OBSTETRICS CLINICAL OUTCOMES MANAGEMENT COMMITTEE

ANNUAL REPORT TO THE PUBLIC FOR 2015

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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OBSTETRIC CLINICAL OUTCOMES MAANGEMENT COMMITTEE 31/12/15

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 292 reviews undertaken for 266 women and or their infants following reporting to the Committee.

Outcomes – Of those cases reviewed (292), the Committee concluded that for the majority of cases, the management was appropriate and not avoidable.

Investigations have taken place by committee members and the full committee and the following areas were identified as issues to be addressed:

- Open and appropriate communication;
- failure to follow protocol;
- a shortage of equipment or equipment failures;
- documentation and adequate handover and omissions in care.

Actions taken included:

- education and training of staff, particularly in the areas of open and timely communication and use and compliance with guidelines/protocols;
- developing specific guidelines;
- providing new resources, specifically obtaining new items of equipment to address and prevent future reoccurrence in cases where there was a shortage of equipment or where equipment failure was identified;
- Education and training to staff to ensure precise documentation and for ensuring adequate clinical handover at relevant points of care; and
- Education and training where specific errors or omission in care was identified.