REPUBLIC OF VANUATU

OFFICE OF THE OMBUDSMAN

PUBLIC REPORT

ON THE

MALADMINISTRATION AT THE VILA CENTRAL HOSPITAL

18 February 2002

0012/2002/02

PUBLIC REPORT ON THE MALADMINISTRATION AT THE VILA CENTRAL HOSPITAL

SUMMARY

The Ombudsman is issuing this Public Report to illustrate how a state service like the Vila Central Hospital can fail to carry out an effective service to the public where proper administrative procedures are either absent and/or not followed. Because of this failure, patients may be deprived of a proper standard of health care delivery as expected.

The Vila Central Hospital (VCH) has a duty to see that patients' files are properly recorded and kept according to the Archives Act of the Republic of Vanuatu. The Management Team of the VCH (formerly headed by Mrs. Michelle Sheehan) had gathered certain patients' file and put them in the former nurses' common room. This enquiry found that some of these files were less than 15 years old and hence, were not ready to be archived according to the Archives Act. The files that were put in this room were in total disarray in a room that was not secure.

The VCH had requested the assistance of a Medical Records Advisor (MRA) to the hospital to suggest improvements to the current system of storing medical records. The MRA issued a report recommending for improvements to administrative procedures and patient record keeping and management. This report was never acknowledged by the Acting Chief Executive Office nor the Management Team of the Vila Central Hospital and therefore, the recommendations were never implemented.

Following this enquiry the Ombudsman found that the Vila Central Hospital Management may have breached the Archives Act by not ensuring that patients' files are properly archived as set out in this Act. Secondly, health care may have been compromised to some patients in this way as their files may have been archived prematurely.

The MRA for the Hospital came with the assistance of aid donors. As the VCH Management failed to carry out the recommendations, valuable money and time was wasted in bringing in this advisor to the country. Accordingly, there were no feasible improvements made in the administration of patients' files.

In addition, the VCH has a duty to inform patients of their right to lodge a complaint. The Hospital had issued a Complaint Form to be used by patients but there was not enough public awareness to make patients aware of how to lodge a complaint using the form.

The Ombudsman found that the failure by Vila Central Hospital to ensure that patients used the complaints procedure put in place is in breach of the principles of good governance, accountability, transparency and "good administrative practice" to service delivery promoted by the Comprehensive Reform Program (CPR).

Based on the above, the Ombudsman has recommended that patients' files are archived according to the Archives Act. The Ombudsman also recommended that the present VCH Management urgently examine and implement the recommendations of the MRA. The Ombudsman also recommended that the VCH carry out an effective public awareness program of their complaint procedures so that patients are aware of their right to complain and how to file a complaint against the hospital.

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1. JURISDICTION

1.1 The Constitution and the Ombudsman Act allow the Ombudsman to look into the conduct of government, related bodies, and Leaders. This includes the Vila Central Hospital, a state service under the Ombudsman Act.

2. PURPOSE, SCOPE OF INVESTIGATION AND METHODS USED

2.1 The purpose of this public report is to present the Ombudsman's findings on certain administrative practices that were carried out at the Vila Central Hospital that are contrary to certain legislation and national policies. The Ombudsman has also made recommendations so that improvements can be made to the system of administration carried out by the Vila Central Hospital Management Team.

2.2 The scope of this investigation is to establish the facts about why the Vila Central Hospital did not properly archive patients' file, carry out the recommendations of the MRA that attended to the Hospital and to inform patients of their rights. It is also to determine:

- whether the administrative practice that the former Vila Central Hospital Management Team has taken to archive patients' files is in compliance with Archives Act;
- whether their actions for not carrying out the recommendations of the MRA can be justified, and
- whether their actions in not informing patients of their right to complain about service at the hospital is in line with the principles of Good Governance.

2.3 This Office collects information and documents by informal request, summons, letters, interviews and research.

3. RELEVANT LAWS, REGULATIONS AND RULES

3.1 CONSTITUTION OF THE REPUBLIC OF VANUATU

The Constitution gives authority to the Ombudsman to carry out an investigation into a complaint that is received from a member of the public who claims to have been a victim as a result maladministration by a government department. **Appendix 'A'.**

3.2 OMBUDSMAN ACT NO 27 OF 1998

The Ombudsman Act gives authority to the Ombudsman to carry out an investigation into the conduct of any government agency. The government agency that is being investigated in this public report is the Vila Central Hospital, which is a state service. **Appendix 'B'.**

3.3 ARCHIVES ACT

The Archives Act states "that all public archives of the age of fifteen years or over that are evidence of private personal *[sic]* or property rights shall be transferred to the custody of the Archivist and be deposited in the National Archives. They shall be kept in the National Archives until such a time when they can be destroyed".

Any person who contravenes or fails to comply with any provisions of this Act commits an offence and shall be liable on conviction to a fine not exceeding VT,100,000. **Appendix 'C'.**

3.4 GENERAL PRINCIPLES OF GOOD GOVERNANCE

One of the principles of good governance that is in line with the Comprehensive Reform Program (CRP) currently taking place in the country is the knowledge of the right to complain. Citizens who have been subject to maladministration, must know how to make a complaint. Public education is essential so that citizens are aware of this. **Appendix 'D'.**

4.1 OUTLINE OF EVENTS

4.1 In 1999, the Ombudsman commenced an enquiry into the Management of the Vila Central Hospital following two complaints that were received.

4.2 The first complaint was that patients' files would suddenly go missing from the Hospital especially in case where a patient dies in the Hospital and there are suspicions of malpractice.

4.3 The second complaint was regarding a patient who attended at the Vila Central Hospital on 22 June 1999 around 8:00pm. He had to wait until midnight until a doctor came to examine him. When the Ombudsman made an enquiry into the matter, he requested this patient's file but the Hospital could not find it anywhere.

4.4 On 23 September 1999, the Ombudsman received a reply to his enquiry by the former Medical Services Manager, Dr Lesley Everard. In her reply she stated the following:

- Patient records not in use are stored in the Medical Records section, which is staffed during office hours by two clerks. After hours the Nurse on duty has access to the records that are needed for patient care.
- The record of a patient admitted to the hospital will accompany the patient to the ward and be kept on the ward for the duration of the admission. When the patient is discharged the record is returned to Medical Records.
- In the case of a patient who dies the record is sent to the Statistics Office.
- All Medical staff have access to records but if a medical record is taken out of the department, the member of staff borrowing the record and the location of the record is noted on a board in the department.
- Records should not be removed from the Hospital premises without the permission of the Medical Services Manager or the Chief Executive Officer.

Dr Everard also requested that there be a meeting held between the Vila Central Hospital and the Ombudsman's Office to discuss this matter further.

4.5 A meeting was arranged and held on 8 November 2000 at the Vila Central Hospital between the Hospital Management, the Ombudsman and two officers of this Ombudsman.

4.6 On our visit to the Vila Central Hospital on that date, we were advised of the following:

- When a patient visits the Hospital during working hours and it is a first visit, they are assigned a medical record number by the Clerk. The patient's personal information is taken. However, this kind of information can be very general especially with addresses, for example, a patient's address may be known as Freshwota in general. Sometimes patients may have more than one name so it makes it hard for the Clerks to retrieve a file.
- There have been recent improvements to this system. The Management Team has introduced attendance forms to the OPD. This form which is green, is filled in for patients who have forgotten their number or whose files can not be found by the Clerk. Later when the patient's file is found, the attendance form will be put in it. At the time of our visits, it was in effective use by doctors at the VCH (a copy of this form can be found in **Appendix 'E'**).

- If however, the complainant finds that the problem is not adequately addressed then he or she can take their complaint elsewhere like the Ombudsman's Office.
- The chart that will be up on the walls will be in simple English for everybody to understand. The Ombudsman suggested that the forms be in all of the three national languages, English, French and Bislama.
- The Chart will be on trial for 6 months after which it will be reviewed again to see if it is effective. It is hoped that the chart will be effective from January 2000.
- The Management Team of the VCH which consists of the Chief Executive Officer (CEO), the Director of Hospitals, the Medical Services Manager, the Nursing Services Manager and the General Services Manager, meets every Tuesday at 8:00am.
- The hospital appreciates that when the Office of the Ombudsman receives a complaint against the Vila Central Hospital that we make sure that the complainant has approached the Hospital already and their complaint has been registered. The Ombudsman agreed to this so that this office can process complaints more efficiently and quickly.

THE MEDICAL RECORDS ADVISOR TO THE VILA CENTRAL HOSPITAL

4.11 On 29 March 2000, the former Medical Services Manager, Dr Lesley Everard advised that the MRA from Australia had arrived the week before. She was initially staying for three months after which her work would be assessed and if there she is required to stay longer then her work permit would be extended. After 3 months, she will prepare a report and make appropriate recommendations. The MRA's aim is to sort out all patients' record numbers, place an appropriate system for filing and update the computer system. At that time, the VCH was also hoping to get some assistance with filing from the Australian Navy Boat that will be coming to Port Vila in April.

4.12 On Tuesday 7 September 2000, two of the officers of the Ombudsman visited the Hospital to follow up on the Medical Records Advisor's (MRA) report and to see the other improvements that the VCH has made since our last visit on 8 November 1999.

4.13 On our visit to the Hospital, we found that there was a new Medical Services Manager, Dr Hensley Garae. The former Medical Services Manager, Dr Lesley Everard is now the Pediatrician in the Children's ward as a result of an internal transfer that took place in May 2000. We had to explain to him about the past meetings that took place between the Hospital and representatives of the Hospital Management Team.

4.14 Dr Garae was, however, able to confirm to us that an MRA, Ms Anne Coote, had come to the Hospital on a three-month contract to improve the record system of the Hospital. He was not sure of the date that she left but it was probably in June or July 2000. Dr Garae admitted that he did not know about any report that the MRA was supposed to prepare. We therefore had to wait and ask the Acting CEO, Mrs. Valentine Ronoleo about this report.

4.15 When we spoke with Mrs. Ronoleo, we mentioned to her that the Ombudsman's Office did not receive a copy of the MRA's report and we do not know what recommendations she had made. Mrs. Ronoleo admitted that she had not read the report so she did not know what recommendations were made.

4.16 Dr Garae stated that there had been a meeting between the MRA, the former Management Team and all the Doctors, about the new record system that would be in place. He mentioned that the former Management Team decided to gather all the old patients' records from the year 1992 and place them in the former Nurses Common Room/Library. Dr Garae stated that in the meeting, he had objected that the records be placed in this "insecure room". He suggested the records be archived at the National Archive and raised the fact that they cannot destroy any records that are under 15 years old. In addition, before they destroy any records, the National Archive and the Head of the Department has to give authorization. Dr Garae stated that in his option, the previous Management Team was at fault in this regard.

4.17 Dr Garae stated that when patients ask him about their individual file, and it cannot be found in the Records room, he tells them the truth that the Management Team had

- There are only two (2) Clerks available so the introduction of the new form has caused more work for them. Another staff member was taken from the laundry to come and assist the two Clerks however, staff required formal training to do this job and this takes time.
- The Hospital cannot afford a full time Clerk so if a patient is admitted during the weekend, a medical record number may not be issued until a Clerk is available. In the past medical record numbers for deceased persons were refused by the Clerks. However, this practice has been stopped.
- Medical record numbers are beginning to be computerized but the numbers only reach 1000. When a patient's number cannot be found on the computer then the Clerks have to physically go through the files to find it.
- Cards are also issued at the Hospital for patients beginning from 1998 however, patients tend to lose them. There is now a fee of VT400 that is charged for patients who lose their cards.

4.7 The former Hospital Adviser, Mr Peter McGregor was negotiating at the time of our visit with a Medical Record Adviser (MRA) to come from Sydney in December 1999 to assess the present management of medical records and to give any recommendations. The MRA would make recommendations for all 5 hospitals in Vanuatu.

4.8 The system in place now is when a file is taken from the medical record room, the person will record it on a board that is in the room. When a file is taken to a ward, it is placed on a trolley that is found in the ward. They are placed according to a number that corresponds to the bed number of the patient. Currently nursing staff is responsible for the files during this time as they do not have a Clerk working in the wards. When the patient is discharged, their file is returned to the medical record room.

When a file goes missing, the following steps are taken:

- The ward register book is checked.
- The medical records and statistics offices are checked.

Medical staff is also discouraged from taking the files home.

4.9 The disciplinary measures for removal of files from the Hospital without the permission of the Medical Services manager or the CEO or staff who lose files are as follows:

- The Medical Services Manager will ask the staff member to return the file. If the file is not returned or the files are removed frequently, the matter will be referred to the internal disciplinary committee.
- The internal disciplinary committee may decide to refer the matter to the Health Practitioner's Board if it is very serious and suspension of the staff member by the Public Service Commission will be considered.
- If there is no registration by the last user of the file then the matter is left as it is.

IMPROVEMENTS IN THE SERVICE OF THE VILA CENTRAL HOSPITAL

4.10 On 21 November 1999, there was a meeting held between the Ombudsman, two of his officers and Mrs. Michelle Sheehan. Mrs. Sheehan explained the following:

- There will be a chart in all of the wards at the VCH to explain the procedure for lodging a complaint.
- On the chart, it will show the first person that contact should be made with if there is a problem. This will be the Nurse in charge of the ward and if the Nurse can resolve the problem, then it will not be taken to the complaint stage.
- If the problem is not resolved then the patient can lodge a formal complaint.
- The patient will be given a Complaint Form (See **Appendix 'F'**) to complete for the Management Team to resolve.
- The completed Complaint Form is given to the Executive Secretary to register and issue a number to be placed into the computer system.
- The Management will then consider the Complaint Form and will try to resolve the matter.

decided to discard them. We were able to visit the old Nurses Common Room/Library and we found that the files that the Australian Navy had assisted with were on the floor and they were in total disarray. Some files were open and four cats making themselves at home on top of the files. The files were not boxed but scattered all over the place for anyone to see. The Nurses' Common Room is not secure as the main door was not locked when we visited. The glass door was also broken.

4.18 Dr Garae also advised that the Management Team that made the decision to move the files to the former nurses' common room were :

- Mrs Michelle Sheehan, Director of Hospitals
- Mrs Valentine Ronoleo, Nursing Services Manager and Acting CEO from January 2000.
- Dr Lesley Everard, Medical Services Manager
- Mr Gideon Ronoleo, General Services Manager
- Mr Stephen Thomas, Pharmacist
- Mr Darren Penny, Emergency Service Manager.

4.19 The evidence that we obtained from our visit to the Hospital on 7 September 2000 is as follows:

- The recommendations that were made by the MRA in her report were not implemented as the Hospital Manager and the Medical Services Manager at that time had not read the report. The Medical Records Manager was not aware of the report therefore he did not know what recommendations were made. The change in the Management Team may have contributed to this. The Office of the Ombudsman only saw the MRA's report when the two officers of the Ombudsman visited the Hospital at this time. A copy of this report can be viewed in **Appendix 'G'**.
- Files of patients taken out of the Record room by the Australian Navy were not properly archived. The files that were left in the former nurses' common room dated from 1992 meant that some of them were less than 15 years old.
- Patient's rights are not displayed on a chart in the Wards so that the public is aware of how to lodge any complaints that they had. There is not enough awareness of patients' rights.
- Nurses in charge of the wards admitted that they were not explaining the internal complaint procedure forms to the patients due to shortage of staff and, busy schedules. The Ombudsman staff that visited the Hospital took time to visit the wards and speak to the patients. The patients that we spoke with were not aware of the complaint forms even though they had some grievances.

5. RESPONSES BY THOSE WITH FINDINGS AGAINST THEM

- A Working Paper was issued on 7 June 2001 and it was given to those that were implicated in the Paper and the present Hospital Management to respond to its contents before a public report is issued. The following responses were received :

- On 12 June 2001, a response was received from Dr Hensley Garae. He stated in his response that the persons who were involved in the decision to remove the patients' files to the former nurses' common room was the former Management team that was headed by Mrs. Michelle Sheehan (please refer to section 4.18 for the details of the members. They must be held accountable for their actions.
  Dr Garae also stated that he was not "part of the mess" that took place at the Hospital nor some of his colleagues that are new to the Management Team.

- On 12 June 2001, two of the present members of the Management Team visited the Ombudsman's Office to give their response to the Working Paper. They are Mr. Stephen Hosea and Ms Andrea Garae.

They advised that although they are in the Management Team, they only attend meetings when they need to talk about drugs, supplies, equipment and donation. They both work in the Central Medical Stores, which does not come within the Hospital structure.

However, they are glad that the Ombudsman is pursuing this case because they are not happy about how files were being left in a room and not properly archived. This also brings into question the credibility of advisors to the Hospital. Some of them do not respect ni-Vanuatu.

This is the second incident where files were not properly archived. The first incident was when the French Hospital was closed at George Pompidou and was transferred to the Vila Central Hospital. Many patients' files were burned.

- On 20 June 2001, the Ombudsman received a response from Mr. Honore Morris. Mr. Morris explained that he was not a member of the Management Team. However, previously the Ombudsman was advised that Mr. Morris was a member of the Management team. We would like to take this opportunity to apologize for this error.

  Mr. Morris went on to advise that in 2000, Mr. Darren Penny who was in the Management Team was going to leave in August of that year so Mr. Morris was asked to be his counterpart to attend the Management meetings. However, he was not part of the Team that made the decision on patient records. He only attended some of the meetings.

  Mr. Morris at the time of his response was working in the Out Patient Department (OPD) of the Vila Central Hospital. The issue of the files was affecting their work seriously at that time. Sometimes when there is an emergency the patient's file could not be located so nurses and doctors did not know the patient's medical history. Some patients who attended the OPD and who have been long time patients of the Hospital also had their files missing.

5.5 On 29 June 2001, the Ombudsman received a response from Mrs. Leipakoa Matariki and Mr. Gideon Ronoleo on behalf of the Vila Central Hospital Management Team. They raised the following points in their response :

- The current Management Team had never seen the report presented by Mrs. Anne Coote. Had they received the report, they would have studied it and considered the recommendations made by her. Ms Coote had presented a copy of the report Mrs. Sheehan, the head of the former Management Team. Mrs. Sheehan's secretary, Mrs. Helen Aru had given a copy of the report to the Ombudsman's Officers at the time of our visit on 7 September 2000.

- After Ms Coote compiled her report, she should have presented it to the VCH Management Team prior to the submission. This is to ascertain that the Management Team is aware of her recommendations.

- The current Management Team was currently recompiling the patients' files that were left in the students' common room. The Hospital Statician will try to sort them out to see which ones will be going to the archives and which ones are to be returned to the filing room in the Outpatients Department.

- The Management Team will also be raising its concerns to the Ministry of Health that in future, any consultants assigned to carry out any task of responsibility in the hospital should work closely with the Management team, in order to avoid issues of this nature.

6. FINDINGS

Finding 1: **THE FORMER VILA CENTRAL HOSPITAL MANAGEMENT MAY HAVE BREACHED THE ARCHIVES ACT**

6.1 The former Vila Central Hospital Management Team that was headed by Ms Michelle Sheehan had a duty to oversee the day to day management of patients' files so that maximum health care is delivered to each patient.

In one of these Management Team meetings, a decision was taken to gather all the old records from 1992 and place them in the former Nurses Common Room/Library. The files were placed in this room and were not properly archived. Since some of the files are not old enough to be archived as stated in the Archives Act, the Management Team may have breached section 7(1) (b) of the same Act. This section of the Act states that "All public archives of the age of fifteen years or over (other than those which under any Act are required to be held in the custody of a specified person or Government office) which in the opinion of the Archivist are of sufficient value to warrant their preservation as evidence of ...public or private personal [*sic*] right shall be transferred to the custody of the Archivist and be deposited in the National Archives."

The former Management Team failed to forward patients' files that are over fifteen years to the National Archives to be archived until such a time that they can be destroyed as provided for in section 13 of the Archives Act (see Appendix 'C'). However, the present Management Team is currently making efforts to recompile these files as stated in their response in section 5.5 above.

Finding 2: **THE FORMER VILA CENTRAL HOSPITAL MANAGEMENT FAILED TO CONSIDER AND CARRY OUT THE RECOMMENDATIONS THAT WERE MADE BY THE MEDICAL RECORDS ADVISOR**

6.2 The former Vila Central Hospital Management Team that was headed by Mrs Valentine Ronoleo had a duty to carry out the recommendations of the Medical Records Advisor, Ms Anne Coote, who is an expert in the field of the administration of patients' files.

The acting Chief Executive Officer (CEO), Mrs. Ronoleo claimed that the recommendations were not implemented because she had not read the report. The CEO did not know that such a report existed until the time of interview with representatives of the Ombudsman.

Such a claim by Mrs. Ronoleo cannot be accepted as she was a member of the Management Team that was formerly headed by Mrs. Michelle Sheehan. Aid donors had assisted the Vanuatu Government in providing an advisor to assist with any improvements to VCH administration and services as well as other hospitals in Vanuatu. For the Management not to consider the MRA's report and carry out the recommendations can be seen as a complete waste of valuable time, expertise and money.

Recommendations by the advisor were reasonable and followed standard hospital procedures. The Management had a duty to follow them to improve the quality of patient care at VCH.

Finding 3: **THE VILA CENTRAL HOSPITAL MANAGEMENT TEAM FAILED TO INFORM PATIENTS OF THEIR RIGHT TO COMPLAIN ABOUT HOSPITAL SERVICES.**

6.3 The Vila Central Hospital Team, both the former and present one, failed to inform patients of their right to complain about hospital services or carry out enough public awareness on the matter.

When the representatives from the Ombudsman's Office visited the VCH and spoke with some of the patients in the wards, most patients were not aware of their rights to complain. One of the principles of Good Governance that is in line with CRP is that people must be given or made aware of their "right to complain". Every person who has suffered an infringement of a right must know that they have a legal right to complain and must know how to make a complaint. Patients at the Hospital at the time of our visit did not know that a "Complaint Form" existed. The VCH Management had therefore failed to carry out enough public education or awareness on this matter.

7. RECOMMENDATIONS

The Ombudsman makes these recommendations based on the above findings to resolve these matters and prevent them from occurring again in the future.

7.1 **The Vila Central Hospital Management should pass all patients' files that are over 15 years of age and are no longer in use, to the National Archives as required by the Archives Act to be archived until such a time when they can be destroyed.**

7.2 **The present Vila Central Hospital Management must ensure that the recommendations of the MRA are carried out and give urgent attention to this matter.**

7.3 **The Vila Central Hospital Management must ensure that effective public education is carried out so that public is aware of their right to complain and how to lodge a complaint.**

7.4 **Charts should be put in all the wards to inform patients of their rights and Complaint Forms should be made available to patients or displayed in a prominent area in the ward.**

Dated the**18th** day of **February** 2002.

Hannington G. ALATOA
OMBUDSMAN OF THE REPUBLIC OF VANUATU

8. INDEX OF APPENDICES

Appendix 'A'

CONSTITUTION

ENQUIRIES BY OMBUDSMAN

5 (1) The Ombudsman may enquire into the conduct of any person or body to which this Article applies-

- upon receiving a complaint from a member of the public (or, if for reasons of incapacity, from his representative or a member of his family) who claims to have been the victim of an injustice as a result of particular conduct.

Appendix 'B'

OMBUDSMAN ACT NO. 27 OF 1998'

FUNCTIONS OF THE OMBUDSMAN

11. (1) The Ombudsman has the following functions:

(a) to enquire into any conduct on the part of any government agency.

Appendix 'C'

ARCHIVES ACT NO. 13 OF 1992

PART 3

CUSTODY AND PRESERVATION OF ARCHIVES

DEPOSIT OF PUBLIC ARCHIVES IN THE NATIONAL ARCHIVES

7. (1) All public archives of the age of fifteen years or over (other than those which under any Act are required to be held in the custody of a specified person or Government office) which in the opinion of the Archivist are of sufficient value to warrant their preservation as -

(b) evidence of public or private personal or property rights or civic rights

shall be transferred to the custody of the Archivist and be deposited in the National Archives.

DESTRUCTION FO ROUTINE PUBLIC ARCHIVES

13. The Archivist may authorize the immediate destruction, or the destruction after the expiration of such specified time as may be agreed upon between the Archivist and the head of the Government office concerned, of any specified classes of public archives that -

(a) by reason of their number, kind or routine nature do not in his opinion possess any enduring value for preservation in the National Archives as public archives; and

(b) are nor required for reference purposes in any Government office after action on them is completed, or after the expiration of such period of years from the date on which action on them is completed as may be agreed upon between the Archivist and the head of the Government office concerned.

OFFENCES AND PENALTIES

20. (1) Any person who -

(b) wilfully or negligently disposes of or destroys any public archives otherwise than in accordance with the provisions of this Act; or

(c) contravenes or fails to comply with any provisions of this Act,

commits an offence and shall be liable on conviction to a fine not exceeding VT.100.000.

(1) Where any person is convicted of an offence under subsection (1), the court convicting such person may, in addition to any penalty imposed for offence, order that that person shall not be entitled to have access to the National Archives for such period as the court thinks fit.

Appendix 'D'

Principles of good governance by Maima Koro, Project Manager for Good Governance

Good governance is generally defined as the "manner in which power is exercised in the management of a country's economic and social resources for development".

9 General principles of governance:

1. **Knowledge of right to complain:**

   A major contribution to good governance is to ensure that every person who has been, for example, unjustly disadvantaged, or has been subject to the impact of corruption or maladministration, or has suffered and infringement of basic human rights, knows that they have a legal right to complain and know how to make a complaint. What is the use of a right, so important to a healthy democracy if people are unaware of it? Usually it is the poor socio economic groups, disadvantaged by lack of money, or lack of education, or illiteracy, who are most affected by bad governance. Effective public education is therefore essential.

Appendix 'E'

VILA CENTRAL HOSPITAL **OPD/EMERGENCY PRESENTATION FORM**

DATE:_____ ARRIVAL TIME:_____ AM/PM

Allergies

HOSPITAL NUMBER:_____ SEX_____

FIRST NAME:_____ SURNAME:_____

DATE OF BIRTH:_____ ISLAND_____

NURSING DIAGNOSIS:

Category

_____

_____ Signature_____

OBSERVATIONS:

TIME	TEMP	PULSE	RESP	BP	PUPIL	O2 SAT	PFM	BSL	COMMENTS

WEIGHT:_____

URINALYSIS:_____

PATIENT HISTORY:

SEEN BY:_____ TIME SEEN:_____

COPY

Appendix F

THE GOVERNMENT OF THE REPUBLIC OF VANUATU
GOUVERNEMENT DE LA REPUBLIQUE DE VANUATU

HOPITAL CENTRAL
Sac Postale Privé 013
Port Vila. Vanuatu
Téléphone : 22 100

CENTRAL HOSPITAL
Private Mail Bag 013
Port Vila. Vanuatu
Phone : 22 100

Complaint No._____
(office use only)

Complaint Form

If you are using this form to make a formal complaint, please do so only after you have discussed the matter with the sister or officer in charge.

I am making a: __formal complaint __suggestion only
(Tick only one.)

Name: _____

Address: _____

Nature of Complaint (please describe briefly in point form only)

_____

_____

_____

_____

_____

_____

_____

How could you solve this problem?

_____

_____

_____

Appendix 'G' COPY

REPORT OF MEDICAL RECORD ADMINISTRATOR

Review Of Current Systems – Medical Records And Health Statistics

The basis of a health statistics collection, and hence of epidemiological reporting, from hospitals is clinical documentation, clinical coding using ICD, and management of patient related clerical procedures. Patients should be uniquely identified, and patient attendance documented consistently in the one set of notes. These procedures rely upon adequate numbers of trained staff, adequate stationary, standard procedures, and the support of clinical staff. There were no national policies on Medical Record retention, patient access to health information, clinical documentation or privacy of health information. In early 2000 none of these prerequisites was met at hospitals in Vanuatu.

Management of Outpatient Attendances

Outpatient attendance can be categorised as Specialist Clinic attendance and General Outpatients attendance. The former are patients with appointments to see specialists for chronic conditions (blood pressure, diabetes, etc) and paediatric patients, and the latter are patients with minor problems who are seen by Nurse Practitioners and Doctors in the Outpatient Department.

A misguided attempt had been made to register every General Outpatient attendance at VCH and Tanna hospitals, including giving every patient a Medical Record Number and a Medical Record folder. Given an attendance rate of up to 200 Outpatients per day at VCH, the system collapsed, as there was insufficient staff to undertake the workload.

It should be noted that at both Lenakel hospital, Tanna and at VCH the move towards a centralised Medical Record was on the recommendation of an external consultant who was unaware of the ramifications of centralisation. A statement outlining the decentralised Medical Record system in hospitals in Vanuatu has now been posted in each Medical Record Department in Vanuatu. **It is recommended that** the Ministry of health adopt a policy of decentralised Medical Records for outpatients at all Hospitals. **It is recommended that** a Health Informatics Committee be established by the Division of HPPI (See Annex A) with, inter alia, the responsibility of reviewing recommendations relating to data collection and Medical Records management in Vanuatu Health Care Facilities.

Management of Inpatient activities

Vila Central Hospital

A month before the arrival of the Medical Record consultant, the VCH Hospital Statistics Officer had abandoned his post. Consequently no Inpatient data was reported for late January and for February 2000 for VCH. The volume of work going through the Medical Record Department for Outpatients meant that procedures for Inpatients had ceased. At least 50% of Inpatients did not get a Medical Record Number or a folder.

The Patient Master Index (PMI) consists of a card index and a computerised index, and neither was updated when patients were given Medical Record Numbers (old or new). The system depended on patients remembering their Medical Record Number. The card index is in rudimentary alphabetical order, and consists of boxes of cards haphazardly lying on top of each other. Advice, again from an external consultant, that the number 0123 is different to the number 123 had been accepted, and the Number Register had not been properly maintained, resulting in multiple patients for the one Medical Record Number.

The file room was disorganised, and only two shelves of filing space remained. Staff were seeking old Medical Records, destroying them, and giving the old number to new patients. Culling of the Medical Record files had not been undertaken since 1990. The content of the Medical Record remains a problem, with clinical documentation loosely held inside manila folders. There is no organisation of clinical documentation in the Medical Record by time or by type of service. Reporting of discharge morbidity was incomplete, discharges reported were those that ended up on the Hospital Statistics Officer's desk.

Lenakel Hospital, Tanna

The procedures at Lenakel Hospital, Tanna, efficiently report complete, timely Inpatient morbidity and mortality data. Training has been undertaken to change the system whereby all deliveries were reported as normal and a more comprehensive picture of deliveries at Lenakel Hospital should emerge for the

second half of 2000. The task of the Hospital Statistics Officer is undertaken by one of the Nurse Practitioners.
There had never been a PMI at Lenakel Hospital, and there was no Number Register, although a register by village of names and numbers was available, (although incomplete). The Medical Record file room at Lenakel Hospital, Tanna, was running out of space, and culling of the file room had never been undertaken.

Northern Districts Hospital (NDH), Luganville, Santo

Morbidity statistics from NDH are inaccurate and incomplete. The Statistics Officer forwards the Inpatient Notification form, which is completed by clinical staff, to the Division of HPPI for clinical coding. No attempt is made to ensure that all discharges are reported. There is no feedback to NDH from the Division of HPPI, and there were no procedures to ensure completeness of the data. There are no staff at NDH trained in ICD-10 clinical coding, or in the diagnoses, procedures and external cause documentation necessary for clinical coding. Bed day statistics are incorrectly collected and hence are under reported. The Percentage Occupancy and the Length of Stay figures are not calculated correctly and are not checked by the Division for HPPI.
The Medical Record Department functions at a minimal level. Medical Record Numbers are issued, but the PMI is not updated. If patients forget their number, finding it is a cumbersome process. The patient master index is not filed in alphabetical order. Medical records of "special" patients eg. Diabetic, asthma, cardiac patients are filed in separate piles. It is estimated that there is a maximum of two years' filing space remaining.

Design And Implementation – Medical Records And Health Statistics

Management of Outpatient attendances

At Lenakel, Luganville and Vila Central Hospitals procedures are now in place for a decentralised Medical Record system, with General Outpatient attendance documented by clinicians in a "Treatment Book" in each Treatment Room; name, age, sex, address, diagnosis and treatment are documented. Outpatient statistics are collected from these "Treatment Books". The Clinician has the right to require that a Medical Record be created for a particular patient. Inpatient and Specialist Outpatient attendance are documented in a Medical Record. The outcome is that the Outpatient statistics collection is complete and accurate, with both attendance's and selected morbidity collected and reported.

Management of Inpatient procedures

Four National policies have been submitted to the Director General of Health for approval (See Annexes B – E)

Vila Central Hospital

Procedures are now in place to ensure that every Inpatient has a Medical Record Number and a folder. It is recommended that assistance be provided to the Ministry of Health to source and implement Medical Record folders with non-metal clips, and with dividers for Inpatient and Outpatient attendance. The ISTA has implemented a computerised Patient Master Index for VCH (VCH PMI), and the staff are trained in its use. VCH data held on the computer at the Division of HPPI has been loaded onto the VCH PMI. The computerised PMI enables phonetic searching by first name, by family name, and by island in an attempt to overcome the problems of naming in Vanuatu. The staff are also now trained in the use of the Number Register and the PMI, and this has gone a long way to resolving the problem of multiple registrations.
The ISTA has implemented a computerised morbidity reporting function (VHIS) at VCH. Only a trained ICD-10 coder can use this system, so it has not yet been installed at NDH, Santo. Data from the VHIS is sent electronically from VCH to the Division of HPPI, replacing the old double entry system. Nevertheless patient identification data is still double entered, once into the PMI and once into the VHIS. It is recommended that assistance be provided for a simple computer network, linking the computers in Medical Records and the Statistics Office in each computerised hospital, with software linking the data in the PMI to the Admission/discharge data in the VHIS

Forty sailors of HMAS Hobart volunteered and spent a day at VCH reorganising the Medical Record file room. All 96,000 records were culled and reorganised into strict numerical order. The VCH file room now holds records of patients who have attended the hospital since 1993 inclusive, all other records have been destroyed. This has increased the amount of filing space available, however planning for a larger Medical Records file room must start now as there is a maximum of two years' space

remaining. It is recommended that assistance be provided to the Ministry of Health to plan and build an enlarged Medical Record Filing Room.

Lenakel Hospital

The computerised PMI has been installed at Lenakel Hospital, Tanna. Tanna data held on the computer at the Division of HPPI has been loaded onto the Tanna PMI. As power is only available in the mornings, a card PMI has also been implemented, and a printout from the data held on Tanna at the HPPI has been provided in bound format. The aim of this concentration on PMI is to reduce the number of multiple registrations.

The Medical Record Clerk at Lenakel Hospital, Tanna, has been trained in culling the Medical Record file room, and filing space should not be a problem in the foreseeable future. The culling procedure involves destroying records of patients who have died or not attended within the last 10 years and reusing the old Medical Record folders.

NDH, Santo

The computerised PMI has been installed at NDH, Santo. PMI data held on the computer at the Division of HPPI has been loaded onto the Santo PMI, and staff trained in its use. The VHIS has not been installed at the at NDH, Santo as there are no staff trained in ICD coding.

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