OBSTETRICS CLINICAL OUTCOMES MANAGEMENT COMMITTEE

ANNUAL REPORT TO THE PUBLIC FOR 2012/13

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 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 384 incidents reviewed by the committee involving 362 women and or their infants.

Outcomes – Of the incidents reviewed, the Committee concluded that in 251 incidents (65 %), the management was appropriate. Communication deficit and failure to follow protocol were the largest groups of deficits identified by the committee. (3.8% of reviews respectively)

The next largest group was where 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 included education of staff, developing specific guidelines and providing new resources in cases where a shortage of equipment or equipment failure was identified.