

**GYNAECOLOGY PRACTICE IMPROVEMENT COMMITTEE
WOMEN & NEWBORN HEALTH SERVICE**

ANNUAL REPORT TO THE PUBLIC FOR 2011
ON
QUALITY IMPROVEMENT ACTIVITIES UNDERTAKEN OR OVERSEEN
BY
GYNAECOLOGY PRACTICE IMPROVEMENT COMMITTEE

**Please send completed reports to:
Dr Simon Towler
Chief Medical Officer
Department of Health
PO Box 8172 Perth Business Centre
Western Australia 6849**

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

Please note: The information you provide in this form must not identify, directly or by implication, any individual health care provider or receiver.

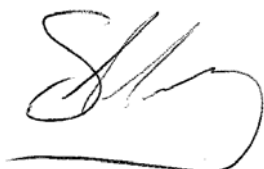
Contact details of person providing the report:

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Signature:



Dr Steve Harding
A/Director Gynaecology, KEMH
Consultant Obstetrician and Gynaecologist, KEMH
Clinical Senior Lecturer, UWA

1. Name of Committee.

Gynaecology Practice Improvement Committee.

2. Name the health care facilities that contribute to this Committee.

King Edward Memorial Hospital for Women.

3. Reason for why the Committee was established and its main functions:

- a) Terms of Reference attached
- b) Chair: Doctor Steven Harding, Medical Director Gynaecology, Obstetrics and Gynaecology Clinical Care Unit

4. Report on issues, projects and/or activities undertaken by the Committee for which Qualified Privilege was required.**a) Description and purpose of project or areas that have been assessed and evaluated.**

The occurrence of the following events to be reported to the Committee for review:

- ◆ Unplanned return to operating theatre
- ◆ Death within 30 days of surgery
- ◆ Post operative fistula
- ◆ Intra-operative visceral trauma
- ◆ Delayed / missed diagnosis
- ◆ Haemorrhage requiring transfusion
- ◆ Unplanned transfer to ICU
- ◆ Unplanned transfer to ASCU
- ◆ Post operative hospital stay > 7 days (Non – Oncology)
- ◆ Post operative hospital stay > 21 days (Oncology)
- ◆ Unplanned readmission to hospital within 30 days related to original event
- ◆ Anaesthetic issue
- ◆ Laparotomy for ectopic pregnancy
- ◆ Radiologically proven pulmonary embolism
- ◆ Proven Deep Vein Thrombosis
- ◆ Significant Other Events

b) What were the methods used?

Following the reporting of incidents various methods of review were undertaken. These include chart review, independent review, presentation and committee discussion of cases. Recommendations made to the Obstetric and Gynaecology Management Committee and the Medical Advisory Committee.

c) What were the results/outcomes?**(i) The number of cases reported and reviewed were:**

For 143 women, 151 events were reported to GPIC in the financial year 2010/11. 121 (80%) women have had their reported events reviewed to date. 8 (6%) of the women had more than one event occurring.

d) What were the lessons learned or recommendations made about how to improve the quality of health care?

The areas covered by this committee are reasonably broad. However, policy has been introduced or modified in many areas of patient care that will improve the quality of the service that KEMH provides.

Clinical guidelines have been modified or new guidelines have been introduced. Clinical staff have been reminded and there was a highlighting of relevant existing guidelines and have been counselled following review of individual cases.

Additional education sessions were devised for presentation to the clinical staff that related to areas of focus highlighted by the reviews that were conducted by the committee.

- ◆ Processes reviewed and staff advised by memos, meetings and education to ensure:
 - Correct documentation of items left insitu
 - Equipment upgraded
 - Documentation of medications
 - Protocol developed for assessment of pelvic masses
- ◆ Review of processes and implementation of new process for management of the deteriorating patient
- ◆ Feedback to external services on outcomes of referrals

e) In which ways did qualified privilege contribute to this project?

Qualified privilege allowed clinicians to participate in this quality improvement committee and openly discuss identified and sensitive information without fear of litigation.

5. Details of the annual report provided to the public.

a) When will it be available?

December 2011

b) How will it be available to the public?

Via the Women Newborn Health Service website.

6. The functions of the Committee has been and will continue to be facilitated by the provision of the immunities and protections afforded by the Act.

The exercise of the functions of the Gynaecology Practice Improvement Committee has been and will continue to be facilitated by the provision of the immunities and protections afforded by the Act. Qualified privilege allows clinicians to participate in this quality improvement committee and openly discuss identified and sensitive information without fear of litigation.

7. It has been and will continue to be in the public interest to restrict disclosure of information compiled by the Committee in the course of the performance of the Committee's functions.

It is imperative that discussion can occur which provides clinicians with an open, honest and non-judgemental environment to reflect upon and discuss patient management to monitor and improve service. This allows for a thorough investigation of specific cases with the identification of system error and individual problems that can be corrected leading to eradication or lessening of error and harm to our patients.

8. Specific examples of improvements to care which are likely to result from the Committee's activities when it is able to operate under the privilege given by the Act.

A specific example was a case involving a tubo-ovarian abscess where the patient did not have a CT prior to theatre. This case highlighted the need for a guideline to be developed by the hospital to guide the management of the patient presenting with an abdominal mass/pain. There has now been a guideline developed for this presentation.