

Clinical Practice Review

THE ROYAL WOMEN'S HOSPITAL QUALITY AND SAFETY UNIT NEWSLETTER

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Sexual Assault Prevention Program for Secondary Schools (SAPPSS)



Toltu Tufa

The phone rings at three o'clock on Friday afternoon. It's the Student Welfare Coordinator from one of the local secondary schools and she sounds distressed. "There's been an incident of sexual assault at our school," she says. "We need someone to come and talk to the students". She tells you students need to understand the definition of sexual assault so that it will not happen again. "Can you come in next week?" she asks. "We can give you half an hour at school assembly."

The scenario described above is an experience that resonates with me and may sound even more familiar to people working in the Sexual Assault and Violence against Women sector. Many school staff – in fact many people in our community – believe that a session or two delivered by the experts will stop incidents of sexual assault from occurring again. However this knee-jerk reaction is not effective in creating real social

change; nor is it consistent with a feminist approach to the prevention of violence. Responding to and preventing sexual assault effectively needs to be informed by structures and frameworks that enable long term, holistic changes (VicHealth 2007).

Toltu Tufa recently joined the Clinical Quality and Safety Unit at the Women's. She was the SAPPSS coordinator at CASA House (Centre Against Sexual Assault) at The Women's between 2009–2010. Her background in psychology and education, coupled with nearly ten years of cross cultural training and community work with women, underlies her commitment to grassroots violence prevention education.

SAPPSS denotes a model developed by CASA House in 2004. It is a comprehensive, whole school model which aims to develop a long-term working partnership between the sexual assault service and the school so as to sustain culture change

over time. It is currently active in twenty schools across metropolitan Melbourne and similarly being trialled across regional Victoria and other Australian states and territories; each in a different phase of implementation.

State and National governments have also magnified the issue of respectful relationships education in schools and with plenty of good reason; one in five young women report experiencing sexual coercion, one half before the age of 17 (Family Planning Victoria, Royal Women's Hospital & Centre for Adolescent Health 2005).

SAPPSS is active in twenty schools across metropolitan Melbourne

What statistics like these and others tell us is that responses to gender-based violence need to be deliberate and well thought out. Perhaps the most distinguishing feature of the SAPPSS model on a practical level is that it enables a continued, working partnership between sexual assault agencies and their local schools. Effectively, the

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Editorial



Leslie Reti

From a Smorgasbord to a Feast

Welcome to our first Clinical Practice Review Newsletter for the year, a bumper edition for summer reading. We should be proud of the depth and breadth of clinical initiatives at the Women's, a sample of which is published here. Hong Tran and Maureen Johnson won the prestigious Victorian Quality Council's Travelling Fellowships. Their plan for international investigations into the management of heavy menstrual bleeding and health literacy are summarised on pages 8 and 4.

'There is nothing more constant than change' Heraclitus' doctrine has almost become a cliché however that is the nature of clinical practice. What's equally important however is that practice change is an improvement, and the only way to show that is to review one's results.

In this issue Poonam Charan and Chris Bayly report on the important non-surgical management of miscarriage and abortion whilst Jenny Ryan describes our response to the increasing caesarean section rate in primigravida. Clinical research is ever active and on page 9 one of our young investigators, Michael Carter, reports on the utility of MRIs of the fetal brain for the investigation of mild ventriculomegaly. And whilst on research, it's worth reading about BioGrid Australia, a collaboration in health research that provides a technology platform for the ethical integration of data on page 14.

On the public health front, Toltu Tufa describes CASA's sexual assault prevention program for secondary schools on page 1 and Kaye Dyson writes about the initiatives to improve breastfeeding rates in the Newborn Intensive and Special Care units on page 12. Less a smorgasbord than a feast of good reading on some of the improvement projects at the Women's.

Leslie Reti, editor

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Sexual Assault Prevention Program for Secondary Schools (SAPPSS)

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partnership takes shape between local agencies (like CASA House) as the expert on the presented material and the local school as the expert on the school terrain. Together, a whole-of-school synergy is created so that everyone across students and staff are presented with opportunities to reduce the incidence of sexual assaults, establish safe environments of communication and improve the school's capacity to enhance young people's access to support.

Change is most powerful when it is relevant, and comes from within. Accordingly, the aim of the SAPPSS model builds on students' knowledge and creates classroom discussion about relationships and attitudes.

The open format of the student program also allows students to build respectful relationship skills within the classroom. To this end, part of my role was to conduct training for teachers and educators to actively model these skills – for example, by respecting students' opinions, by challenging attitudes that support violence, and by maintaining group safety and openness.

SAPPSS was the silver recipient of the 2010 Public Healthcare Awards and is currently identified as a leading practice program in Victoria (Flood, Fergus & Heenan 2009).

The SAPPSS student curriculum has been extensively evaluated and the results have shown positive shifts in students' knowledge, skills and attitudes towards sexual assault and respectful relationships over both the short and medium term (Imbesi 2008). Students consistently reported that the curriculum allows them to talk about sensitive issues they were not able to discuss elsewhere. Some examples of young people's comments include "It's the only place we ever get to talk about this stuff."

Adolescence is a time when young men and women develop attitudes, expectations and practices concerning relationships and intimacy (Carmody 2009). Similarly, attitudes are powerfully constructed and reinforced during school years and secondary school is seen as an ideal time to introduce respectful relationships education. Young men and women cannot be expected to change in isolation from the broader context of their lives and communities.

As schools become more engaged in respectful relationships education – or are required by government policies to do so – SAPPSS offers an effective model that has demonstrated sustainable change and development in schools.

Although the SAPPSS model is quite well-established, it will continue to change and evolve as CASAs and schools continue to work together in sustained partnership.

Toitu Tufa

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Improving Health Literacy at the Women's



Maureen Johnson

What is health literacy and why are we hearing the term more and more, in health, in education and in the general media? More importantly, will a commitment to improve health literacy lead to more equitable access to health services and improve health outcomes?

One of the earliest and possibly most straightforward definitions of health literacy was put forward by Ratzan and Parker in 2000, who describe it as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed

to make appropriate health decisions.” So while good health literacy may include functional abilities, such as reading and numeracy skills, or the cognitive and social abilities required to evaluate, question and use health information, it is also impeded by determinants such as language, culture and social connectedness.

Responsibility to improve health literacy falls on the broader community but there is considerable onus on health care providers to ensure that health information can be obtained, processed and understood by our diverse community.

Indeed some commentators have argued that health providers are responsible for low rates of health literacy because little effort is made to ensure health information is accessible.

There are many good reasons for taking health literacy seriously. To begin with, nearly 60% of people in Australia, between the ages of 15 and 74, have poor health literacy (ABS 2006).

This means that more than half the population struggle to find, understand and use written and verbal health information.

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International White Ribbon Day

The Women's held a highly successful men's breakfast on November 25th, International White Ribbon Day.

White Ribbon Day was created by a handful of Canadian men in 1991 on the second anniversary

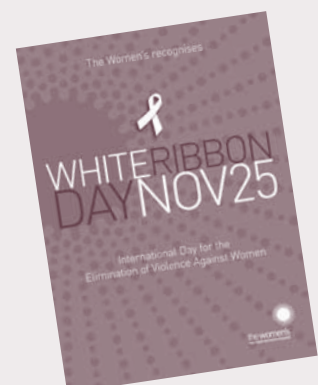
of one man's massacre of fourteen women in Montreal. They began the White Ribbon Campaign to urge men to speak out against violence against women. In 1999, the United Nations General Assembly declared November 25 the International Day for the Elimination of Violence

Against Women (IDEVAW) and the White Ribbon has become the symbol for the day.

This year at the Women's, Conference Room A was filled to capacity with men having breakfast to hear an address by Todd Harper VicHealth CEO who spoke about violence against women being a public health and human rights issue.



L-R: Chris Gamble (Executive Director of HR and IT), Dale Fisher (Chief Executive), Todd Harper (CEO, VicHealth), Les Reti (Director, Clinical Governance) and Stewart Leslie (Vice-chair, Board of The Women's).



Improving Health Literacy at the Women's

(continued from page 6)

From a purely economic perspective it has been found that people with poor health literacy are more likely to use emergency services, are hospitalised more and are less likely to be compliant with medications and to use preventative services. An American study estimated that low health literacy costs the American economy up to \$73 billion per year (Institute of Medicine 2000). In terms of risk, poor health literacy, particularly where language and culture are concerned and the concept of 'shared meaning' or understanding, has already proven to be crucial in patient provider interactions. A number of examples can be found in the literature where the notion of health literacy

or poor communication has led to preventable adverse events.

A focus on health literacy is even more critical now than it ever has been. There is an increased expectation for people to take responsibility for their health; to participate in decision making, to manage chronic disease and to make day-to-day decisions about nutrition, lifestyle, family health and more. In a time where there is an increasing abundance and complexity of information – overwhelming to health providers let alone health consumers – it is no wonder then that poor health literacy is linked with poor health outcomes.

The Victorian Quality Council has provided an opportunity for me through their travelling scholarship

program to investigate how health literacy is being advanced in other parts of the world and to consider how we can improve our approach in Victoria and especially at the Women's. I manage the Women's Consumer Health Information Program at the Women's, and will travel to America, Canada and Europe in April and May 2011 to gather information on innovative approaches that may be useful in a Victorian context. I am particularly interested in how health services are reorienting to work toward system wide and sustainable efforts to improve health literacy. I also hope to look at collaborations and knowledge sharing between health services, community and universities.

Maureen Johnson

Medication (as Distinct from Surgery) for Management of Miscarriage and Abortion

There is a large body of evidence that medication can be safely used for the treatment of miscarriage and to induce abortion and that this is preferred to surgery by a substantial proportion of women.

Medication Abortion

Optimal regimens require mifepristone and misoprostol; while misoprostol is available in Australia (approved by the Therapeutic Goods Administration for gastrointestinal indications), mifepristone has not yet been

registered. Several doctors at the Women's have been authorised by the TGA to prescribe it, so that we can now offer optimal regimens of medication abortion when indicated; according to women's preferred method up to 9 weeks gestation and for all cases after 18 weeks. We generally recommend surgical abortion when available at 10–17 weeks, but medication abortion remains an option.

Experience at the Women's to date

Mifepristone has been used at the Women's since early 2008 in an

increasing proportion of women having abortions beyond 18 weeks after diagnosis of fetal anomaly. Experience has now reached 100 cases, and is being analysed with a view to publication. Our findings are consistent with the published literature, with the induction-delivery interval (from first misoprostol dose) substantially shorter than with previously used regimens involving misoprostol alone.

Following recent revisions to our TGA approved protocol,

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Chris Bayly



Poonam Charan

Medication (as Distinct from Surgery) for Management of Miscarriage and Abortion

(continued from page 5)

we are increasingly providing medication abortion as an alternative to surgical abortion in early pregnancy and the CPG for this will soon be published.

Medication Management of Miscarriage

Regimens are less well developed than for abortion and the place of mifepristone is unclear. Nevertheless it is well established that surgery can be safely avoided for most women who prefer to do so.

Women treated at the Women's are now able to make an informed choice on their options for therapy of early pregnancy failure.

Implementation of the evidence-based medical protocol can also be expected to lead to a better use of staff resources over time. In the initial stages, we are offering medical management with misoprostol to all women where the retained products of conception (RPOC) are approximately 20–35 mm in size or there is a gestational sac or fetal pole less than 9 weeks in size. Patients will be admitted into the ward for the duration of the treatment (up to 8 hours).

As our staff gain experience, we anticipate increasing flexibility of this regimen and potentially outpatient management and follow up.

A CPG outlining choice of method and treatment regimens has been published on the intranet and feedback on its use in

clinical practice would be very welcome before we make it more widely available through the Women's public internet. A brochure for women about the various management methods is now available to support the routine availability of all suitable options.

Aspects of Clinical Care

For both miscarriage and abortion patients it is particularly important to record whether and when products of conception have been passed; in all cases of miscarriage and if there is any doubt after abortion, tissue should be sent for histological examination.

After medication abortion or management of miscarriage, follow up care should be based on clinical picture rather than ultrasound findings; curettage should not be performed purely because of ultrasound identification of RPOC in the absence of bleeding, pain or infection. While it is important to be certain that there is no continuing pregnancy after medication abortion, in other cases, most RPOC will pass spontaneously given time. Therefore ultrasound examination should only be undertaken if it will change management.

Attention to emotional health and wellbeing is always important; consider referral to Women's Social Support or other relevant services if indicated (see CPG).

Supervision of Care

Please contact Poonam Charan, EPAS Fellow, with any clinical queries. She will oversee management of miscarriage, ectopic pregnancy and complicated abortion during her working hours, reverting to the receiving registrar/consultant for the day if she is unavailable. The care should be delivered by the receiving JMS team, in consultation with Poonam re choice of treatment method and about complications. Follow up can be arranged with EPAS nursing staff (message on answering machine if not available) after miscarriage and Choices Clinic for abortion patients.

See <http://intranet.thewomens.org.au/MiscarriageManagement>

A CPG on pain and bleeding in early pregnancy is also on the intranet and consumer information is on the internet site.

**Poonam Charan
and Chris Bayly**

‘The Feminisation of Obstetricians and Gynaecologists’ – Catching up with our Client Base

Why might all the Level 1 O&G trainees at the Women’s in 2010 be women? asked the editor of Clinical Practice Review in March. Why ever not, and indeed, what took so long? one might reply. The Queen Victoria Hospital, which was established by women for women and later morphed into Monash Medical Centre, had three out of three women trainees in its 1981 intake.

Can you imagine the Women’s not appointing a single female Level 1 equivalent trainee for 20 years? That’s 100% male Level 1s for 20 years. This happened in the living memory of some of us, prior to the appointment of Janet Duke in 1979. One woman was then appointed each year (out of four positions), until we were told that if the women already appointed were up to scratch, consideration would be given to appointing two women the next year: imagine that! Appointing them on whose merits you might wonder. Apparently we were adequate, as two were appointed the following year and the overall proportion of women has gradually increased since then.

When I was a registrar, having a baby and training were incompatible: one had to be completed before the other began; some colleagues even reported being asked about their

personal contraception during job interviews, or not being appointed because of being married.

I am delighted that it is now manageable, if challenging, to become a mother during O&G training (see Hong Tran’s article in the March newsletter) and proud that the Women’s has worked hard to make this possible, despite the headaches for staffing, rostering and planning a balanced training experience.

In 2003, the Hospital conducted *The provider gender project* in response to difficulties experienced by staff in consistently responding to requests by women for female doctors. The project reported preference for female providers to be common in O&G care, with provider gender being particularly important to some women.

The many requests for women doctors could not be met even then, when already over half the O&G junior medical staff were female. Concerns were raised about training and workload imbalances, with female trainees landing the heavier workloads and missing out on some experience in order to meet demands for female doctors. Some expressed concern about discrimination by patients against male providers. These problems in delivering clinical care appear to have diminished as the proportion of women practitioners has increased.

It has taken a generation to change some of the attitudes and prejudices that have tended to discourage women from training in O&G; a few examples:

- a woman being told she had kept a man out of a job
- being advised at orientation to wear a collar and tie at all times
- meetings repeatedly addressed as ‘Gentlemen’ even when several female consultants were present

One male consultant, encountering three women obstetricians conversing in the foyer, inquired as to whether this was a ‘takeover’. Whatever made him feel threatened, perhaps the answer to his question is ‘yes’. It is appropriate that a majority of O&G specialists should be women. I hope that compassionate men with enthusiasm for O&G continue to be attracted to and feel welcome in the specialty, that neither men nor women are exposed to the discrimination of the past and that all have access to the sort of mentoring and encouragement from both male and female colleagues that I have been fortunate to experience. Continuing workforce development is needed to provide ongoing adequate staffing and training flexibility for work-life balance for men and women that is already an order of magnitude better than a generation ago.

And yes, some years the entire Level 1 intake may be women.

Chris Bayly



Chris Bayly

Heavy Menstrual Bleeding – Can We Improve the Flow?



Hong Tran

Imagine a ‘one stop shop’ where in one visit a patient can have not only a consultation and examination, but also a diagnostic hysteroscopy and curette, and if necessary even a polypectomy or Mirena insertion.

After the Christmas celebrations when most of you will be eagerly anticipating the Boxing Day sales or contemplating New Years resolutions, I will have started my journey to Italy and the United Kingdom as part of a Victorian Travelling Fellowship. I was fortunate to be one of the six recipients of the 2010 Victorian Travelling Fellowships awarded by the Victorian Quality Council of and Department of Health. The focus of my research project relates to the important topic of Heavy Menstrual Bleeding (HMB), and in particular how to improve access to medical care, updating management algorithms, and evaluating the feasibility of outpatient hysteroscopy.

Why is the topic of HMB so important? It is not only a common problem which affects one in five women of reproductive age in Australasia¹, but it also significantly impairs the quality of life of affected women and utilises substantial health care resources.

Heavy Menstrual Bleeding is one of the three most common reasons for gynaecological referral to the Women’s Hospital, and perhaps not surprisingly there is a dedicated unit (Gynae 1) for this.

This project provides a perfect opportunity to encompass both my roles as a gynaecology registrar and the Quality and Safety fellow. At the moment there are no uniform guidelines for the investigation and management of patients presenting with HMB. As such, the clinician is faced with a dilemma of which investigation, if any, should be organised ranging from blood tests, pelvic ultrasound, endometrial sampling with either pipelle, dilatation and curettage, or hysteroscopy dilatation and curettage. Following this, conservative, medical or surgical options can be considered. Medical management includes anti-inflammatories, tranexamic acid or hormonal medications. Surgical options include uterine artery embolisation, endometrial ablation, myomectomy or definitive treatment with hysterectomy.

Consequently, the assessment of HMB can be complex, and is dependent on multiple patient and disease-related factors. In 2007, the UK produced the *National Institute of Clinical Excellence (NICE) guidelines on Heavy Menstrual Bleeding*². However, this publication was specific to the UK and quite bulky in length, making local implementation at the Women’s impractical. Indeed, even within

the UK there have been significant differences in adherence to the NICE guidelines, and a National audit is currently underway to assess the reasons for this.

During my travelling fellowship, I plan to visit a number of centres in the UK (Sheffield, Bradford, Birmingham and London) that have demonstrated a high compliance rate with the NICE guidelines. These centres have also been able to streamline the management of HMB. Whilst abroad, I intend to learn from the expertise of these centres, and use this experience to develop clinical practice guidelines for the Women’s.

The second part of my fellowship in Italy will be to visit Professor Stefano Bettocchi, who developed the ‘BETTOCCHI’ hysteroscope used in outpatient hysteroscopy clinics. Imagine a ‘one stop shop’ where in one visit a patient can have not only a consultation and examination, but also a diagnostic hysteroscopy and curette, and if necessary even a polypectomy or Mirena insertion.

Each of the centres that I am visiting can provide this service, whereas in contrast there is no such service in Victoria. I firmly believe that this would be invaluable to the Women’s, and would help streamline medical care and improve patient’s hospital experience.

Mild Ventriculomegaly in a Tertiary Centre where Fetal MRI is Available

Much can be learnt from the expertise of other centres of excellence. I hope to make the most of my travelling fellowship, and return with suggestions on how we could potentially improve the 'flow' of patients with HMB at the Women's.

Hong Tran

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Advances in fetal ultrasonography have allowed not only the diagnosis of gross abnormalities but also the detection of developmental variations in the growing fetus. However, the clinical significance of some of these findings may be uncertain and there is opportunity for research in this area.

As part of my RANZCOG ITP Training at the Women's, I conducted a retrospective study evaluating the perinatal outcomes of mild ventriculomegaly (VM). The study's purpose was to increase our knowledge of the clinical significance of this ultrasound finding. I was fortunate enough to present the data from the first part of my project at the AAOGU (Australian Association of Obstetric and Gynaecological Ultrasound) 2010 conference in April.

The measurement of the fetal brain lateral ventricular size is a routine component of the second trimester morphology scan. The mean ventricular diameter in the second and third trimester is 6–7mm. Ventriculomegaly (VM) is the finding of a ventricular diameter greater than or equal to 10mm. Ventricular width greater than 15mm is known as severe VM and has a known set of outcomes with generally an unfavourable course.

Mild VM is defined as a ventricular diameter between 10–15mm

(10mm being more than three standard deviations above the mean) and has a variable prognosis. Mild ventriculomegaly (VM) is most commonly found on second trimester anomaly scan, in approximately 0.5–2% of fetuses¹. It is important to note that VM is an imaging finding rather than a diagnosis.

Mild VM may be a transient and normal developmental variant, with normal outcomes in approximately 80% of patients. However, it may also be the only sign of a serious underlying pathology.

There is a paucity of literature regarding the clinical significance of mild VM. Counselling of women with the detection of mild VM is consequently challenging. There have been reports that mild VM is associated with an increased risk of extracranial anomalies, central nervous system anomalies (e.g. malformations of cortical development and agenesis of the corpus callosum), aneuploidy (trisomy 21 is approximately 9 times more likely in the presence of mild ventriculomegaly), congenital infections (e.g. CMV and toxoplasmosis), perinatal death, and abnormal intellectual development. Furthermore, mild VM will progress to more severe VM in approximately 15% of cases.

Over a 6 year period during 2003 to 2008, 190 singleton fetuses



Michael Carter

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Mild Ventriculomegaly in a Tertiary Centre where Fetal MRI is Available

(continued from page 9)

were assessed at the Women's Fetal Management Unit after having mild VM found at the midtrimester ultrasound. Of this number, 91 (46%) fetuses had presumed isolated mild VM, with no other obvious anomalies or markers of aneuploidy on ultrasound. The remaining 106 fetuses had evidence of additional findings including neural tube defects (16%), agenesis corpus callosum (12%), other brain anomalies (12%) and extra-cranial anomalies (14%). Abnormal karyotypes were found in 2.5% of these fetuses.

A subset of these patients (28/91 or 31%) have had a fetal MRI for further investigation of the apparently isolated mild VM. Most of these patients were seen after 2006, as part of the ongoing Victorian Fetal MRI Project. Of these 28 MRIs performed, 6/28 (21%) have shown an additional finding not initially suspected on ultrasound (see table below).

List of Additional Findings on MRI

Enlarged surface CSF spaces

Dysgenesis of Corpus Callosum

Periventricular Cysts

Bilateral frontal cerebral mantle anomaly (MF of cortical development)

An additional MRI abnormality rate of 21% in cases of apparently isolated VM is higher than that previously reported in the literature and reflects the high-risk populations seen at the Women's Fetal Management Unit. Ouahba² reported a rate of 6%, and

Salomon³ reported a rate of 16.7% in cases where the ventricular diameter was 12–15mm.

Of the 91 women, 38 delivered at the Women's (this included two terminations), and 53 women delivered externally.

In the second phase of this study, I plan to evaluate perinatal mortality (live birth, still birth and neonatal death rate), neonatal assessment at delivering hospital and early development (via GP, paediatrician, parental survey). Ethics approval has been granted for both patients and treating doctors to be contacted.

I would like to thank Dr Ricardo Palma-Dias for his help with this project.

Michael Carter

Level 2 RANZCOG Trainee

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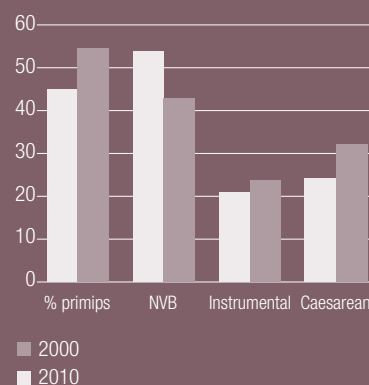
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Project Primip

The purpose of Project Primip is to present a consistent, evidence – based care plan for normal healthy primipara woman in labour and to improve the overall care and birth outcomes for primiparous women attending the Royal Women's Hospital.

The overall caesarean section rate ranges between 20% and 30% in most western countries and continues to climb. Over the last nine years the caesarean section rate for primips at the Women's has been steadily increasing. Notably, the proportion of primiparas attending the Women's has also increased from 45.1% in 2000 to 54.5% in 2010. In 2000 the caesarean section rate for this group was 24.4% and in 2010 it is 32.4%.

Proportion of primiparas attending the Women's



Project Primip will focus on strategies to improve the care in labour for primiparous women with a view to:-

- Increase the vaginal birth rate
- Reduce the Caesarean rate
- Ensure the third and fourth degree tear rate remains at / below target rate for method of birth.
- Ensure compliance with provision of standardised, evidence based care / management

Project Primip will address this by using three comprehensive strategies

Strategy 1:

Review of Oxytocin Regimen

Strategy 2:

Bundle of labour care

Strategy 3:

Supportive one-to-one care for women in established labour

Strategy 1: Review of Oxytocin Regimen

In June 2010 the Women's introduced its new oxytocin regimen. This was adopted from the Victorian Maternal and Neonatal Clinical Network, which published a set of guidelines for induction and augmentation of labour in May 2010. The New Oxytocin Regimen and Management of uterine hyperstimulation CPG are now published on the Women's intranet.

Strategy 2: Bundle of labour care

A bundle is a group of evidence – based interventions related to a disease process that when executed together result in better outcomes than when implemented individually.

Successful implementation of the bundles is based on the 'all or nothing' strategy. In other words it is a structured way of improving the process of care outcomes. The bundle of labour care consists of three key elements:-

- Strict adherence to Care in Labour & Birth guideline. (reviewed Aug 2010)
- 2 Hourly documentation with ongoing intrapartum management plan
- Compliance with Risk Assessment Tool for perineal trauma

The New Care in Labour and Birth CPG has been developed with a great deal of consultation and collaboration. It is now published on the Women's intranet, and its key elements include the definition of active labour, the development of algorithms for recognition and management of delay in first and second stage and two hourly documentation of labour plan.

Strategy 3: Supportive one-to-one care for women in established labour

This requires raising the awareness of the significance of being with woman in labour and staying in the room with her. To assist in this, the Project Primip logo will be placed on the door of the woman's room. In-services have also been conducted with the Management team in the birth Centre to assist in appropriate staffing and delegation of resources.

In preparation for Project Primip, the Birth Centre Management Team has held daily education sessions with emphasis on strict adherence to the New Care in Labour and Birth CPG. The focus of these education sessions is on the diagnosis of labour, and management of delay in first and second stage. Staff can also access the self-directed learning PowerPoint on the Birth Centre Resources page.

Completion of the related module on Catalys will contribute to required Continuing Professional Development hours. *Please note this is not yet available on Catalys, but will be coming soon!*

Evaluation of the project will be through the ongoing auditing of compliance to strategies and of birth outcomes.

Thank you to CPIU for data

Jenny Ryan



Jenny Ryan

Right from the Start



Kaye Dyson

Supporting Breastfeeding in Newborn Intensive and Special Care at the Women's

The advantages of breastfeeding are well known, and most women in Australia initiate breastfeeding. A wide range of social, cultural and environmental factors affect the decision to initiate and maintain breastfeeding. In the neonatal unit, these factors are amplified, and one of the recognised barriers to successful breastfeeding in this setting is the health care system itself.

Breastfeeding is challenging in the neonatal setting, for mothers and their families, for those who care for vulnerable infants, and not least, for preterm and unwell infants. Inadequate staff knowledge and skills, inconsistencies in clinical practice, fragmentation of care, poor availability of specialist support, ineffective communication and documentation and mother/infant separation are factors that originate in the organisation of health care environments.

In addition, prematurity, infant and maternal medical conditions, psychosocial and socioeconomic factors, disempowerment of parents, anxiety about the infant, conflict between staff and parents, and dislocated lives all impact negatively on the success of breastfeeding.

Breastfeeding rates in Newborn Intensive and Special Care (NISC) at the Royal Women's Hospital (the Women's) have been thought

to be suboptimal both for initiation of breast milk expression and on discharge/transfer from the hospital. Anecdotal feedback from regional and metropolitan Level II hospitals to the Women's indicates that babies discharged from NISC are less likely to be breastfeeding or receiving breast milk than babies transferred from other tertiary hospitals. Feedback from NISC parents has indicated that they have not felt fully supported as they established breast milk expression and the transition to breastfeeding for their preterm or unwell infants.

Limited and ad hoc specialist lactation services have been available to Neonatal Services since the establishment of Breastfeeding Education and Support Services (BESS) in 1994. However, the BESS Review (2003), the Report of a Twelve Week Trial of Increased Lactation Support to NISC (2008), the Neonatal Model of Care Project Report (2009), the NHITH review (2009) and the Enhancing Breastfeeding Support in NISC Project (2010) have all identified the need for increased and more integrated lactation services in NISC to meet demand from parents and staff for specialist support.

The jointly-sponsored Maternity and Neonatal Services 'Enhancing Breastfeeding Support in NISC' project was conducted in 2009 to 2010 with the primary aim of developing a strategy to improve breastfeeding support in NISC. This was an exciting project bringing together Maternity Services and Neonatal Services to strive to improve breastfeeding supporting NISC together. Project objectives included: the review of staff education, parent

resources, and the breastfeeding 'friendliness' of the NISC environment. The project findings and outcomes are detailed in full in the Final Project Report. The project identified eight main themes related to enhancing support of breastfeeding in NISC.

The themes are:

1. Right from the start
2. Liquid Gold: the value of breast milk
3. Hit and Miss: Staff knowledge, skills and attitude and the provision of professional breastfeeding support
4. Sitting with the mother: learning to breastfeed
5. Mothering the baby
6. Transitions
7. People, not pamphlets: Information and resources
8. A place to breastfeed

These eight themes have informed the development of the 'Right from the Start' strategy which is the major outcome of the project.

This project identified that there is a widespread and genuine commitment to the 'ideology' of breast milk in NISC without the corresponding staff resources, knowledge and skills to effectively support the transition to breastfeeding.

By encouraging all mothers to provide breast milk for their vulnerable infants for as long as possible without giving them the practical, consistent and supportive care they require to make the transition to breastfeeding, we may inadvertently set some women up for feelings of failure when it 'doesn't work out' for them.

There is a growing body of evidence on the effectiveness of interventions to support breastfeeding. A 'pro-breastfeeding' attitude does not necessarily equate to the ability to provide effective support. The evidence shows that what does work is the re-orienting of health services, implementing a coordinated and multifaceted approach, continuity and timeliness of care, and professional and peer breastfeeding support throughout the continuum of pregnancy, birth and the postnatal period (ANBS 2009).

As one mother said:
"You're trying right from the start to express and to feed so you need the help right from the start."

Effective interventions specific to the neonatal setting include: Baby Friendly Health initiative (BFHI) accreditation of the associated maternity services, multidisciplinary staff training, Kangaroo Care/skin-to-skin contact, simultaneous breast milk pumping, comprehensive lactation programs, maternal participation in care and breastfeeding education for parents (Renfrew et al 2009, Chambers and McInnes 2008, WHO 2006).

The overall aim of the 'Right from the Start' strategy is to enhance breastfeeding support in Newborn Intensive and Special Care (NISC) at the Royal Women's Hospital. It is targeted towards all who play a role in the provision of care: policy makers, managers, educators, clinicians and support staff.

It provides a best practice model of care where proactive

and consistent support is provided for mothers of vulnerable infants in all the Women's services throughout the continuum of pregnancy, birth, postnatal, neonatal and post discharge periods.

Implicit in the strategy title are two major themes which form the foundation and the framework for supporting breastfeeding in NISC

1. Right support: right advice, right help, right information and right care at the right time.
2. Right from the start: right from the first time each woman receives care at the Women's, and from the moment her preterm or sick infant is born.

The strategy objectives, implementation actions and recommendations are divided into eight sections

1. Clinical practice
2. Effective support
3. Coordination and continuity of care
4. Parenting support
5. Environment
6. Transition to full breastfeeding
7. Transition to breastfeeding at home
8. Quality and research

This strategy has the potential to become a benchmark for enhancing breastfeeding support in neonatal settings nationally and internationally, thereby cementing the Royal Women's Hospital's reputation as a leader in the healthcare of women and their infants.

A number of initiatives have already commenced to improve breastfeeding support in NISC. Lactation consultants from BESS attend the multidisciplinary team meetings every week and are able

to discuss the feeding plans for all infants in the unit with the rest of the healthcare team. An implementation working group, entitled *Right From the Start* has been set up to guide and facilitate the implementation for the recommendations from the *Right From the Start* strategy.

Kaye Dyson
Breastfeeding Education and Support Services Team

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- Australian Health Ministers Conference. The Australian National Breastfeeding Strategy 2010–2015. Commonwealth of Australia 2009
- McInnes RJ, Chambers J. Infants admitted to neonatal units – interventions to improve breastfeeding outcomes: a systematic review 1990–2007. *Maternal and Child Nutrition* 2008; 4: 235–263
- Enhancing Breastfeeding in Newborn Intensive and Special care Project. Breastfeeding Education and support Service. Judith Russell 2009
- Right From the Start: Supporting Breastfeeding in newborn Intensive and Special care at the Women's. Judith Russell 2009

Biogrid Australia

Earlier this year a Grand Round presentation featured Biogrid Australia (BA). In response to requests for further information, Maureen Turner, General Manager of BA provided the following.

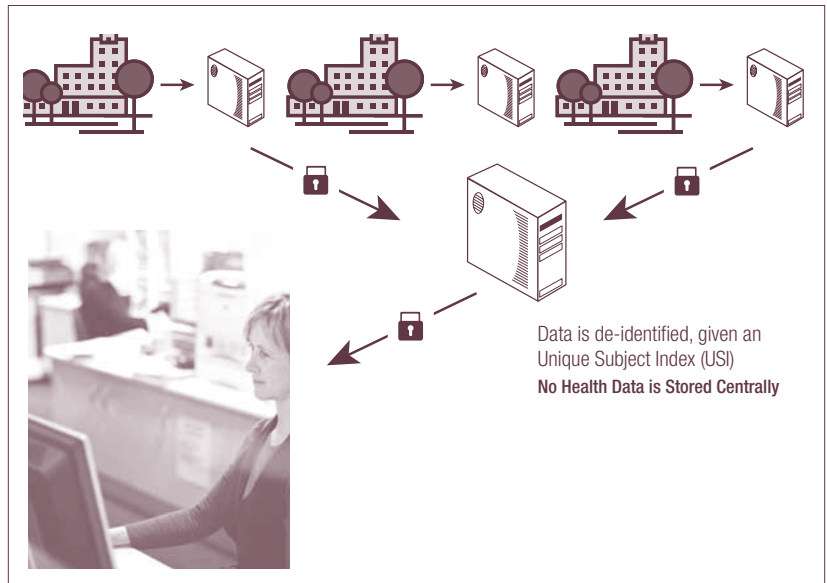
Funded by the Victorian and Australian governments and led by clinical researchers, BioGrid Australia began in 2003 with the aim to facilitate easier access to health data across multiple health institutions, geographic regions and diseases. This has been made possible through the establishment of a secure and privacy protected collaborative platform to improve health research outcomes.

BioGrid Australia, led by a consortium of 21 Australian health organisations, aims to promote collaboration in health research by providing a technology platform for the ethical integration of data.

Today, BioGrid is a not-for-profit data sharing technology organisation with a network across 36 hospitals and research institutes, BioGrid enables secure and ethically approved access to clinical and genetic data.

Through BioGrid, authorised health researchers access data on over 180,000 patients with approximately 4,500 data queries performed each month. Data is currently being collected for 14 Cancer streams, Diabetes, Epilepsy and Cystic Fibrosis.

Through the BioGrid platform, these patient data reside with each of the participating health organisations and can only be accessed remotely via a Federator,



as these health data is not stored centrally. As these data query is processing, these data is de-identified and given a unique number to secure patient privacy.

In order to access these data, researchers must obtain authorisation from these data custodians, the BioGrid Scientific Advisory Committee and the BioGrid Management Committee. Once authorisation is granted, data is accessed. Authorised researchers are then able to query and analyse these data using statistical analysis and query tools.

Connection across multiple sites has provided support for many publications and presentations such as:

- Referral practices for familial cancer¹
- Chemotherapy prescribing – appropriate dosing analysis and recommendations²
- Prediction of appropriate therapy using pharmacogenomics – epilepsy³
- Cost effectiveness of national bowel cancer screening program

In addition to establishing the health data network, BioGrid has developed a number of software applications to support health researchers with data collection and data management. BioGrid can also provide assistance with data analysis and report generation using SAS, SPSS and Stata.

BioGrid has facilitated successful research outcomes in the areas of quality audit, screening programs, understanding impact of lifestyle factors and co-morbidities, understanding psychosocial factors and the potential of consumer driven data collection through cart-wheel.org

The generation of a web-based Rare Tumour Database called cart-wheel.org (Centre for Analysis of Rare Tumours) for the first time provides an ethically approved portal for consumer-driven research into rare tumours and

molecular sub-types of common tumours, utilising the expertise and infrastructure of BioGrid Australia. This will serve as an outstanding tool to assist consumer participation in research, particularly as patients with rare tumours make up 20% of all cancers, 30% of all cancer deaths, yet receive less than 5% of research funding and have very few options for treatment and support.

In addition, cart-wheel.org has been designed to contribute substantially to molecular stratification of patients with common tumor types looking for or suitable for clinical trials of novel molecularly targeted therapeutics, a major challenge looking forward. The web-based format will allow patients and other health consumers and researchers equitable access to this international resource with flexible levels of involvement by consent.

This will provide the first international site for coordination of patient information, including clinical, histological and molecular data, with therapeutic implications. With funding from a Consumer Grant (Victorian Cancer Agency) and consumer involvement, cart-wheel.org including a data-entry questionnaire was launched on the 14th April 2010 by Professor Sir Gustav Nossal at Walter and Eliza Hall Institute of Medical Research. cart-wheel.org and BioGrid are currently working with consumer groups and researchers to ensure that this exciting resource contributes to improvements in outcomes for cancer patients.

The Principal Investigator of the cart-wheel.org Rare Tumour Database Project is Dr Clare L Scott MBBS PhD FRACP. Dr Scott is Cory Fellow and Laboratory Head, Walter and Eliza Hall Institute of Medical Research, Medical Oncologist at The Royal Melbourne Hospital and the Rare Tumour Stream Leader, BioGrid Australia. For more information visit www.cart-wheel.org or www.biogrid.org.au

Maureen Turner



**BIOGRID
AUSTRALIA**
Health through information



CART-WHEEL
Center for Analysis of Rare Tumors

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- 2 K Field, S Kosmider, M Jefford, R Jennens, M Green, P Gibbs. Chemotherapy treatments for metastatic colorectal cancer – is evidence-based medicine in practice? *Journal of Oncology Practice*, November 2008: 271–276
- 3 Petrovski S, Szoek CEI, Sheffield LJ, D'Souza W, Huggins R, O'Brien TJ. A multi-SNP pharmacogenomic classifier is superior to single SNP models for predicting drug outcome in complex diseases. *Pharmacogenetics and Genomics [JIF: 5.775]*, 2009; 19(2): 147–152

Upcoming Events

Alumni Event

On February 28th, the Women's Foundation will host a morning tea for staff alumni at the hospital. The event will include a showing of 'Our Hospital in Time and Place' and presentations from several senior Women's staff.

The Women's Foundation is actively seeking to engage staff alumni and provide resources for their interest. If you know of a former colleague who might like to attend this event or receive mail, including the Clinical Practice Review, from the Women's, please direct them to Dr Sarah White, Director of Communications (sarah.white@thewomens.org.au; 8345 2007).

Celebrating Anniversaries

There are two significant anniversaries to note in 2011. March 8th will be the 100th Anniversary of International Women's Day, a global day to recognise the economic, political and social achievements of women past and present.

In August, we will mark the 155th Anniversary of the Royal Women's Hospital. From its beginnings in a small house in East Melbourne to a \$285 million dollar hospital in Parkville, the Women's has played no small part in helping the women of Victoria through research, advocacy and advances in medicine.



Perinatal Psychotropic Medicine Information Service (PPMIS)



Swee Wong

Early this year the Department of Health called a tender to provide a specialised information service and resource to the healthcare professionals.

This new service aims to provide access to resources for prescribing of psychotropic drugs in the perinatal period. It is jointly funded by the Commonwealth and State Governments, as part of the National Perinatal Depression Initiative to improve detection of antenatal and postnatal depression and treatment for expectant and new mothers experiencing depression. The services will be managed by the Mental Health, Drugs and Regions Division of the Department.

The Pharmacy Drug Information Service at the Women's was successful in winning the tender to provide this specialised resource. The pharmacy department has been providing a drug information service for healthcare professionals and consumers for over 25 years. The current service, with equitable access across the state, provides advice to prescribers, other healthcare workers and consumers

regarding the use of medicines, including psychotropic medicines, during the perinatal period via:

- telephone
- email and
- web-link *Ask a pharmacist*

The service receives just under 4,000 calls a year from the various groups: Doctors (42%) Pharmacists (5%) Nurses/ midwives (14%) Public (39%).

Approximately 10% of these calls relate to one or more psychotropic drugs and these queries are further related to pregnancy (58%), lactation (40%) and other (2%).

The pharmacy department uses its expertise and specialist knowledge to publish the following resources, which have been available since the early 1990s and updated regularly:

- Drugs and Pregnancy guide
- Drugs and Breastfeeding guide

The current version is the combined publication *Pregnancy and Breastfeeding Medicines Guide* launched in early May 2010

This exciting new service, PPMIS will be guided by a steering group and will:

- develop and maintain a webpage with resources

for the management of psychotropic drugs used in the perinatal period through the Women's website. The information will include:

- collation of existing guidelines – locally, nationally and internationally
- current evidence-based information on management of psychotropic medicines in the perinatal period
- up-to-date resources with new evidence
- suggestions on how to find further information
- be an extension to the current drug information service and will include the access to expert advice of the issues surrounding psychotropic drugs in the perinatal period.

To support and complement the new PPMIS, the Centre for Women's Mental Health will also establish a service offering assessment for women who are taking psychotropic medicines and who are planning pregnancy.

The PPMIS Web site was launched on December 1st and is available at <http://www.ppmis.org.au>

Swee Wong

For any further enquiries regarding **Pharmacy news** please contact rwh.pharmacy@thewomens.org.au

Please let the editor have your views on the contents of this newsletter, or any other matters involving clinical practice which may be of interest to our readers. **Leslie Reti** at leslie.reti@thewomens.org.au

Hong Tran, Fellow, Quality and Safety at hong.tran@thewomens.org.au

For further information <http://www.thewomens.org.au> For intranet users <http://intranet.thewomens.org.au/qualityandsafety>