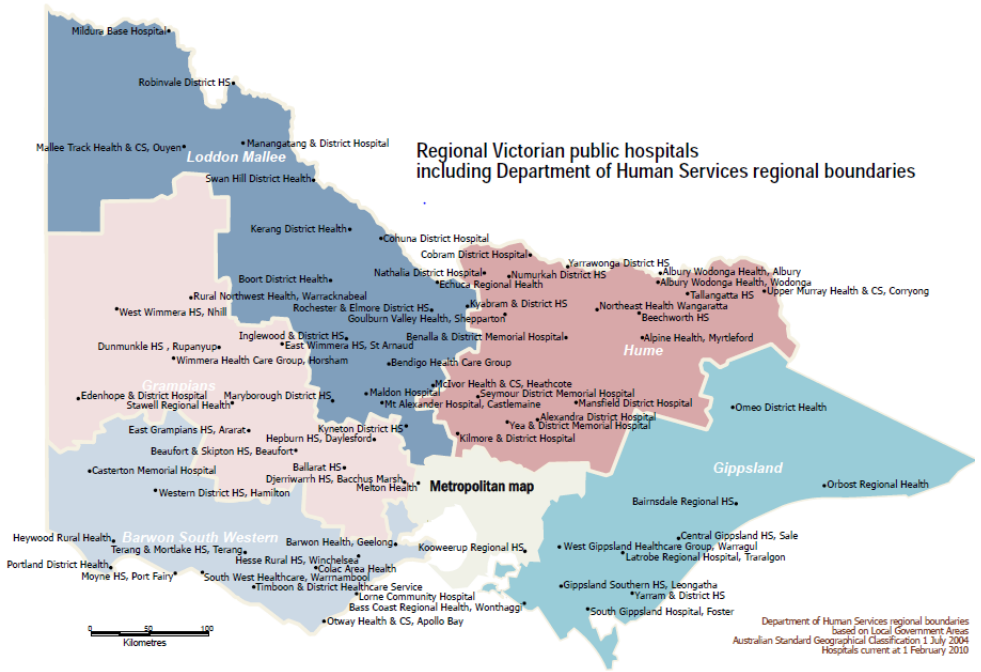


Regional Maternal & Perinatal Morbidity and Mortality Committees

Jill Butty- Quality Lead & Director Quality and Safety
Royal Women's Hospital

Tuesday 23rd May, 2017

Introduction

At last, action on health oversight

Bacchus Marsh Hospital investigation: Midwives were 'reading ultrasound manual' before stillbirth

'Catastrophic event': Bacchus Marsh hospital investigated over seven 'avoidable' baby deaths

Maternity funds win for Bacchus Marsh hospital

Former Victorian hospital chairman concerned over Government handling of baby deaths scandal

MAURICE BLACKBURN WELCOMES PANEL TO INVESTIGATE BACCHUS MARSH HOSPITAL

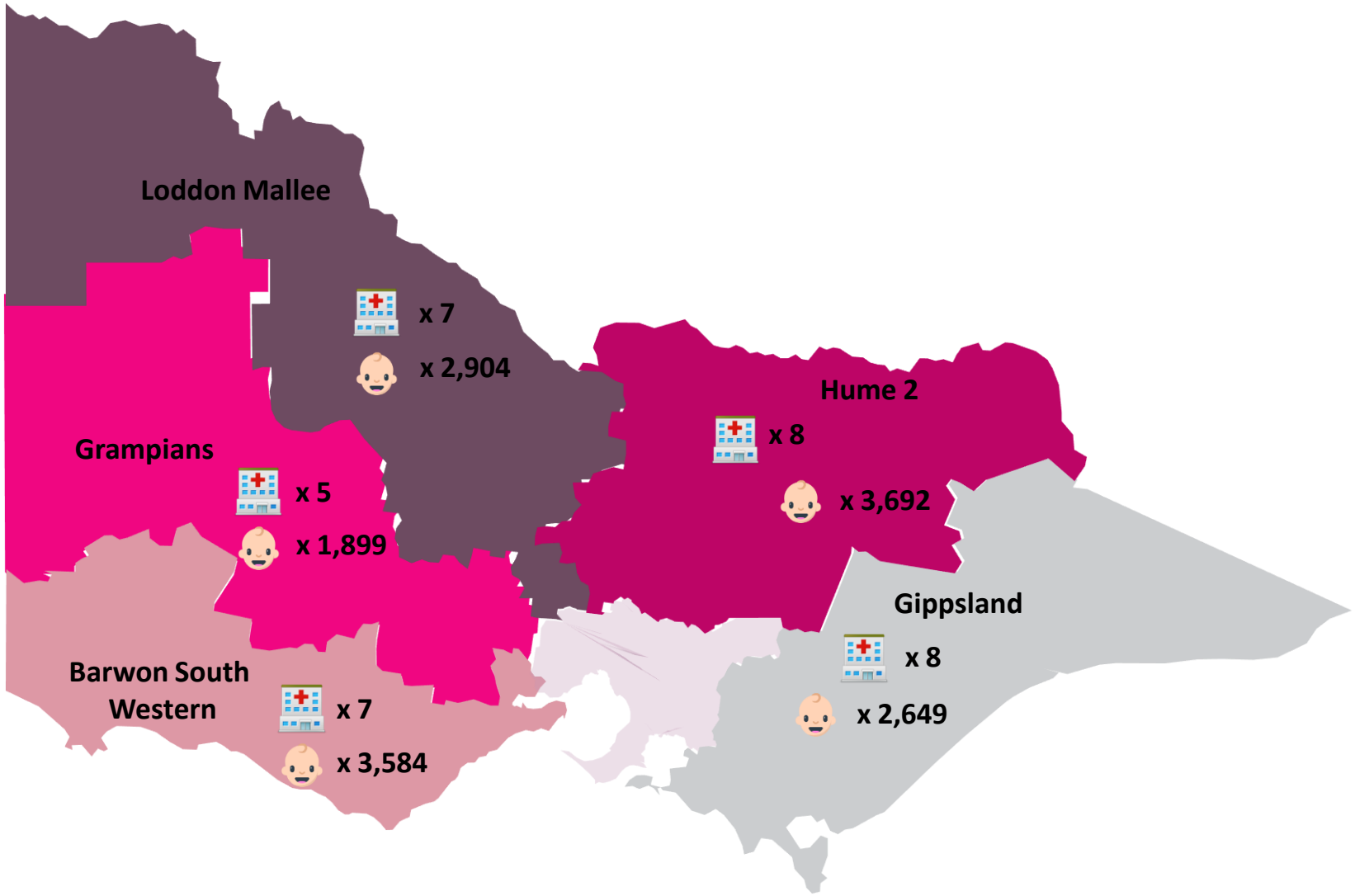
25 February 2016
Maurice Blackburn has welcomed the state government's decision to set up a panel to bolster hospital safety and in the wake of multiple perinatal deaths and injuries at Bacchus Marsh hospital.

Deaths of seven babies in Victorian hospital may have been avoidable, probe finds

Key objectives

- Prevent **avoidable** harm
- Support **transparency** regarding the M & M process
- **Learning** across & between services and disciplines
- Standardise the process & tools
- Provide **peer support** and clinical **leadership**
- Promote an inclusive multidisciplinary process to committee membership & attendees
- Ongoing **sustainable** system; outcome focussed to improve **quality and safety**
- Promote access to timely data
- Link to MNCN & PIPER, MSEP & PROMPT, Indicator Project

Regional Sites and births 2014-15



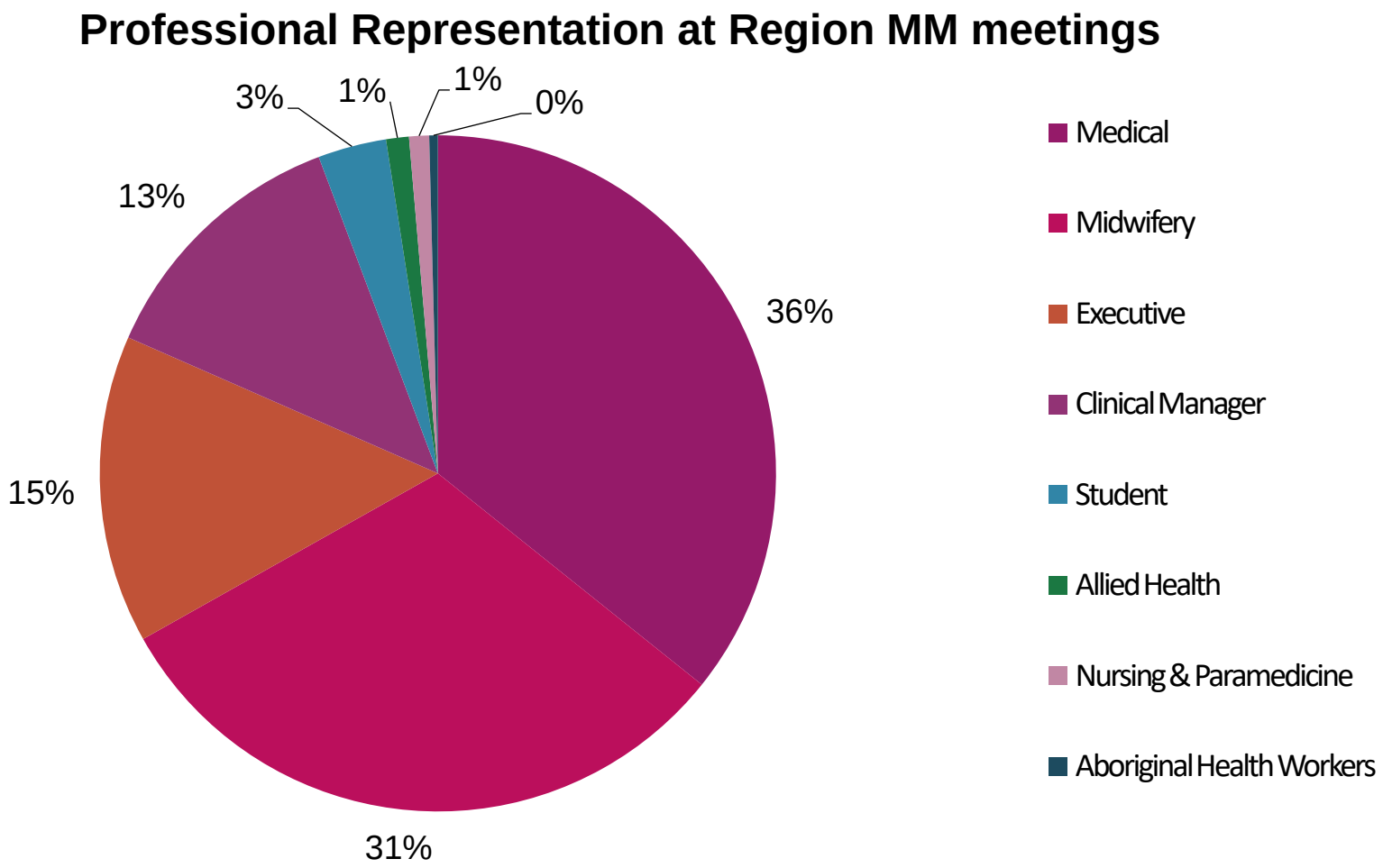
Total number of babies per region (sourced from Victorian perinatal services indicators 2014-15)

So far 2016 - 17

- **Six regional** M & M Committees content included;
  - Maternal & Perinatal Mortality – **109 cases presented at regional meetings in 2016**
  - Selected Morbidity (PPH > 1500mls & Apgar <7 at 5 mins) – **38 cases (introduced late 2016)**
  - PIPER & Ambulance transfers introduced mid 2016
  - **Standardised** tools & templates
  - Quarterly cohort data

- **Action list & recommendations collated** from each meeting
- Services report back at the next meeting

Results


Professional Representation at Region MM meetings
3%
1%
1%
0%
13%
36%
15%
31%
Medical
Midwifery
Executive
Clinical Manager
Student
Allied Health
Nursing & Paramedicine
Aboriginal Health Workers

Regional Maternal and Perinatal Mortality and Morbidity Committees online collaboration space

The Royal Women's Hospital (the Women's) on behalf of the Victorian Department of Health and Human Services has been engaged to provide support to regional hospitals for the establishment of regional maternal and perinatal morbidity and mortality committees.
These regional committees have been developed to assist in building the capability of health services to learn from maternal and perinatal mortality and morbidity review. The committees will also promote consistency in the application of the PSANZ guidelines more broadly through engagement with clinicians and existing review committees.

This online space will provide an opportunity to share learning from the committee meetings and resources developed to support the project. We will also keep you informed regarding future meeting dates, a resource library and will use this site to conduct our evaluation of meetings.

If you have further questions or require information please contact Bree Bulle Project Director.

Regional Victorian public hospitals
including Department of Human Services regional boundaries

Committee Meeting Dates

Gippsland - Meeting 1
20 May 2016

Hume 1 - Meeting 1
03 June 2016

Hume 2 - Meeting 1
05 August 2016

Loddon Mallee - Meeting 1
13 July 2016

more..

Resources

Confidentiality Deed (168 KB) (docx)

Information about the RMPMMC (265 KB) (docx)

Have Your Say – Online Feedback

How satisfied are you... *

	Very satisfied	Satisfied	Neutral	Unsatisfied	Very unsatisfied	Not relevant
with the time of the meeting?	○	○	○	○	○	○
with the quality of the presentations at the M&M meeting?	○	○	○	○	○	○
with the M&M meeting format?	○	○	○	○	○	○
with the quality of the venue?	○	○	○	○	○	○
with the quality of the overall meeting?	○	○	○	○	○	○
with the quality of the Video-conferencing (if relevant)?	○	○	○	○	○	○
with the meetings' overall value in helping you improve your professional effectiveness?	○	○	○	○	○	○

Please comment on any of the above satisfaction scores.

Please limit answer to 255 characters

255

Is there anything you would like to follow up after the meeting?

- ○ Yes
- ○ No

If yes, please specify in the additional comments and provide your email address.

the women's
the royal women's hospital
victoria australia

Survey feedback

Overall feedback is **positive** regarding the usefulness of the **RMPMMC**

"CTG monitoring interpretation to identify a compromised fetus"

"Good collegiate discussion"

"The process is excellent & there were important discussions that come out of my anaesthetic department. I would certainly like to continue being involved"

Improvements to the meeting?

Mostly relate to the venue & quality of the VC /TC service available & resource required to prepare cases

Common themes

- **Communication** - discharge plan between tertiary, regional and rural services
- Standardised reporting for ultrasound (Prof Permezel RANZCOG & ASUM)
- Recognising & responding – **fetal surveillance / CTG management**
- Management of **reduced** fetal movements
- **Fetal growth** assessment and documentation
- Management of **obesity & diabetes** in pregnancy
- **Escalation** guidelines/access to medical records out of hours
- Maternal going to sleep position at term
- Use of & interpretation **fetal fibronectin**
- **Post dates** monitoring & surveillance

Challenges

- IT support for VC
- Travel for remote clinicians
- Rural GP engagement
- Committee membership & attendees
- Suitable venue
- Case preparation

Link to other services?

- DHHS
- PIPER
- Ambulance Victoria
- Maternal Newborn Clinical Network (MNCN)
- PSANZ
- CCOPMM
- Metropolitan services
- Professional organisations
- Safer Care Victoria

Further morbidity for consideration

- Any baby delivered regardless of outcome which was **FGR** (< 2800gm/3rd centile) delivered **beyond 40 weeks** (high priority)
- Unplanned ICU admission
- Peripartum hysterectomy

Correlation with the **Maternity Indicators** project to be introduced mid 2017.

Questions

Jill Butty

- **Quality Lead Regional Maternal and Perinatal Mortality and Morbidity Committees (RMPMMC); Director Quality and Safety Royal Women's Hospital**

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