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Do inquiries into health system failures lead to change in clinical governance systems?

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Introduction

Inquiries into health system failures are highly visible to the community, undermine the public’s trust in the health system, are expensive and have a profound effect on all involved. Politicians, the community and health professionals rationalise that an Inquiry is required so that lessons can be learnt and used to improve outcomes for patients and their families (Walshe & Higgins, 2002). However, there is little evidence about whether inquiries do lead to some sustained positive change. This article reports some of the results of a study to investigate if changes to improve care were instigated following an Inquiry into patient care at King Edward Memorial Hospital (KEMH) in Western Australia.

Background

In Australia alone between 2000 and 2005, there were several important Inquiries including: the King Edward Inquiry in Western Australia (WA) (2001), the Campbelltown and Camden Inquiry in New South Wales (2003) and the Bundaberg Inquiry (2005) in Queensland.

Although the circumstances in each of these cases were different, there were similarities in the significant findings of all three including: (1) ineffective or inadequate systems to monitor and report adverse events, (2) the absence of transparent systems and support to deal with patients and staff concerns about quality and safety, and (3) a lack of an effective medical credentialing and performance review system (Davies, 2005; Douglas, Robinson, & Fahy, 2001; Faunce & Bolsin, 2004). It is also striking to note that similar findings to these three Australian cases were described in the report of the high profile Bristol Royal Infirmary inquiry in the United Kingdom (Faunce & Bolsin,
Inquiries of this type tend to be highly politicised and very visible to the general public (Walshe, 2003; Walshe & Higgins, 2002). However, there is very little reported on the outcome aspect of changes that result from these inquiries (Edmondson, 2004).

To investigate the influence of inquiries on change a case study approach was used to examine firstly if change had occurred at KEMH post Inquiry, how the Inquiry influenced the change, and why the Inquiry impacted on change (accepting the impact could have been positive or negative). This paper reports only the first part of the study identifying if changes did occur post Inquiry.

The KEMH inquiry report “identified problems with the delivery of services at KEMH. The problems covered clinical, administrative and management issues. They ranged in seriousness, with some being very serious” (Douglas et al., 2001:x).

Problems that influenced care were identified in the following areas:

- Care planning, care delivery and documentation;
- Inter-hospital performance;
- Clinical policies and guidelines;
- Incident reporting and management;
- Staffing problems;
- Education and Training;
- Consultant accountability and cover;
- Junior doctor supervision and training;
- Credentialing of doctors;
- Performance management of clinicians;
- Involving women and families in care;
- Managing complaints; and
• Quality improvement and accreditation (Douglas et al., 2001).

The specific areas of medical credentialing, clinician performance review, and consumer involvement in care were chosen as the clinical governance processes to be examined in this study. These areas were chosen for two main reasons.

First, credentialing and performance review processes are excellent examples of administrative functions that are important for patient safety, easily measured in terms of structure, process and outcome, and require cultural change from clinical staff. It is an area highlighted in the final Inquiry report as an area of significant deficiency (Douglas et al., 2001).

The second reason centers on involvement of consumers in care, and is more difficult to measure objectively. Yet, in terms of what is valued by patients and families, it is of great importance. At the KEMH Inquiry, it was an area of major focus, and requires significant cultural change from clinical staff (Braithwaite, 2005; Edmondson, 2004).

Methods

A case study strategy (Yin, 2003) was used to investigate the effect of the Inquiry on changes in processes at KEMH. Case studies are different from other types of qualitative research in that the focus is in developing an in depth description and understanding of the case being studied by using multiple sources of data such as interviews, observations, documents and archives (Creswell, 2007). The data sources chosen for this case study were documents and archives (henceforth reported together as documents) and interviews. These sources were chosen as each set of data gives a different perspective of the case and provides ample opportunity for cross-verification of important findings (Punch, 2005; Yin, 2003).
The University of Notre Dame Human Research and Ethics committee approved the study.

**Document Sources**

Documents were obtained from a variety of sources including Hansard (the official record of the WA Parliament for the Legislative Assembly and the Legislative Council), the Department of Health West Australia, the Department of Health and Ageing, various media, KEMH and the KEMH website, Quality and Safety websites, and academic journals and conference reports and the final Inquiry Report itself.

Documents were identified in several ways. Initially by studying the transcript from the final report of the Inquiry where particular documents, such as reports or reviews held by the Department of Health West Australia, the WA Government Publisher, Hansard, or more generally, documents available either electronically or in print, were identified. Interview participants identified some documents as support for their views or as a direction to the researcher that they might yield information. Some documents were identified by interview participants and others were identified through a review of pertinent recommendations of the final Inquiry report. For each of these, a list of possible documents that would support implementation was compiled.

There were two types of documents examined. Those for internal organisational use that are in the main generated to provide direction or review for the staff within the organisation such as policies, guidelines and reports or reviews by external bodies. The second type examined was journal/conference reports, KEMH generated reports and audit compliance reports by external bodies.
Many of the documents were available as part of the public record and thus were easily accessible. Other documents such as some internal KEMH Policies, different committee terms of reference and other external reports were acquired using Freedom of Information Legislation (*Freedom of Information Act*, 1992).

**Interview Sample**

The interview sample of five was drawn from senior members or officers of clinical professional, regulatory and consumer representative organisations external to KEMH. The purposive sample (Punch, 2005) was chosen deliberately from organisations that had either direct interactions with clinicians or consumers providing advocacy or policy advice, or those that had a role in the registration, accreditation or credentialing of clinicians. Senior members or officers of these organisations are in the unique position of having knowledge and experience of the clinical governance systems and processes in place at KEMH as experienced by patients, families, clinical staff or management of KEMH. This knowledge is gained through their frequent and ongoing interactions with these groups. While having this knowledge of the KEMH, these senior officers were not members of the staff of KEMH involved in the delivery of the service, and thus were less likely to have a vested interest in representing a view of KEMH that would portray only a positive image. As such, it was felt that a more rounded and complete view of changes would be gained from this purposive sample.

In addition, limiting the number to five participants from different professional backgrounds and experiences provided ample opportunity to identify themes within the data without being overwhelmed by the amount of data that a much larger sample might generate. This rationale to limiting the sample size to five key informants, while ensuring a broad cross section of views specific to the case being studied is supported by Creswell (2007:128)
who identifies that limiting sample size to 4-5 in a single study provides ample opportunity to identify significant themes.

Data Analysis

Documents

The documents were examined using a normative analytic approach as described by Neuendorf (2002). This approach requires an evaluation of the data from the perspective of the current situation compared to the desired state. Thus, for this study a set of criteria were developed to identify if the documents reflected either the changes required by the Inquiry or evidence of implementation. This set of criteria acted as a checklist when reviewing the documents. Each document was reviewed against these criteria for evidence that demonstrated compliance with the specific recommendations relating to both medical credentialing and performance management (25 recommendations), and/or consumer involvement in care (15 recommendations).

Specifically, to meet the Inquiry recommendations the documents reviewed for credentialing and performance review needed to demonstrate that there was a process describing the credentialing committee’s scope and function. The credentialing process was to cover all levels of medical practitioners, there was to be a robust process ensuring that the list was updated as required, and updated lists were to be distributed appropriately to all clinical areas. As well, there was to be robust performance management processes for all clinicians described in policy documents.

The Inquiry report identified the deficiencies in consumer participation in care were in the four areas of: communication with women and their families; psychological concerns, responses to poor outcomes; and involving women in treatment decision-making. To meet the requirements for consumer
participation in care the documents reviewed for evidence of changes in consumer participation in care were examined for either a description of a process or policy, or a description of an outcome that dealt with the specific behaviours identified as deficient at the Inquiry.

The checklist for both parameters comprised the following criteria:

- No evidence identified demonstrating compliance with Inquiry recommendations. The term used for this criterion is **no evidence**;
- Policy procedure or guideline described the process or expected behaviour as per the Inquiry recommendation. The term used for this criterion is **specific**;
- Policy, procedure or guideline describes the process or expected behaviour in detail but not exactly as per Inquiry recommendation or with a required element omitted. The term used for this criterion is **implied**;
- A KEMH organisational or KEMH staff member produced document claiming that a policy, procedure or process was in place, or an outcome described that would indicate implementation. The term used for this criterion is **self-reported evidence**; and
- An external report produced by an external agency following examination of KEMH processes stating that policy, procedure or guideline had been implemented. The term used for this criterion is **external evidence**.

**Interviews**

The Miles and Huberman framework (Miles & Huberman, 1994) was used for data analysis of the interviews. *NVIVO 7 (2006-2008)* provided the opportunity to build models throughout the process of analysing the data. This program uses a system of coding to nodes which are used to store data
about the specific theme of category. Before analysis commenced several parent nodes were established that provided initial organisation for the coding. These parent nodes included categories such as barriers to change, changes in credentialing, changes in consumer involvement, influences on change, and Inquiry findings. These categories were those that reflected the major research questions and the literature reviewed as part of the development of the study. Beneath these parent nodes, child nodes were created. The initial child nodes provided a separation of source and so were labeled identified in documents and identified by participant. These preliminary nodes provided the early framework for beginning the data analysis. Very quickly however, as themes emerged in the source data, new parent and child nodes were added. As each new parent or child node was added, the previous sources that had been coded were rechecked to identify if that theme had not been identified on first coding. Codes were established, merged, re-established and linked throughout the process of data analysis. Figure 1 provides an example of a developing code node hierarchy.

Eventually this led to the aggregating of data to identify the emerging themes. Stake (1995:74-77) and Creswell (2007:163-164) describe this as categorical aggregation and discuss the role of intuition, researcher knowledge of the context and case, together with the actions of searching for corroborating or disconfirming information in the sources that leads to this sorting and combining of the data into themes.

Several strategies were employed to ensure the data analysis was robust and reliable. Firstly throughout the study, clinician mentors familiar with the context and subject matter were accessed to discuss and take on the role of devil’s advocate proposing alternative suppositions. Secondly, participants were contacted in the final stages of the data analysis seeking their feedback
in relation to the interpretation of the data. Thirdly, double analysis and reanalysis was employed. This involved coding a segment and then recoding after a time interval. The target was 90% congruency between initial and reanalysis (Miles & Huberman, 1994).

Findings: Document analysis

Credentialing & Performance Review

The Inquiry recommendations for credentialing and performance review required the following:

- Credentialing committee scope and function (terms of reference, meeting frequency, administrative functions);
- Credentialing list management (in terms of currency maintenance and distribution);
- Medical staff credentialing requirements (process of notification, monitoring and currency maintenance); and
- Performance management for each clinical group (initial process in place, ongoing development and review processes).

Each document was examined for references or evidence to support any changes as summarised above. Table 1 below illustrates that those documents produced for internal organisational use clearly demonstrated compliance with the requirements of the recommendations of the Inquiry. Other reports undertaken by external agencies indicate that the processes as described in the policies are actually occurring in the hospital.

Table 1 inserted here
**Consumer involvement in care**

The final Inquiry report identified 15 consumer improvement recommendations pertaining to changes that had to be made by KEMH. They were divided into the subcategories of: communication with women and families (5); psychosocial concerns (4); responses to poor outcomes (4); and, involving women in care (3). For the purpose of the document review two of the recommendations in relating to responses to poor outcomes have been combined as both recommendations dealt with similar aspects of the same element. Table 2 below illustrates that of the 15 Inquiry consumer improvement recommendations; evidence was identified in the documents for the majority of the recommendations demonstrating compliance with requirements for improvement. It is notable that where evidence of implementation was identified, there were multiple sources of documentary evidence. However, Table 2 also highlights three areas where no evidence was found in the documents. These were the areas concerned with the provision of regular communication training and workshops for all clinical staff.

Table 2 inserted here

**FINDINGS: Interviews**

Credentialing and Performance review

Three coding themes emerged in the coding analysis for credentialing and performance review. These were: medical credentialing and performance management, midwifery credentialing and performance management; and,
the effect medical credentialing and performance management had on clinicians.

The positive results from the document analysis findings were corroborated by the interviews which explored the participants’ perceptions about changes in regards to credentialing and performance management. Participants believed that there had been significant changes within the area of medical credentialing and performance management. The comments by these participants are typical of all those who made comments on this category:

... (KEMH) have certification and privileging policies in place to clarify scope of practice within the service which is connected to safety and quality care ...

... the credentialing documents that were being produced were very comprehensive ... before in the past it was “did you have that qualification?” and then you had a job ...

Participants were all impressed with the breadth and scope of the credentialing process especially in comparison to other sites within Western Australia. They commented on the processes being applied to all levels of medical staff as well as to specific procedures. One example of these comments is:

... the difference of course is that King Edward has a procedures specific credentialing system that most other sites don’t have comprehensively ... and the other thing about King Edward is that their credentialing system starts from junior staff level and not just at consultant level and I think all the other site ... are consultant only ...

The participants from the regulatory and professional organisations spoke in very definite terms of the initial reaction of medical and midwifery staff to the changed processes and expectations in terms of credentialing and performance management. These are encapsulated by the following comment:
... for I would say the majority it did change their behaviour ... eventually... initially it was an aggressive ... yes I suppose aggression describes the type of behaviour because they were being asked to comply with policies they felt that they had no ownership of or that they didn’t develop ...

Participants believed that there had been significant changes within the area of medical credentialing and performance management. This is supported by the document analysis. There were no negative comments at all in this section, with several participants commenting on the positive model that KEMH was demonstrating to other hospitals.

Consumer involvement in care

The participant interviews corroborated these findings with six coding themes emerging in the coding analysis of the interview transcripts for this section. Four of the themes positively identified there had been an improvement in the processes that involved consumers in care. These themes were: general improvement; involvement in clinical care decisions; the management of critical incidents; and continuity of care. All categories of participants made positive comments recognizing improvements- these included:

... I mean ... from that consumer perspective ... the general feel would be that it had improved...

... generally feeling more comfortable at being able to ask questions... feeling that people were accessible to ask questions...

... going on a number of women I know who have made comments to me there is much better access, and there are people available for them to ask and they are encouraged to ask questions ...

In relation to the management of critical incidents a participant from the consumer organisation commented that:
... there also seems to be genuine multi-disciplinary formal structured processes that people are given access to so that they can have their questions answered and so that they can grieve and make choices about arrangements for, in the case of neonatal death or stillbirth, cremation or burial, or what have you. Whereas before decisions were often made for people and information was often withheld ...

There were two negative themes that were identified from the participant interviews. One of these was labeled needs improvement and was directly related to the need for communication improvement between clinicians and women. An example of this was one clinical professional participant stating:

... but I've been involved in a few reviews of obstetric cases and practitioners ... and they have been concerned ...[with] problems with communication, or accessing information or accessing practitioners for information ... other people ... have come out and have tried to access different hospitals because they have not been happy with what was going on. I think the numbers ... the few numbers going through ... felt they weren’t getting the information they needed ... Yet ... I see that with all the policies that have been put in place from the recommendations that were suggested that this has been followed up and things have been put in place but...

The second negative theme related to clinicians’ interactions with women and their families and was labeled clinician deafness. This was described by participants as situations where clinicians do not hear or understand what it is that patients want from their therapeutic interactions or perhaps more worryingly display a rather shameful attitude of indifference to peoples’ needs. Several examples of comments about this are revealed below:

... the deafness to the patient reports ... [long pause] ... the deafness language, fleeing from your distressed patient ... it’s the other... the mentality of the other ... you can only do that to a person if you are not seeing them as similar to yourself ... (participant from consumer organisation)

... [the patient reports that the hospitalisation] was fine, the birth wasn’t bad but (expletive)... [they say] I hate that hospital. These are the ones you worry about ... the people who still had a good outcome but don’t like the hospital
because there's something about the cultural dynamic of the service they got ...

Thus, the interview analysis confirmed the document findings, with participants giving examples of where improvements had been made structurally in terms of policies and procedures, but also noting that in terms of the human communication with patients and families, there were still improvements that needed to be made. This is of significance in that many of the patients who gave evidence at the inquiry identified that communication between clinical staff and patients was an area of weakness in the care they received.

Discussion

Credentialing and performance review for medical practitioners is a relatively new process for medical practitioners (Du Boulay, 2000). Initially there was marked resistance to implementing credentialing processes. However, it is now recognized that in a health environment, which is becoming increasingly complex with a multitude and diverse number of clinical procedures, credentialing and defining scopes of practice are key elements of corporate and clinical governance systems (Wolff & Taylor, 2009). Credentialing and defining the scope of clinical medical practitioners practice are governance responsibilities of the board (or the responsible entity) (Wolff & Taylor, 2009).

Given that the increasing recognition and acceptance that credentialing and performance review are an essential requirement of an effective clinical governance system the expectation is that health organisations will have robust systems in place. In Australia and Internationally there is a plethora of policies identifying the requirements and describing the processes (Clinical governance issues paper, 2001; Credentialing and defining the scope of clinical practice for the medical practitioners in Queensland, 2009; Introduction to Clinical Governance- A background paper., 2003; Leape &
Repeated health care failures where the lack of these processes is identified would question how well credentialing and performance review systems are implemented.

One of the key findings of this study is that there was significant evidence of improvements in the areas of credentialing and performance management post Inquiry. At the Inquiry, it was noted that there was denial by clinicians that this was an important problem (Douglas et al., 2001:xiii-xvii). The Inquiry identified significant deficits in these areas. The evidence that was given and made public about these issues was overwhelming and the sheer volume made it difficult to deny that there was a problem. Tompkins (2006) suggests that the recognition that there was a problem and change was required resulted in ownership and leadership of key executive and clinical leaders and drove the changes that occurred (Tompkins, 2006).

In the area of improving the involvement of consumers in their care there was noteworthy progress evidenced in the documents and confirmed by the participants’ interviews. However, there was no evidence identified in the documents that KEMH had implemented training and education for clinicians to improve communication skills in their interactions with patients and families. The participant interviews concurred with this lack of documentary evidence that improvements had not been made in this area as required by the Inquiry recommendations.

Thus, the findings indicated that the areas where changes occurred were in the administrative functions and the implementation of these. Changes were not demonstrated in processes that would increase the skills of clinicians at the interface between clinicians and patients in the delivery of care. The area of care and communication at the coalface has been a problematic one for some considerable time (Browne & Hemsley, 2008; Callaghan, 2002; Johnson & Beacham, 2006; Wellard, Lillibrige, Beanland, & Lewis, 2003). There may
be many reasons for this but in the context of the study undertaken here it is our belief that the lack of sustained change reflects an essential difficulty of health practitioners engaging with consumers who seek to make choices in their care (McPherson, Smith-Lovin, & Cook, 2001; Mol, 2008).

The expert health professional culture is a powerful barrier for patients and their families to overcome, especially when they are physically and emotionally vulnerable (Patients for patient safety- Statement of case, World Health Organisation; Wellard et al., 2003). There have been many initiatives to educate and empower patients in order that they can play an effective role in planning their care. However, up-skilling and empowering consumers to be actively involved and feel confident to question clinicians without a concurrent up-skilling of clinicians to recognise and understand the expert health professional barriers which impede a patient being actively involved is unrealistic, and is not likely to succeed (Davis, Koutantji, & Vincent, 2008; Wachter, 2008; Wellard et al., 2003).

**Recommendations**

This study was limited to investigation of two issues arising from the recommendations from one Inquiry. There would be considerable merit in undertaking a further case study to examine the other areas of clinical governance at KEMH that were the focus of recommendations of the Inquiry report. As well the results have paved the way for further research to investigate the outcomes of other inquiries into health care failures. Although considerable time and resources would be required, the benefits of a case study utilising a multiple case design would potentially be more compelling in terms of identifying if inquiries to make a difference and result in changes to improve care for patients. Inquiries need to be followed up to ensure that change that leads to improved consumers experiences is real rather than cosmetic.
Conclusion

The findings then demonstrated that there had been changes in some areas and not others following the Inquiry. In the main, the areas where changes occurred were in the administrative functions and the implementation of these. Changes were not demonstrated in processes that would increase the skills of clinicians at the interface between clinicians and patients in the delivery of care.
REFERENCES


Figure 1: Example of developing code node hierarchy for the main theme of changes in credentialing
<table>
<thead>
<tr>
<th>MEDICAL CREDENTIALING RECOMMENDATIONS</th>
<th>POLICIES/GUIDELINES</th>
<th>CLINICAL GUIDELINES</th>
<th>EXTERNAL REVIEWS/REPORTS</th>
<th>JOURNAL/CONFERENCE REPORTS</th>
<th>KEMH REPORTS/REVIEWS</th>
</tr>
</thead>
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<tr>
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<td>Self-report Evidence</td>
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<td>Self-report Evidence</td>
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<td>Self-report Evidence</td>
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KEY: Specific = Policy or procedure as per Inquiry recommendation; Implied = process described in detail but not as per Inquiry recommendation; Self-reported Evidence = KEMH self reported evidence indicating implementation of policy or procedure; External evidence = external review indicating implementation of policy or procedure; No evidence = no evidence identified demonstrating compliance with Inquiry recommendations.
### Table 2: Document Analysis - Consumer Involvement in Care

<table>
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<th>RESPONSES TO POOR OUTCOMES</th>
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<th>POST INQUIRY REVIEWS</th>
<th>POST INQUIRY JOURNAL/CONFERENCE REPORTS</th>
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<td>Guidelines for sensitive discussions</td>
<td>Specific</td>
<td>Specific</td>
<td>Specific</td>
<td>Self-report evidence</td>
<td>Self-report evidence</td>
</tr>
<tr>
<td>Poor outcome discussion &amp; care *</td>
<td>No evidence</td>
<td>No evidence</td>
<td>Specific</td>
<td>No evidence</td>
<td>No evidence</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>INVOLVING WOMEN IN DECISION-MAKING</th>
<th>POLICIES/GUIDELINES</th>
<th>CLINICAL GUIDELINES</th>
<th>POST INQUIRY REVIEWS</th>
<th>POST INQUIRY JOURNAL/CONFERENCE REPORTS</th>
<th>ANNUAL REPORTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy re involvement in clinical decision making</td>
<td>Specific</td>
<td>Specific</td>
<td>External Evidence</td>
<td>Self-report evidence</td>
<td>Self-report evidence</td>
</tr>
<tr>
<td>Communication skills re subjective experiences &amp; assessment strategies</td>
<td>No evidence</td>
<td>No evidence</td>
<td>No evidence</td>
<td>No evidence</td>
<td>No evidence</td>
</tr>
</tbody>
</table>

**KEY:** Specific = Policy or procedure as per Inquiry recommendation; Implied = process described in detail but not as per Inquiry recommendation; Self report evidence = KEMH self reported evidence indicating implementation of policy or procedure; External evidence = external review indicating implementation of policy; No evidence = no evidence identified demonstrating compliance with Inquiry recommendations

* recommendation 44 and 46 combined