Improving the care we provide

Annual Quality of Care Report
The Royal Women's Hospital

2001–2002

Contents

Acknowledgments The Royal Women's Hospital would like to gratefully acknowledge the Royal Women's Hospital Community Advisory Committee and the Women's and Children's Health Board of Directors Quality Sub-Committee for their contribution to this report. The Women's and Children's Health Board of Directors wish to acknowledge the work and contribution of all clinicians for their daily efforts to improve the quality of care of our patients and their families.

Introduction

In this, our second annual quality report, changes have been made in response to feedback from our first report published in 2001. As well, there is more detailed input from our Community Advisory Committee on what our consumers want in a report on quality.

The 2001/2002 Annual Quality of Care Report for The Royal Women's Hospital presents information on the quality of clinical services at the hospital. It describes where we have focused resources to improve performance, to improve patient choice and access to services. The report also describes the organisational infrastructure that we believe is a pre-requisite to continually improving our performance.

The Annual Quality of Care Report documents for the consumer and government the activities and systems that The Royal Women's Hospital undertakes to improve the care we provide, but is in no way definitive of all activities being undertaken.

What does The Royal Women's Hospital do?

In 2001/2002 4,794 babies were born at The Royal Women's Hospital, and we cared for over 1,000 premature and sick babies in our Neonatal Intensive and Special Care Nursery.

In addition to caring for the mothers and babies of Victoria, the hospital also provided care for a range of services to women including;

- Gynaecological cancer treatment
- General gynaecological services
- Urogynaecology services
- Reproductive services
- Health Information

Between 35% and 45% of women using our services are born in countries other than Australia.

The Royal Women's Hospital

The Royal Women's Hospital is a specialist hospital ensuring that women's health issues are protected, developed, and improved.

The key to our future development is:

Having women at the focus of the design and delivery of care;

Ensuring our staff's commitment;

Use of appropriate technology;

Advocating for Women's Health.

Maintaining Safety and Improving Quality of Care

The framework for managing safety and quality improvement within the Royal Women's Hospital is that of clinical governance.

Our Board of Directors is required to ensure:

Effective systems are in place to maintain safety and promote improved quality of care;

It receives regular reports from throughout the hospital and monitors that improvements in quality continue to occur.

Ensuring excellence in care

Excellence in care relies on:

- A consumer focus to care
- A willingness to identify mistakes and learn from them
- Regularly reviewing practice
- Ensuring practice is based on good evidence
- A system for credentialing staff

Clinical governance is an umbrella term for all the things that help to maintain and improve high standards of patient care. Although the name is new, clinical governance includes many things already familiar to health clinicians; clinical audits, clinical risk management, evidence-based practice, patient/consumer input and feedback, clinical supervision, continuing professional development and reflective practice.

Consumer focus to care

This means that the needs of our consumers are central to designing our models of care. One way improvement in care is ensured is from the complaints process, this being a key component of a consumer focus to care.

- The complaints process is managed at The Royal Women's Hospital by the consumer advocate.
- The consumer advocate role is to:
- Respond promptly to consumer (and/or family and friends) grievances/complaints;
- Facilitate satisfactory resolution of complaints in partnership with health care professionals;
- Provide advocacy and support to women using our services;
- Resource and support staff to actively participate in complaints management and resolution processes;
- Be a pro-active and integral part of the hospital's quality team in ensuring that our hospital is responsive to the needs of consumers and the wider community.

The Consumer Advocate Service receives an average of 350 complaints each year. 89% of these complaints are resolved to patient's satisfaction.

The following is a summary of trends in complaints occurring over the period July 2001 to June 2002.

Trend one

The majority of complaint issues are associated with 'communication' problems within the organisation, some of which are systemic and others specific to individual service providers. Many were as a result in a breakdown of communication between service areas.

Our response

The hospital introduced a Team Midwifery Care Model in May 2002. It is designed to ensure that patients have access to high quality 'continuity of care', before, during and after the baby is delivered. Patients receive consistent information emanating from a multidisciplinary team of healthcare providers that are assigned to the patients upon the first hospital visit.

Trend two

The 'access' category is the second largest in the number of complaint issues received. The vast majority of issues related to 'waiting lists' and more specifically patients being 'dropped off the list' or 'not been placed' on the list in the first instance.

Our response

The hospital introduced the surgical waiting list form in late 2001. This form was designed to incorporate all key information requirements for both the clinicians and patients, who were each given a completed copy of the form. A new streamlined process to complement the introduction of this form has resulted in a notable decrease of waiting list complaints.

Trend three

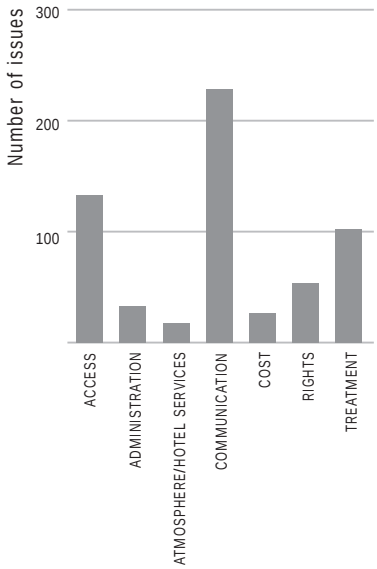
The 'treatment' category rated third in the number of complaints issues. The 'inadequate treatment' subcategory predominantly associated to nursing care featured significantly over the past 12 months.

Our response

The hospital established its own nurse agency the Royal Bank Health Recruitment in late 2001 to ensure a consistently high standard and adequately skilled group of nurses across the hospital.

The number of complaints for the period July 2001 to June 2002 was 363 with an associated 616 issues. This demonstrates the complexity of the complaints made.

Complaint issues by area
for the year July 2001 to June 2002



Willingness to identify mistakes and learn from them

Patient Medical Record Screening

Adverse Events screening is a key component of our hospital's clinical risk management (patient safety) strategy. Patient records are reviewed in order to identify unexpected, unwanted clinical events (adverse events).

This process is now well accepted by clinical staff of the hospital resulting in faster identification and review of adverse events which in turn leads to regular implementation of improvements in care.

In the months July 2001 to June 2002 a total of 548 records were reviewed at our hospital.

Reviewing Practice

In 2002 our hospital embarked on a process of systematic clinical review (audit) which involved all clinical departments.

An example of this audit process was a review of abnormal smear cytology results (which may indicate suspicious cell changes and alert to immediate intervention). The audit found all requirements for reporting and follow up of smear cytology results are being met within our hospital.

Basing practice on good evidence

What does evidence based medicine/practice mean?

Evidence Based Health Care (EBHC) refers to the need for clinical practice to be supported by the most up to date evidence or knowledge available. Evidence and expert opinion are applied to the specific circumstances of each patient with the aim of providing appropriate and high quality care.

Our hospital uses a number of strategies to incorporate EBHC principles into daily practice such as practice guidelines, clinical pathways, multidisciplinary education programs and policies.

Credentialing staff

Credentialing

Ensures all staff are properly qualified and trained to perform the care they provide.

All staff working within our hospital are qualified and registered with prescribed professional bodies.

Credentialing of junior medical staff has been formalised in both obstetrics and gynaecology. This process requires junior staff to attain satisfactory experience in certain areas and provide documentation of sufficient skills to practise in these areas.

Quality activities around our hospital

Research and education

The role of Research and Education Services is to foster and promote research and educational activities in support of clinical services.

The service's Department of Perinatal Medicine and its Pregnancy Research Centre study pregnancy complications such as pre-eclampsia, fetal growth restriction and early pregnancy loss. The research is of value to the whole community because pregnancy complications such as fetal growth restriction can have lasting consequences that not only affect the growth and development of the baby, but also can increase the child's risk of developing diseases such as diabetes, ischaemic heart disease and hypertension later in life.

Research & Education Services organises monthly education seminars to ensure staff are up-to-date with contemporary clinical and research issues at our hospital and in other institutions.

Highlights

The Department of Perinatal Medicine's Pregnancy Research Centre celebrated a decade of clinical and research highlights with the establishment of its new website.

The expertise of Research & Education staff was highlighted by their contribution to the 'Three Centres Consensus Guidelines on Antenatal Care'. The guidelines are used by our hospital and other leading maternity hospitals in Australia to offer world's best practice antenatal care for normal pregnancies. The service also contributed to the development of fetal care guidelines for the Royal Australia and New Zealand College of Obstetrics and Gynaecology.

Community Health Services

Community Health Services is committed to fostering the good health and wellbeing of the women of Victoria. Innovative health programs are developed in response to public needs. The programs address the needs of women across all ages and cultural backgrounds. There is an emphasis on continuity of care in partnership with community providers.

Community Health Services continually reviews and improves its services seeking community input to identify the needs and concerns of women. Community Health Services currently operates the following programs.

Women's Health Program

The Women's Health Program is dedicated to helping the women in Victoria maintain good psychosocial and medical health.

The program helps women make informed choices about their health care by providing the most up-to-date information. It provides screening and health assessment for well women, counselling, support and clinical services for women with unintended pregnancy; as well as contraception, sexual counselling and menopause services.

Violence Against Women Program

The Centre Against Sexual Assault (CASA) provides a range of services to victim/survivors of sexual assault. The program supports women who have experienced sexual assault and undertakes public and professional education on issues related to domestic violence. This year more than 50 educational sessions were presented.

Support and Development Program

The program consists of a wide range of services and activities within the hospital including, Aboriginal Women's Health Business Unit, the Child Care Centre, Community Liaison Worker, Consumer Advocacy Service, Family Accommodation, Pastoral Care, Language Services and Women's Social Support Service.

Highlights:

An important resource for women from diverse cultures became available with the publication of "Responding to Cultural Diversity in Women's Health: A Resource for Health Professionals" written in collaboration with the University of Melbourne's Key Centre for Women's Health in Society.

Women throughout Australia, particularly in rural regions, benefited from the development of the Women's Health Information Centre website and adoption of a 1800 number, both providing access to online consumer health information.

The WOMAN clinic was established, offering a comprehensive nurse assessment service for women over 45 years.

Women's Individual Needs Project

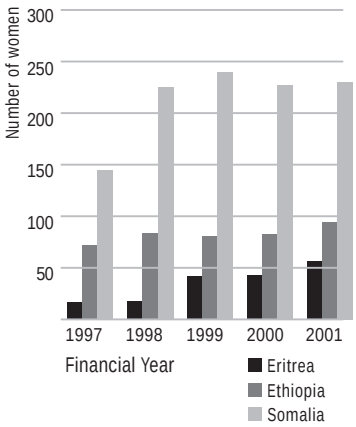
The World Health Organisation definition:

> 'Female genital mutilation comprises all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.'[1]

Our hospital was successful in 1999 in obtaining funding to develop the Women's Individual Needs (WIN) Project. The aim of the project has been to promote culturally sensitive and tailored responses to individual women's needs. One of the groups targeted is women affected by female genital mutilation (FGM) or female circumcision; this practice is culturally based in many communities around the world.

Over the past decade, our hospital has provided birthing care to increasing numbers of women from the Horn of Africa (see graph below), predominantly Somalia, Ethiopia and Eritrea, where female circumcision affects many.

Birthing care at RWH for women from the Horn of Africa



This means there are approximately 100 vaginal births per year to women who have been circumcised[2] or affected by FGM, which often leads to special needs and care during childbirth and in many cases the need for ongoing support.

A key strategy of the WIN project has been to enhance clinical care competency and culturally sensitive practices of medical and midwifery staff through the development of a range of education training resources.

Unique to this process was the inclusion of hospital consumers (Somalian, Ethiopian and Eritrean women) who participated in a series of focus groups to inform the direction and priorities for the clinical practices associated with their obstetric care.

Gynaecological Services

Gynaecological Services is one of the leading providers for the care of women with gynaecological conditions in Victoria.

The service performs in excess of 11,500 surgical procedures each year.

During 2002, a major reorganisation and change in focus occurred in the general gynaecology service. The service is now made up of three general gynaecology units, each with a special | interest and focus:

- Menstrual disorders, typically treated with non-surgical methods;
- Pelvic pain and endometriosis;
- Pelvic floor disorders.

The reorganisation allowed the general gynaecology units to concentrate expertise and carry out best practice by providing women with the best evidenced-based and up-to-date care available.

Gynaecological Services has an active training program for which they are widely known. The Urogynaecological Fellowship is an example. It is the only Fellowship in Australia accredited by the Royal College of Obstetrics and Gynaecology that trains doctors in the sub-speciality. With applicants from around the world, it is a highly sought after position.

Department Of Anaesthesia

The Department of Anaesthesia is responsible for provision of nearly 12,000 anaesthetics and approximately 1500 labour epidurals per year. In addition, the Acute Pain Service reviewed and managed 1,817 post-operative inpatients, cared for 143 High Dependency Unit patients, and reviewed over 4,000 patients in the Pre-operative Assessment Clinic. The department is also responsible for all adult resuscitations within the hospital, and plays an active role in ongoing education regarding acute resuscitation and advanced life support skills for all staff. The department has an active research arm, employs a research nurse, and received a $225,000 NH&MRC grant for one of its projects this year.

High Dependency Unit

Our hospital has a four-bed High Dependency Unit (HDU) located within the Oncology Unit. It is designed to provide care for post-operative and maternity patients who require one-to-one nursing care, and closer medical attention, but do not require intensive care.

Admission numbers to HDU have increased by approximately 43% over the last two years.

In the first six months of 2002, the percentage of obstetric HDU patients has increased from 20% to 39% of the total number of HDU patients.

The increase in patient numbers through the unit reflects the change in patient demographics, with an older obstetric and gynaecological population, who have additional medical problems that need managing.

It is anticipated that this trend will continue over the next 5 years to 10 years.

Waiting list management

In 2001/2002 there has been a large reduction in the total number of women on the waiting list and a reduction in waiting time for women on the Category 2 and 3 lists.

This has occurred as a result of examining waiting list processes through the Designing Care Project which involved consultation with consumers and increased operating session utilisation strategies.

The success of the Designing Care project is measured in a 75% reduction in complaints about waiting list access issues made to the consumer advocate and a 50% reduction in the number of women who fail to attend at their Pre-Admission Clinic appointment in 2001/2002.

RWH ELECTIVE SURGERY PERFORMANCE 2001/2002	2001	2002
CATEGORY 1 PROPORTION OF PATIENTS ADMITTED WITHIN 30 DAYS (%)	100	100
CATEGORY 2 PROPORTION OF PATIENTS ADMITTED WITHIN 90 DAYS (%)	100	100
AVERAGE WAITING TIME (DAYS) FOR CATEGORY 2 PATIENTS ON THE WAITING LIST AS AT JUNE 30TH	29.3	24.5
AVERAGE WAITING TIME (DAYS) FOR CATEGORY 3 PATIENTS ON THE WAITING LIST AS AT JUNE 30TH	136	114
TOTAL WAITING LIST	680	396

How do we make sure that women waiting for surgery receive an operation date as soon as possible?

All operating sessions are booked with the aim of making sure that women in Category 1 and 2 have their surgery performed within the time frames set by DHS, Category 3 women receive an operation date as soon as possible.

At the time of diagnosis and when the decision for surgery is made, all women are given their own copy of the waiting list form that states they are on the waiting list for an operation. This form has telephone numbers to ring if the woman has any questions about the time frame for her operation, the type of operation that is required, the category (urgency that the operation is needed) and an approximate time to wait for surgery. In addition, women allocated to the Category 3 schedule have contact numbers and instructions to make an appointment at the Gynaecology Clinic for review if they have not received an operation date within six months. Women are encouraged to return at anytime if they feel their symptoms have got worse.

How do we know that names we have on our waiting list are current?

When women are added to the waiting list they are given information with instructions requesting that they notify the hospital of any change of contact details, phone numbers and address. Our hospital regularly contacts women on the waiting lists to ascertain if they still require or wish to have the surgery performed. A check is also made of their contact details to ensure that the waiting lists are accurate and up-to-date at all times.

Hospital initiated postponements

During 2001/2002 a total of 3,152 women who were on our hospital waiting list had an operation date allocated to them. There were 139 cancellations of which 32 were initiated by patients (various reasons given) and a further 17 patients failed to attend.

90 postponements were initiated by The Royal Women's Hospital for the following reasons:

REASON FOR HOSPITAL INITIATED CANCELLATION	NUMBER
INDUSTRIAL ACTION	4
LIST OVERRUN DUE TO OPERATION COMPLICATIONS	14
LIST OVERBOOKED	14
MEDICALLY UNFIT (COLD, FLU, PRE-EXISTING MEDICAL CONDITION)	34
PATIENT DID NOT FAST	4
HOSPITAL BOOKING ERROR	3
INSUFFICIENT HOSPITAL STAFF – ANAESTHETIST	6
– NURSES	0
SURGERY NO LONGER APPROPRIATE (PREGNANT) OR REQUIRED (RESOLVED, CONSERVATIVE R_x OPTION FOLLOWING REVIEW)	11
Total	90

Clinical Indicators for Gynaecology Services

Clinical Indicators are used to measure clinical management and outcomes of patient care.

During 2001/2002 the surgical indicators identified by DHS were collected. The number of identified operations undertaken were extremely small therefore these indicators are neither appropriate nor useful for the scope of work performed at the hospital.

Gynaecology Services are now in the process of identifying useful indicators that will allow us to measure the appropriateness and effectiveness of the care we give.

Discharge framework

Over the last twelve months the hospital has focused on developing a hospital-wide framework for effective discharge.

Improvements include:

A discharge policy and procedure has been written and a hospital-wide process of identifying women with complex needs and who require additional care planning for discharge has been developed.

Referral pathways for encouraging women back in to the community have also been developed and staff have use of a resource directory to assist them in this process.

The promotion of an electronic discharge summary as an effective communication tool with community based care providers.

Linkages have been promoted with community based services.

An occupational therapy consultancy to identify our hospital's occupational therapy requirements was conducted and as a result a centralised system for lending of aids and appliances (eg frames, bath seats, crutches) necessary for a safe discharge has been established.

Maternity Services

Maternity Services offers a comprehensive range of services to childbearing women in order to meet the needs of its socially and culturally diverse consumer population.

TEAMCARE Model

During 2001-2002, Maternity Services underwent a major change when it adopted The Royal Women's Hospital TEAMCARE model.

> The new model places women at the centre of care, offering increased continuity of care and giving them the opportunity to make informed choices about the model of care they wish to adopt for their pregnancy and birth experience.

Midwives play a primary role in the care of women with uncomplicated pregnancies whilst obstetricians lead small, multidisciplinary teams in a range of sub-specialties to provide care for high-risk women.

The TEAMCARE model allows Maternity Services to provide individualised care for women within a team-based environment where dedicated doctors, midwives and allied health professionals work collegially to achieve the best possible outcomes for women and babies in terms of both safety and satisfaction.

Patient Satisfaction

The DHS 'Patient Satisfaction Monitor' for maternity patients at our hospital was 2% lower than the state average for other maternity hospitals in 2001. The change in philosophy and structure as outlined above are all aimed to address the issues identified from this survey.

Maternity Results

	RWH	HOSPITAL CATEGORY AVERAGE
OVERALL CARE INDEX	66	68
ACCESS AND ADMISSION	69	69
GENERAL PATIENT INFORMATION	69	71
TREATMENT AND RELATED INFORMATION	67	69
COMPLAINTS MANAGEMENT	66	70
PHYSICAL ENVIRONMENT	56	61
DISCHARGE AND FOLLOW UP	66	70

Clinical Indicators for Maternity Services

In 2000, The Royal Women's Hospital, in partnership with the Centre for the Study of Mothers' and Children's Health and the Health Issues Centre, was contracted by the Department of Human Services to develop a set of performance indicators for use across the state's maternity hospitals. The Final Report, 'Measuring Maternity Care'[3], published in May 2001, recommends the implementation of nine performance indicators for the state. Our hospital is now in the process of collecting and reporting on these indicators with the first report using the indicators due later this year.

> Consumers will soon be able to compare the performance of all maternity services on these principles and indicators[4].

Women's Hospitals Australasia

Women's Hospitals Australasia (WHA) is a national organisation advocating for the health care needs of women and neonates in Australia and New Zealand. It represents all major women's hospitals and health units throughout Australia and New Zealand. As a member of this organisation The Royal Women's Hospital regularly reports key performance data, which can be measured against other women's health services to allow comparison of performance and benchmarking.

An example of data sent is below:

Caesarean section rates (a lower number is preferable as this means there is less radical intervention involved). The hospital's rate is consistent at 23.81%. The overall average for WHA group was 23.45%.

Vaginal birth after caesarean section (a higher number is preferable, as this means there is an increase in more natural birthing). The hospital has a rate of 12.79% compared to WHA average of 28.14%. A new protocol has been developed to improve this rate.

Neonatal death rates (per 1000) The hospital has recorded fewer deaths of babies (than expected) than the state average over five years. This means the hospital is doing well in managing the care of high-risk patients over a period of time[5].

Instrumental deliveries against all vaginal deliveries (a lower number is preferable as this means there is less intervention during birth). The hospital rate is 17.23% of deliveries use instruments against all vaginal deliveries. The WHA overall average was 14.49%.

It should be noted that although this data is representative and useful, it does have some limitations. The Royal Women's Hospital is a large tertiary referral hospital, which accepts patients in higher risk categories and this data may not truly reflect outcomes against clinical care and performance.

The challenge in the application of indicators is to achieve consistency in definition, data entry and collection and also in analysis and reporting methods.

Evidence Based Practice for Maternity Services

The Three Centres' Consensus Guidelines on Antenatal Care were published in October 2001. The objective of these guidelines is to provide Mercy Hospital for Women, Southern Health Service and The Royal Women's Hospital with consensus statements on aspects of antenatal care for low risk women based on the best available evidence.

The guidelines provide information enabling the integration of evidence with experience and clinical judgement in antenatal care. The guidelines have been adopted into practice as part of the new TEAMCARE model.

Baby Friendly Hospital

In 1995, The Royal Women's Hospital became the first public hospital in Australia to achieve the status of a 'Baby Friendly Hospital'. Our hospital was re-accredited as Baby Friendly in 1999. The next assessment for re-accreditation is due shortly. The review process is undertaken by The Australian College of Midwives and is based on the World Health Organisation (WHO)/UNICEF process.

The Baby Friendly Hospital initiative is a worldwide accreditation program aimed at improving breastfeeding rates. To achieve accreditation, hospitals undergo a review process and are required to provide evidence of positive practices to support, encourage and assist women in their decision to breastfeed.

> The Royal Women's Hospital has maintained breastfeeding rates at discharge between 80% and 88% between 1998 and 2002.

Regular audits are conducted to ensure that our hospital complies with the WHO Ten Steps to Successful Breastfeeding.

Neonatal Services

The Intensive and Special Care Nurseries at The Royal Women's Hospital are the largest in Victoria. The nurseries are recognised for their skill in treating extremely premature infants and other sick babies born at term.

There were 1100 admissions during 2001. 98 babies were admitted between 23-27 weeks gestation, with birth-weights ranging from 365 grams to 1315 grams. The overall survival rate for infants born between 25-30 weeks gestation is now 92%.

Babies are considered to be full term when they are born around their due date or within 2-3 weeks of this i.e. between 37-42 weeks gestation. During 2001, 337 term babies were admitted to the Special Care Nursery and a further 106 to the Intensive Care Unit.

> The Newborn Baby Research Centre has expanded this year, and now has the most active research program in newborn care in the country, with an international reputation for excellence.

Research is vital when considering and evaluating new methods of care, and current studies include exploring the most effective way to help premature babies breath following birth, learning about brain development in premature babies and how to improve this, and the development of tests for early detection of infections.

Neonatal Services rated highly when compared with or benchmarked against other Australian and New Zealand Neonatal Services using the ANZ Neonatal Network data set.

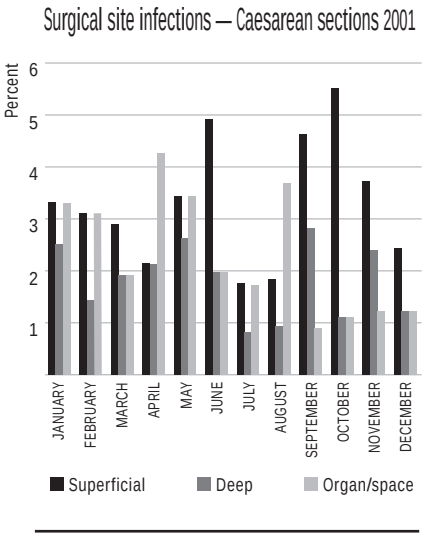
Neonatal Services is the centre for three international research trials and approximately ten clinical trials are in progress. It was the most productive neonatal unit in terms of presentations at the Australia and New Zealand Perinatal Society meeting, and has been awarded five NHMRC grants.

Infection Control

The purpose of infection control is to manage and prevent the transmission of infection. The Royal Women's Hospital Infection Control Service is responsible for:

- development and review of infection control polices and procedures;
- education of staff and patients. The service is an important resource for information about obstetric and gynaecological infections as well as infection control issues;
- promotion of staff health through an active immunisation program; and
- monitoring and investigation of infections which may occur whilst patients are in hospital, and after they are discharged home.

Monitoring and Investigation of Infection



The focus over the last twelve months has been on caesarean sections and premature babies.

Whilst the hospital's current caesarian infection rate is slightly higher than the recommended threshold, measures have been put in place to address this issue. Links have been established with other maternity services across Melbourne and interstate to provide comparison rates for infections.

Premature babies in the intensive care nursery have an increased risk of infection. Their ability to fight infection is not well developed and they undergo many high-risk procedures. The most common risk for these babies is bloodstream infections. This may be due to the presence of intravenous lines essential for the treatment and feeding of these infants. By monitoring this population, the rate of infection and the factors responsible for infection can be identified. Hand washing reminders, correct antibiotic use and skin preparation are important ways of reducing infection rates. The incidence of blood stream infections over the past twelve months have been below the accepted average.

Appendix One

Maternity Performance Indicators

Principle 1

Maternity services provide optimal safety for women and babies

1.1 Standardised perinatal mortality ratio.

1.2 The rate of term infants transferred or admitted to special care nursery or neonatal intensive care unit for reasons other than birth defects.

Principle 2

Maternity services ensure early detection and appropriate interventions where appropriate

2.1 The rate of administration of antenatal corticosteroids to women delivered or transferred prior to 34 weeks gestation.

Principle 3

Maternity services provide appropriate clinical care

3.1 The rate of vaginal birth amongst women in the birth immediately following a primary caesarean section.

3.2 Outcomes for the standard primipara including 3rd and 4th degree tears, induction of labour and caesarean section.

Principle 4

Maternity services promote parenting confidence and optimal health of mothers and their babies

4.1 The proportion of women offered appropriate interventions in relation to smoking.

4.2 The provision of appropriate breastfeeding support and advice.

Principle 5

Maternity services respond to the needs of a diverse range of women and are customer-focused

5.1 The proportion of women who receive timely hospital antenatal clinical services.

5.2 The proportion of women of non-English speaking backgrounds without proficiency in English, who receive appropriate interpreter services.

References

1. Female Genital Mutilation. A joint WHO/UNICEF/UNFPA Statement. Geneva, World Health Organisation 1997 – Page 3
2. RWH Obstetric Network Database 2001
3. Department of Human Services, Victoria. *Measuring Maternity Care – A Set of Performance Indicators, 2001*
4. See Appendix 1
5. Perinatal Data Collection Unit. *Hospital Profile of Perinatal Data – The Royal Women's Hospital 1999*

Feedback Form

RWH Annual Quality Report

Please tick applicable category

☐ Consumer

☐ Department of Human Services, Victoria

☐ Women's and Children's Health Clinician

☐ Clinician from other organisation

☐ Other

Please comment on this year's report:

How could the report be more meaningful for you?

Once completed, please return this form to:

Quality Coordinator, Clinical Analysis and Development Unit
Royal Children's Hospital
Flemington Rd, Parkville
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