OBSTETRICS CLINICAL OUTCOMES MANAGEMENT COMMITTEE

ANNUAL REPORT TO THE PUBLIC FOR 2013/14

ON

QUALITY IMPROVEMENT ACTIVITIES UNDERTAKEN OR OVERSEEN

BY

OBSTETRICS CLINICAL OUTCOMES MANAGEMENT COMMITTEE – KING EDWARD MEMORIAL HOSPITAL FOR WOMEN

If you require any further information, or have any queries, please contact the Office of Safety and Quality in Healthcare on 9222 4080.

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The *Health Services (Quality Improvement) Act 1994* provides for the approval and protection of quality improvement committees reviewing, assessing and monitoring the quality of health services and for related purposes. Section 9 of the *Health Services (Quality Improvement) Regulations 1995* each committee is to make a report available to the public at least once in each period of 12 months.

The following fulfils the requirements of the committee under section 9 of the *Health Services (Quality Improvement) Regulations 1995.*

A copy of the committee's Terms of Reference is attached.

Activity of the Committee:

Description – The Committee reviews and monitors clinical services and clinical issues within defined criteria (as per the Terms of Reference) including cases where there was a 'near miss'.

Action taken – There were a total of 413 reviews undertaken for 396 women and or their infants following reporting to the Committee.

Outcomes – Of those cases reviewed (413), the Committee concluded that in 288 cases (69%), the management was appropriate. Investigations have taken place by committee members in 91% cases, 9% pending. Communication deficit and failure to follow protocol, were the largest groups of deficits identified by the committee (23 and 21 of 413 reviews respectively).

The next largest group was documentation deficit (14). Of interest, the number of cases in which the deficit was thought to be delay in management was lower than previous years (5).

Actions taken included:

- education of staff, particularly in the areas of communication, guidelines and documentation,
- developing specific guidelines; and
- providing new resources in cases where a shortage of equipment or where equipment failure was identified.