

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

ANNUAL REPORT TO THE PUBLIC FOR 2012

ON

QUALITY IMPROVEMENT ACTIVITIES UNDERTAKEN OR OVERSEEN

BY

**GYNAECOLOGY PRACTICE IMPROVEMENT COMMITTEE
NORTH METROPOLITAN HEALTH SERVICE**

**Please send completed reports to:
Director, Office of Safety and Quality in Healthcare
Department of Health
PO Box 8172 Perth Business Centre
Western Australia 6849**

Contact details of person providing the report:

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Signature:



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*.

The committee's Terms of Reference is attached.

Issues, projects and/or activities undertaken by the Committee for which Qualified Privilege was required are outlined below.

The occurrence of the following events are 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

The methods used included clinical chart review, flowchart and mapping of an event, root cause analysis, presentation and discussion of cases. Subsequent

recommendations were made to the Obstetric and Gynaecology Management Committee, Medical Advisory Committee and associated external services.

The lessons learned or recommendations made about how to improve the quality of health care:

The areas covered by this committee are reasonably broad. 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 counselled and reminded of existing guidelines.

Education sessions devised for presentation to the clinical staff.

Specific actions included:

- Processes reviewed and staff advised by memos, meetings and education to ensure:
 - Staff reminded of correct documentation of surgical procedures
 - Equipment upgraded after equipment failure
 - Correct documentation of medications
 - Protocols reviewed
 - New resources arranged
 - Specific staff training on documentation and communication
- Outside agency advised regarding policy deficit to support changes and decrease / eradicate reoccurrence.
- Feedback to external services on outcomes of referrals and changes to processes that will support improved patient safety.

The annual report will be provided to the public in December 2012 via the WNHS website.

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.

It is important 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.