Department of **Health**
Government of **Western Australia**

Internal Audit

IMPLEMENTATION OF THE DOUGLAS INQUIRY RECOMMENDATIONS

King Edward Memorial Hospital

REVIEW
FINAL REPORT

Trim No 03-04130

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1. EXECUTIVE SUMMARY

Introduction

The report of the Inquiry Into Obstetric and Gynaecological Services at King Edward Memorial Hospital 1990 – 2000 (Douglas Inquiry) was tabled in the Western Australian Parliament in December 2001. In January 2002 the Department of Health (DoH) established an Implementation Group chaired by the Deputy Director General HealthCare Division, and including a member of the Douglas Inquiry panel, to oversee the implementation of the report's 237 recommendations. The Implementation Group disbanded in June 2003 after it had agreed that it had "completed its task given that all recommendations had been implemented, except the four requiring some form of legislative action".

The DoH Internal Audit Branch audited the implementation process of the 237 recommendations in three stages. The first stage in 2002 reviewed the system of implementation and the evidence presented to the Implementation Group to support the 54 recommendations, which had been signed off at that time. The second stage in 2003 reviewed the supporting evidence for a further 106 recommendations which the Implementation Group had signed off. This third stage in 2004 reviewed the supporting evidence for signing off the remaining 77 recommendations and the ongoing compliance with all of the 237 recommendations as at 2004.

Audit Objective

The audit objective was to examine and report on the process of implementing the remaining 77 Douglas Inquiry Report recommendations and the status of the ongoing compliance of all of the 237 recommendations as at July 2004, and subsequent developments up to March 2005.

Overall Assessment

It is considered that there is satisfactory ongoing compliance with the substance of all of the Douglas Inquiry recommendations (DI recommendations) for which Women's and Children's Health Services (WCHS), of which KEMH forms part, are responsible. Internal Audit noted a number of instances where the arrangements used to implement the DI recommendations differed from the arrangements required by the text of these recommendations in the DI Report. Although Internal Audit located documentation which indicates that the Implementation Group gave tacit approval to these differing arrangements, there was no formal instrument of delegation from either the Minister for Health or the Director General granting the Implementation Group the authority to implement any recommendations in an amended form.

The DoH is responsible for the ongoing progress of several more of the DI recommendations, and has referred these recommendations to agencies external to the DoH. The DoH is currently following up the status of these recommendations.

The WCHS Executive has also taken the initiative by establishing its own Douglas Inquiry Audit Committee to ensure that the satisfactory ongoing compliance with the DI recommendations is maintained and to identify areas requiring remedial action. Following the release of the Pepperell Report in March 2004, the DI Audit Committee expanded its terms of reference to incorporate responsibility for the ongoing review of the recommendations contained in that report, and to consider any of the 237 DI recommendations identified as requiring ongoing monitoring. Internal Audit supports these initiatives as evidence of the WCHS Executive's commitment to ensuring the continuation of the high standard of health services provided.

2. BACKGROUND SCOPE & OBJECTIVES

2.1 Background

The Inquiry Into Obstetric and Gynaecological Services at King Edward Memorial Hospital 1990 – 2000 (Douglas Inquiry) commenced in April 2000 following a review that raised concerns about patient safety at the hospital. These concerns included:

- Delivery Suite management and practices;
- The number of adverse events occurring after hours;
- Obstetric outcomes below the national benchmark; and
- Inadequate training and supervision of junior medical staff.

Following the tabling of the Douglas Inquiry Report (DI Report) in Parliament on December 2001, the Department of Health (DoH) established an Implementation Group in January 2002, chaired by the Deputy Director General HealthCare Division, and including a member of the Douglas Inquiry panel, to oversee the implementation of the 237 recommendations in the report. The Implementation Group disbanded in June 2003 after it had agreed that it had "completed its task given that all recommendations had been implemented, except the four requiring some form of legislative action". The Implementation Group agreed that it no longer needed to meet as King Edward Memorial Hospital (KEMH) had processes in place to continue to audit the 43 recommendations identified for ongoing review, and the DoH Internal Audit Branch was to undertake an independent review of the implementation of all recommendations.

As KEMH along with Princess Margaret Hospital (PMH) now comprises the Women's and Children's Health Service (WCHS) sharing the same Executive and Corporate structure, this report uses the term WCHS unless the issue specifically relates to KEMH, or KEMH is used in the document being referred to.

The DoH Internal Audit coverage of the implementation of the recommendations was undertaken in three stages. The first stage in 2002 reviewed the system of implementation and the evidence presented to the Implementation Group to support the 54 recommendations, which had been signed off at that time. The second stage in 2003 reviewed the supporting evidence for a further 106 recommendations which the Implementation Group had signed off. This third stage in 2004 reviewed the supporting evidence for signing off the remaining 77 recommendations, and the ongoing compliance of all of the 237 recommendations as at 2004.

Although the DI Report contained 237 recommendations, the outcome was that WCHS was responsible for implementing only 225 of these recommendations. This was due to:

- 4 recommendations being referred to the DoH as requiring legislative action;
- 5 recommendations concerning Associate Consultants no longer being applicable as WCHS had abolished the status of Associate Consultant at KEMH in May 2003;
- 1 recommendation concerning cases being referred to the Medical Board for action;
- 1 recommendation being subsumed into the implementation of recommendation no. 31 of the Health Reform Committee Report (Reid Report); and
- 1 recommendation being a lead in to a series of recommendations concerning Quality Improvement, rather than being a recommendation itself.

After WCHS had satisfactorily implemented one other recommendation, it was referred to the DoH to be progressed further, with the result that WCHS is now responsible for the ongoing progress of 224 DI recommendations.

Following the disbanding of the Implementation Group, the WCHS Executive implemented several initiatives to monitor the ongoing compliance with the Douglas Inquiry recommendations. In October 2003 the WCHS Executive established the "Douglas Inquiry Audit Committee; Women's and Children's Health Service" (WCHS DI Audit Committee) to provide evidence of ongoing audit, in relation to the 43 recommendations which the Implementation Group identified as requiring proof of ongoing audit. The WCHS DI Audit Committee was also required to assess the procedures in place to monitor compliance with these 43 recommendations. The WCHS DI Audit Committee meets monthly. Initially it was chaired by the Manager, Performance Review Services, WCHS, but since November 2003 it has been chaired by the WCHS Area Chief Executive.

There have been several other developments which impact on the Douglas Inquiry recommendations. In November 2003 Dr Humphrey, then Medical Director, Obstetrics and Gynaecology Clinical Care Unit at KEMH, issued a confidential report "An Assessment of the State of Implementation of the Findings of the Douglas Inquiry" (Humphrey Report). In February 2004 Professor Pepperell of Melbourne University presented his report "The provision of Independent Advice, Clinical Review and a Written Report on Selected Cases Managed at the King Edward Memorial Hospital" (Pepperell Report) to the Director General of the DoH. In March 2004 the Minister for Health tabled an edited version of the Pepperell Report in the Western Australian Legislative Assembly. The Pepperell Report contains 17 recommendations, four of which can be matched to five of the Douglas Inquiry recommendations.

At its meeting in July 2004 the WCHS DI Audit Committee agreed to expand its terms of reference to incorporate the Pepperell Report recommendations, and to consider any of the 237 Douglas Inquiry recommendations identified as requiring ongoing monitoring.

The Implementation Group signed off a number of recommendations as having been implemented in an "amended" or "modified" form which differed from the text of the Douglas Inquiry Report. In his interim report to Parliament on 26 September 2002, the Minister for Health stated that eight of the recommendations had "been signed off in an amended form to reflect the current scarcity of specialist staff and organisational practicalities".

The Implementation Group also signed off some of the recommendations concerning Clinical Incident Management and Clinical Governance as being implemented although the arrangements by which these recommendations were implemented differed from the arrangements required by the text of the recommendations in the DI Report. Although Internal Audit has located documentation which indicates that the Implementation Group gave tacit approval to these differing arrangements, there was no formal instrument of delegation from either the Minister for Health or the Director General granting the Implementation Group the authority to implement any recommendations in an amended form. Internal Audit considers, however, that the arrangements by which these recommendations were implemented will probably result in WCHS obtaining a better outcome in the achievement of the substance of the DI recommendations, than if they had been implemented in strict compliance with the text of the DI recommendations.

In its audit of the 43 recommendations, the WCHS DI Audit Committee identified issues caused by the ambiguous wording of some of the DI recommendations, and doubt as to the level of compliance which is required for some of the DI recommendations to be considered as satisfactorily achieving the substance of these recommendations. At its meeting in June 2004 the WCHS DI Audit Committee agreed that when its audit of all of the 43 recommendations was completed the Area Chief Executive would formally write to the Director General to seek clarification of the wording of those recommendations which were ambiguous, and to determine the level of compliance with the recommendations which would be acceptable. This will bring some certainty to the process, and will facilitate transparency in evaluating the degree of ongoing compliance with the recommendations.

As the WCHS DI Audit Committee was ensuring ongoing compliance of a number of recommendations, it was decided that Internal Audit would rely on the Committee's coverage of these recommendations, and audit the ongoing compliance of the remainder of the recommendations. The

proposals for future DoH Internal Audit involvement in the audit process are outlined at 2.6 "Future DoH Internal Audit Coverage".

KEMH has had several significant achievements since the DI Report was tabled. It has introduced the Nurses' Professional Portfolio in the Obstetrics and Gynaecology Clinical Care Unit. This provides in portable form, a comprehensive history of the nurse's career including education, work experience and professional development activities, as well as the information required for the nurse's performance management. The Nurses' Professional Portfolio as used at KEMH was modified from NHS version. The WA Nurses Board has further modified the KEMH version, and will make it's implementation mandatory in WA public and private hospital sectors, with the appropriate acknowledgement to KEMH.

In January 2005, as part of its ongoing compliance with the DI recommendations, WCHS implemented the Emergency Department Information System (EDIS) at KEMH. This system will provide data for Quality Improvement activities, and will allow management to monitor the performance of the KEMH Emergency Centre.

The implementation of the DI Report recommendations has provided a valuable experience for WCHS, from which it has learned many lessons. This provides WCHS with the potential to disseminate this knowledge learned from the implementation process, throughout the health industry both in Australia and overseas. This potential is supported by the document "Lessons From The Inquiry Into Obstetrics And Gynaecological Services At King Edward Memorial Hospital 1990 – 2000" issued by the Australian Council for Safety and Quality in Health Care in July 2002, which states at page 8:

> "There is no way of knowing how the Hospital's performance compares overall with other Australian hospitals. However, we can draw valuable lessons from the Inquiry and its extensive case reviews of patient, families and staff, that may be applicable to other hospitals and may point to potential improvement opportunities."

The knowledge learned from the implementation of the DI Report recommendations could be disseminated in various forums including WCHS organising DI Report implementation seminars, staff making presentations at domestic and international conferences, seminars, workshops, symposia, etc. Such presentations would demonstrate WCHS achievements since the DI Report was tabled, and promote WCHS in its aim to be regarded as a centre of excellence in the provision of women's health services.

2.2 Audit Objective

The audit examined the progress of implementing the remaining 77 recommendations which had not been reviewed in stages 1 and 2, focussing on how the system of implementation was working and continuing compliance to date. The audit also examined the continuing compliance of the recommendations whose implementation had been audited in stages 1 and 2.

2.3 Audit Scope

The audit examined the evidence used to support management's assertions that the 77 recommendations had been implemented, which formed the basis of the Implementation Group's decision to sign off on these recommendations. The audit also examined evidence used to support management's assertions of ongoing compliance with these 77 recommendations and with the recommendations which were audited in stages 1 and 2.

2.4 Previous Reviews

DoH Internal Audit has undertaken two previous reviews of the implementation of the recommendations. Stage 1 in 2002 reviewed the system of implementation and the evidence presented to the Implementation Group to support the sign off, for the 54 recommendations which had been

signed off at that time. Stage 2 in 2003 reviewed the supporting evidence for a further 106 recommendations which the Implementation Group had signed off as being implemented.

2.5 Prior Period Audits

Stage 3 of the audit reviewed the recommendations which were audited in Stages 1 and 2, to determine their ongoing compliance.

2.6 Future DoH Internal Audit Coverage

In his statement to the WA Legislative Assembly on 18 June 2003 the Minister for Health announced that the Implementation Group had completed its work of overseeing the implementation of the recommendations contained in the DI Report, and that of the 237 recommendations, all had been signed off except for the four recommendations requiring legislative action. The Minister also said that KEMH would continue to audit the 43 recommendations which the Implementation Group identified as requiring ongoing audit, and that the Internal Audit Branch of the DoH would provide an independent audit of the implementation of the recommendations.

The DoH Internal Audit Branch has now undertaken detailed audits of the implementation process of all of the recommendations, and of the ongoing compliance with these recommendations as at 2004. The WCHS DI Audit Committee now has the responsibility for the ongoing audit of the compliance with the DI Report recommendations and the Pepperell Report recommendations. The DoH Internal Audit Branch now proposes that for the next few years it will undertake an annual audit of the work of the WCHS DI Audit Committee to provide an independent verification of the ongoing compliance with the Douglas Inquiry and Pepperell Report recommendations. These audits will probably take place in October/November of each year and will review the results of the WCHS DI Audit Committee audits, the action taken on the recommendations of these audits, and the WCHS DI Audit Committee's proposed audit coverage for the subsequent 12 months. The first such audit has been programmed for the final quarter of 2005 and will also include coverage of the implementation status of the recommendations made in this DoH Internal Audit report. The WCHS Executive has advised that it supports a review of the work of the WCHS DI Audit Committee by the DoH Internal Audit Branch in October/November 2005.

2.7 Acknowledgements

Many people have been involved during the three years it has taken to complete the entire audit of the implementation of the Douglas Inquiry recommendations, and of their ongoing compliance. We would like to acknowledge the excellent assistance and cooperation we have received over this period from the WCHS Executive, management and staff at all levels. In particular we thank the management and staff of the Performance Review Services section who provided much of the required documentation as well as clinical advice and the results of their own audit work. We would also like to thank the staff in the DoH Legal and Legislative Services Branch, and the Research and Clinical Policy Branch of the Clinical and Aged Care Directorate, HealthCare Division, who provided valuable background information about the work of the Implementation Group, and advised on issues which arose during the audit.

3. RESULTS OF CURRENT REVIEW

The overall results of the audit are shown in section 3.1 of the report. The risk ratings shown for each recommendation are those allocated by the Implementation Group using their risk assessment matrix. This process allocated 9 as the highest risk rating down to 1 being the lowest risk rating. A copy of the risk assessment matrix is included at Attachment 1.

This report concentrates on the status of ongoing compliance with the recommendations at the time of the audit in 2004, and subsequent developments up to March 2005.

3.1 Ongoing Compliance Status of 237 Recommendations as at 2004

The overall results of the audit of the ongoing compliance status of the 237 recommendations in 2004 are summarised by risk rating in the following table:

Ongoing Compliance Status	Risk Ratings						Total
	9	**6**	**4**	**3**	**2**	**1**	
Satisfactory	27	100	67	10	19	1	**224**
With DoH [1, 2]		2			2	1	**5**
With Medical Board [3]					1		**1**
Subsumed into Reid [4]		1					**1**
Lead in to 8 recs [5]		1					**1**
No Longer Applicable [6]		2	2		1		**5**
Total	**27**	**106**	**69**	**10**	**23**	**2**	**237**

Notes

[1] The Implementation Group referred 4 of these recommendations to the DoH for legislative action. Refer section 3.2.1

[2] For the other recommendation the DoH has submitted an application to the Australian Council for Safety and Quality in Health Care for funding to undertake a comparative data analysis national project. Refer section 3.2.2.

[3] The Implementation Group referred this recommendation to the Medical Board for their action.

[4] This recommendation is considered to be subsumed into the implementation of recommendation number 31 of the Reid Report.

[5] This recommendation is considered to be a lead in to the subsequent 8 recommendations in the DI Report.

[6] These 5 recommendations are no longer applicable as the status of Associate Consultant at KEMH has been abolished.

3.2 Recommendations Referred to the Department of Health for Action

As at March 2005 there are five DI recommendations which have been referred to the DoH for further action. The DoH has referred four of these recommendations to the WA Solicitor General for advice and, for the fifth recommendation, has submitted an application for funding to the Australian Council for Safety and Quality in Health Care.

3.2.1 Recommendations Referred to the WA Solicitor General

The Implementation Group referred four recommendations to the Department of Health as requiring legislative action. These recommendations were:

- R2.2 (No.2) Legislative Framework Risk Rating 1
- R11.6.2 (No. 165) Statutory Mortality Committees Risk Rating 6
- R11.6.3 (N. 166) Health Act definitions of "death" and "stillbirth" Risk Rating 6
- R11.6.6 (No.169) Statutory reporting obligations for doctors and nurses Risk Rating 2

On 4 April 2002 Dr Brian Lloyd, Deputy Director General HealthCare Division, in his capacity as Chairman of the Implementation Group, initially referred three of these four recommendations to the WA Solicitor General. (R2.2 No. 2, R11.6.2 No. 165 and R11.6.3 No. 166) On 14 March 2003 the Solicitor General replied stating the issues referred were being considered. Dr Lloyd responded to the Solicitor General on 15 July 2003, providing details of all four recommendations and requested advice and comment on the progress of these four recommendations. As at March 2005 no further communication had been received from the Solicitor General. As the Solicitor General has now had almost three years to consider his response, Internal Audit considers that it may be an opportune time for the DoH to request the Solicitor General to provide the current status of these four DI recommendations.

Recommendation	Management Response
To provide substantial ongoing compliance with these four Douglas Inquiry recommendations the Director General of the Department of Health write to the Solicitor General requesting their current status.	AGREED. A FURTHER LETTER REQUESTING ADVICE FROM THE SOLICITOR GENERAL HAS BEEN SENT FROM THE ACTING DIRECTOR GENERAL ON 5 APRIL 2005. DR NEALE FONG, ACTING DIRECTOR GENERAL COMPLETED

3.2.2 Recommendation Referred to the Australian Council for Safety and Quality in Health Care

Comparative Data Analysis

R7.5.2 (No. 62) Risk Rating 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."

The WCHS has completed the Pilot Project Report. In June 2004 the DoH Research and Clinical Policy Branch of the Clinical and Aged Care Directorate, HealthCare Division, made an application to the Australian Council for Safety and Quality in Health Care, for funding to undertake the national project. As at March 2005, there has been no outcome of the application despite several follow-up activities/inquiries by the DoH.

Recommendation	Management Response
To provide substantial ongoing compliance with the Douglas Inquiry recommendation R7.5.2 (No. 62) the Director General instruct the Research and Clinical Policy Branch of the Clinical and Aged Care Directorate, HealthCare Division actively pursue the funding application to the Australian Council for Safety and Quality in Health Care.	AGREED THE RESEARCH DEVELOPMENT AND POLICY SUPPORT UNIT OF THE CLINICAL POLICY BRANCH, STATEWIDE POLICY DIVISION (NAME UNDER NEW STRUCTURE) IS IN THE PROCESS OF FINALISING A FUNDING AGREEMENT WITH THE ACSQHC AND THE DEPARTMENT OF HEALTH. FUNDS HAVE BEEN RESERVED BY THE ACSQHC FOR THE NATIONAL MATERNITY DATA COLLABORATION PROJECT. FUNDS ARE EXPECTED TO BE RECEIVED IN APRIL/MAY 2005 AND THE PROJECT WILL BE MANAGED BY DR BRIAN LLOYD, CHIEF MEDICAL OFFICER. THE PROJECT IS EXPECTED TO START IN JULY 2005. IT IS INTENDED THAT THIS WORK WILL BE EMBEDDED WITHIN THE WCHS CLINICAL GOVERNANCE FRAMEWORK TO ENSURE SUSTAINABILITY. DR BRIAN LLOYD, CHIEF MEDICAL OFFICER COMPLETION DATE: MAY 2005

3.3 Administrative Issues Identified

The Stage 3 audit identified several administrative issues as requiring management attention. These issues and the relevant recommended action are detailed hereunder.

WCHS DI Audit Committee

The WCHS DI Audit Committee was initially established to review ongoing compliance with the 43 recommendations identified by the Implementation Group as requiring ongoing audit. The WCHS DI Audit Committee has since expanded its terms of reference to include review of ongoing compliance with the Pepperell Report recommendations, and to consider any of the 237 Douglas Inquiry recommendations identified as requiring ongoing monitoring.

Internal Audit supports these initiatives, and considers that the WCHS DI Audit Committee continue to operate for a sufficient period until the hospital can demonstrate that there is substantial ongoing compliance with both the Douglas Inquiry and the Pepperell Report recommendations. To this effect it may be beneficial for the WCHS Area Chief Executive's performance agreement with the Director General to include a requirement to retain the WCHS DI Audit Committee and its activities for the next few years.

Recommendation	Management Response
To provide substantial ongoing compliance with the Douglas Inquiry and Pepperell Report recommendations, the WCHS Area Chief Executive's performance agreement with the Director General include a requirement to retain the WCHS DI Audit Committee and its activities for sufficient period until the hospital can demonstrate that there is substantial ongoing compliance with both the Douglas Inquiry and the Pepperell Report recommendations.	AGREED THE WCHS WILL RETAIN AND SUPPORT THE WCHS DI AUDIT COMMITTEE AND ITS ACITVITIES UNTIL THE DIRECTOR GENERAL AGREES THAT THERE IS SUFFICIENT EVIDENCE OF SUBSTANTIAL ONGOING COMPLIANCE. MR GLYN PALMER, AREA CHIEF EXECUTIVE. COMPLETION DATE: ONGOING

Approval Process for Amending DI Recommendations

The Implementation Group signed off a number of recommendations as having been implemented in an "amended" or "modified" form which differed from the text of the DI Report. In his interim report to Parliament in September 2002, the Minister for Health stated that eight of the recommendations had "been signed off in an amended form to reflect the current scarcity of specialist staff and organisational practicalities".

The Implementation Group also signed off the recommendations concerning Clinical Incident Management and Clinical Governance as being implemented although the arrangements by which these recommendations were implemented differed from the arrangements required by the text of the recommendations in the DI Report. Although Internal Audit has located documentation which indicates that the Implementation Group gave tacit approval to these differing arrangements, there was no formal instrument of delegation from either the Minister for Health or the Director General granting the Implementation Group the authority to implement any of the recommendations in an amended form. Internal Audit considers, however, that the arrangements by which these recommendations were implemented will probably result in WCHS obtaining a better outcome in the achievement of the substance of the DI recommendations, than if they had been implemented in strict compliance with the text of the DI recommendations.

In its audit of the 43 recommendations, the WCHS DI Audit Committee has also identified issues caused by the ambiguous wording of some of the DI recommendations, and doubt as to the level of compliance which is required for some of the DI recommendations to be considered as satisfactorily achieving the substance of these recommendations.

At its meeting in June 2004 the WCHS DI Audit Committee agreed that when the audit of all of the 43 recommendations was completed the Area Chief Executive would formally write to the Director General to seek clarification of wording of those recommendations which were ambiguous, and to determine the level of compliance with the recommendations which would be acceptable. This will bring some certainty to the process, and will facilitate transparency in evaluating the degree of ongoing compliance with the recommendations.

Recommendation	Management Response
After the WCHS DI Audit Committee has completed the audit of the 43 recommendations identified for ongoing review, the Area Chief Executive and the Director General develop a protocol to formalise the process of resolving issues concerning clarification of ambiguous wording in the Douglas Inquiry recommendations, and for determining the level at which ongoing compliance with the substance of the recommendations can be considered as satisfactory.	AGREED PROCESS DISCUSSED AND AGREED BY THE WCHS AREA CHIEF EXECUTIVE AND THE DIRECTOR GENERAL ON 22 SEPTEMBER 2004 AND CONFIRMED ON 23 NOVEMBER 2004. AWAITING WRITTEN CONFIRMATION FROM THE DIRECTOR GENERAL FURTHER COMMENT MARCH 2005 WRITTEN CONFIRMATION OF THE PROCESS WAS RECEIVED FROM MR M DAUBE PRIOR TO HIS RESIGNATION AS DIRECTOR GENERAL. ONCE AUDITS OF THE NOMINATED RECOMMENDATIONS HAVE BEEN COMPLETED, DISCUSSIONS WILL BE HELD WITH DR N FONG, A/DIRECTOR GENERAL TO CONFIRM THE PROCESS. MR GLYN PALMER, AREA CHIEF EXECUTIVE COMPLETION DATE: JUNE 2005

Recording Attendance at Postgraduate Education Activities

Resident Medical Officers (RMO) and Registrars are required to regularly attend various postgraduate education activities. The medical staff attend these activities and sign an attendance list which is sent to the Postgraduate Medical Education (PGME) Administrative Assistant based in KEMH, who enters these attendances in a spreadsheet. At the end of each month the medical staff are required to submit an "Essential" Postgraduate Activities form which lists the activities attended during the month to Medical HR based in PMH. Medical HR then enter these attendances in a database.

These arrangements cause several difficulties. Medical HR advised Internal Audit that there were delays in receiving the "Essential" Postgraduate Activities forms and hence the database was not up to date. As the attendance lists are sent to the Postgraduate Medical Education Administrative Assistant in KEMH and the "Essential" Postgraduate Activities forms are sent to Medical HR in PMH, the documents cannot be cross-checked to verify that the medical officer actually attended the activity as claimed. Only the medical officers sign their Essential" Postgraduate Activities form.

As the medical officers are based at KEMH and attend their postgraduate education activities there, it would be appropriate for them to submit their "Essential" Postgraduate Activities forms to the Postgraduate Medical Education Administrative Assistant, who, if granted access, could then enter details of these activities in the database. The advantages of this arrangement would be:

- The data is captured at source;
- The data would only be entered once, at present it is entered into two separate systems;
- There would be a single database for recording postgraduate education activities;
- Missing "Essential" Postgraduate Activities forms can be promptly followed up; and
- The Administrative Assistant can check the "Essential" Postgraduate Activities forms to the attendance lists to verify attendance at the activity.

Recommendation	Management Response
To provide substantial ongoing compliance with the Douglas Inquiry recommendations relating to attendance at postgraduate medical education activities, all documentation relating to attendances by medical staff at these postgraduate medical education activities at KEMH be sent to the Postgraduate Medical Education Administrative Assistant. The Administrative Assistant be given access to the relevant sections of the postgraduate medical education database to enter details of these attendances.	AGREED A NEW DIRECTOR OF POSTGRADUATE MEDICAL EDUCATION WILL BE APPOINTED IN DECEMBER 2004 AND A PGME DEPARTMENT ESTABLISHED UNDER HIS LEADERSHIP. ADMINISTRATIVE PROCEDURES AND SYSTEMS WILL BE REVIEWED AS PART OF THE ESTABLISHMENT OF THIS DEPARTMENT. FURTHER COMMENT MARCH 2005 A RECORD OF ATTENDANCES AT PGME ACTIVITIES WILL BE MAINTAINED BY THE PGME ADMINISTRATIVE ASSSISTANT WHO WILL BE GIVEN ACCESS TO THE PGME DATABASE. DR JOLYON FORD, DIRECTOR POSTGRADUATE MEDICAL EDUCATION KEMH. COMPLETION DATE: APRIL 2005

Attachment 1

RISK ASSESSMENT MATRIX

The seconded officers developed the following three by three matrix, adapted from AUS/NZ 4360 Risk Management 1999 standard. Each recommendation was assessed under the two criteria of importance and urgency and assigned values of between one and three for each, with 1 = low importance and/or urgency and 3 = high priority. These two values were then multiplied together to go an overall risk score. For example if a recommendation was deemed to be of medium priority (=2) and of high importance (=3), it's overall risk score would be 2 x 3 = 6.

Severity (Importance) **For individual patient safety and/or whole of system**	**Priority (Urgency)**		
	Low Priority (1)	**Medium Priority (2)**	**High Priority (3)**
Low: (1) Minimal impact on clinical outcomes – no immediate threat to patient safety or system.	Low	Low	Medium
Medium: (2) There may be harm to patients and/or system failures if the recommendation not progressed expediently.	Low	Medium	High
High: (3) Significant issues with standards, quality of care or compromise of patient rights resulting in a threat to clinical outcomes.	Medium	High	High

Action required by timeliness and timeliness was suggested as:

Risk Rating	**Action Required**
High	Immediate action– remedy within three – six months
Medium	Implement recommendations within six – nine months.
Low	Implement recommendations within twelve months.

Those with a risk score of 9 were suggested to be the first priority and of highest interest to the organisation and Implementation Group.