



THE WOMEN'S QUALITY ACCOUNT 2016



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

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24,000 INTERPRETER REQUESTS

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MEAGHAN'S STORY

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ABOUT THE WOMEN'S

The Royal Women's Hospital is Australia's first and largest specialist hospital dedicated to improving the health of all women and newborns. The Women's leads the way in women's and newborn healthcare and has advocated and advanced the issues of women's health in Australia for 160 years.

We are a high performing healthcare provider with a reputation for excellence and innovation. Located at two sites, Parkville and Sandringham, the Women's provides healthcare for local women and their newborns, as well as those with complex needs from throughout Victoria. As a statewide tertiary hospital, we have a unique role as a leader and advocate, sharing our expertise in specialist maternity, neonatal, gynaecology and women's cancer care across Victoria and beyond.

We are a major teaching hospital, internationally recognised for our research and a source of trusted health information for women and health professionals. The Women's is also a significant provider of

professional development and secondary consultations to midwives, nurses, general practitioners and other specialists. Many practitioners and researchers from around Australia draw on our specialist expertise in areas such as pregnancy and drug use, women's and newborn research, women's and infant mental health, and reproductive and sexual health.

The Women's is committed to the social model of health, which recognises that a broad range of environmental, socioeconomic, psychological and biological factors impact on health, and we have a range of distinctive programs and services, offering support to women beyond clinical interventions.

THE WOMEN'S DECLARATION

Our origins as the first hospital in Australia for women who were pregnant, vulnerable and often destitute and our long-standing commitment to evidence-based medicine have created a proud legacy of excellence in care for the most disadvantaged in our community.

This culture has endured through more than a century-and-a-half of transformations in health and healthcare, as well as major changes in the social, economic and legal status of women.

Our Declaration, which reflects the principles and philosophies fundamental to the Women's, captures the essence of who we are and what we do.



CHAIR AND CHIEF EXECUTIVE OFFICER'S MESSAGE

In this, our 160th anniversary year, we are proud to present *The Women's Quality Account 2016* (formerly our *Quality of Care Report*).

This report demonstrates our leading role as Australia's first and largest specialist public hospital dedicated to improving and advocating for the health of women and newborns, transforming treatment to meet changing demands and expectations, and ambitiously striving to always do better.

As one of Victoria's leading public health services, we view safety and quality improvement as a critical priority for our hospital, and for the system more broadly. We take very seriously our responsibility to be transparent and accountable and welcome the Quality Account process as an important public reporting mechanism. It allows us to communicate with our patients, consumers, and other health services about how we have performed and how we have worked to achieve improvement.

Our commitment to safe, high quality care is unwavering. In addition to effective governance, monitoring and evaluation of data, listening and responding to our patients' experiences of their care is vital to our continuous improvement cycle and core to our work.

Over the past year we, as an organisation, have been formalising our commitment to improving the patient experience and embedding this goal in all that we do. 'Creating an exceptional patient experience' has been mandated as a priority by the Women's Board and is the cornerstone of our *Women's Strategic Plan 2016–2020*.

We are now implementing a number of hospital-wide strategies to engage patients, families and staff with our patient experience model and reorient our culture, processes and systems so all aspects of our work adopt a patient-centred approach. The Quality Account process is a useful way for us to benchmark our current performance and track the success of our patient experience initiatives.

This document is different to those of previous years. To highlight the importance of transparency and accountability, all Victorian health services are now required to follow a new format that has an increased emphasis on quality and safety data and how it compares with peers and/or state indicators. We fully support this approach and we hope the information provided in this report equips our consumers, carers and the community so they can participate more actively in their care and our improvement initiatives.

We hope you enjoy reading *The Women's Quality Account 2016* and we look forward to receiving your feedback on how we can improve our service and meet the needs of our patients and the community.



Dr Sue Matthews
Chief Executive Officer, the Women's



Ms Lyn Swinburne AM
Board Chair, the Women's

YEAR IN REVIEW

In 2015/16 there were

9,395

babies born

83,147

women cared for

28,032

emergency visits

197,005

outpatient visits

1,712

babies admitted to intensive
and/or special care nursery

250,000

episodes of care

189

countries of origin of patients

90

languages spoken
by our patients

approximately

24,000

requests for interpreter services

69

different religious
beliefs followed



Discussing the individual needs of their patients are WIN Coordinator, Cherise Smith (seated) and Marita Walsh, a team manager with Maternity Services.

TAILORING CARE TO INDIVIDUAL NEEDS

As a tertiary hospital, the Women's has the unique capacity to care for women with very complex needs and we go to great lengths to ensure the safety, quality and experience for each and every one of them.

As part of this commitment, our Women with Individual Needs (WIN) clinic, provides midwifery and social work support to pregnant women who have a learning difficulty, acquired brain injury, or an intellectual, physical or sensory disability.

Believed to be the only clinic of its kind in Australia, WIN works closely with other hospitals and external services, to engage and assess the individual needs of each patient and respond accordingly.

For two of our recent patients, this involved sourcing special equipment, specific training of staff and an exceptionally strategic and multidisciplinary approach to their ante and postnatal care. This customised approach was developed in consultation with the women themselves and included their partners and the hospital, as well as external health care services and agencies involved in their care.

Alice*, from regional Victoria, has arthrogryposis multiplex congenital. Suzanne*, from Melbourne's west, has spinal muscular atrophy type 2. Both women had planned caesareans at the Women's and were extremely pleased to have experienced a birth with minimal stress and no unforeseen complications.

WIN Coordinator, Cherise Smith says that for Suzanne and Alice, as with all WIN patients, the team developed a

tailored plan for each of them to ensure smooth coordination of their care across multiple support agencies and health services, as well as with their families and personal support networks.

'It is all about meeting the individual needs of each patient. No two cases are the same but you gain a wealth of experience the more cases you deal with,' explains Cherise.

Many of the WIN patients have complex medical and support needs so numerous agencies are involved. As many as 10 different agencies can be represented at a meeting to coordinate care for one patient.

Cherise stresses the importance of listening to and considering the needs of each individual and making the necessary adjustments to ensure we provide the best possible care.

'It is all about meeting the individual needs of each patient. No two cases are the same but you gain a wealth of experience the more cases you deal with.'

'These women just want to be treated as mainstream patients who happen to have a special need, just like someone who may be seen through a specialist clinic for diabetes.'

The outcomes and quality of experience for these patients is like a building block. While each case is different, they help strengthen the professional relationships and inter-agency communication necessary for building a multidisciplinary approach.

** Names changed to protect our patients' privacy.*

ALICE'S STORY

Alice, who has arthrogryposis multiplex congenital, is a short stature person at just over a metre tall.

To ensure the best possible specialist care during her pregnancy, Alice was referred from rural Victoria to the Women's for regular consultations. From 29 weeks' gestation, Alice and her partner stayed at our family accommodation in Parkville to ensure easier access to the hospital.

The WIN team liaised regularly with several agencies including Alice's disability workers, and Yooralla occupational therapists specialising in the care of mothers and newborns who arranged specialised equipment including an electric bed that could be raised and lowered easily, a customised mattress to minimise pressure spots, and a wheelchair. The Women's organised a special shower mat for the family accommodation, a small item but of huge benefit, as well as food packages and assistance with transport costs and parking fees. Alice's partner was also accommodated in Alice's hospital room with some meals provided.

'The level of support and care was much more than I had expected and experienced at other hospitals. It was very good,' says Alice, who gave birth to her 2.4kg son at 36 weeks.

'For a disabled mother, however, and as my husband is my main carer, it would have been good if there had been even more support for him.'

SUZANNE'S STORY

Suzanne, who has spinal muscular atrophy type 2, has a full-time carer at home and required full nursing support for all her daily living needs during her stay at the Women's.

In Suzanne's case, the WIN team liaised with everyone involved in her care from ward and antenatal staff through to surgery staff and her carers at home. Several multidisciplinary meetings were held to ensure that Suzanne's needs were met and that all possible scenarios were anticipated and planned for.

Travelling to the Women's for antenatal visits was an enormous effort for Suzanne so the WIN team worked across the hospital to coordinate her medical appointments such as ultrasound, blood tests, physiotherapists and occupational therapy so they occurred on the same day.

Suzanne also benefited from WIN's outreach program in which patients are visited in their homes for child birth education and post natal visits.

During her early appointments, Suzanne felt there was miscommunication between her specialists and a lack of understanding of her condition and specific needs. However, this was rectified once the Women's consumer advocate provided support to Suzanne and worked with colleagues to improve information sharing and understanding of Suzanne's condition.

Having spent much time in mainstream hospitals due to her disability, Suzanne says she found her experiences with some staff patronising. Fortunately, she found that the midwives in general had a far better approach and understanding. As a result, all WIN staff have been asked to be more sensitive to the way in which they deliver care to patients, and how it can be perceived.

Overall, Suzanne said she appreciated the planning undertaken by the Women's for her stay and the multidisciplinary approach.

Marita Walsh, a team manager with the Women's Maternity Services, says the hospital took particular care in preparing for Suzanne's stay. A special hoist was organised for moving her between her wheelchair and bed and staff were specifically trained in its use. A room was made available to accommodate the hoist and other necessary equipment such as an electric wheel chair, commode chair and an additional bed for Suzanne's partner. To ensure continuity of care, a specific team was rostered so that Suzanne would have the same staff involved in her care throughout her stay.

Due to Suzanne's spinal atrophy and possible complications post anaesthetic, her caesarean section was coordinated with the availability of an intensive care unit bed at the Royal Melbourne Hospital. While Suzanne was at the Royal Melbourne post caesarean, her baby was cared for in the special care nursery at the Women's with midwives regularly taking her to her mother for bonding and breastfeeding.

Director of Quality and Safety at the Women's, Jill Butty says that, as a tertiary specialist hospital, the Women's often has challenging and complex caseloads.

'Every case is different. But the Women's strives to provide the best possible quality and safety of care for all patients. The experience and lessons learned from these cases build on an ongoing knowledge base for future complex cases.'

1. CONSUMER, CARER AND COMMUNITY PARTICIPATION

1.1 DOING IT WITH US NOT FOR US: STRATEGIC DIRECTION 2010–13: 'THE ORGANISATION ACTIVELY CONTRIBUTES TO BUILDING THE CAPACITY OF CONSUMERS, CARERS AND COMMUNITY MEMBERS TO PARTICIPATE FULLY AND EFFECTIVELY'.

The Women's engages patients and their families in multiple ways to help inform improvements to our service. Always striving for excellence, we are constantly drawing on feedback from sources such as the Victorian Healthcare Experience Survey (VHES), targeted focus groups, online surveys, and during leadership walkarounds where leaders ask patients about their care and seek input into how we can improve.

Healthcare organisations internationally have turned their focus and priority setting to the 'patient experience'. This follows a natural evolution of quality and patient safety and addresses the key aspects of quality from the perspective of patients and their families. On a daily basis, we demonstrate exemplary care and service excellence above and beyond, but we are not always consistent across the organisation. Our challenge is to create a culture and practices that consistently deliver an exceptional experience for every patient, every time, everywhere within our organisation. To that end, we launched a comprehensive patient experience program this year that aims to change the way we work with staff, patients and families to evaluate and improve the delivery of our care and services. The first stage of our Creating Exceptional Experiences Program includes a bespoke course for staff that integrates the voice of patients and their families through first-person patient experience videos. We listened to the stories of real patients and real families and used them to design a course that reflects how we can improve our care. Almost 400 staff have graduated from the course so far this year and our goal is to have full staff completion by 2020.

The Women's has a sustained history of consumer partnership with continuous evaluation in all areas of the organisation. Consumers attend and deliver presentations, as well as share their own individual stories at educational training sessions. Consumers from diverse clinical areas meet with us and provide meaningful feedback, ensuring staff are receiving input from a consumer's perspective. For example, the Reproductive Loss team has included consumers at training sessions for the past five years and consumers were included as co-speakers at our most recent international neonatal conference in November 2015.

The Women's Community Advisory Committee promotes improved outcomes for patients and the broader community through effective community participation and interaction with the hospital. The committee advises the hospital on establishing and maintaining effective systems to ensure that we meet the needs of the communities we serve, and that the views of women and their partners are integrated into our decision-making processes. This year, a father joined our Community Advisory Committee to better reflect the community we serve.

Our social media platforms are another effective community engagement mechanism and so too is our website, which attracts more than 7,000 visitors each day. Most of these visits are from clinicians looking to use our best practice guidelines, and consumers searching for health information from a trusted source.

1.2 PROVISION OF ACCREDITED INTERPRETERS

The Women's has a range of policies and programs that support the needs of our culturally diverse patients. Our Equity Strategy ensures that appropriate collection of data reflects the demographics of our catchment area and that we respond with improved programs, such as those for women affected by female genital mutilation, homeless women and those at risk of domestic violence.

Our patients come from 189 different countries and speak 90 different languages, highlighting the importance of the interpreter service at the Women's. We are constantly evaluating the interpreter needs of our community and continue to hire interpreters with new languages.

As reflected in our 2015/16 data in the accompanying table, we met the needs of 85 per cent of our patients who required an interpreter service.

INTERPRETER SERVICE 2015/2016

Number of patients who received an interpreter service	3,366
Number of patients who indicated they required an interpreter service	3,946
Percentage of patients requiring an interpreter service and who received one	85%

See 24,000 Interpreter Requests on page 10

1.3 PATIENT EXPERIENCE SCORE — VICTORIAN HEALTHCARE EXPERIENCE SURVEY

The Victorian Healthcare Experience Survey (VHES) collects, analyses and reports the experiences of people attending Victoria’s public healthcare services. Administered on behalf of the Department of Health and Human Services (DHHS), it is distributed to a small group of eligible participants who are randomly selected to receive a questionnaire. The survey is anonymous and is a valuable tool in measuring and reporting on the patient experience, contributing to the improvement of safety and quality of our healthcare.

The average rate of patients who chose to complete the 2015/2016 survey was just over 20 per cent, as indicated in the accompanying table. This represents less than one per cent of our total number of patients in that period.

Maternity patients (who comprise 40 per cent of our patient population) have not been included in the VHES in past years. The first survey of maternity patients was conducted in the January to March 2015 quarter. This information is now being used to inform our patient-focused Creating Exceptional Experiences Program currently being implemented across the hospital.

‘Our challenge is to create a culture and practices that consistently deliver an exceptional experience for every patient, every time, everywhere within our organisation.’

VHES 2015/2016

	Percentage of patients who said they had a positive experience	Response rate %
April to June 2016	90.7	18
January to March 2016	91.4	22
October to December 2015	93.2	20
July to September 2015	94.5	22

Examples of improvements

The Women’s Emergency Care (WEC) VHES results showed that we needed to improve our pain management. Our results for the question, ‘Emergency Department staff definitely did everything to manage pain’ was just 61.5 per cent in the January to March 2015 quarter. We subsequently undertook a focused initiative to improve the effective management of pain for WEC patients. As a result, our score improved to 82.3 per cent in the corresponding 2016 quarter.

The WEC initiative focused on reducing the wait time for patients presenting with moderate to severe pain (score of 6 – 10 out of 10). The December 2016 audit revealed that the timeliness of pain management was down to 39 minutes from previous audits of 83 minutes. The introduction of pain scores at triage began in March 2015 after comments from patients in the Victorian Patient Satisfaction Monitor revealed that pain relief was expected to occur in a shorter timeframe. This new system enables nurses and midwives to assess the pain scores and make recommendations for analgesia. Medical staff are then prompted to prescribe, based on the assessment by nurses and midwives and to facilitate the IV insertion for morphine when able.

We also saw in the VHES results, that we could improve our discharge processes.

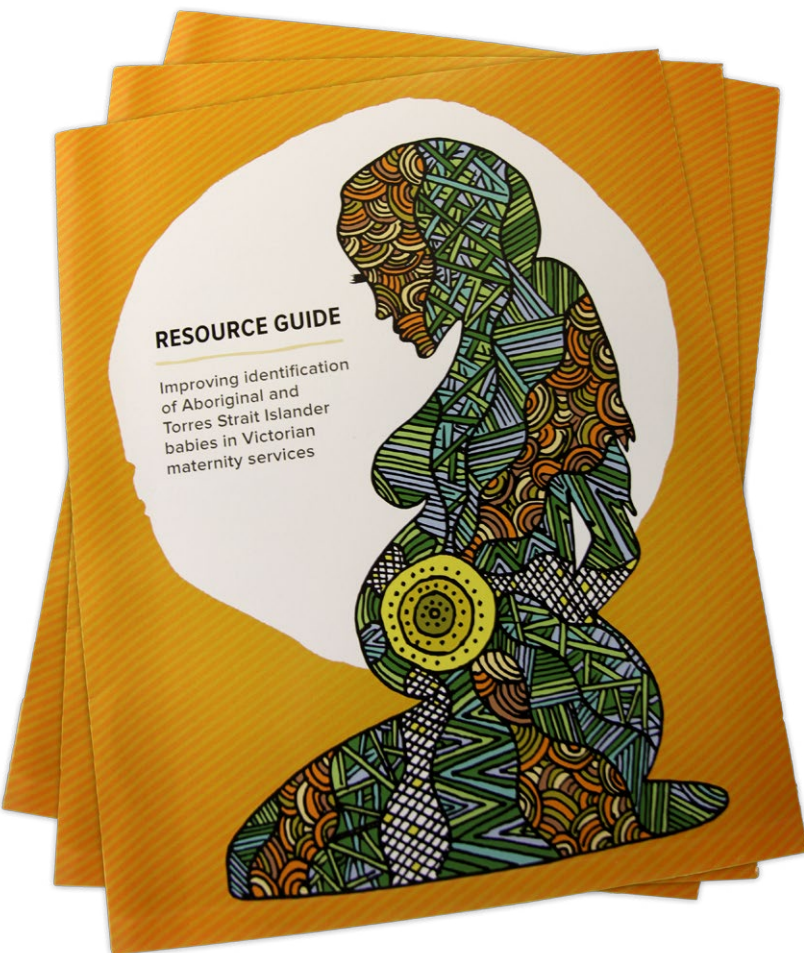
The time of discharge can be a stressful period for some patients and their families as there is a great deal to cope with and much information to absorb. The need for patients to understand the medications they are going home with is particularly important to ensure they continue their recovery after leaving hospital. If medications are taken incorrectly, patient safety is at risk. The Women’s undertook a pilot project in the Gynaecology Ward to improve our patients’ understanding of medications upon discharge. As a result, we have changed how pharmacists at the Women’s partner with medical, nursing and midwifery staff to help improve the overall discharge process. This has involved changing ward pharmacy hours so pharmacists can attend ward rounds to refine the prescribing and dispensing of medication and the provision of information for patients. Now, more prescriptions are being dispensed by the pharmacists before discharge at 10 am, reducing waiting times for discharge dramatically. In 2015, it took an average of just over two hours to resolve any issues with each prescription. This has been significantly reduced to an average of 14 minutes per prescription.

In January to March 2015, 85.4 per cent of respondents rated the discharge process as ‘very good’ or ‘good’. In the January to March 2016 quarter, this rose to 87.6 per cent.

1.4 IMPROVING CARE FOR ABORIGINAL PATIENTS PROGRAM

The Improving Care for Aboriginal Patients Program (ICAP) is an extension and enhancement of the Aboriginal Hospital Liaison Officer (AHLO) Program, established in 1982. ICAP builds on the work done by AHLOs across Victoria to improve the access of Aboriginal and Torres Strait Islander people to mainstream health services through accessibility and cultural responsiveness.

As a public health service providing care for Aboriginal and Torres Strait Islander people, there are four key reporting areas (KRAs) that provide evidence of our success. These include engagement and partnerships, organisational development, workforce development and systems of care.



The Resource Guide for helping to improve identification of Aboriginal and Torres Strait Islander babies is an important tool being used at the Women's. The Maternity Services Education Program at the Women's contributed to the development of the guide, a statewide initiative, together with the DHHS, VACCHO, AHLO, Koori Maternity Services and Aboriginal families and maternity clinicians across Victoria. The cover artwork is reprinted with permission from Shakara Montalto, a proud Gunditjmara woman and artist.

KRA 1 – Engagement and partnerships

The Women's has continued to establish and maintain partnerships, and engage and collaborate with Aboriginal organisations, Elders and Aboriginal communities in many ways. These include:

- developing relationships with Victorian Aboriginal Child Care Agency (VACCA) Lakidjeka to ensure effective engagement with DHHS for child protection meetings involving Aboriginal families
- strengthening relationships with VACCA Koori Connect to provide increased care for Aboriginal women and families with complicated pregnancies requiring lengthy inpatient stays
- participating in the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) ICAP forums; and developing relationships with workers from community and health services across Victoria
- strengthening relationships with Indigenous Hospitality House and William T Onus Aboriginal Hostel to provide accommodation to rural and interstate women attending the Women's for care, and their families.

KRA 2 – Organisational development

The Women's is committed to a culture that acknowledges, respects and is responsive to Aboriginality. We deliver culturally responsive healthcare through organisational development that includes management and operational staff, as well as culturally responsive planning, monitoring and evaluation.

This has been reflected in the following ways:

- Sorry Day commemorations at the Women's
- the launch, during NAIDOC week, of the Women's Aboriginal health videos which helped to identify Aboriginal health champions across the organisation and promote the work and relationships of Aboriginal and non-Aboriginal staff at the Women's

- development and implementation of the Women's Leave Policy that acknowledges and provides ceremonial leave to Aboriginal staff at the Women's
- an updated Welcome to Country Policy to ensure appropriate acknowledgements are made at meetings and in-services across the Women's
- presentation of a Grand Round seminar on Aboriginal health to acknowledge Reconciliation Day.

KRA 3 – Workforce development

At the Women's, workforce training, development and support is provided and appropriately targeted to Aboriginal and non-Aboriginal staff at all levels of our organisation. This includes strategies to support staff retention, professional development, on-the job support and mentoring, cultural respect and supervisor training.

Initiatives include:

- 'Healing the Spirit' cultural competency training provided by Aunty Robyn Nelson; and in-service training for areas with Aboriginal cadets and graduates before their placement
- professional development sessions as part of the Aboriginal nurse / midwife graduate program
- on-the-job support for Aboriginal graduates and cadets through our clinical education unit and dedicated staffing resources; a new Allied Health cadet role; and priority placements to support Aboriginal students of midwifery and nursing to complete their studies
- hosting a program for six nursing and midwifery students and employment of four Aboriginal undergraduate nursing and midwifery cadets; and support for Aboriginal cadets and graduates to present at international conferences.

KRA 4 – Systems of care

The Women's provides culturally competent healthcare and a holistic approach to health for Aboriginal patients with regards to 'the place of family'. Our culturally responsive healthcare supports access, assessment, care planning, patient support, discharge planning, referral, monitoring and recall processes.

Initiatives include:

- The creation of a shared-care model and the identification of key contact points between the Victorian Aboriginal Health Service (VAHS) and the Women's to provide a clear pathway for culturally appropriate care for Aboriginal women. In addition, we liaised with the VAHS Family Wellbeing Program to provide women and their families with material aid and transport.
- The development of a partnership with Mallee District Aboriginal Service to ensure shared-care is available for rural Aboriginal women and their families.
- The creation of a co-managed service between Ngwala Willumbong Co-operative and the Women's to improve the coordination of care for Aboriginal women attending both Ngwala and the Women's.
- The establishment of a research relationship with VACCHO. 'Improving the health of Aboriginal mothers and babies through continuity of midwife care' aims to bridge the gap between existing community-based care for Aboriginal women and the care women receive in hospital. The goal is to have a known midwife care for all Aboriginal women having babies at the study sites.

- The continuation of the Women's Koolin Balit project, in partnership with VAHS, VACCHO, Njerna Aboriginal Co-operative, DHHS and Koori Maternity Services. This work aims to increase awareness among pregnant Aboriginal women of the harms associated with drug use during and after pregnancy and to develop the capacity of services to support Aboriginal women to better understand and manage the impact of their drug use on their health, and that of their babies.
- The involvement in 'Cultural Safety in Maternity Care workshops' at three regional/rural maternity services that were facilitated by the Maternity Services Education Program based at the Women's, the Paediatric Infant Perinatal Emergency Retrieval Service (PIPER) and VACCHO.
- The continuation of our Aboriginal Newborn Identification Project with a focus on reviewing and improving our ability to support Aboriginal and Torres Strait Islander mothers by educating and resourcing medical and nursing staff to 'ask the question'. We have introduced cot cards and posters to aid identification and enhance our ability to make referrals to appropriate services.
- The development of a caseload midwifery program for Aboriginal and Torres Strait Islander women in partnership with La Trobe University. This \$5 million project has been funded by the National Health and Medical Research Council, the Women's, the VACCHO, the Mercy Hospital, Sunshine Hospital and Goulburn Valley Health.

24,000 INTERPRETER REQUESTS



Originally from Ethiopia, Emebiet Haftetsien would be 'lost' without the assistance of interpreters such as Etyنش Brha.

With an amazing team mirroring Melbourne's rich cultural diversity, our Interpreter Service plays an important role in our hospital and is one of the exceptional experiences we deliver at the Women's, with up to 100 service requests per day and between 20,000 to 24,000 per year.

In 2015/2016, our patients originated from 189 countries and spoke 90 different languages. Amongst such a diverse group of women, some are likely to feel vulnerable by simply being in a hospital environment and this can be further compounded by language and communication issues.

The Interpreter Service at the Women's has 20 talented interpreters (permanent and casual) who facilitate communication between patients, clinicians and other staff. Our in-house interpreters can interpret in 16 languages, but this figure increases to more than 80 with the help of agency interpreters including face-to-face and telephone interpreters from Victoria and interstate.

The main requests are for Arabic interpreters, with Chinese (both Mandarin and Cantonese) and Vietnamese jostling for second ranking, followed by Greek, Hindi/Urdu, Amharic Turkish, and Italian.

Our Interpreter Service manager, Poni Poselli has noticed the emergence of diverse African languages in recent years, and an increase in young, expectant women needing interpreter services, reflecting the changing demographics of the Women's local catchment area.

'I would be "lost" without an interpreter,' says expectant mum Emebiet Haftetsien from Ethiopia with the assistance of Women's interpreter Etyنش Brha. 'Many times I can't explain things to the doctor or midwife and they can't talk to me, so having Etyنش means I can understand what is happening and communicate what I need to say... it is less stressful. It is a good service.'

Emebiet has developed a special relationship of trust with Etyنش who also interpreted on her behalf when her first child was born at the Women's.

Initially trained in animal husbandry and nutrition in her homeland of Ethiopia,

Etyنش has been working as an interpreter for about 15 years. She is nationally accredited and is continuously upskilling to keep up-to-date with her understanding of medical terminology and procedures to ensure accuracy in her work.

'It is so rewarding being a "voice" for our patients who come from so many different countries,' says Etyنش, adding that no two days are the same given the diverse needs of patients requiring interpreter services.

Poni believes she is privileged to be managing such a professional and dedicated group of interpreters who are all accredited with NAATI, the National Accreditation Authority for Translators and Interpreters.

'The women who come to us — as well as clinicians and other hospital staff who need to be able to effectively communicate with patients - really benefit from having such a wonderful and valuable service available to them.'

Given the diverse backgrounds of our interpreters, their own cultural richness and colour are woven into the fabric that makes the Women's so special.

2. QUALITY AND SAFETY

2.1 FEEDBACK AND COMPLAINTS

The Women's aims to provide our patients with the best possible care at all times and we always welcome feedback. This helps us to continually improve our services by increasing our understanding of what works for our patients and their families and what might need to change.

We have a number of mechanisms through which our patients and consumers, past and present, can provide feedback about their care and our services. These include:

- **Consumer advocates**
Clearly promoted on our website and across the hospital, our consumer advocates are available to all patients at the Women's and can be contacted via the telephone, email or mail. Patients are assured that the details of their complaint/s are not included in their medical record and will not affect their care or treatment in the hospital. Our consumer advocates are impartial and actively listen to feedback and discuss any complaints or concerns patients and family members might have, no matter how big or small. The advocates offer support by confidentially discussing and investigating concerns, and helping to resolve any problems. If patients have tried to resolve their complaints with us, but are not satisfied, our consumer advocates refer them to the Health Services Commissioner.
- **Digital channels**
Our website invites the community to make contact via a user-friendly online form. Social media channels such as Facebook are popular mechanisms for patients to provide feedback. In most cases, feedback is positive and is forwarded to relevant staff. Other comments and enquiries are always acknowledged and directed to relevant areas of the hospital for an appropriate response.
- **'Have your say' at the Women's**
'Have your say' is a closed digital platform that engages our patients and consumers to provide comments and feedback on specific topics and is a tool that enables us to test new ideas and initiatives with members of the community.

The number of complaints/feedback received by the Women's in 2015/2016 was 838. Of these, 1.67 per cent (14) were referred to the Commissioner. This compares with 670 and 1.49 per cent (10) in the previous year and 591 and 0.84 per cent (5) in 2013/2014. The increasing trend is due to a statewide initiative to actively encourage patients and consumers to provide feedback to help inform improvements to Victoria's healthcare sector.

Example of improvements

The Women's received feedback from several patients on our maternity wards that they were unable to spend as much time as they would like resting or with their babies and families. This was due to the number of clinical staff, volunteers, meals and cleaning staff frequently entering their room. Our maternity ward managers took this on board and worked with colleagues to change the culture on the ward. This included limiting access to patient rooms post-birth to essential staff only and the use of simple 'do not interrupt' signage on doors. Staff and visitors now think twice before entering a room and disturbing the woman and her family.

Another example of improvement is a reduction in the number of 'no shows' for day surgery. An audit of day surgery cancellations had found that of the 180 patients who postponed their surgery within seven days or less, 121 had not made contact to confirm

the new date for surgery. At the time, the process for confirmation of surgery involved the triage nurse contacting all patients the week before they were scheduled to ensure attendance. This task was time consuming and caused short-notice cancellations that were often too late to fill from the waiting list.

At a leadership walkaround, a triage nurse suggested to the Chief Executive Officer that the bookings office send text message reminders to patients listed for surgery. The bookings office trialled the idea by sending text messages to all patients scheduled for surgery in a specific week. By the Friday before the week of surgery, all but three patients had confirmed. During the trial week, no patients postponed their surgery or failed to attend on the day. The Women's now sends text messages to patients the Monday morning before the week of their surgery.

2.2 PEOPLE MATTER SURVEY

The People Matter Survey is an employee opinion survey conducted by the Victorian Public Sector Commission. It provides organisations like the Women's with an indication of what is important to its workforce and how they perceive the quality and safety culture. The response rate for the 2016 People Matter Survey at the Women's was 30 per cent.

Patient safety score above state average

The Women's had a positive patient safety score in the 2016 People Matter Survey, with a higher overall result than the average for our peer health organisations. Our patient safety score was 75 per cent compared with the statewide average of 74 per cent.

The Women's is addressing our lower scoring areas through a number of initiatives including improved patient safety training of new and existing staff, and increased supervision of trainees.

2.3 POSITIVE WORKPLACE CULTURE AND PREVENTION OF BULLYING AND HARASSMENT

The Women's has maintained a consistent result in the percentage of staff who reported personally experiencing bullying at work during 2015/2016.

In the past 12 months, 18 per cent of staff respondents reported they had personally experienced bullying at work, compared with an average of 20 per cent for our peer healthcare organisations.

Prevention of bullying in the workplace

The Women's takes very seriously the issue of workplace bullying and harassment. In 2015/16, a staff Mental Health and Wellbeing Plan was incorporated into the annual Occupational Health and Safety Plan. Our Occupational Health and Safety Plan is monitored by the Women's Consultative Occupational Health and Safety Committee, which meets quarterly.

Our anti-bullying and harassment strategies include:

- Broad communication of staff health and wellbeing information and support. This includes the creation of dedicated health and wellbeing pages on our intranet and a staff event during Health and Wellbeing Week in August 2015. The intranet materials promote self-management of mental health and wellbeing and provide easy access to useful information including details of support services available for staff.
- Delivery of three training sessions for supporting managers in relation to mental health in the workplace. These sessions were facilitated by the Women's Employee Assistance Program (EAP) provider. Fifty-five managers completed the training in 2015/2016 and further sessions are scheduled for 2016/2017.

2016 PEOPLE MATTER SURVEY STAFF RESPONSES TO PATIENT SAFETY QUESTIONS

	'Agreed' %	State average %
Patient care errors are handled appropriately in my work area.	78	76
The health service does a good job of training new and existing staff.	73	66
I am encouraged by my colleagues to report any patient safety concerns I may have.	82	83
The culture in my work area makes it easy to learn from the errors of others.	68	68
Trainees in my discipline are adequately supervised.	65	64
My suggestions about patient safety would be acted upon if I expressed them to my manager.	74	77
Management is driving us to be a safety-centred organisation.	75	77
I would recommend a friend or relative to be treated as a patient here.	85	80

- Continued provision of the EAP Manager Assist Program. This is a one-on-one external service that provides support to managers on staff management issues including health and wellbeing. The utilisation rate for the EAP in 2015/2016 was 5.31 per cent, an increase of 1.33 per cent over the previous year.
- The launch of our Contact Officer Program, an integral part of the Women's Respectful Workplace Behaviours Program. Our contact officers support and assist staff so they are aware of the options available in relation to workplace conflict and potential bullying and harassment concerns. Twelve contact officers have been appointed and have attended training with the Victorian Human Rights and Equal Opportunity Commission. This program has been promoted through *Inform*, our regular online staff newsletter, and also at staff training sessions. A dedicated intranet page has been created and includes information and contact details for the officers. In June 2016, recruitment commenced for five more contact officers.
- Face-to-face and online mandatory training has continued and is monitored and reported to the Executive to ensure compliance rates are met across the hospital. The completion rate for Respectful Workplace Behaviours Program as at 30 June 2016 was 83 per cent.

2.5 ACCREDITATION STATUS

The Women's was surveyed in March 2015 under the EQulP National Program which includes the national standards from the Australian Commission for Safety and Quality in Health Care. We received full four-year accreditation with a small number of recommendations that required follow up and further work. As part of our ongoing accreditation requirements, the Women's submitted a self-assessment report to the Australian Council on Healthcare Standards (ACHS) in May 2016.

2.6 ADVERSE EVENTS

The nature of work in hospitals is inherently risky and the Women's strives to always deliver the best possible and safest care for all patients. When incidents do occur, however, it is important that we learn from them to reduce the chance of them happening again. We have a process for identifying and mitigating risks, reporting and investigating incidents and learning from them in order to prevent any recurrence.

In the case of serious incidents, the Women's conducts an in-depth review. This involves a range of clinicians with relevant knowledge and expertise who conduct a formal review into how and why the incident occurred, and where possible, make recommendations to prevent any recurrence.

A defined list of sentinel events (ISR1-rated events) is reportable to DHHS and requires the completion of a root cause analysis within two months of the incident. We conduct a root cause analysis of all ISR1-related events to ensure they are investigated thoroughly.

These root cause analyses are undertaken by a multidisciplinary team including clinicians, person/s with knowledge of the affected system or department and, in some instances, external experts. At the Women's, we always include clinicians who were and were not involved in the event. The focus of the analysis is to identify process and system issues that we can improve, not to interrogate or blame individuals.

Less serious incidents may undergo an in-depth review, which identifies issues where improvements could be made. These usually identify practical recommendations that are monitored as part of clinical management and by our Quality and Safety Committee.

A thorough and rigorous review is useful in providing feedback to staff, and answering questions that the patient and her family may have. This method provides a transparent and fair process for reviewing adverse events as well as medico-legal assurance and comprehensive documentation that can be used to improve our systems and processes.

'...the Women's strives to always deliver the best possible and safest care for all patients.'

2.7 QUALITY AND SAFETY INDICATORS

At the Women's, quality improvement is an ongoing priority that helps us enhance patient care, achieve better clinical outcomes and increase patient satisfaction. The Women's collects many indicators to inform us about our quality and safety. To ensure transparency, we report publicly the following: medication safety; falls; pressure injuries; preventing and controlling healthcare-associated infections, specifically intensive care unit central line-associated blood stream infections and the *Staphylococcus aureus* bacteremia (SABs) rate; and safe and appropriate use of blood and blood products.

Medication safety

The use of medication is the most common intervention in healthcare. Medicine misuse, under or over use and adverse reactions result in an estimated 140,000 hospital admissions annually in Australia. Most adverse drug events are preventable.

At the Women's, we monitor, report and investigate all medication errors to try to prevent them recurring. We have a low rate of medication errors that cause harm to the patient compared with the benchmark for peer hospitals.

The Women's rate for July-December 2015 was 0.02 per cent compared with the DHHS benchmark of 0.04 per cent. This is reflected in the accompanying table for clinical indicator 6.3 (medication errors/adverse events requiring intervention) reported to the Australian Council on Healthcare Standards (ACHS). The Women's had an even lower rate of 0.01 per cent for the first half of 2016



A nurse double checks the identification and allergy wrist bands of a patient before administering her medication.

**CLINICAL INDICATOR 6.3
MEDICATION ERRORS/ADVERSE EVENTS REQUIRING INTERVENTION 2015/2016**

	Women's Jul-Dec 2015	ACHS public hospital peer comparison Jul-Dec 2015
Number of medication errors resulting in an adverse drug reaction requiring intervention beyond routine observation and monitoring	7	
Number of occupied bed days	40,371	
Rate %	0.02	0.04

Falls

Falls-related injuries are one of the leading causes of morbidity and mortality in older Australians. More than 80 per cent of injury-related hospital admissions in people aged 65 years and over are due to falls and falls-related injuries.

The Women's has a low rate of falls and a very low rate of falls-related injuries due to our patient population, which comprises a high percentage of young and relatively fit women.

Our total number of patient-related falls in 2015/16 was 48 (0.5 per 1000 bed days). None of the falls reported resulted in serious harm to the patient. However, such incidents are always a concern for us and we have implemented a number of strategies to reduce them.

These strategies include:

- reviewing and upgrading equipment, for example, new recliners in Day Surgery to reduce the risk of falls post operatively
- creation of a Patient Injury Falls and Faints Committee that reviews incidents bimonthly (patient and staff), reports on audits, and discusses and acts upon new and emerging risks across the organisation
- ongoing review of the Falls Prevention and Management Guideline
- ongoing staff education
- improved incident reporting in 2015/2016 with the introduction of mandatory fields in relevant reporting documents specific to falls injuries
- clinical audits to determine barriers to following process, and to identify changes to the system that may improve outcomes
- patient and family education whilst in hospital.

Pressure injuries

Pressure injuries are a major contributor to the care needs of patients within the health industry. Pressure injuries can occur in any patient with any or all of the associated risk factors. Risk factors are not restricted to decreased mobility, but also include nutritional status, skin integrity, age and the level of oxygenated blood supply to pressure points.

A pressure injury can occur in children and adults and in any setting, including acute areas such as operating theatres and intensive care units. In the majority of cases, pressure injuries are preventable.

At the Women's in 2015/2016, the total number of pressure-related incidents was 71 (0.77 per 1000 bed days). Eighty per cent of these were reported from Neonatal Services where such injuries result from the use of nasal prongs to ensure our premature babies receive sufficient oxygen. Pressure injuries are classified by how serious they are and the impact they have on the patient. The classification has four stages with Stage 1 being the least serious. No Stage 3 or Stage 4 pressure injuries were reported at the Women's in 2015/2016.

The following initiatives are in place to reduce pressure injuries:

- Continuous Positive Airway Pressure (CPAP) working group looking at strategies to reduce CPAP-related pressure injuries
- patient identification (ID) working group implemented new thermal printed ID bands for babies and comfy cuffs for micro-premature babies
- clinical audits to determine barriers to following process, and to identify changes to the system that may improve outcomes
- ongoing staff and patient education
- improved incident reporting in 2015/2016 with the introduction of mandatory fields in relevant reporting documents specific to pressure injuries
- timely reconciliation of coding data.

Infection prevention and control

At least half of healthcare-associated infections are considered to be preventable. Australian and overseas studies have shown that mechanisms exist to reduce the rate of infections caused by healthcare. Infection prevention and control practice aims to reduce the development of resistant infectious agents and minimise the risk of transmission through isolation of patients with infectious agents. However, just as there is no single cause of infection, there is no single solution for prevention. Successful infection prevention and control practice requires a range of strategies across the healthcare system.

Neonatal central line-associated bloodstream infection

At the Women's, our sickest babies are treated in neonatal intensive and special care nurseries. They sometimes require a long-term intravenous catheter to allow us to administer fluids, medications and blood products. The longer the catheters are in place, the higher the risk of infection.

Data for neonatal central line-associated bloodstream infection (CLABSI) are collected, reviewed internally and submitted quarterly to Victorian Healthcare Associated Infection Surveillance System (VICNISS).

As reflected in the accompanying table, the Women's had low rates of central line-associated bloodstream infections in 2015/2016 and was below the VICNISS five-year aggregate for all Neonatal Intensive Care Unit babies.

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION RESULTS 2015/16					
Baby weight	<750g	751-1000g	1001-1500g	1501-2500g	>2500g
The Women's central line infection rate	2.5	1.2	0.0	0.0	0.0
VICNISS five-year aggregate	3.7	2.2	1.3	2.5	1.1

Infection rate = CLABSI per 1000 central line days

Staphylococcus aureus bacteremia (SABs)

Staphylococcus aureus, or *S. aureus*, is a common bacterium that lives on the skin or in the nose. It is also called golden staph and in most situations it is harmless. However, if it enters the body through a cut in the skin, it can cause a range of mild to severe infections that may cause death in some severe cases.

Hospital patients are more likely to be infected by golden staph because of surgical or other wounds. These people can become seriously ill if their golden staph infections resist treatment from most types of antibiotics, and they may require isolation from other patients.

Standard hygiene practices can help to prevent this and the following are undertaken by hospital staff at the Women's:

- always washing hands when they are soiled for any reason
- using an alcohol-based hand rub solution (with or without chlorhexidine) between patients when taking observations such as pulse and temperature, bed making or performing other similar duties

STAPHYLOCOCCUS AUREUS BACTEREMIA (SABs) 2015/2016			
	Number of SABs	Occupied bed days (OBD)	Rate per 10,000 OBD
The Women's 2015/2016	2	52,626	0.4
DHHS Statement of Priorities target			< 2
VICNISS 5-year aggregate (n=66)	1,790	18,329,796	1.0

- washing hands before, and after, performing procedures on patients
- wearing gloves, gowns and masks if necessary
- handling used equipment and laundry with care
- isolating infected patients when required
- thoroughly cleaning all surfaces
- wearing pins that say, 'It's OK to ask if I have washed my hands' to ensure patients and their families are partners in their care.

The Women's carefully monitors and treats any patients with *S.aureus* bacteremia. In the past year the Women's had a very low rate of *S. aureus* bacteremia infections which put us well below the DHHS target. These results are reflected in the table above.

Safe and appropriate use of blood and blood products

Blood and blood products are a vital resource, provided by the Australian Red Cross Blood Service and funded by the National Blood Authority.

While the use of blood and blood products can be lifesaving, there are also risks associated with their administration. The Women's has a Transfusion Committee that reviews current practice, assesses risks, identifies opportunities for improvement, implements practice improvement and measures the results.

Transfusion-related events are one of the measures the Women's uses to determine patient safety. Incidents or reactions that are of a serious nature are reported to DHHS in a 'deidentified' fashion through the Blood Matters Serious Transfusion Incident Reporting (STIR) system which is a central reporting system for serious adverse events involving the transfusion of fresh blood or blood components.

The following table includes the number of transfusion reactions the Women's reported to STIR for 2015/2016.

TRANSFUSION REACTIONS AT THE WOMEN'S 2015/2016

Confirmed reactions reported to STIR	2
Number of transfusion episodes	934
Rate %	0.02

The Women's rate of reactions was well below the Australian Council on Healthcare Standards (ACHS) benchmark of 0.18 per 100 transfusions. (Source: *Australasian Clinical Indicator Report 2007–2014*).

2.8 HAND HYGIENE COMPLIANCE AND INFLUENZA IMMUNISATION

Hand hygiene and influenza immunisation are important for patient safety. All staff at the Women's are regularly informed of the importance of hand hygiene and the benefits of flu immunisation through seasonal campaigns, mandatory training, and on-the-ward reminders.

Hand hygiene targets and results

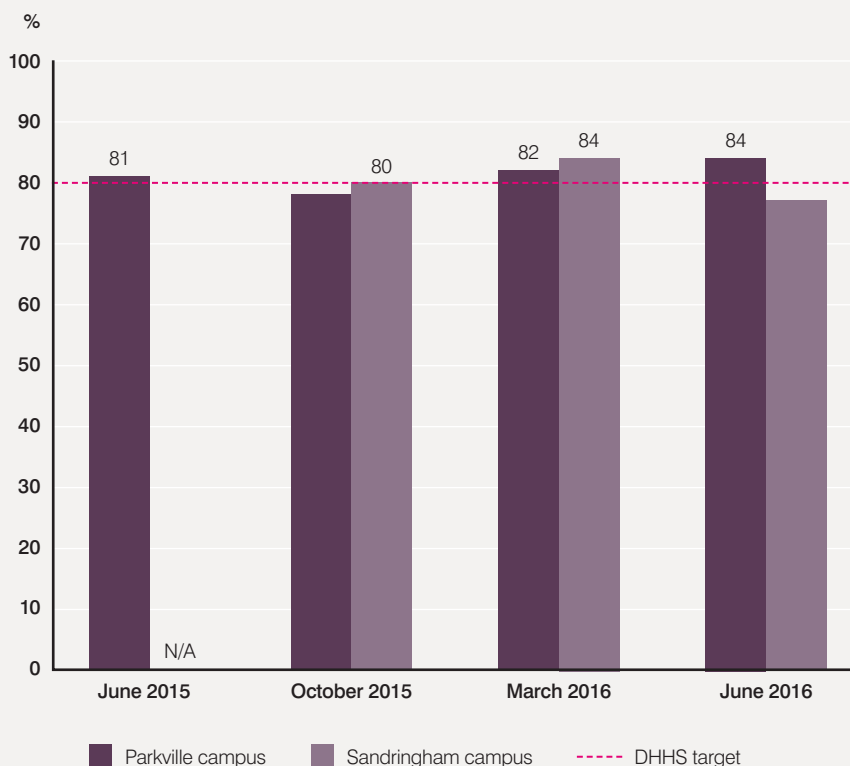
Contaminated hands can easily cause the spread of infectious diseases from one person to another. Correct hand washing — hand hygiene — is critical in a hospital setting and can help prevent the spread of germs, like bacteria and viruses, that cause disease. The DHHS recommended minimum compliance target for Victoria was 80 per cent for the whole of 2015/2016. The national target was 70 per cent.

Our Parkville campus achieved its highest rating of 84 per cent for hand hygiene compliance in the final quarter of 2015/2016.

At Sandringham, we did not meet the 80 per cent DHHS benchmark for the last audit period, although previous results were above target. An improvement plan has been developed to address this and includes:

- reviewing the placement of alcohol hand rub
- providing on-the-spot education and guidance during the auditing process
- the training of two hand hygiene champions to assist with onsite education and auditing of staff
- monthly visits of our Infection Prevention and Control team to support our Sandringham staff.

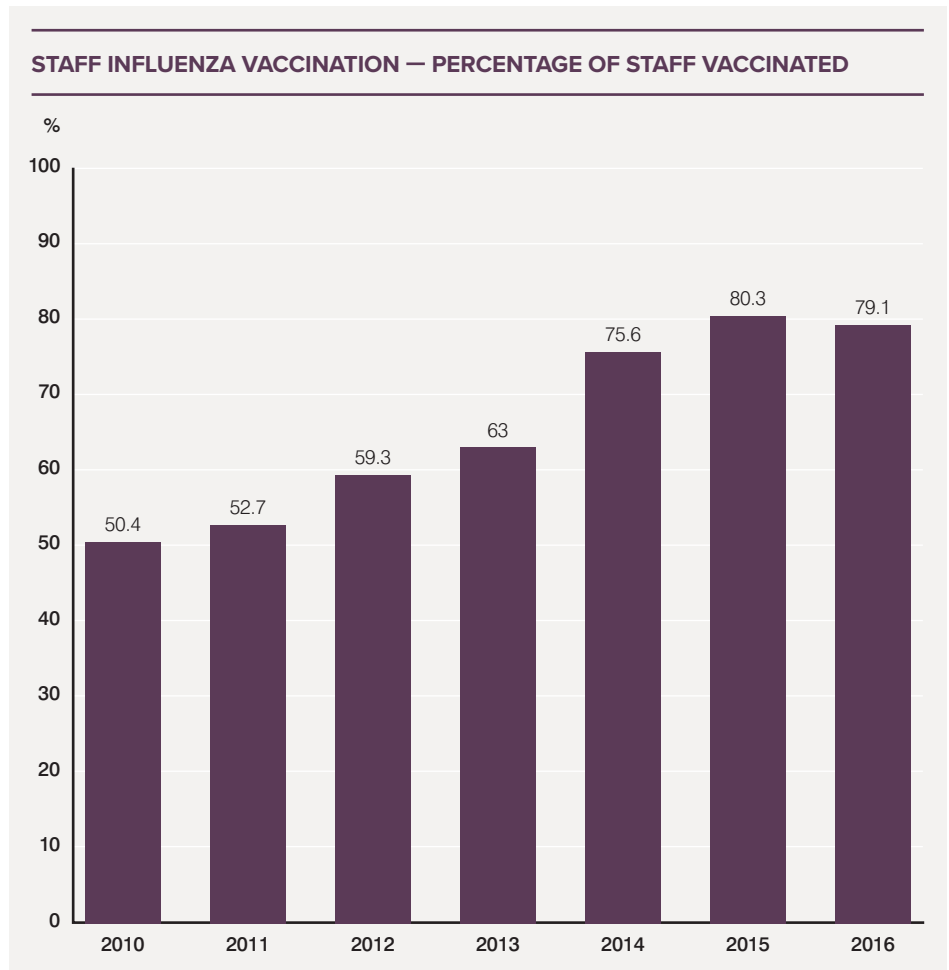
HAND HYGIENE COMPLIANCE 2015/2016



Staff influenza immunisation

Influenza or flu vaccines protect against influenza viruses. As a hospital that cares for the most vulnerable in our community, we strongly encourage our staff to help protect those we care for, as well as our workforce.

The DHHS sets a target of 75 per cent compliance for influenza vaccination. Our 2016 staff influenza campaign was conducted from 18 April to 19 August with an achievement rate of 79.1 per cent across both our campuses at Parkville and Sandringham. More than 200 staff attended the first session.



More than 200 staff attended our first immunisation session for the year.

2.9 VICTORIAN PERINATAL SERVICES PERFORMANCE INDICATORS

Our perinatal area collects many indicators to tell us how we are tracking on patient safety. For this report, the DHHS requires that public health services report against at least two 2013/2014 Victorian perinatal services performance indicators.

The Women's has chosen to report on two indicators that reflect both quality and safety:

- Indicator 1c: the rate of third and fourth degree tears in standard primipara giving birth vaginally; and
- Indicator 8a: the rate of breastfeeding initiation for babies born at 37+ weeks' gestation.

Indicator 1c – Rate of third and fourth degree tears in standard primipara giving birth vaginally

In obstetrics, a perineal tear is a spontaneous (unintended) laceration of the skin and other soft tissue structures that occurs in women as a result of vaginal childbirth. Tears vary widely in severity. The majority are superficial and require no treatment, but severe tears that are classified as third and fourth degree can cause significant bleeding, long-term pain and/or dysfunction. The rate at the Women's is higher than the State average and has led to the development of a working party to review the overall care for vaginal births.

A standard primipara refers to a woman aged 20 to 34 years who is giving birth for the first time and who is free of medical complications. The woman is pregnant with a single baby that is growing normally and is born head-first between 37 and 40 weeks' gestation. This indicator focuses on low-risk, uncomplicated pregnancies, where the rate of complications during labour and birth is expected to be low.

In 2013-2014, the Women's rate for third and fourth degree perineal tears in the standard primiparae was 6.1 per cent compared to the State average of 5.7 per cent.

Over the past five years the Women's has worked successfully to reduce the rate of third and fourth degree perineal tears for all women having a vaginal birth, not just those defined as the 'standard primiparae'. The rate has decreased from 4.6 per cent in 2010 to 3.5 per cent in the first six months of 2016.

Despite the decrease, we have still received complaints from patients concerning their care after experiencing a third or fourth degree tear. In fact, our Creating Exceptional Experiences Course uses the voice of women and their families to show the impact our care has on them. One of those stories (*Meaghan's Story*) is from a woman who experienced a 4th degree tear. Her story is shared with staff in the course, to allow them to reflect on how we could improve. As a result a working group has been formed and is reviewing the feedback from our women to make further improvements.

📖 See *Meaghan's Story* on page 20.

Indicator 8a – Rate of breastfeeding initiation for babies born at 37+ weeks' gestation.

In line with the World Health Organisation, the Women's promotes breast milk as the best source of food for the healthy growth and development of infants, providing protection from illness and death due to infectious and chronic diseases later in life. We strongly encourage breastfeeding through a number of support initiatives.

At the Women's, 96.8 per cent of women initiate breastfeeding (for babies born at 37+ weeks' gestation), compared with the State average of 94.2 per cent.

As distinct from 'breastfeeding initiation', an 'exclusive breastfeeding' rate of 75 per cent from birth to discharge for women with healthy term infants is part of the international Baby Friendly Hospital Initiative benchmark for hospitals providing maternity care. This benchmark includes all women who give birth at the organisation (not just those choosing to breast feed) regardless of the level of acuity.

Hospitals can apply for special consideration if they can demonstrate that clinical or cultural circumstances are a barrier to achieving the rate.

As a tertiary referral hospital, our Parkville site has significant challenges in meeting the 75 per cent exclusive breastfeeding target for the following reasons:

- High risk pregnancies and subsequent birth interventions are associated with significant breastfeeding challenges (for example, complicated pregnancy, diabetes, maternal mental health, poor obstetric history, delay in first feed) and lower breastfeeding rates.
- Low socio-economic status and education, smoking and high maternal body mass index are associated with lower breastfeeding intention and poorer breastfeeding rates, both in terms of initiation and duration. Our Parkville campus builds on the ethos from which the hospital was formed — to care for the most disadvantaged women.
- Breastfeeding rates at Sandringham are likely to be higher due to a higher socio-economic population and lower obstetric risk.

Our Parkville site will reapply for Baby Friendly Hospital Initiative accreditation in late 2016 and our Sandringham campus will apply for the first time.

2.10 VICTORIAN AUDIT OF SURGICAL MORTALITY

The Women's has not received a report from the Victorian Audit of Surgical Mortality for the 2015/2016 reporting period as our level of mortality is below the feedback threshold.

MEAGHAN'S STORY

In 2015/2016, the Women's launched a comprehensive patient experience program that aims to change the way we work with staff, patients and families to evaluate and improve the delivery of our care and services.

Patient stories are a key part of our Creating Exceptional Experience (CEE) course and some of the stories are captured in video form with our patients graciously allowing us to use them to improve the care at the Women's. These powerful and sometimes confronting videos are having a profound impact on course participants and clinical practice at the Women's. They are proving to be a driving force to raise the exceptional experience bar even higher.

The accompanying article is an edited transcript from the video story of patient Meaghan (not her real name) and her experiences, both positive and negative, when her first child was born at the Women's. Meaghan was a consumer participant in the development of the CEE Program which proved to be cathartic for her and incredibly valuable to the program. Reflecting our determination to 'put our patients at the heart of everything we do', Meaghan's input has already led to improvements, and her case study has been shared at both national and international levels.

Some people may find Meaghan's story confronting and disturbing.

My patient experience was quite diverse. I went through my pregnancy in the caseload program at the Women's, which was a really positive experience, having one-on-one interaction with a midwife and having someone I could talk to about my concerns, my ideas about how I wanted things to go and generally, just having someone who I felt I could relate to and find comfort in. Obviously having your first child is quite a big and often an overwhelming experience.

The day after the birth of my first child, the doctor came in the afternoon and said, 'How are you going?'

I said, 'Oh, I'm okay but I don't really understand what happened to me.'

He gave me a confused look and picked up my chart and flicked through and said, 'Oh, you had a fourth degree tear' and prior to that he had no knowledge what had happened to me at all and he just thought I was another mum who'd had a vaginal birth, the baby's doing really well, and it's all over.

I asked him what a fourth degree tear was because I still didn't really understand. He just described it in a really clinical-like matter of fact way that, 'you have torn all the way through all the muscles in your anus and it's been stitched up and you will probably have some consequences'.

There was a lot of mix up about my medication. I was having a lot of Endone. I hadn't really taken much pain relief before in my life. The Endone was really, really affecting me. I didn't even realise I was taking Endone. I didn't understand any of the medication I was taking. Every four to six hours I was given a plastic container with six different pills. No one explained what I was taking and why.

Then the different doctors started changing the quantity of softeners and laxatives that I had. Then a nurse came in and asked why I wasn't taking any laxatives. I said I didn't really know what she was talking about. She then said, 'Well, it has got on here you don't want to take laxatives any more'. I hadn't given permission or declined any pills. I was just really trusting everything everyone was saying to me.

I did have the opportunity to ask questions but I felt the answers were not consistent so therefore I was probably even more confused. I had quite a few temp staff who cared for me and I asked quite a few questions about where to get something or if I was doing the right thing. However, they weren't sure because they were not sure of the hospital's procedures and how things were supposed to happen.

I hadn't realised if you had a fourth degree tear and traumatic birth that you had access to a psychologist at hospital. No one told me.

The healthcare team that knew my story the best and who I felt really understood what had happened to me and took a great deal of concern in my continuity of care was the physio team. I saw the team quite regularly after my birth. That was quite important because they gave me back a sense of hope and that I didn't have to be incontinent and that I could potentially change that. I've got irreparable damage so am always going to have trouble but they helped me understand how I could minimise that.

One of the most critical things the physio department helped me through was how to have intimacy again. The physio I saw explained that my brain associated that part of my life with trauma and that would take mental and physical work to rewire again. The physio department not only looked after me physically but also really brought out the emotional trauma. And it was one of the physios who first recommended I needed to see a psychologist. Up until that point I hadn't realised. I felt they (the physiotherapists) were really important in my healing and they were the first team to really give me that sense of power and control back over my body.

The recording of patient stories is helping to raise the exceptional experience bar even higher at the Women's.



'...I really want to thank you for the opportunity to share my story. It was a really important part of the process for me. I had a bit of an epiphany after the video session. I realised that I had a really powerful experience, and before sharing my story it had a lot of power over me. But the opportunity that you gave me allowed me to change the focus of the power, and use it for change – instead of letting it hang over me. Hopefully that power and energy can help other people now. The opportunity that you gave me offered me validation and witness, and I wouldn't have the strength that I now have without it...'

— email from Meaghan

OUTCOMES

In response to Meaghan's story, the Women's has worked hard to improve our care and support for women experiencing third and fourth degree tears. We have made a number of changes to our practice.

Outcomes include:

- Meaghan's story (in both written and filmed format) is being used to inform our CEE course design and training material and has been incorporated into clinical education and training of new doctors at the Women's.
- The sharing of Meaghan's story showed us that the experiences of women with third and fourth degree perineal tears was not visible in how we represent and report data. There is now an increased understanding and realisation across the Women's that data does not always reveal the full picture in terms of the patient's experience of our care, and that the patient voice is critical if we are to learn and improve.
- Meaghan's story is now used in our statewide leadership capacity to train clinical staff in Victorian regional health services in maternity education.
- A working group focusing on service redesign has focused on service gaps and areas needing review. A multidisciplinary working group has been formed to review clinical services and needs for improved patient care.
- Physiotherapists have changed practice to ensure women who have third and fourth degree tears are invited to a post-partum physiotherapy group session two weeks post birth.
- Six former patients joined us for a workshop to discuss patient experience in reference to perineal trauma and injury. This was an opportunity to learn what was most important to them when they sustained an injury of this kind. It also facilitated patient input into the service redesign to ensure the best approach to caring and communicating with these patients during their care.

3. CONTINUITY OF CARE

3.1 VICTORIAN HEALTHCARE EXPERIENCE SURVEY — 'LEAVING HOSPITAL'

Part of the Victorian Healthcare Experience Survey (VHES) specifically measures a number of indicators that help us understand how patients perceive their readiness for discharge.

These include whether or not:

- the patient feels they have received enough information about managing their care at home
- the patient's family and home situation have been considered
- adequate arrangements have been made for any services the patient might need at home.

Note: Respondents for the 2015/2016 VHES were categorised as 'non-maternity adult inpatients' which means only gynaecology patients were surveyed at the Women's.

In relation to the number of patients who felt they had sufficient information about managing their care at home after discharge, the VHES results for 'non-maternity adult inpatients' at the Women's has dramatically improved. While the June 2015 quarter result indicated 66 per cent believed they had sufficient information, the same quarter in 2016 showed an increase to 80 per cent.

There was also an increase in the positive response to the question about whether hospital staff took into account the patient's family or home situation when planning discharge. This increased from 67 per cent in the March 2016 quarter to 72 per cent in the June period.

The responses to the question regarding arrangements for services has also improved from 67 per cent in March 2016 to 72 per cent in June 2016.

These improvements are partly due to the development of a guideline for 'criteria met discharge' of gynaecology patients. 'Criteria met discharge' refers to the clinical criteria used by nursing staff to assess a patient's readiness to leave hospital. The guideline outlines the process and details the communication required within the multidisciplinary team to ensure safe and expedient discharge. The guideline also includes prompts for staff to check with patients whether they have enough information to manage their care at home and whether their social circumstances have been taken into account.

3.4 ADVANCED CARE PLANNING

An Advanced Care Plan (ACP) allows people to let others know of their preferences for medical care towards the end of life. Whilst most of our patients are not more than 75 years of age, an Advanced Care Planning working group has been established to support those who are. We have liaised with the ACP team at Alfred Health to learn from their established processes. The working party has identified requirements for recording whether or not a patient has an ACP upon registration at the hospital and this will be recorded within our Patient Master Index (iPM).

If the patient meets any of the identified 'triggers' for an ACP, we have a process to capture this information in the patient's medical record and to obtain a copy of the ACP, if available. If the patient does not have an ACP, she will be provided with relevant information about completing one.

The ACP guideline assists us to care for women who may require end-of-life care.

In addition, we have a framework for caring for a baby who is dying in intensive or special care.

The framework is underpinned by the following:

- The best interest of the baby should be at the forefront of all decisions.
- Respect for life should be tempered by the duty to do no harm when ongoing treatment will cause more harm than benefit.
- Palliative care is the active and total care of the baby's mind, body and spirit, including supporting the family, by the multidisciplinary team.
- Life-sustaining treatments may cease during palliative care. However, treatments intended to relieve suffering and provide comfort will not cease.
- Families have the right to accurate, consistent and timely information about the condition, prognosis and management options.
- Providing equitable care requires exploring and respecting the culture and beliefs of the family, and adapting care/decision making appropriately.
- Healthcare professionals have an obligation to respect family or group decisions regardless of personal beliefs, along with a duty to express varying views within team discussions.
- Healthcare professionals have the right to be heard and supported and to choose to not be directly involved.
- The Women's has an obligation to provide professional development and support around palliative care issues to all health professionals.

The following indicators for public health services have not been reported on in our *Quality Account 2016* as they are not applicable to the Women's:

- 2.11 Residential aged care indicators
- 2.12 Mental health seclusion rates
- 2.13 Clinical mental healthcare quality improvement



The Royal Women's Hospital acknowledges and pays respect to the Kulin Nations, the traditional owners of the country on which our sites at Parkville and Sandringham stand and we pay our respects to their Elders past and present.



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