OBSTETRICS CLINICAL OUTCOMES MANAGEMENT COMMITTEE

ANNUAL REPORT TO THE PUBLIC FOR 2011/12

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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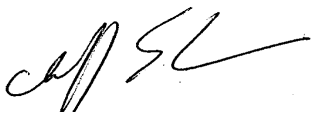

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The *Health Services (Quality Improvement) Act 1994* provides for the approval and protection of quality improvement committees reviewing, assessing and monitoring the quality of health services and for related purposes. Section 9 of the *Health Services (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 any delivery where there was maternal or fetal morbidity or mortality and cases where there was a 'near miss'. See the attached terms of reference for a list of the types of events reviewed.

Action taken – There were a total of 260 incidents that were reviewed by the Committee.

Outcomes – Of the incidents reviewed, the Committee concluded that in 187 cases (71%), the management was appropriate. There were another 16 cases where the documentation was inadequate to be able to be certain there was no system problem, but none were identified.

The next largest group was that the Committee felt that there had been a delay in management. This includes an increasing number of cases when an additional theatre has to be opened. This is a result of increased complexity and increasing busyness.

Actions taken in other cases included education, developing specific guidelines and providing new resources in cases where a shortage of equipment or equipment failure was identified.