C/58/2022

Implementation of Patient Safety Measures and Documentation Protocols for Healthcare Provider Identification

Following an investigation in a case of alleged medical misconduct and negligence towards a female patient who was forced to be examined by a male doctor, this Office was informed that both the Medical Council and the Nursing Council have investigated the complaint but found no conclusive evidence of professional misconduct or negligence due to the inability to identify the staff present with the patient on the day on the incident.

Whilst the Ombudsman cannot review the decisions of the Medical Council or the Nursing Council on issues related to alleged medical negligence or professional misconduct within the medical field, the Ministry of Health and Wellness was requested on 07th November 2024 to consider the possibility of establishing an effective record-keeping system. This system would ensure that, in cases of alleged fault, individual responsibilities could be accurately traced and maintained.

On 22nd January 2025, the Ministry submitted to us a copy of a correspondence dated 06th January 2025 entitled "Patient Safety Measures and Documentation Protocols for Healthcare Provider Identification" addressed to all Regional Health Directors. The correspondence listed the following eight measures to be implemented and adhered to by hospital staff concerned with immediate effect:

(i) Wearing of Identification Badges by all hospital staff while on duty within the hospital premises.

(ii) The Master Register in each ward and the Notice Board in the wards must clearly display the names of the Specialist and Medical Health Officer (MHO) responsible for the admitted patients.

(iii) Ward Managers/Charge Nurses and Unit Heads must ensure that daily job allocations for Nursing Officers, Hospital Attendants and other technical staff are properly documented.

(iv) Occurrence and Movement Books should be maintained and updated in a timely manner. The movement of all the health personnel should be recorded in the movement book.

(v) Records of all staff consulting/examining in-patients, outpatients (OPD), units and patients in the Accident & Emergency Departments must be maintained. This is critical for identifying staff in case of any future need.

(vi) The treating doctor of the patient must document examination and treatment provided, in the patient folder and casualty card in a timely manner. The documentation must

include the names and signatures of the doctor/s present. Pharmacy prescription should be written clearly and in legible manner. Major operating notes should be written and verified by the operating surgeon.

(vii) Nursing Officers and Healthcare Assistants involved in patient care and medication administration must record these activities in the respective record books promptly, with signature, date and time.

(viii) Visiting rules and times must be strictly enforced.

As per the Protocol, adherence to the above instructions was mandatory, with regular audits conducted to ensure compliance. Furthermore, failure to comply could lead to disciplinary action.

This Office is satisfied with the steps taken and trusts that these measures will be properly implemented.