anaesthetist are to be informed as soon as possible during the event. They are to attend as soon as possible.
22.	R5.20.18	Hypertensive crises are not to be managed in a general ward area, but only in a high dependency unit.
23.	R5.20.19	A consultant or senior registrar is to be notified immediately of any serious high-risk situation (for example, severe pre-eclampsia or moderate or large antepartum haemorrhage).

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
24.	R5.20.20	KEMH is to develop and implement, for use in the Emergency Centre and throughout the Hospital, clinical practice guidelines on ectopic pregnancy, bleeding in early pregnancy and abdominal pain.
25.	R5.20.21	**Gynaecology-oncology** KEMH is to formally review the operation of its gynaecology-oncology service to determine whether it should be transferred to another teaching hospital with full Intensive Care Unit facilities.
26.	R5.20.22	**Adult Special Care Unit** KEMH is to develop and implement guidelines to ensure that there are clear lines of responsibility for care in the Adult Special Care Unit. The guidelines are to contain criteria for the transfer of patients to a full Intensive Care Unit.
27.	R5.20.23	KEMH is to develop and implement guidelines for the management of post-operative shock and haemorrhage, including management of fluid and electrolyte balance.
28.	R5.20.24	**Clinical care planning** KEMH is to develop and implement guidelines to ensure that the standard of clinical care planning is improved. The guidelines are to include contingency planning and require statements of rationale for any unusual plan, or any change of plan.
29.	R5.20.25	All patients (except healthy women at low obstetric risk) are to have written care plans that have been approved by an experienced registrar or a consultant. Any changes to these care plans are to be approved by a consultant and the approval is to be documented.
30.	R5.20.26	The on-call consultant is to be informed of all new admissions of women in high-risk categories and is to approve the care plan. These actions are to be documented.
31.	R5.20.27	In cases of pre-term labour or pre-term pre-labour rupture of the membranes, particularly at the margins of viability, care planning is to be explicit in relation to how labour, birth and neonatal care should proceed. It is essential that the woman takes part in formulating these care plans.
32.	R5.20.28	**Coordination of care** KEMH is to develop and implement a clear policy statement to ensure that there are fail-safe lines of communication when a midwife or nurse holds concerns for patient safety or comfort that have not been adequately addressed by the junior medical staff.
33.	R5.20.29	In consultation with private specialists utilising its facilities, KEMH is to develop and implement a policy for the medical care of privately insured women in emergencies.
34.	R5.20.30	KEMH is to develop and implement a policy, with clear lines of communication and accountability, relating to the follow-up of important test results.
35.	R5.20.31	Each antenatal inpatient is to be seen daily, including weekends and public holidays, by a registrar or consultant.
36.	R5.20.32	Women who are admitted to KEMH with serious non-urgent conditions, such as mild or moderate hypertension in pregnancy, are to be seen by a consultant within 24 hours.
37.	R5.20.33	The care plans of all women who attend the Emergency Centre are to be approved by an experienced registrar or a consultant.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
38.	R5.20.34	**Communication with women and their families** 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.
39	R5.20.35	Women are to be provided with written information concerning treatment options and, where possible, given sufficient time to review the information.
40.	R5.20.36	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.
41.	R5.20.37	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.
42.	R5.20.38	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.
43.	R5.20.39	**Psychosocial concerns – generally** 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.
44.	R5.20.40	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.
45.	R5.20.41	A woman is not to be discussed by clinicians in her presence or within her hearing without including the woman in the conversation.
46.	R5.20.42	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.
47.	R5.20.43	**Responses to poor outcomes** 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.
48.	R5.20.44	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.
49.	R5.20.45	KEMH is to develop and implement guidelines for discussing poor outcomes with women and their families.
50.	R5.20.46	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.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
51.	R5.20.47	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.
52.	R5.20.48	**Involving women in decision-making** 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.
53.	R5.20.49	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.
54.	R5.20.50	**Documentation** KEMH is to improve its standard of documentation. Patient clinical files, in particular, are to be of sufficient quality and detail so that the documentation adequately informs other professionals taking over care of a woman and/or a baby.
55.	R5.20.51	In line with safe practice, the partogram or a second stage observation sheet is to have space to allow 5 minutely recording of the fetal heart rate in the second stage of labour.
56.	R5.20.52	The same standard of documentation and care planning is to be required from consultants as from other staff. This standard is to apply equally for public and private patients in KEMH.
57.	R5.20.53	KEMH is to develop and implement a standard organisational format for the patient clinical files used in the Hospital.
58.	R5.20.54	Integrated progress notes are to be used by clinicians and allied health professionals involved in the care of women and/or babies.
59.	R5.20.55	If it is not possible to write notes in the patient's clinical file during a crisis, detailed documentation of events is to be made as soon as possible.
60.	R5.20.56	KEMH is to introduce a hand held (patient-held) antenatal record for public and private patients.
61.	R7.5.1	**Comparative data analysis** In collaboration with other tertiary obstetric and gynaecological hospitals in Australia, the Health Department of Western Australia ("HDWA") and KEMH are to conduct further comparative analyses on stillbirths in tertiary obstetric and gynaecological hospitals.
62.	R7.5.2	HDWA and KEMH are to work with interstate tertiary obstetric and gynaecological hospitals to establish and publish – (a) annual comparative analyses similar to the analyses conducted for the Inquiry by the Consortium; (b) benchmarks and/or performance indicators for obstetric and gynaecological practice and outcomes; and (c) benchmarks and/or performance indicators based on the standardised primigravida.
63.	R7.5.3	KEMH is to establish processes for the review of all maternal, perinatal and gynaecological deaths in the Hospital.
64.	R9.2.1	**Consultant and senior medical cover**

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
		KEMH is to introduce immediately on-site, 24 hours a day, 7 days a week obstetric cover by senior doctors at the Hospital. For the purpose of this and the next two recommendations, a senior doctor is a consultant, a sub-specialty fellow or a Level 5 or 6 registrar who has completed 4 years of clinical training. The senior doctor is to be in active obstetric practice at the Hospital.
65.	R9.2.2	The on-site cover is to be shared equitably among the senior doctors – to ensure that there is supervision of junior doctors after-hours by consultants as well as other senior doctors.
66.	R9.2.3	There should be a backup consultant at all times but, until this is introduced, there is to be a backup consultant on-call after-hours when the on-site senior doctor is a Level 5 or Level 6 registrar or a sub-specialty fellow.
67.	R9.2.4	KEMH is to provide for after-hours on-call consultant gynaecological cover.
68.	R9.2.5	KEMH is to introduce a strategic program, incorporating quantitative and qualitative measures, to address current and future medical staffing cover requirements.
69.	R9.2.6	**Dedicated Delivery Suite cover** The roles and responsibilities of the dedicated Delivery Suite Consultant are to be developed and the position is to be retained.
70.	R9.2.7	The role and responsibilities of the consultant rostered to the Delivery Suite on a weekday are to be developed.
71.	R9.2.8	The consultant rostered to the Delivery Suite on a weekday is not, during that time, to be rostered to any other area. This is primarily to provide service and close direct and indirect teaching and supervision to the junior medical staff.
72.	R9.2.9	**Emergency Centre** The consultant on-call for the Emergency Centre is to spend an appropriate amount of time during each day in the Emergency Centre for service, teaching and supervision purposes.
73.	R9.2.10	The Hospital is to formally review the needs of the Emergency Centre to determine the extent to which consultant presence and other medical cover is required for the area.
74.	R9.3.1	**Clinical accountability** 'Team leaders' of clinics are to be full-time consultants of KEMH.
75.	R9.3.2	The Hospital is to investigate the implementation of a team model of care, including the proposal under which a small team of consultants who have the same junior staff working for them would look after a cohort of patients.
76.	R9.3.3	Patients attending clinics at KEMH are to be informed of the names of all consultants attached to the clinic which the patient is attending.
77.	R9.3.4	A patient's clinical file and notes is to reflect not just the 'day designation' of the clinic, eg 'Monday – Gynae' but is also to list the consultants attached to that clinic.
78.	R9.3.5	For gynaecology clinic patients, and for gynaecological inpatients, the minimum level of consultant attention should be that each case is discussed with the consultant and a care plan is approved. When this happens the consultant is responsible for the care plan and the other clinicians are responsible for their own actions.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
79.	R9.3.6	There is no need for consultant involvement for obstetric patients who are at low-risk of complications. The care of these patients should be coordinated by midwives. If, however, consultants wish to have clinical responsibility for the care of these patients, KEMH is to develop and implement, within 3 months, a mechanism to ensure that individual consultants are accountable for that care.
80.	R9.3.7	Obstetric patients who are at medium-risk or high-risk of complications are to have the attention of a consultant. The minimum level of attention should be that each case is discussed with the consultant and a care plan is approved. When this happens the consultant is to be responsible for the care plan and the other clinicians are to be responsible for their own actions.
81.	R9.3.8	A patient's clinical notes and other patient clinical documentation is to clearly reflect the name of the consultant, if any, having clinical responsibility for the patient.
82.	R9.3.9	Where a patient has a number of significant episodes of care, the patient's clinical notes and other clinical documentation is to clearly reflect the name of the consultant having clinical responsibility for each of these episodes.
83.	R9.3.10	Separate on-call rosters for obstetrics and gynaecology are to ensure that after-hours unbooked patient admissions are made under the on-call consultant attached to a relevant clinic team – for example, the admission of a gynaecology patient to a gynaecology clinic under the responsibility of the on-call gynaecologist.
84.	R9.3.11	Inpatients are to be informed of the clinic or sub-specialty unit under which they are admitted, the names of the consultants attached to that clinic or unit and the name of the consultant currently on service for that clinic or unit.
85.	R9.3.12	Inpatient bed cards are to list details of the clinic or sub-specialty unit, the names of the consultants attached to that clinic or unit and, for gynaecological clinic patients, the name of the patient's responsible consultant.
86.	R9.3.13	KEMH is to ensure that its clinical information systems are able to record, and do in fact record, the name of the consultant who provided each significant component of care.
87.	R9.3.14	Junior medical staff induction programs are to emphasise the importance of notifying the responsible consultant of unbooked admissions and referral to other consultants.
88.	R9.3.15	If it is a requirement for administrative purposes that there is to be a single named person for funding by diagnostic related group ("DRG"), this person is to be the consultant responsible for the most significant episode of care.
89.	R9.4.1	**Credentialling** The role of the Medical Credentialling and Clinical Privileging Advisory Committee (the "Credentialling Committee") is to be expanded to oversee the credentialling of junior medical staff.
90.	R9.4.2	The Credentialling Committee is to meet at least quarterly.
91.	R9.4.3	The Credentialling Committee is to approve a list of the clinical privileges granted to each medical staff member in respect of particular procedures, together with the conditions applying to the privileges granted (the "credentialling list").
92.	R9.4.4	Medical staff are not to perform procedures except in accordance with the credentialling list (including any conditions to which the grant of privileges is subject).

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
93.	R9.4.5	The Credentialling Committee is to ensure that each medical staff member is notified in writing of – (a) the outcome of each application by that medical staff member for the grant of clinical privileges, together with the conditions, if any, that apply to that grant; and (b) the list of clinical privileges held, from time to time, by that medical staff member.
94.	R9.4.6	The credentialling list is to be capable of timely amendment so as to enable medical staff to perform procedures for which they have been granted clinical privileges.
95.	R9.4.7	The credentialling list is to be readily accessible in all relevant areas and to all relevant personnel of the Hospital.
96.	R9.4.8	The requirement to perform procedures in accordance with the credentialling list is to be a term of the employment or engagement contract of each member of the medical staff.
97.	R9.4.9	The Hospital is to develop and implement effective monitoring and enforcement processes to ensure that procedures are performed in accordance with the credentialling list.
98.	R9.4.10	The Credentialling Committee is to review each consultant's clinical privileges at least every 3 years.
99.	R9.4.11	The Credentialling Committee is to take a proactive stance to identify those procedures for which consultants will need to apply for clinical privileges.
100.	R9.4.12	Particularly in the early stages of its operation, the Credentialling Committee is to refine their credentialling process as its members and the medical staff become more familiar with the functions and objectives of the process.
101.	R9.4.13	The Hospital is to consider whether the deliberations of the Credentialling Committee should be protected under the *Health Services (Quality Improvement) Act 1994*.
102.	R9.4.14	The Hospital is to develop and implement guidelines for determining whether a new surgical procedure should be performed at the Hospital, the conditions under which it should be performed and the respective roles of the Credentialling Committee and the Ethics Committee in that process.
103.	R9.4.15	**Associate consultants** KEMH is to develop and implement a formal policy and procedures for the granting and renewal of admitting privileges to associate consultants.
104.	R9.4.16	The grant of admitting privileges to an associate consultant for the first time is to be valid for no more than 12 months. The grant of further admitting privileges is to be subject to clinical review. Thereafter, admitting privileges are to be granted for periods of no more than 3 years and are to be subject to clinical review.
105.	R9.4.17	There is to be a list of those associate consultants who hold admitting privileges.
106.	R9.4.18	The list is to be readily accessible in all relevant areas and to all relevant personnel of the Hospital.
107.	R9.4.19	The list is to be updated to reflect the state of admitting privileges at any time.
108.	R10.3.1	**Process for policies and guidelines** KEMH is to develop and implement a policy relating to the process for the initiation,

NO.	INQUIRY REF NO.	RECOMMENDATION
		formulation, distribution, implementation, amendment, review, monitoring and enforcement of clinical policies and guidelines (the "guidelines process policy").
109.	R10.3.2	The guidelines process policy is to be formalised and published in a format that is readily available to all staff.
110.	R10.3.3	The guidelines process policy is to identify the particular persons and bodies, including committees, responsible for each of the steps in the process.
111.	R10.3.4	The guidelines process policy is to contain realistic time limits to ensure timely formulation and follow-up measures to ensure regular and timely review of policies and guidelines.
112.	R10.3.5	KEMH is to nominate a person to be responsible, as a guideline coordinator, for facilitating the guideline process.
113.	R10.3.6	There is to be an effective education program for staff relating to the guidelines process policy.
114.	R10.3.7	**Initiation and formulation** KEMH is to develop and implement formal procedures for initiating and formulating new policies and guidelines or amendments to existing policies and guidelines.
115.	R10.3.8	These procedures are to include measures to facilitate reporting by staff of concerns about existing policies or guidelines or the need for new policies or guidelines.
116.	R10.3.9	In line with the NHMRC's recommendations, a multi-disciplinary panel consisting of representatives of all relevant groups, including consumers, is to decide whether a policy or guideline is necessary, the purpose of the policy or guideline and the desired health outcomes.
117.	R10.3.10	The initiation and formulation of policies and guidelines is to be based on the best available evidence.
118.	R10.3.11	Each policy or guideline is to include reference to the level or levels of evidence used in its formulation.
119.	R10.3.12	Consistent, and clearly defined, terminology is to be used to describe policies, guidelines, pathways etc.
120.	R10.3.13	**Distribution and implementation** KEMH is to develop and implement formal procedures for distributing and implementing new and amended guidelines.
121.	R10.3.14	These procedures are to include electronic distribution as one option. The use of the Hospital's intranet for circulation of guidelines as well as a reference point is commendable and should continue.
122.	R10.3.15	These procedures are to incorporate an effective consultation process.
123.	R10.3.16	**Monitoring and enforcement** KEMH is to develop and implement formal procedures for monitoring and enforcing compliance with new and amended policies and guidelines.
124.	R10.3.17	These procedures are to differentiate between mandatory policies and discretionary guidelines.
125	R10.3.18	These procedures are to identify which clinicians are able to deviate from particular policies or guidelines, and under what circumstances they are able to do so.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
126.	R10.3.19	The persons and bodies responsible for ensuring compliance with policies and guidelines are to be clearly identified.
127	R10.3.20	The monitoring and enforcement procedures are to ensure that instances of non-compliance are dealt with in a timely and effective manner.
128.	R10.3.21	There is to be an audit process to allow regular and ongoing evaluation of the extent of compliance with guidelines, particularly mandatory policies. This evaluation should also assess whether – (a) clinical practice is becoming more consistent with the terms of the policies and guidelines; and (b) the policies and guidelines have contributed to any changes in clinical practice or health outcomes.
129.	R10.4.1	**Review of selected guidelines** KEMH is to review its clinical practice guidelines, including the 7 sets of policies and guidelines reviewed in this Chapter. The review is to be in accordance with the earlier recommendations set out in R10.3.
130.	R10.4.2	The *Clinical Guidelines* is to contain all the Hospital's clinical practice policies and guidelines.
131.	R10.4.3	Copies of the *Clinical Guidelines* are to be located, together with copies of the Hospital's administrative policies and manuals, in each clinical area.
132.	R10.4.4	A 'pocket book' version of the *Clinical Guidelines* is to be produced for the use of KEMH clinicians.
133.	R10.4.5	KEMH is to continue to provide access to the *Clinical Guidelines* on its intranet and, particularly having regard to its role as a teaching hospital is to consider Internet access for others.
134.	R11.2.1	**Incident reporting** KEMH is to develop and implement a formal incident reporting process, including a formal policy and procedures.
135.	R11.2.2	This policy is to – (a) contain a clear definition of the incidents, and the category of incidents, that are to be reported; (b) specify by whom, how, to whom and when incidents are to be reported; (c) require incidents to be reported on a particular form or forms; and (d) impose an obligation on all clinicians, including doctors, to report incidents.
136.	R11.2.3	KEMH is to maintain a comprehensive register of all reported incidents.
137.	R11.2.4	KEMH is to ensure, through effective training and communication, that all clinicians are familiar with its incident reporting policy and procedures.
138.	R11.2.5	The requirement to report incidents, in accordance with the Hospital's policies and procedures, is to be a term of each clinician's employment or engagement contract.
139.	R11.2.6	Those in relevant management positions are to be responsible for monitoring and ensuring compliance with, incident reporting – and be held accountable for non-compliance.
140.	R11.2.7	The Hospital's incident reporting is to be subject to regular external audit and review.
141.	R11.3.1	**Management of individual incidents**

NO.	INQUIRY REF NO.	RECOMMENDATION
		KEMH's formal incident reporting policy and procedures should include special measures for the reporting and management of incidents where patients have been harmed, especially where the harm is serious, and poor health care management may have contributed to that harm. Included among these incidents are those that result in patient complaints and those that result, or have the potential to result, in medical negligence actions or other legal actions against the Hospital.
142.	R11.3.2	In addition to the requirements applying to incident reporting generally (see R11.2), the special measures should ensure that – (a) these incidents are reported to the Chief Executive – whether or not he or she is a 'non-clinical person'; and (b) a clinician who fails to report an incident should be subject to disciplinary action.
143.	R11.3.3	KEMH should take appropriate measures – through education, encouragement and support – to ensure that, particularly when things go wrong, clinicians are more open with patients, explain to them what happened and offer an apology.
144.	R11.3.4	KEMH should review its patient complaints policies and procedures to ensure that – (a) Complaints management is better coordinated; (b) There is a regular audit of complaints; (c) Complaints are seen – and used – as an opportunity for improvement; (d) Consumers are provided with clear advice about the complaints process; and (e) Clinicians deal with patients with greater openness and respect.
145.	R11.3.5	KEMH should review and reformulate its "Critical Incident Debriefing" policies and procedures to be more relevant and useful and take action to ensure that both doctors and nurses are provided with appropriate support, including counselling and debriefing.
146.	R11.4.1	**Review of incidents** KEMH should develop and implement a formal policy and procedures to deal with the review and follow-up of incidents.
147.	R11.4.2	All incidents are to be reviewed to determine what went wrong, whether they were preventable and how things can be improved.
148.	R11.4.3	Reviews are to be conducted using the 'systems' approach that focuses more on organisational factors and less on the individuals who made the error.
149.	R11.4.4	Reviews are to be conducted in a supportive environment that encourages the open discussion of mistakes, adopting (as a starting point) a culture where errors are recognised as an inevitable part of health care.
150.	R11.4.5	The clinicians involved in reviewed incidents are to be given prompt, sensitive and effective feedback.
151.	R11.4.6	The lessons identified from the review process are to result in changes to the Hospital's policies and practices.
152.	R11.4.7	These changes are to be communicated effectively to clinicians.
153.	R11.4.8	Those responsible for the review and follow-up processes are to ensure that the processes are complied with – and are to be held accountable if they are not.
154.	R11.4.9	KEMH is to establish an Incident Review Committee.
155.	R11.4.10	The Incident Review Committee is to be multi-disciplinary, comprise a majority of practising clinicians and is to meet monthly.

NO.	INQUIRY REF NO.	RECOMMENDATION
156.	R11.4.11	The Incident Review Committee is to be provided, by the person or body to whom all KEMH incidents are reported, with details of all incidents.
157.	R11.4.12	The Incident Review Committee is to review incidents where patients have been harmed in circumstances where poor health care management may have contributed to that harm, and other incidents, including 'near-misses', that are appropriately reviewed outside the directorate in which they occurred.
158.	R11.4.13	The Incident Review Committee is to review incidents in accordance with the requirements set out in the preceding recommendations.
159.	R11.4.14	The Incident Review Committee is to report to the Chief Executive – unless the Committee is an approved committee under the *Health Services (Quality Improvement) Act*, in which case it is to report in accordance with that Act.
160.	R11.4.15	Significant adverse events, including all incidents that have resulted, or have the potential to result, in medical negligence claims, are to be reviewed by an appropriately qualified clinician, preferably from outside the State.
161.	R11.4.16	The Hospital's incident review practices are to be subject to regular external audit and review.
162.	R11.5.1	**Reporting to the Coroner** KEMH should formulate and adopt procedures to ensure that deaths required by law to be reported to the Coroner, are in fact reported.
163.	R11.5.2	The CEO and the directors of each of the clinical care units at KEMH are to be responsible for the enforcement of, and compliance with, these procedures.
164.	R11.6.1	**Statutory mortality committees** The State Government is to develop and implement, as soon as possible, an effective system for the identification, investigation, review and reporting of maternal, perinatal and infant deaths.
165.	R11.6.2	Close attention will need to be given to matters such as – (a) the inclusion or amendment of definitions of maternal, perinatal and infant mortality (and related terms including stillbirths) – particularly having regard to the work that has been done towards the development of a national uniform classification system; (b) the streamlining and integration of requirements and procedures for identifying and reporting deaths, including the removal of inconsistencies within the *Health Act* and between the *Health Act* and the *Births, Deaths and Marriages Registration Act;* (c) the review of the current reporting obligations on doctors and nurses under sections 335 and 336 of the *Health Act* for the purpose of determining – (i) whether those statutory obligations, and the administrative requirements to give effect to those obligations, can be streamlined having regard not only to the provisions of the *Health Act* but also to the parallel reporting requirements to the Coroner and the Registrar of Births, Deaths and Marriages; (ii) whether the practical benefits in retaining some or all of the obligations outweigh the administrative burden on doctors and nurses in complying with the obligations; and

NO.	INQUIRY REF NO.	RECOMMENDATION
		(iii) whether, in practice, compliance with the obligations can be enforced; (d) whether there should be a power to exclude categories of deaths from those that are to be investigated and, if so, the extent and criteria for the exercise of that power; (e) legal and administrative arrangements to ensure that investigations and reviews are completed in a timely manner; (f) legal and administrative arrangements to ensure that the mortality committees carry out their educative roles, including producing timely reviews, case summaries, recommendations, “constructive comments” and statistical data; (g) legal and administrative arrangements to ensure proper reporting by, and public accountability of, the mortality committees; and (h) the membership, including the leadership, of the mortality committees.
166.	R11.6.3	The definitions of ‘death’ and ‘stillbirth’ under the *Health Act* are to be broadened so that they are consistent with the definitions adopted by the NHMRC.
167.	R11.6.4	The Western Australian Medical Certificate of Cause of Death form is to be amended to include two tick boxes indicating the existence of – (a) pregnancy within the last 42 days; and (b) pregnancy between 42 days and 365 days prior to death.
168.	R11.6.5	There should continue to be an independent check of relevant records and data (currently carried out by the EDPH) to identify the maternal deaths, and also the perinatal and infant deaths, in this State.
169.	R11.6.6	If doctors and nurses are to continue to be subject to statutory reporting obligations, those obligations are to be observed and enforced and administrative arrangements are to be put in place to ensure that they are observed and enforced.
170.	R12.2(c).1	**Supervision** The consultant rostered to the Delivery Suite on each weekday is to be responsible for the clinical training of junior medical staff working in that area.
171.	R12.2 (c).2	Each senior doctor is to attend a “train the trainer” course within 12 months of the date of this Report.
172.	R12.2 (c).3	Consultants are to have the prime responsibility for the supervision and training of registrars in training. Hospital policy is to be developed to recognise and specify this responsibility of consultants.
173.	R12.2 (c).4	Each registrar is to be allocated to a consultant who is to act as a mentor. In his or her capacity as a mentor, the consultant is to meet with the registrar at least monthly. The allocated consultant may be the registrar’s RANZCOG training supervisor. Every full-time consultant should participate in this scheme.
174.	R12.2 (c).5	Each resident is to be allocated to a mid-level registrar who is to act as a mentor. In his or her capacity as a mentor, the registrar is to meet with the resident at least monthly.
175.	R12.2 (d).1	**Postgraduate medical program** Residents and registrars are to be given time off from clinical work to attend a prescribed number of educational meetings each week.
176.	R12.2 (d).2	The prescribed educational meetings are to be reflected in the roster of each resident and registrar.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
177.	R12.2 (d).3	A system of recording attendances of residents and registrars at educational meetings is to be established, and attendance is to form part of a regular performance appraisal of residents and registrars by the Hospital.
178.	R12.2 (d).4	Each resident and registrar is to be required to be present and participate in the educational meetings.
179.	R12.2 (d).5	Notes and/or recordings of educational meetings are to be taken and made accessible to a resident or registrar who cannot attend a meeting.
180.	R12.2 (d).6	The Postgraduate Education Committee is to take responsibility for and play an active role in developing, conducting and evaluating a postgraduate medical program for residents and registrars. The Committee is to nominate a consultant to undertake these responsibilities on its behalf.
181.	R12.2 (d).7	A program of educational sessions which link clinical experience with theory is to be developed. The program should provide for the differing educational needs of residents and registrars.
182.	R12.2 (d).8	There is to be regular review and assessment of the training, and the development of knowledge and skills, of the residents and registrars.
183.	R12.2 (e).1	**Orientation** On the first day of their employment, all new residents and registrars are to attend an orientation program on the administrative aspects of the Hospital.
184.	R12.2 (e).2	All new residents and registrars are to attend an initial orientation, of at least 2 days in length, covering clinical issues. The orientation program is to include skill development in perineal suturing and basic CTG interpretation. There are to be follow-up sessions throughout the first 3 months.
185.	R12.2 (e).3	The Hospital is to explore the use of facilities such as the Collaborative Training and Education Centre (“CTEC”) and the Centre for Advanced Surgical Training (“CAST”) and develop an orientation or induction program for residents and Level 1 registrars with the objective of developing skills and knowledge prior to providing clinical care to patients.
186.	R12.2 (f).1	**Surgical training** A formal program of compulsory training in surgical skills is to be developed, to reflect the needs of the various levels of training of the residents and the registrars at the Hospital.
187.	R12.2 (f).2	This program is to incorporate the facilities provided by CAST and CTEC.
188.	R12.3.1	**Midwifery training** The period of time during which a midwife is precepted should be based on individual needs. It should be concluded only when both parties agree that it is no longer needed.
189.	R12.3.2	The position of the Clinical Development Midwife is to be filled on a permanent basis. The position’s role and responsibilities should be monitored to ensure that supervision of trainees continues to be a substantial part of the role and responsibilities.
190.	R12.4(a).1	**CTG interpretation** Residents are to attend a basic course in CTG interpretation before commencing work in a clinical area at KEMH.
191.	R12.4(a).2	Registrars are to attend an advanced training course in CTG interpretation before commencing work in the Labour Ward. Residents and registrars should be certified

NO.	INQUIRY REF NO.	RECOMMENDATION
		as competent before interpreting CTG traces and managing a patient with a non-reassuring trace.
192.	R12.4(a).3	Midwives are to complete the basic CTG interpretation course before being given responsibility for a patient in the Labour Ward.
193.	R12.4(a).4	Midwives are to attend the advanced CTG interpretation training course within 12 months of commencing work in the Labour Ward.
194.	R12.4(b).1	**Perineal suturing** Residents are to undergo training in perineal repair before commencing work in Delivery Suite.
195.	R12.4(b).2	Registrars, residents and midwives are to be assessed as competent in perineal repair before performing perineal repairs on patients without supervision.
196.	R12.4(b).3	A senior clinician who is competent in perineal repair is to be responsible for the training of junior doctors in perineal repair.
197.	R12.4(b).4	Within 3 months of this Report, all Level 1 and 2 registrars and residents currently employed at the Hospital should be required (a) to undergo a formal assessment of their perineal repair skills; and (b) unless formally assessed to be competent, to attend a compulsory perineal workshop.
198.	R13.3.1	**Appointment of consultants** The Hospital is to develop and implement a formal policy and procedures for the appointment of consultants.
199.	R13.3.2	The policy and procedures are to be consistent with, and require compliance with, the *Public Sector Standards*.
200.	R13.3.3	The selection panel for a consultant appointment is to include a senior human resources officer who is to be responsible for ensuring that the Hospital's policy and procedures are followed.
201.	R13.3.4	A consultant is not to be appointed unless a properly constituted selection panel is satisfied, through appropriate referee reports and other means, that the consultant has the skills necessary to carry out his or her responsibilities.
202.	R13.3.5	An appointment at the end of a consultant's probation period is not to be made before a thorough review has been completed.
203.	R13.4.1	**Appointment of registrars** All newly appointed registrars are to be closely supervised by a more senior doctor until they have demonstrated sufficient skills to be able to function more independently.
204.	R13.6.1	**Appointment of directors** KEMH is to review whether it is appropriate that the positions of directors of clinical care units – and medical directors in particular – continue to have the major management responsibilities currently set out in their job descriptions.
205.	R13.6.2	While the director positions at KEMH continue to have major management responsibilities – (a) vacancies should be advertised widely to attract the best applicants; (b) positions should be filled only by people who have the skills, particularly the

NO.	INQUIRY REF NO.	RECOMMENDATION
		management skills, necessary to carry out the responsibilities of the positions; and (c) appropriate training should be provided to ensure that occupants of the positions have and maintain the necessary management skills.
206.	R13.6.3	Medical directors of clinical care units should remain active clinicians and undertake a minimum of two clinical sessions per week and a share of on-call duties.
207.	R13.7.1	**Appointment of midwives and nurses** Selection panels are to include a member from outside the area recruiting for the position. Selection panels for Level 3 positions and above are to include a midwife or nurse from outside the Hospital.
208.	R13.7.2	Selection panels are to ensure that referees are contacted and, in formulating their appointment recommendation, selection panels are to take into account the responses from referees.
209.	R13.9.1	**Performance management of consultants and directors** The Hospital is to develop and implement a performance evaluation and management policy and procedures for consultants and directors of clinical care units.
210.	R13.9.2	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.
211.	R13.10.1	**Performance management of registrars** The Hospital is to develop and implement a performance evaluation and management policy and procedures for registrars.
212.	R13.10.2	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.
213.	R13.10.3	Feedback about a registrar's performance is to be sought from senior staff with whom that registrar has worked in the period under review.
214.	R13.10.4	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.
215.	R13.11.1	**Performance management of residents** 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.
216.	R13.11.2	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.
217.	R13.12.1	**Performance management of midwives and nurses** The Hospital is to develop and implement a performance appraisal policy and process that is specific to the needs of nurses and midwives.
218.	R13.12.2	The standards of satisfactory clinical performance are to be the ANCI competencies for nurses and the AMCI competencies for midwives.
219.	R13.12.3	The roles and responsibilities of those involved in initiating, conducting and ensuring compliance with the process are to be clearly identified.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
220.	R13.13.1	**Reappointment of consultants** The Hospital is to formulate and implement a formal policy and procedures for the reappointment of consultants.
221.	R13.13.2	The policy is to specify clearly the roles (including the powers and obligations) of those involved in the reappointment process, including the relevant directors, the Electoral Committee and the Chief Executive.
222.	R.13.13.3	The criteria to be used in making recommendations for reappointment and in decisions to reappoint are to be clearly specified.
223.	R13.13.4	All relevant factors, including ‘management issues’, are to be taken into account in determining whether a consultant should be reappointed.
224.	R13.13.5	The policy and procedures are to make it clear that the Chief Executive – whether or not a ‘non-medical person’ – is obliged to assess independently, and does not simply ‘rubber-stamp’, a recommendation, including a recommendation from the Electoral Committee.
225.	R14.2.1	**Accreditation** KEMH is to be accredited by an approved external body.
226.	R14.2.2	The accreditation process is to include clinical audits.
227.	R14.4.1	**Quality Improvement** KEMH is to develop and implement policies and procedures to incorporate the following recommendations.
228.	R14.4.2	The governing body of the Hospital is to be responsible for, and actively involved in, quality improvement processes and systems that ensure the delivery of safe patient care.
229.	R14.4.3	A Clinical Governance Committee, involving clinicians and members of the Executive, is to be established to assess and monitor, on an ongoing basis, the quality and safety of patient care at the Hospital.
230.	R14.4.4	The Clinical Governance Committee is to be responsible to the governing body of the Hospital.
231.	R14.4.5	The Clinical Governance Committee is to be provided, directly or through the governing body, with the minutes and recommendations of the Incident Review Committee (see R11.4 above).
232.	R14.4.6	The Clinical Governance Committee is to be given authority to assign quality improvement activities to staff members, and to monitor the progress and results of those activities.
233.	R14.4.7	Staff assigned to quality improvement tasks are to be assigned sufficient time for these tasks.
234.	R14.4.8	The Clinical Governance Committee is to be responsible for regular (at least annual) clinical audit of patient care in the Hospital.
235.	R14.4.9	Details of the clinical audit, including numbers and type of cases examined, the process for selection of cases, and the follow-up of results of the clinical audit, are to be approved by the governing body and set out in the written processes of the Clinical Governance Committee.

KEMH INQUIRY RECOMMENDATIONS

NO.	INQUIRY REF NO.	RECOMMENDATION
236.	R14.4.10	The Clinical Governance Committee is to report on a 12-monthly basis to the governing body on – (a) the details and results of the clinical audit; (b) the extent and nature of other quality improvement activities in the Hospital; and (c) proposals for future quality improvement activities, including medical quality activity, nursing and midwifery quality activity, and multi-disciplinary quality activity.
237.	R14.4.11	The Executive of the Hospital is to report, on a 12-monthly basis, to the Director General of the HDWA on the results of clinical audit and other quality improvement activities in the Hospital and those results are to be published.