THE WOMEN'S QUALITY OF CARE REPORT 2013

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

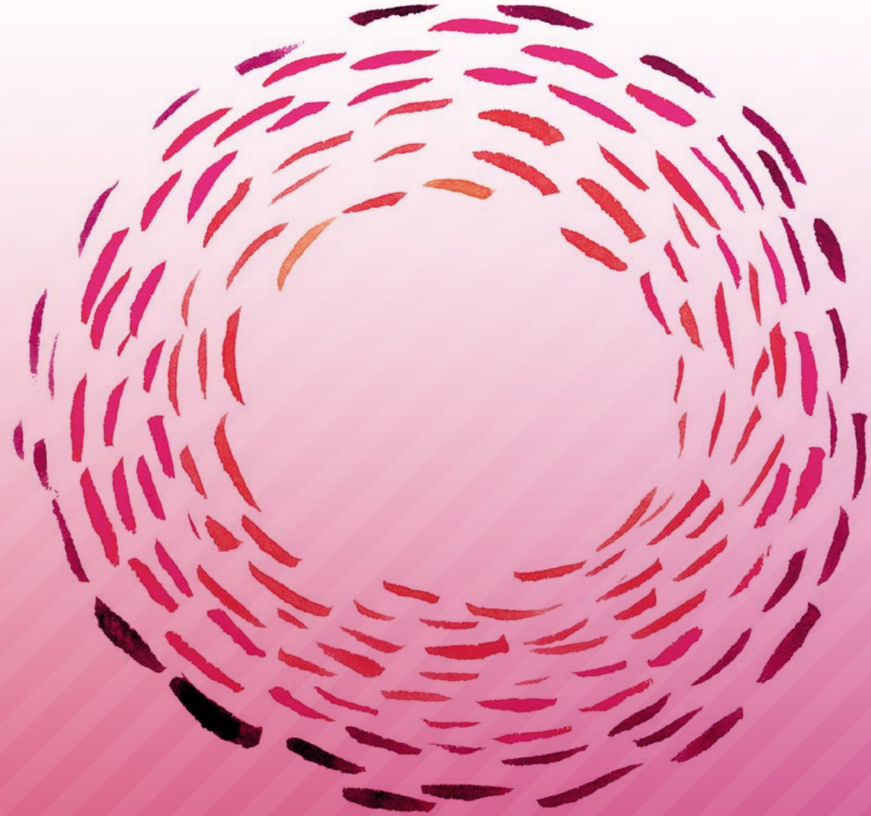
The Royal Women’s Hospital (the Women’s) has led the advocacy and advancement of women’s health in Australia for 157 years.

As a tertiary level hospital and one of Australia's major teaching hospitals, we are committed to excellence and innovation to improve the health and wellbeing of women and newborns.

The Women’s Declaration reflects the principles and philosophies fundamental to our hospital.

It captures the themes from consultation with our local community, with our staff, and with women from across Victoria.

Our Declaration reflects who we are and what we do:



THE WOMEN'S DECLARATION

We recognise that sex and gender affect women’s health and healthcare

We are committed to the social model of health

We will care for women from all walks of life

We will lead health research for women and newborns

We will innovate healthcare for women and newborns

We will be a voice for women’s health

In everything we do, we value courage, passion, discovery and respect

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Babies born sick or premature can spend many weeks, even months in our hospital.

We recognise that parents are the most important members of the care giving team.

Here, new mum Sanaz Spadaro feeds her daughter Scarlett in the Women's Newborn Intensive and Special Care unit.

FROM THE CHIEF EXECUTIVE AND CHAIR

This *Quality of Care Report* marks the halfway point of the Royal Women's Hospital (the Women's) *Strategic Plan 2011-2015*.

Our *Strategic Plan* is the document that guides all of the Women's initiatives and operations. It defines our direction across the key stages of a woman's life cycle: newborns, young women (19 years and under), women of childbearing age, women in mid-life and women in the later years.

Each story in this report describes how we are improving the health and wellbeing of women and newborns according to our *Strategic Plan*.

Our *Strategic Plan* is aligned with Victoria's plan for a healthier future as developed by the Victorian Department of Health and with the National Women's Health Policy. The Plan is also based on a survey of 1000 women that the Women's undertook to understand what you – our consumers and community from across Victoria – want from us.

Much of what we do at the Women's is a direct result of what you tell us. We develop new programs, embed new procedures and discuss new ways of doing things with the help of consumer and community participation in dozens of meetings, workshops and discussions. We talk to our patients, their families and visitors, the partners we work with, our clinical and support staff, our community and, of course, health policy makers in Victoria and around Australia. And we listen.

In November last year, the Women's held an Open Access Board Meeting so that our community could meet the Board, Hospital Executive Committee and Consumer Advisory Committee. We were delighted to host more than 100 people at the meeting and report back to our community on the work of the hospital.

The end of the 2012/13 year marked not just the midpoint of our Strategic Plan, but also the end of an era at the Women's when Dale Fisher, our Chief Executive for 12 years, and Rhonda Galbally, the Chair of the Board for nine years, both left. Dale and Rhonda are great champions of not only women's health but also of community consultation. When added to the Victorian Honour Roll for Women, Dale said, "The real owner of the Women's is the Victorian community and I see my job [as Chief Executive] to continue to build on its strengths for the benefit of future generations."

Over the past decade, Dale and Rhonda have led a committed, passionate staff – and established a strong culture of listening to consumers and the community – to create a very special women's hospital that is vital, relevant and strong. We feel honoured to now be part of carrying that work further for the benefit of future generations.

We are very pleased to present you with the Royal Women's Hospital *Quality of Care Report 2012/13.*

Lisa Dunlop
Chief Executive (Acting)
The Royal Women's Hospital

Margaret Fitzherbert
Chair
The Royal Women's Hospital

WORKING WITH OUR COMMUNITY

Consumer participation in health services results in better outcomes for patients and improved insights for the people who work in the system.

To keep us in touch with the needs of our most marginalised and vulnerable women, the Women's has established a series of committees and advisory groups that connect us with their communities – immigrant and refugee women, women of Aboriginal and Torres Strait Islander backgrounds, women with disabilities, women with drug and alcohol issues, young women and women with serious mental illness.

Our Community Advisory Committee (CAC) provides leadership and direction for incorporating community participation in our quality and safety improvement activities. The CAC advocates to the Board so that our hospital priorities continue to include and value community participation and a consumer perspective on improving services.

The Women's Aboriginal Advisory Committee has developed a plan that details the Women's activities to improve the health and wellbeing of Aboriginal and Torres Strait Islander women by building community trust in the quality and safety of the health services we provide. The Committee is working to develop our Aboriginal and Torres Strait Islander workforce and to ensure our broader workforce is culturally competent. The accurate identification of Aboriginal and Torres Strait Islander patients and their referral to support services into all areas of the hospital remain key priorities.

The Women's Disability Reference Group, believed to be the first such reference group attached to a hospital in Australia, works to the theme of "Nothing about us – without us". Work from this group has informed the accessibility requirements for the re-development of the hospital's website, reviewed outpatient registration forms and resulted in the purchase of scales (with assistance from the Women's Foundation) so that women with mobility aids can be weighed appropriately.

The Disability Reference Group has also reviewed the Well Women's Clinic to ensure that its services are appropriate for women with a disability. The Well Women's Clinic offers a free, confidential health service for women who don't have symptoms but would like a women's health check up. Services include Pap testing, teaching breast self examination, testing for sexually-transmitted infections, health information and advice, sexuality and safe sex information and advice in preparing for pregnancy.

Pictured: Agum Maluach participating in one of our Young Women's Contraception Workshops

Pictured: Olivia Du Vergier participating in one of our Young Women's Contraception Workshops

PROJECT PRIMIP

More natural births for first-time mums.

We want to develop ways to provide best practice, evidence-based care to ensure women receive the right care at the right time by the right practitioner.

In medical terms, a primipara (or “primip”) woman is a woman who is pregnant for the first time.

Project Primip was developed because, at the Women’s, we recognise the significance of a first birth. Our goal was to develop a consistent, evidence-based care plan for healthy primipara women in labour so their first birth was as safe as possible. Importantly, we also want their birth experience to be a good, positive experience for them.

One of our goals is to increase the rate of normal (vaginal) births for healthy primips by reducing the rate of caesarean sections (CS). The rate of CS across the Western world is increasing, with the overall CS rate ranging between 20% and 30% in most Western countries. Over the last nine years, the CS rate for primipara women at the Women’s has also been steadily increasing.

Project Primip, which started in 2010, focused on strategies to improve information and care in labour for primipara women to increase the vaginal birth rate.

The Women’s developed the 'Bundle of Labour Care' as part of Project Primip. The Bundle provides a standardized protocol that includes information for supportive one-to-one care, and a labour management plan.

Project Primip resulted in:

- An **increase** in the rate of vaginal birth:
  - From 54.6% to 56.7% for women who spontaneously went into labour, and
  - From 32.1% to 33.6% for women whose labour was induced
- A **decrease** in the rate of unplanned CS:
  - From 18.3% to 12.5% for women who spontaneously went into labour, and
  - From 43.2% to 36.9% for women whose labour was induced

The success of Project Primip means the Women’s now offers a structured, consistent, evidence-based care plan to all women with a low-risk pregnancy. The ‘Bundle of Labour Care’ strategy is now embedded into our Birth Centre culture and is normal practice for all low-risk women who labour and birth at the Women's.

Pictured: Karen Moffat (Clinical Midwife Consultant and Birth Centre Coordinator), Jenny Ryan (Midwifery Director, Birth Centre) and Dr Kobus du Plessis (Medical Director, Birth Centre)

Pictured: New parents Rebekah and Samuel with baby Elora

THE YOUNG MUM'S PROGRAM

Our community told us that we needed to focus on the needs of young women. In response, we developed a Young Women's Strategy to improve the information and care we provide to women aged 19 years and under.

Young pregnant women are a special group with their own distinctive healthcare needs. They are more likely than other mothers to smoke during pregnancy, to have a low body mass index and to have pre-existing and postnatal mental health issues. Their babies are more likely to have a low birth weight, be admitted to intensive or special care and be formula-fed, not breastfed. This group is also at high-risk of poor mother-baby bonding after birth, which can cause significant and life-long problems for the baby.

The Women's conducted an extensive review of national and international maternity services that particularly aim to help young women. Crucially, we also reached out to young women who had recently given birth at the hospital to seek their views on what had worked for them and what had not. This research – and our staff's years of practical experience – told us that young women require a more intense level of care in mainstream maternity services.

A trial of caseload midwifery conducted at the Women's, and published in 2012, found that women who have this model of care were less likely to have a caesarean section and more likely to have a normal (vaginal) birth. The trial, known as COSMOS, was one of the largest in the world and involved more than 2000 women with low-risk pregnancies giving birth at the Women's.

Caseload midwifery involves a woman receiving care from just one midwife throughout her pregnancy and labour. This provides a continuity of care so that a woman and her midwife can develop a personal relationship, which in turn allows the midwife to provide personalised information and care.

Young women now receive caseload midwifery care during pregnancy and labour and up to six weeks after the birth of their baby at the Women's. The midwife is assisted by a multidisciplinary team that includes a full-time social worker, to prepare them for the additional demands of being a young mum, a psychologist to help improve mother-baby bonding, a drug counsellor if required, a dietician, and a careers adviser. The aim is to improve the young women's health and wellbeing during pregnancy, to promote positive health practices and to provide accessible and appropriate health care services.

Pictured: (L-R) COSMOS Midwives: Cecile Carbonnel, Juanita White, Orlagh Mulligan, Chani Thompson, Marie Bommelaer, Sarah Lorkin and Tamara Fay

A YOUNG MOTHER'S VIEW OF COSMOS

On 3 January 2013, after seven hours and sixteen minutes of labour, Kirsty Rowlands gave birth to baby Christopher. Kirsty was the first mother to give birth in the Women's Young Mum's Program.

Midwife Sarah Lorkin provided all of Kirsty's clinical care, supporting her during pregnancy, labour and birth, in-hospital and at home after Christopher was born.

Kirsty describes her experience as 'incredible'. She says that as she approached the birth she felt well prepared, she also felt very confident in her new role as a mother, all of which she attributes to her midwife Sarah and the Young Mum's Program.

Kirsty says the best thing about the program was the opportunity to develop a relationship with her midwife, which builds confidence and knowledge and makes for a positive experience overall.

"If I ever have another baby I definitely want to do it at the Women's," she said.

Pictured: Kirsty Rowlands and baby Christopher

EMOTIONAL WELLBEING IN PREGNANCY AND EARLY PARENTHOOD

Promoting improved maternal mental health leads to a better mother-baby bond.

Our goal is to advance specialist mental health services for women and their families.

Pregnancy is one of the most vulnerable times for a woman to become depressed or anxious, especially if they have a history of mental illness. Our Centre for Women's Mental Health (CWMH) supports pregnant women who are suffering from anxiety and depression, or who have suffered from them in the past.

In consultation with past patients, our CWMH developed and piloted a five session Emotional Wellbeing in Pregnancy and Early Parenthood Group Program.

It is offered to women and their partners to assist in the management of mental illness during pregnancy and after birth, and to promote secure parent-infant bonding. The program provided psycho-education on mental health during the adjustment to parenthood, self-care strategies, discussed changes in the couple's relationship during early parenthood, and talked about bonding with infants when there might be maternal mental illness.

The program's aims were to promote early detection and intervention of emerging anxiety and depression during pregnancy and immediately after the birth, and to improve the mother's bonding, or "maternal attachment", with her baby.

Pre and post-test measures revealed a significant reduction in participants' levels of depression and anxiety, and significant improvement in maternal attachment.

These preliminary findings suggest that the Emotional Wellbeing in Pregnancy and Early Parenthood Group Program is an effective and acceptable early intervention approach for women and their partners as they prepare for the path of parenthood.

Pictured: New mum Sechelle with baby Laila

MINDBABYBODY

A mindfulness-based group program to prevent psychological distress for new mothers.

The transition from pregnancy, through birth to the early days of parenting can be very emotionally, physically and socially difficult. Mental health issues, such as anxiety, stress and depression, are common.

The MindBabyBody Group Program developed by our Centre for Women's Mental Health (CWMH) targets maternal stress, anxiety and depressive symptoms during pregnancy. Its goal is to take a broad approach to improving the mother's health, and especially her mental wellbeing, before the baby is born. The aim is to provide tools to help the mother, and her baby, after the birth.

Our MindBabyBody program builds on proven techniques, which use components of mindfulness meditation and cognitive behavioural therapy, but also adds a third component: mindful-movement and yoga exercises. It is well suited to pregnancy and being conducted in group sessions.

The success of this mindfulness-based program suggests that it can be safely incorporated into routine maternity care as a valid and worthwhile approach.

MINDFULNESS

Mindfulness is about experiencing the world that is 'here and now.'

It offers a way of freeing yourself from old, automatic and unhelpful ways of thinking.

Pictured: Dr Kristine Mercuri, Consultant Psychiatrist and Facilitator of the MindBabyBody program

RETINOPATHY SCREENING SERVICE FOR PREMATURE BABIES

Detecting eye damage in premature babies for fast and effective treatment.

We are investing in new clinical technology that improves the health of women and newborns.

Retinopathy of Prematurity (ROP) is an eye disease that affects babies born prematurely. In most cases, ROP is mild and resolves spontaneously, but it may lead to blindness if it is not detected and treated.

ROP is one of the most common causes of visual loss in childhood that leads to lifelong vision impairment and blindness. Singer Stevie Wonder is blind because he was born prematurely and developed ROP.

The smallest and most vulnerable babies will have at least five – and perhaps as many as 12 – eye examinations while they are in newborn intensive and special care.

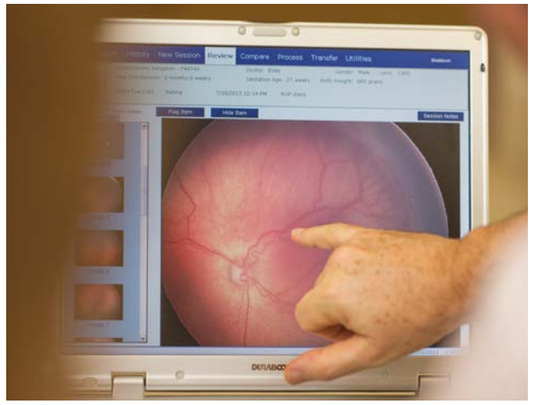
Many hospitals in Victoria are not able to provide on-site screening for ROP, because there is a lack of available, suitably-trained, ophthalmologists (specialist eye doctors) to do the screening. This means that many babies need to stay in specialist facilities, like the Women's, for ROP screening, rather than going to a hospital closer to their home.

The Women's has developed a nurse-led Newborn ROP Screening Service as a solution. We trained two neonatal nurses to use a type of digital camera, a RetCam, that takes images of the retina at the back of the eye. These images are assessed by supervising ophthalmologists who diagnose ROP and plan the treatment and re-screening for the baby.

This service has the potential to be developed as an outreach service across Victoria to assist at other Special Care Nurseries.

The Newborn ROP Screening Service was made possible by donations to the Royal Women's Hospital Foundation from the Oscar & Luca Fund and the Mathieson Family.

Pictured: ROP Nurses Christine Lim and Bernadette Golding undertaking a retinopathy screening session, under the supervision of Ophthalmologist Dr James Elder



Pictured: Images from a retinopathy screening

NURSE-LED CLINIC FOR NIPPLE CONSTRUCTION

When a woman has a breast reconstruction after cancer or trauma, the finishing touch is to have a coloured nipple/areola created on the new breast mound.

The psychological effects of a mastectomy (the removal of a breast) and breast reconstruction after a cancer diagnosis and treatment are often overlooked. Women who have had a mastectomy have higher rates of depression and thoughts of suicide compared to women who have had a breast reconstruction.

Since 2010, the Combined Breast Service of the Women's and Royal Melbourne Hospital has offered women the opportunity to have a breast reconstruction. The team can reconstruct the breast mound and the physical nipple, but they had not been able to re-create a coloured nipple and areola (the coloured area around the nipple), and this can cause psychological distress.

Nipple tattooing is a process in which the nipple and areola complex is recreated, using tattoo pigments to colour the area so that it looks as natural as possible.

Our Combined Breast Service realised the importance of being able to provide nipple tattooing in a safe, secure and familiar environment for our patients. This led to Breast Care Nurse, Monique Baldacchino, being trained in the art of nipple tattooing.

Monique attended a course in London, where she learned the theory and skills required to perform nipple tattooing. Funding for her study tour was provided by the Treasure Chest Charity, a Victorian not-for-profit organisation that raises funds to assist hospitals to increase their capacity to perform breast reconstructions.

It is believed the Women's is the only public hospital in Australia that offers a nurse-led nipple tattooing service.

"When the women see the results," says Monique, "they often cry tears of joy that their breast looks like it used to. For me and the women I see, it is a lovely way to spend a Friday afternoon."

Pictured: Breast Service Nurse Coordinator Monique Baldacchino with the nipple tattooing machine

When she was 57, Maree Plumstead received the devastating news that not only did she have breast cancer, but the type of cancer meant an excision would not be effective. She needed a mastectomy. In one operation, her nipple and breast were removed, and skin from her stomach was used to reconstruct her breast. A flap of skin was used to make a new nipple. Some months later, the final step was to tattoo the new nipple so that it looked as much like the remaining one as possible. Maree had two sessions with Monique and said she was 'delighted' with the results. "Monique spends a lot of time to get things just right – I'd thoroughly recommend the service to any woman who has a breast reconstruction."

ABORIGINAL NURSING AND MIDWIFERY CADETS

Nursing and Midwifery Cadets from the 'Closing the Health Gap' Victorian Aboriginal Program complete their work experience at the Women's.

We are designing and delivering targeted services to our increasingly diverse community.

Over the past 10 years, the Women's has been working to create a safe and welcoming environment where Aboriginal and Torres Strait Islander women and their babies enjoy high quality clinical care as well as cultural and social support.

Community consultation identified priority actions to improve outcomes for Aboriginal women and their babies. The priority areas are to implement strategies for: increasing identification of Aboriginal and Torres Strait Islander consumers, increasing cultural awareness among our staff, creating a culturally safe environment for Aboriginal and Torres Strait Islander families, and increasing and supporting the Aboriginal workforce.

In 2012, the Women's Clinical Education Program received a grant from the Department of Health and the Department of Education, Employment and Workplace Relations to conduct an Aboriginal Nursing and Midwifery Cadetship pilot.

The program offered Aboriginal and Torres Strait Islanders students in the second or third year of a nursing or midwifery bachelor degree the chance to complete their studies whilst working at a Victorian public health service.

The pilot program promoted the development and training of these students by providing a range of resources to support their academic, personal and professional growth. These resources include clinical support and mentoring and the possibility of ongoing employment in a graduate program.

The partnership between the Women's Clinical Education and Aboriginal Women's Health Business Unit was crucial to the cadetship project being embedded in the hospital processes. Additional cultural support, consultation and advice for the project were provided by the Women's Aboriginal Advisory Committee.

Karen Blake, the pilot's co-ordinator, said the program has had a positive response.

"Aboriginal nursing and midwifery students who work as cadets at the Women's have the potential to improve how Aboriginal women are cared for and this program provides a great opportunity to imbed a strong culture of respecting Aboriginal Australia within the Women's," Karen said.

An evaluation of their cadets' work experience demonstrated an increase in the cadets' knowledge across the domains of women's health, maternity and neonatal health as well as the workings of a tertiary hospital.

"We were really pleased with the positive feedback on the recruitment and orientation process as well as the support and mentorship that the Women's provided," Karen added.

The Women's also identified that provision of Cultural Awareness training for non-Aboriginal staff was crucial to the success of the cadetship pilot.

As of May 2013, 34 sessions have delivered cultural awareness training to 572 participants from the Women's and there have been a significant number of hours invested in cultural competency training.

The cadetship and its support will also potentially increase the Aboriginal and Torres Strait Islander people's trust in the cultural safety of our hospital and have a positive impact on the health of Aboriginal women, babies, family and communities in the Victorian Public Health Service.

CLOSING THE HEALTH GAP

Health outcomes for Aboriginal and Torres Strait Islander mothers and babies continue to be the poorest of any population group in Australia. By increasing the numbers of Aboriginal and Torres Strait Islander students that complete nursing and midwifery courses, we hope we can improve the health of Aboriginal women and their babies.

Pictured: Aboriginal Nursing and Midwifery Cadetship Coordinator, Karen Blake with one of the cadets, Ash Nichols

AWARD WINNING MATERNITY CLINICAL INFORMATION SYSTEM

A clinical information system is recognised for its ability to manage risks and improve the outcomes for women delivering their babies at the Women's.

We are investing in new clinical technology that improves the health of women and newborns. We are seeking to implement clinical information systems that support staff in their work.

The Maternity Clinical Information System (MCIS), installed in November 2008, is a real-time electronic record that enables staff to enter maternity data over the course of a woman's labour, birth and post-natal period.

The Women's is the only hospital in Victoria with this system in a maternity setting. Having all the patient's information in one place provides clinicians with the information they need to make the best clinical decisions. The system also records data so that the impact of new clinical practices can be measured for safety and effectiveness, with the aim of improving birth outcomes for women and ultimately their birth experience.

Jenny Ryan, Midwifery Director of the Birth Centre, says the system has been specifically configured to meet the needs of the Women's staff. It provides flexibility so that the system can be easily updated to reflect changing patient needs or emerging health risks.

"From a manager's perspective, the MCIS allows the organisation to monitor birth outcomes in a really efficient way," Jenny says.

"The system also improves the capturing of clinical incidents for reporting purposes. In addition, it enables us to design future projects, by identifying clinical risks through the system."

A clinical risk is an incident in which the treatment or care that is given is not what the clinician intended. Identifying clinical risks highlights where there are system and communication errors.

AWARD WINNING SYSTEM

The Women's Maternity Services won the Risk Management Award at the prestigious 2012 Institute of Public Administration Australia's Leadership in the Public Sector Awards. The award was given for the implementation of the Maternity Clinical Information System (MCIS).

The Women's was the only Victorian hospital nominated for the award.

Pictured: Jenny Ryan, (Midwifery Director, Birth Centre), and Karen Moffat (Clinical Midwife Consultant and Birth Centre Coordinator) with the IPAA Award, which recognises outstanding achievements and practices of teams that demonstrated leadership in, and commitment to, promoting a culture of risk management across an organisation.

PLACENTAL ADHESIVE DISORDER SERVICE

Improving the care of women with potentially life-threatening abnormal placenta attachment.

We are strengthening tertiary services and providing research-led care for women and newborns with complex needs.

'Placental abruption' is the term used to describe what happens when a pregnant woman's placenta begins to detach from her uterine wall before her baby has been born. There are varying degrees of placental abruption: the placenta can detach in small areas, or it can completely detach from her uterus.

For clinicians, the management of Placental Adhesive Disorders is challenging. There is a high risk of the mother dying or suffering severe haemorrhaging or having to undergo technically difficult surgery while she is pregnant.

We see approximately 10-15 Placental Adhesive Disorder cases every year at the Women's. We decided that a working group should be established across the Women's and the Royal Melbourne Hospital to work out the best process for managing the condition at both sites.

The guideline and surgical checklist were developed by the group and in consultation with a patient. They are now posted on the staff intranet and are being actively used. We are also continuing to critically assess each case to further improve and fine-tune this work.

With more widespread awareness of the problem and an expertly developed resource now available, the next stage will be an assessment of outcomes before and after the guideline was developed. More research into Placental Adhesive Disorder is vital and will be ongoing.

Pictured: Dr Elske Posma, Obstetrician Consultant, and Mr David Wrede, Gynaecology Specialist, looking over the placental disorders clinical guideline and surgery checklist

RESEARCH HIGHLIGHT:

VACCINE LEADS TO DRAMATIC DECREASE IN HUMAN PAPILLOMAVIRUS (HPV)

A study by the Centre for Women's Infectious Diseases found a dramatic decrease of 77% in the HPV types targeted by the "cervical cancer vaccine".

Researchers at the Women's have found that since a vaccine against four types of human papillomavirus (HPV) has been introduced for women, the prevalence of HPV has significantly decreased. This vaccine is also known as "the cervical cancer vaccine" because long-term HPV infection causes cervical cancer. The vaccine also prevents genital warts.

The Women's study, which was published in the *Journal of Infectious Diseases* in 2012, compared HPV rates in family planning clinics in Victoria, New South Wales and Western Australia before and after the introduction of the vaccine.

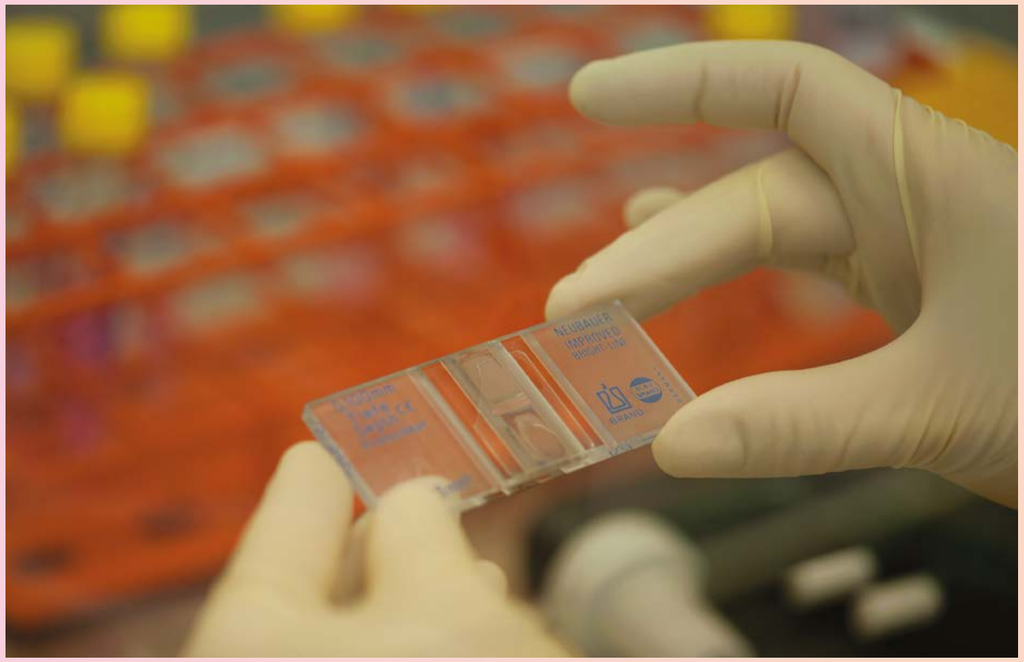
The Women's Associate Professor Sepehr Tabrizi, the lead author of the study, said the paper showed a remarkable decrease in vaccine-preventable HPV infections just a few years after implementation of the Australia-wide vaccination program.

"Our research confirms the effectiveness of the HPV vaccine and complements previously published studies that demonstrate fewer pre-cancerous changes in the cervix, as well as a reduction of genital warts amongst the vaccine-eligible age group," Sepehr said.

Another finding is that the decrease in HPV prevalence is also detectable in those that had not been vaccinated. "In the overall community, there has been a 20% decrease of HPV prevalence," said Sepehr. "This is the first report of such a positive vaccine impact outside of clinical trials."

"It is however important to note that, while these results show great impact of the vaccine, women still need to continue to have regular Pap tests as well."

Director of the Centre for Women's Infectious Diseases, and senior author on the paper, Professor Suzanne Garland said Australia is in a unique position. "We were the first country to successfully implement a government-funded HPV vaccination as well as the first to measure such positive effects. We will continue the study by looking at the effectiveness of the vaccine in protecting against HPV types not in the vaccine formulation and look forward to reporting on the results."



RESEARCH HIGHLIGHT:

MEMORY DURING MENOPAUSE

Our research on memory issues in menopausal women validates that, while they may have concerns, they have no scientific reason to worry.

Many women complain of forgetfulness during menopause, but few studies have provided a detailed examination of a woman's memory at this important stage of their lives.

A study conducted by the Women's Gynaecology Research Centre in 2012 examined how a woman perceived her memory and how she performed on a memory performance test across the menopausal transition.

The study recruited 130 women aged 40 to 60 from outpatient Menopause and Gynaecological clinics at the Women's. They were then divided into menopausal stage groups according to the internationally recognised STRAW criteria which measures changes in women's menstrual patterns.

All women completed self-report measures of physical menopause symptoms and a comprehensive evaluation of memory.

The results showed no difference between pre-, peri-, and postmenopausal groups in memory performance. However, perimenopausal women, who are in the menopause transition phase, reported more frequent memory mistakes and less contentment with their memory than pre and postmenopausal women.

Our results suggest that women do not need to be concerned about objective memory impairment at this time in their life. Nevertheless, their perceived experiences should be taken seriously. As a result, we plan to provide preventative health information and group intervention programs for women who are concerned about their memory during midlife.

Pictured: Professor Martha Hickey, Obstetrics and Gynaecology Specialist and Dr Christina Bryant, Senior Lecturer, Clinical Psychology

IMPROVING PAIN RELIEF AFTER CAESAREAN SECTIONS

We are developing ways to provide best-practice, evidence-based diagnostic, treatment and care options.

The Women's Department of Anaesthesia has a long history of teaching, education and innovation. Founded in 1951 by Dr Kevin McCaul, it was the first obstetric anaesthesia department in Australia.

For more than 20 years the department has also provided an Acute Pain Service (APS). This is done through a multidisciplinary team, which promotes the best way of providing acute pain management to our patients.

The APS also collects quality assurance data that helps improve anaesthetic and analgesic care for women. Anaesthetic means loss of feeling, while analgesic means loss of pain.

In 2011, data revealed an increasing trend, from 7% in 2007 to 14% in 2011, for women who experience moderate to severe pain after caesarean section (CS) birth. We set out to investigate why, with the main objective to improve pain relief after CS and specifically to promote pain management that:

- Did not interfere with a woman's ability to move around so that there was a reduced risk of blood clots and minimal interference with breastfeeding
- Was associated with a high degree of patient satisfaction
- Was safe and had a low incidence of side effects such as nausea or constipation
- Was applicable to our patient population, including women from non-English speaking backgrounds and women with special analgesic needs.

After a review of the literature, analysis of our experience and discussions with our patients, we determined that the use of multimodal analgesia—different types of analgesia delivered in different ways—can reduce the frequency that women need to ask for pain relief.

Ongoing monitoring has demonstrated that the improved analgesia has been maintained and is resulting in high levels of patient satisfaction.

Pictured: Kristy Fuller with her partner Gordon Loch and their two children Ethan and Mackenzie.

Kristy Fuller's baby Ethan was born via an emergency caesarean section (CS) after he became stuck in her birth canal and his heart rate dropped drastically. Kristy had a natural birth with her first child, Mackenzie, two and half years previously, so was unprepared for the pain and discomfort a CS would cause her.

"When the anaesthetic wore off, my recovery was very painful," she says. "The staff at the Women's were wonderful. They gave me pain relief as and when I needed it and were constantly monitoring my progress."

"I couldn't speak more highly of them or their management of my pain."

CENTRAL CITY COMMUNITY HEALTH SERVICE

A free health service in the city, supported by the Women's, for women who are disadvantaged and homeless.

Our goal is to improve our reach across Victoria through partnerships and by sharing our expertise. We will continue to provide support for women's health clinical services.

The Women's was approached by the Melbourne City Council, which had researched homeless women or women who frequented the city and found that their ability to access healthcare was poor.

The shared goal was to establish a service that addressed the special health needs of women who are homeless or who face homelessness.

The Central City Community Health Service, located near the Victoria Market in Melbourne's central business district, has been purpose-designed to help. The Clinic offers Pap tests, testing for sexually transmitted infections, pregnancy tests and a range of education and health information that is helpful and practical. It also acts as a central point within the homeless sector to provide referrals to specialist services at the Women's.

The Women's is working in partnership with the Doutta Galla Central City Community Health Centre. Staff are co-located with a range of community service providers, including the Royal District Nursing Service's homeless person's nurses, a psychologist, a podiatrist, legal services, a dietician and an optometrist.

Since the Central City Community Health Service opened last year, data have been collected on demographics and referral pathways to ensure we are providing appropriate care.

The anecdotal feedback from the women attending the clinic has been overwhelmingly positive.

Pictured: Jacinta Waters, Acting Director of Women's Health Services, and Pip Brennan, Women's Outreach Clinic Coordinator, at the Central City Community Health Service

PREVENTING VIOLENCE AGAINST WOMEN

Violence against women is a violation of human rights and is a crime against the individual and the community. It is not an individual or private problem. At the Women's, we have a range of services to help victims of violence, particularly female victims of intimate partner violence, and we collaborate with other organisations to help in practical and appropriate ways.

We are strengthening our violence against women prevention and management programs.

ACTING ON THE WARNING SIGNS – A HEALTH/LEGAL PARTNERSHIP TO ADDRESS FAMILY VIOLENCE

A partnership between the Women's and the North Melbourne Legal Service (NMLS) has the capacity to empower and protect a significant number of Victorian women by providing legal assistance within the hospital.

Intimate partner violence is the leading preventable contributor to death, disability and illness in women aged 15 – 44 years in Victoria[1].

Many women experiencing this kind of violence are also burdened by economic hardship and are vulnerable to discrimination. For these women, free and accessible legal advice about intervention orders, separation and divorce, child support and parenting matters can make a significant difference.

Since 2009, the NMLS has provided a weekly legal assistance outreach clinic at the Women's Social Support Services and a monthly outreach clinic at CASA House, the Women's Centre Against Sexual Assault.

From this work, it was clear that basing a legal clinic in a hospital had a number of advantages for women affected by family violence. These included support and information in a safe and neutral environment, access to a more holistic and multidisciplinary model of professional care, and free legal advice about their rights and entitlements, empowering women to know their options and alternatives.

In 2012, the Major Grants Program of the Legal Service's Board funded NMLS to work with the Women's on a project called 'Acting on the Warning Signs', one of the first advocacy health alliances in Australia to address violence against women.

The project is developing and evaluating a model for improving women's safety and recovery that begins with training clinicians to recognise indicators of family violence, how to respond sensitively and appropriately with health and legal information, and ways they can provide referrals to legal and social support services.

Between December 2012 and June 2013, the project trained 73 health professionals including 27 doctors. From August 2012 to July 2013, the NMLS has provided more than 50 appointments at the hospital. The pilot began in August 2012 and will finish formally in November 2013. The evaluation report is scheduled to be available in mid-2014.

With what we learn from this unique health-legal alliance, we will be able create a model for other community legal services and hospitals to work in partnership to address family violence.

[1] VicHealth, *The Health Costs of Violence: measuring the burden of disease caused by intimate partner violence: a summary of findings, DHS 2004 (reprinted 2010), p10*

WORKING TOGETHER TO REDUCE VIOLENCE AGAINST WOMEN

Like much of the Women's work profiled in this report, this project has depended on significant support from partner organisations and individuals who freely give their time and expertise.

In this case, Women's health practitioners from social work, clinical education, midwifery, obstetrics and gynaecology worked closely with legal practitioners from the North Melbourne Legal Service on this innovative model of care.

The project is supported by a reference group that provides technical assistance and advice. The group consists of health professionals, lawyers in private practice, community lawyers, a member of the Judiciary, a representative from the Victorian Equal Opportunity and Human Rights Commission, a senior constable, academics and a range of other individuals.

Evaluation is being conducted by a team of multi-disciplinary researchers in social work, criminology and General Practice at the University of Melbourne. We look forward to reporting on the results.

CASA HOUSE 25 YEAR ANNIVERSARY

We celebrated the 25th anniversary of the Women's Centre Against Sexual Assault (CASA House) in July 2012 at a ceremony called Celebrating Survival: the First 25 Years.

On Wednesday 25 July 2012, a special event was held at the Women's to commemorate the work of CASA House, a department of the Women's, and our partners who work with the CASA House team.

CASA House is committed to ensuring that victim/survivors of sexual assault are provided with the counselling and advocacy they require. Its services are free and confidential and available to:

- Adult victim/survivors of recent and past sexual assault regardless of gender
- Non-offending family members, partners and friends
- Community members
- Professionals, individuals and groups
- Health, community support, education and legal agencies.

The event started with a Welcome to Country performed by Aunty Di Kerr, an elder of the Wurundjeri people.

The first guest speaker at the anniversary event last year was Ms Kate Gilmour – Assistant Secretary-General and Deputy Executive Director (Programme) of the United Nations Population Fund (UNFPA).

From 1986-1992, Kate was coordinator and then program development manager at the Women's, where she pioneered programs on sexual assault and developed a new human rights framework for sexual assault services in Australia.

The second guest speaker was Associate Professor Les Reti, who was the founding Chair of the Committee of Management of CASA House. Les is the Clinical Director of Gynaecology, Cancer and Perioperative Services at the Women's and is also the Director of Clinical Governance. A practising gynaecologist, Les has had an interest in women's health issues for more than 30 years. He is on multiple state and national committees advocating for women's health.

Pictured: CASA House 25th Anniversary event guest speaker, Kate Gilmour

THE FAMILY VIOLENCE ACTION PLAN

During 2012/13, information about family violence was developed in consultation with Aboriginal and Torres Strait Islander and immigrant and refugee women. A reference group developed key messages, which were tested with women in the community.

The Family Violence Action Plan aimed to improve women's access to information about the health impacts of family violence, and to link women with family violence services. The project targeted Aboriginal and Torres Strait Islander women and selected immigrant and refugee groups; including, Arabic, Chinese, Turkish, Somali and Vietnamese speaking women.

The project aims to build and strengthen partnerships between the Women's and culturally specific family violence agencies in Victoria, and to improve referrals between services, case management and collaborative work in primary prevention.

We worked with key community organisations and leaders in the various cultural and language groups to develop messages that would resonate with women.

We worked with groups of women to ensure the messages were useful and relevant to them. The participants were not expected to have a history of family violence, but many did, and provided very compelling feedback on their needs in terms of information and access to services.

A series of palm cards and online fact sheets have been developed and distributed throughout the hospital. They have also been distributed to clinicians and external providers through training events and other meetings.

The Family Violence Plan was made possible by a grant from the IOOF Foundation.

Pictured: Palm cards on family violence with information on support services

WHITE RIBBON DAY MEN'S BREAKFAST

Guest speaker at the Women's 2012 White Ribbon Day Breakfast was the Police Chief Commissioner Ken Lay, who described how family violence and violence against women was a significant issue for the Victorian community. The Women's works closely with Victoria Police on several education and response services for sexual assault.

QUALITY OF CARE DATA

CONSUMER, CARER AND COMMUNITY PARTICIPATION

Community Participation Indicators.

Standard 1: Indicator 100%

The Women's has adopted the State Government's *Doing it With us Not for us Strategic Direction 2010-13* policy. Patients, carers and other consumers actively participate in the improvement of the patient experience and patient health at the Women's, through our Consumer Advisory Committee and other consumer and community committees.

We have recently worked with young women, aged 19 years and younger, on hospital steering committees, workshops and focus groups as part of our Young Women's Strategy to inform future service development.

We strive to continually improve patient care, particularly for Aboriginal women. The *Improving Care for Aboriginal and Torres Strait Islander Patients* (ICAP) program at the Women's met all four key result areas in 2012-13 (see p28 for ICAP program results).

The Women's use a variety of approaches to report and record on consumer participation, including the Women's website, the *Quality of Care Report*, community networks and social media.

Standard 2: Indicator 2.1 = 79%; Indicator 2.2 = 84%

Consumers and carers are involved in decision-making about their treatment and care at all stages, where appropriate, which is facilitated with evidence-based, understandable and accessible information and support.

According to the Victorian Patient Satisfaction Monitor (VPSM) survey, our consumer participation score was 79%. The VPSM records that 84% of women were given an active say in making decisions about what happened during their labour and/or birth. This a high proportion given that the Women's is a tertiary maternity centre and choice can be limited by medical emergency.

Standard 3: Indicator 3.1 = 100%; Indicator 3.2 = 74%

The Women's is accredited by the World Health Organisation as a 'Health Promoting Hospital'. This is in recognition of our efforts to incorporate the concepts, values and standards of health promotion into the organisational structure and culture of the hospital. The health information we provide is evidence-based and developed in partnership with women and health care professionals.

The Women's maintains a list of 180 consumer fact sheets in 24 community languages. In 2012/13, 22 new fact sheets were developed (compliant with the Department of Health guidelines). The Consumer Health Information unit produced four new print publications this year and revised six previous publications and 26 fact sheets.

Some 74% of respondents to the VPSM rated our health information as being good to excellent.

Standard 4: Indicator 4 = 100% (6/6)

Consumers are active participants in developing the services and health information we provide. Surveys, focus groups and individual interviews with women provide our hospital with information on how to best meet consumers' needs through service, community and program development and quality improvement activities. Consumers sit on the Board Quality Committee and the Hospital Ethics Committee (see p5 *Working with our Community*).

Standard 5: Indicator 5.1

The Women's prides itself on its capacity to respond to diversity in the community. The Women's has developed a new Equity Framework to further strengthen the many innovative approaches to diversity currently in place across the hospital. The principles underpinning the Framework will apply across all types of diversity that includes, but is not limited to, ethnicity, sexual orientation, socio-economic status, religious beliefs, disability, location and other forms of systemic disadvantage. Specific priority areas for the Equity Framework include immigrant and refugee women and newborns, women with disabilities and their newborns, Aboriginal and Torres Strait Islander women and newborns, and highly vulnerable and disadvantaged women and newborns.

CULTURAL RESPONSIVENESS FRAMEWORK

Standard 1:

Views of Aboriginal organisations are sought regularly and are managed through our Aboriginal Women's Health Business Unit (AWHBU). In particular, the Women's works closely with the local Aboriginal Community Controlled Health Organisation (ACCHO) and communities. In 2012/13, progress was made on a Memorandum of Understanding between the Women's and ACCHO.

The Women's Maternity Services Education Program is partnered with the Victorian Aboriginal Community Controlled Health Organisation to deliver pregnancy care education to midwives and Aboriginal Health Workers in the Koori Maternity Services.

The Women's Language Services provide interpreters to consumers who require assistance with English. This enables accurate communication between people with a low level of English and their health care providers, so that consumers can make informed decisions about their lives and health.

Standard 2: Indicator 2.1 = 40% (8/20)

Cross-cultural training at the Women's is provided annually through the AWHBU, Clinical Education Team, Grand Rounds and External Training and Development workshops.

Eight of the 20 senior managers at the Women's have undertaken leadership training for cultural responsiveness, which represents 40% in total since July 2012.

Standard 3: Indicator 3.1 = 95.5%; Indicator 3.2 = 40%

The Women's use a Policy, Guideline and Procedure Manual for the Women's Language Services that complies with the Department of Health's *Language Services Policy*.

The Women's provide in-house interpreters in the following languages: Arabic, Assyrian, Cantonese, Chaldenian, Greek, Italian, Laotian, Mandarin, Somali, Thai, Turkish, and Vietnamese. For after hours and weekends, interpreter services are provided by the Translating and Interpreter Service available via the Women's switchboard.

In 95.5% of occasions during 2012/13, patients who required a professional interpreter were provided with one. This equates to 26,133 occasions of service for 12,449 patients.

The top 10 languages requested in 2012/2013 were Arabic, Vietnamese, Mandarin, Turkish, Cantonese, Greek, Somali, Hindi and Italian.

Language Services provided an increased number of AUSLAN interpreters during 2012/13 in the Pregnancy Clinics, the Birth Centre and in the postnatal wards.

On 793 occasions, Language Services was unable to provide an interpreter due to agency interpreters being unavailable. There is a shortage of interpreters in some of the emerging languages and in some of the "old" languages (Italian, Greek, and Arabic).

There is an increasing request for the following languages: Bengali, Burmese, Gujurati, Nepali, Nuer, Pashto, Persian, Rohingya and Swahili.

The Women's maintains a list of 180 consumer fact sheets in 24 community languages. Twenty-two new fact sheets were developed in 2012/13, compliant with the Department of Health guidelines. Consumer Health Information produced four new print publications this year and revised six previous publications and 26 fact sheets.

Standard 4: Indicator 4.1 = 81.2% Indicator 4.2 = 91%

The number of refugee and immigrant women who indicated on the VPSM survey (WAVE 23 July – December 2012) that their cultural and religious needs were met was 81.2%.

The Women's Food Service Operation Plan is designed to meet the cultural and religious needs of our patients and includes detailed reference to the hospital menu, which is in line with Department of Health recommendations and meets the Australian Guide to Healthy Eating.

Appropriate KPIs measure compliance with contractual agreements and are reported on quarterly.

Additional monthly audits measure compliance with quality, safety and patient satisfaction standards. The 2013 Food Survey results indicate that 91% of meals offered met with patients' cultural and religious needs.

Standard 5: Indicator 5.1 = 50% (6/12)

Refugee and immigrant consumers, carers and community members are involved in the planning, improvement and review of programs and services at the Women's.

During 2012/13, 50% of the CAC members were refugees or immigrants.

Standard 6: Indicator 6.1 = 27.8% (572/2061)

All Women's staff are provided opportunities each year to participate in cultural awareness training. Out of 2061 staff, 572 participated in cultural awareness professional development training during 2012/ 13. This represents 27.8%, which is a considerable increase compared to the previous reporting year of 6.3%.

KEY RESULT AREAS 1-4 OF THE IMPROVING CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER (ICAP) PROGRAM

Key result area 1: Establish and maintain relationships with Aboriginal communities and services

Through the Women's Aboriginal Advisory Committee, Aboriginal women are consulted regularly on service planning, implementation and evaluation to improve patient care.

After extensive research and community consultation, Aboriginal and Torres Strait Islander women's health has been included as a priority in the Women's Strategic Plan 2011-2015, in our Diversity Action Plan: Reconciliation 2011-2014, our Community Participation Plan 2011-2015 and Population Health Plan.

The Aboriginal Women's Health Business Unit (AWHBU) and Aboriginal Health Associates provide Aboriginal women and their families with information about the hospital's services, their rights and responsibilities.

The Women's work closely with the local ACCHO and communities, and progress was made during 2012/13 on a Memorandum of Understanding with ACCHO.

Close the Gap Day, Sorry Day and NAIDOC week events and recognition of Aboriginal and Torres Strait Islander Children's Day are acknowledged annually at the Women's. A program of collaborative cultural events has been developed to build relationships and community is invited, through the Aboriginal Advisory Group, to these events.

Every year on Sorry Day, we reaffirm our commitment to righting the wrongs of the past, to commemorate and honour the Stolen Generations and to stop and reflect on our journey towards reconciliation.

In 2013, the Women's signed the Close the Gap Statement of Intent.

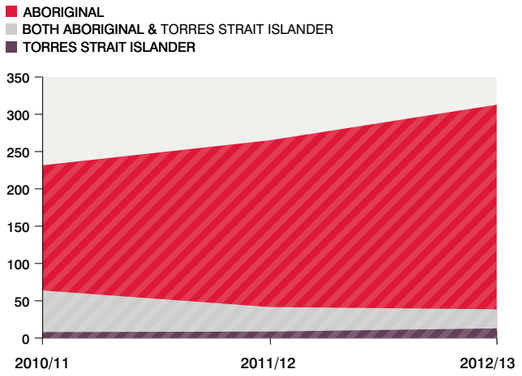
Key result area 2: Provide or coordinate cross-cultural training for hospital staff

The AWHBU runs regular cross-cultural training sessions with all areas of the hospital and works with the Clinical Education team to instil in all staff the importance of identifying Aboriginal and Torres Strait Islander patients, so that culturally responsive care is provided. Aboriginal cultural competency sessions are provided throughout the year. Cross cultural training and 'asking the question' training has been made available to all staff, including development of an online cross cultural training tool.

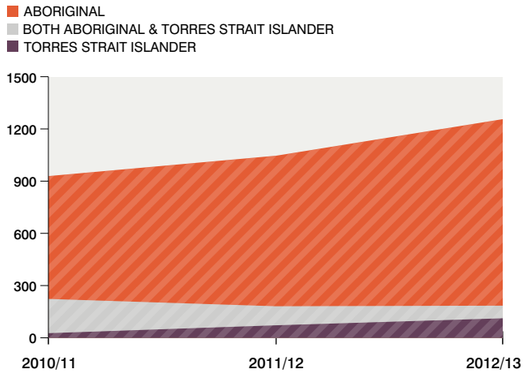
A 'Welcome to Country', which acknowledges the traditional owners of the land, is incorporated into all major hospital events and, when appropriate, a traditional smoking ceremony is performed by a community elder.

Acknowledgement of traditional owners of the land has been placed on the Women's website and the information about the AWHBU is located throughout hospital patient areas, as is health information specific to Aboriginal communities.

Inpatient separations
Aboriginal & Torres Strait Islanders



Outpatient appointments
Aboriginal & Torres Strait Islanders



Key result area 3: Set up and maintain service planning and evaluation processes that ensure the cultural needs of Aboriginal people are addressed when referrals and service needs are being considered, particularly in regard to discharge planning

The Women's AWHBU employs two Aboriginal workers and provides a safe space for women and their families. The unit workers gather feedback from women about their experiences in the service formally via survey and informally. This feedback is provided to the manager of the Unit and utilised in service planning, particularly in regard to discharge planning. Aboriginal staff are involved in development, review and refinement of post acute care and discharge planning arrangements.

Aboriginal-specific post acute planning policies, procedures and protocols are in place. Our Maternity Services Education Program is partnered with the Victorian ACCHO to deliver pregnancy care education to midwives and Aboriginal Health Workers in the Koori Maternity Services.

In 2012/13, the Women's participated in an Aboriginal Nursing and Midwifery Cadetship pilot (see p14). By increasing the numbers of Aboriginal and Torres Strait Islander students that complete nursing and midwifery courses and training in tertiary hospitals, we believe will assist in improving the health of Aboriginal women and their babies.

The Women's also worked with community members to develop culturally sensitive palm cards and online information as part of a Family Violence Action Plan (see p22). These materials have been provided to clinicians and external providers through training events and other meetings.

These and other strategies will be formalised in our Aboriginal Employment Plan, which is part of Karreeta Yirramboi, the Victorian Government's Indigenous Employment Strategy.

Views of Aboriginal organisations and Aboriginal service users are sought regularly. A representative from the Women's Aboriginal Advisory Committee is on the Women's Consumer Advisory Committee.

Key result area 4: Establish referral arrangements to support all hospital staff to make effective primary care referrals and seek the involvement of Aboriginal workers and agencies

Aboriginal staff are involved in development, review and refinement of referrals to primary care through our Aboriginal Women's Health Associates program and the Women's AWHBU.

Views of ACCHO and Aboriginal service users are sought via meetings, consultation and conversations.

A database of referral information and protocols relevant to Aboriginal patients has been developed and implemented, including identification of circumstances where Aboriginal staff should be involved in treatment or communication.

GOVERNANCE

Clinical governance is about being accountable for providing good, safe care to patients and is fundamental to continuous improvement in patient safety.

A 2013 Quality Plan has been developed to align with the Women's Strategic Plan 2011-15, to ensure that the quality of our clinical services is monitored for continual improvement of patient care and safety. The Plan is managed by the Women's Quality and Safety Committee, which reports monthly to the Women's Board Quality Committee. This is consistent with the Department of Health's Clinical Governance Policy Framework.

ACCREDITATION

The quality of care we provide is at the core of our services to the community. We achieved the required National Safety and Quality Care Standards for accreditation at a periodic review in March 2013.

According to the surveyors, the Women's was the first acute hospital in Australia to undergo a survey with the Australian Council of Healthcare Standards under the new National Standards. The survey team were impressed with the level of commitment and passion displayed by our staff, and described the Women's as having a "sophisticated system of governance" and being "a leading organisation in Australia" for consumer participation initiatives.

QUALITY AND SAFETY IMPROVEMENTS

The Women's operates on international best practise in reducing the risk of pressure injuries, falls and faints, and experiences extremely low rates of these events at the hospital. Any incident is taken very seriously, investigated and reported to the Board Quality Committee at monthly meetings. There were no serious injuries reported during 2012/13.

Infection Prevention and Control

The Women's provides care for many patients who are at an increased risk of infection. Any hospital admission carries with it the small possibility of an infection. The more vulnerable the patient and the more procedures required during an admission, the greater the risk of infection.

The Women's Infection Prevention and Control Department works to prevent or minimise the spread of infections by:

- monitoring the infection rates from common procedures, such as surgical operations and insertion and management of intravenous lines
- comparing our infection rates with other hospitals in Melbourne (and more broadly, in Australia and internationally) to ensure we are providing the best possible care
- educating staff around appropriate practices
- auditing compliance with guidelines and practices
- educating and observing staff performing hand hygiene and procedures requiring aseptic technique
- providing easy access for staff to be vaccinated.

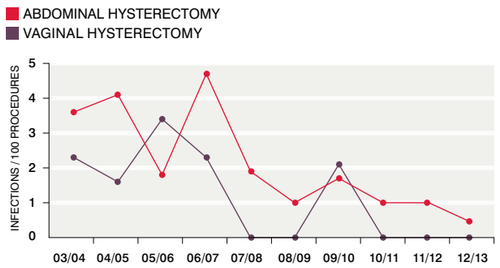
Hysterectomy and Caesarean Section Wound Infections

Infections occurring following a hysterectomy have been monitored by the Women's for six months of each year since 2004 and reported to the Victorian Healthcare Associated Infection Surveillance System (VICNISS) for comparison with other Victorian hospitals.

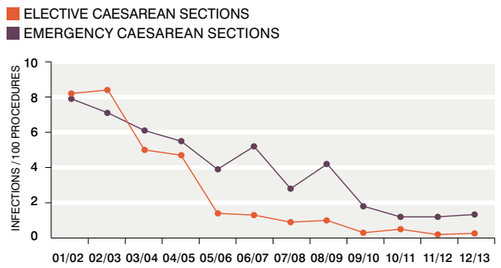
Caesarean section wound infections have been monitored since 2001 and these are also reported to VICNISS. The Women's rates are consistently within or below the VICNISS average rate for Victorian hospitals.

All caesarean section infections are reviewed and a number of factors have resulted in decreased rates of infection. Interventions identified include the timing of antibiotics given during surgery and the length of time the dressing is left on post-surgery.

Hysterectomy wound infection rate / 100 procedures



Caesarean wound infection rate / 100 procedures



Bloodstream Infections

Intravenous therapy (a line or a drip) known as an IV, is used to administer fluid and medication directly into a patient's bloodstream. A central line is when the IV is inserted into one of the body's major veins or arteries, which carries a higher risk of infection.

All healthcare associated bloodstream infections are monitored to determine if they have been caused by the use of an IV line.

Bloodstream infections in babies admitted to the Newborn Intensive and Special Care (NISC) unit are reported to VICNISS. The number of infections is reported against the total number of IV line days for each month. The Women's ranks well within VICNISS average rates for Victorian hospitals.

A Neonatal Infection Working Group meets to review policies and procedures to prevent infections. This group consists of the Infection Prevention and Control Department and NISC doctors and nurses.

2012/2013		
Baby's weight at birth	Central line infections / 1000 central line days	Peripheral line infections / 1000 peripheral line days
< 750 gms	6.3	0
751–1000 gms	0	0
1001–1500 gms	1.7	0
1501–2500 gms	0	0
> 2500 gms	0	0

The number of infections are reported against the total number of line days for each month.

Hand Hygiene

At the Women's, hand hygiene is considered to be everyone's responsibility. Support, education and compliance monitoring are provided by the hospital's Infection Prevention and Control Department under a comprehensive Hand Hygiene Program. The Women's Hand Hygiene Program focuses on four key elements:

1. Education (general and targeting specific groups)
2. Mandatory online competency training
3. Ease of access to hand hygiene facilities
4. Observing (auditing) hand hygiene practices.

Compliance audits are performed three times per year. The World Health Organisation target for compliance is 55% and the Department of Health target for compliance is 70%. At the last audit, the Women's achieved above the minimum compliance targets with a rate of 73%.

2012/2013 Audit Period	Compliance Rate
October 2012	75%
March 2013	74%
June 2013	73%

Vaccination

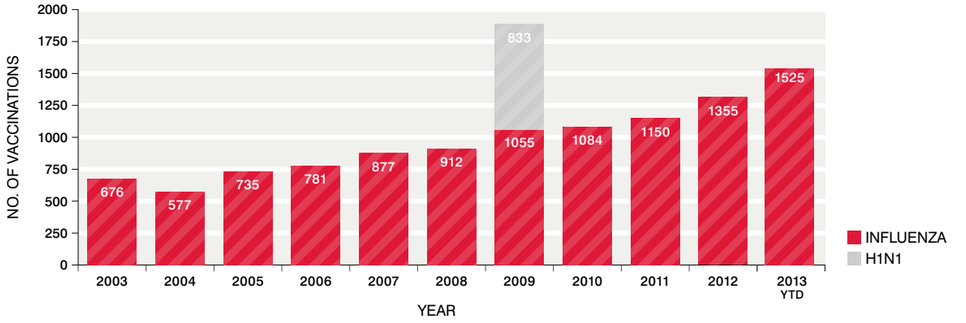
As 'seasonal' influenza (flu) in pregnancy carries an increased risk of complications for mothers and their unborn baby, a free annual flu vaccine is recommended for pregnant women during flu season.

An audit in 2012 revealed that 79% of postnatal patients had not had their flu vaccine. Updated information on flu vaccination during pregnancy is available in the antenatal clinic and ward and can also be viewed on the Women's website.

This information is also disseminated to our Shared Care General Practitioner Affiliates.

The flu vaccine is offered to all antenatal inpatients. Staff are also actively encouraged to have an annual flu vaccination to protect themselves and their vulnerable patients, including newborns. More than 1,500 staff received the flu vaccine this year.

Staff Influenza Vaccinations



Whooping Cough

Whooping cough (pertussis) is an acute, highly contagious respiratory infection, spread person to person by airborne droplets. It is most dangerous for newborn babies because they have no immunity to the disease and can have difficulty breathing.

The government started a whooping cough booster vaccine in 2006 for parents of newborns. However, since the number of cases has now decreased, this program has finished.

A whooping cough booster is still recommended for parents of newborns. This includes women who are planning pregnancy, pregnant (third trimester) or post-partum. Information is available in our antenatal clinic, postnatal units and on the Women's website.

More than 1,150 staff have been immunised since the introduction of the program in 2006.

Directed Donations of Breast Milk

The Women's receives occasional requests from mothers who are unable to produce sufficient breast milk for their baby to use another woman's breast milk.

The Women's formed a working party consisting of doctors, midwives and nurses to review the current practice within the hospital and at other hospitals in Australia. Guidelines have been developed to assist in counselling parents to inform them prior to making the decision to use another woman's breast milk.

The guideline includes advice about the screening of the donor and consumer information.

Safe Use of Blood Products

Obstetric Transfusions:

Safe and available blood for transfusion is an essential part of care for women who experience major bleeding in association with pregnancy and childbirth.

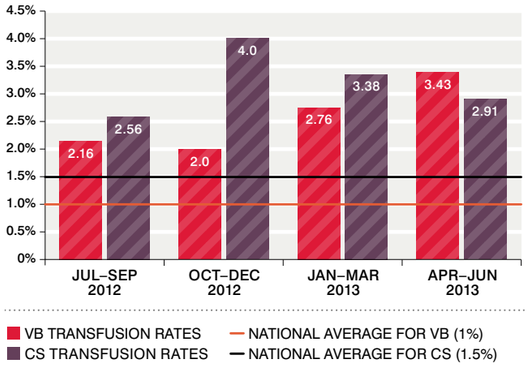
At the Women's we routinely monitor the number of women who receive blood transfusion after vaginal birth or caesarean section birth. This information is compared with national data provided by the ACHS.

Transfusion rates at the Women's are consistently higher from national rates. (see graph)

An audit was undertaken in March 2013 to explore reasons for these differences. Audit results showed that in the majority of cases, blood transfusion was appropriately given and that the increased Women's rates probably reflect the increased numbers of complex patients at this hospital.

Transfusion activity, audits and quality activities are reviewed at the hospital Transfusion Committee which reports to the Quality and Safety Committee.

VB = VAGINAL BIRTH
CS = CAESAREAN SECTION



FEEDBACK AND DISTRIBUTION OF THE QUALITY OF CARE REPORT

Many people have contributed to this year's Quality of Care Report. We are most grateful to the patients, the staff, the Board members, Community Advisory and other committee members, consumers and carers who have shared their stories with us.

Feedback from previous year's reports has been extremely positive. We have taken on board your feedback and focussed more on the individuals who tell the Women's story in their own ways.

Last year's report was distributed throughout the hospital in waiting rooms and communal areas, was mailed to key stakeholders in our community and available on our website www.thewomens.org.au/ReportsPublications.

We value your feedback and encourage you to email us at communications@thewomens.org.au

Pictured: Amer Kut at one of our Young Women's Contraception Workshops

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the women's
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