



OUR JOURNEY CONTINUES...

QUALITY

OF CARE

REPORT 2004

THE ROYAL WOMEN'S HOSPITAL MELBOURNE

THE ROYAL



WOMEN'S
HOSPITAL



WE LISTEN

WE CARE
WE CHANGE

AND WE GROW

The Royal Women's Hospital is Australia's largest specialist hospital dedicated to improving the health of all women and newborn babies throughout the journey of life. The Women's is committed to a holistic philosophy of health and provides comprehensive health services ranging from health promotion to clinical intervention. We provide clinical expertise and leadership in maternity services, gynaecology, cancer services and care of newborn babies.

OUR JOURNEY CONTINUES...

INTRODUCTION

MESSAGE FROM THE ROYAL WOMEN'S HOSPITAL

We are pleased to present The Royal Women's Hospital Annual Quality of Care Report.

This report is one way in which our hospital exercises its responsibilities on clinical governance. The Board, management and clinical leadership of the hospital has a responsibility to ensure that we have the right systems in place to monitor and improve the quality and safety of care provided to women, babies and families. The Quality of Care Report is a public account of those systems and of the outcomes of our care.

We are confident that we have the right people and the right processes in place to ensure the quality of our care to our patients. Yet we also know that the pursuit of quality is a continual journey – there are always further improvements to be achieved.

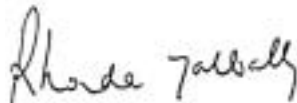
This is a very exciting time in the life of the Women's. We now have our own Board of Directors and we are looking forward to the redevelopment of the Women's at its new location adjacent to the Royal Melbourne Hospital. There has been broad consultation with Victorian women on how they view and value their hospital and we are making sure that this consultation continues throughout the redevelopment project. The five community principles identified through the consultation continue to underpin our partnership with our community and provide criteria against which the redevelopment is tested. These principles are: community values, quality, access, service options and patient care.

Our 2003 priority was to support a reflective approach to the review of our clinical performance. Over the last 12 months, as a result of our efforts, we believe that we have made considerable progress towards a more open, transparent and accountable culture.

If there are errors that occur in our care, our practice is to be accountable and to learn from such errors. A priority for this year will be to formalise open disclosure by implementing 'Open Disclosure' standards at The Royal Women's Hospital.



Dale Fisher
Interim CEO



Rhonda Galbally
Chair, The Royal Women's Hospital Board

THE JOURNEY CONTINUES

This is the fourth Women's Quality of Care Report. The aim of the report is to inform the women for whom the hospital provides services, our community, staff and community partners, the public and the Department of Human Services about the quality and safety of health care provided. The report conveys information about how we improve quality and safety of clinical care, our progress, data about how we compare with other hospitals and what we think our most important priorities are. This is a constant journey.

Since last year's report, we have held a number of group discussions with women who use the Women's and received feedback about what they thought about the report. We found that the women liked the detail in the report and had suggestions about how to improve it. We returned to some of those women this year after our initial planning and tried to improve the report based on their views. We worked with our Community Advisory Committee and the Quality and Safety Committee. The information provided has been a collaboration of work by clinicians, consumers and staff at the Women's.

As far as possible, we have organised the report around how women use the hospital rather than how we organise and manage the hospital. This year, we describe three service pathways: pregnancy and childbirth, women's health, which includes gynaecology and cancer services, and neonatal services for premature and sick babies.

We serve women from many countries and cultural backgrounds and this reflects patterns of migration and asylum in Australia. We meet a diverse range of women's clinical needs. The Women's acknowledges the special debt we owe to indigenous Australian women and their families because of the role played by hospitals such as ours in the past separation of families.

CLINICAL GOVERNANCE

Clinical governance is how we are responsible and accountable for quality and safety of care. Our two key committees for the past year have been the Women's Quality and Safety Committee and the Quality Subcommittee of the Board of Women's & Children's Health, to which we reported on quality and safety every two months. The Women's Quality and Safety Committee met monthly and discussed quality and safety issues brought to it and how to improve the processes and systems so that our clinical staff provide excellent care. Clinical managers from the executive of the hospital are on this committee, which has good multidisciplinary membership and attendance.

The Women's has a Quality and Safety Plan. We checked our Quality and Safety Plan against the framework developed this year by the Victorian Quality Council and are confident that it is consistent with that framework. The Women's Quality and Safety plan is based on:

- providing leadership and management on quality and safety
- using the best available research evidence to inform clinical services
- identifying and managing risks to patients and staff
- engaging consumers
- access to services
- constant effort for quality improvement
- committed, qualified and competent staff.

This provides a framework for quality and safety activities across the hospital. Each clinical area develops its own quality plan based on this. The clinical directors and managers are responsible for quality and safety in their areas of responsibility. The Quality and Safety Unit works closely with them. We are able to use the Quality and Safety Plan to monitor how we are going.

On July 1, we separated from Women's & Children's Health to become The Royal Women's Hospital and this will require confirmation of our future directions. Based on our analysis of our progress against the Victorian Quality Council Framework, our priorities will be to:

- consolidate current proactive, learning and reflective approach to clinical incidents, errors and near misses
- consolidate senior clinical commitment and leadership
- ensure we have good data systems to support clinical review
- continue to build capacity through staff education and training in leadership, change management and quality and safety methods
- strengthen the role of patient/consumers.

ACCREDITATION

The Victorian Government requires all health services to achieve and maintain accreditation with an approved accrediting body. In Victoria acute hospitals are accredited through the Australian Council on Health Care Standards (ACHS). Accreditation is awarded when it has been demonstrated that hospital performance meets the ACHS standards.

The Women's underwent re-accreditation late in 2002 as part of Women's & Children's Health, and was fully accredited, with no high priority recommendations for improvement, and a number of recommendations. With the recent disaggregation of Women's and Children's Health back to separate sites, the Women's will undertake its stand alone Periodic Review in March 2005.

WHAT DO CONSUMERS WANT FROM THE HOSPITAL?

- **Community values**, including retention of a women's health service and traditions of cultural and religious respect.
- **Quality** of staff, technology and teaching, training and research.
- **Access**, including access by patients as well as access to technology, expertise and research.
- A balance in **service options** between critical care and community care, general and specialist services, and obstetrics and gynaecology.
- Family-friendly patient care which responds to the needs of the whole patient, and which protects privacy and dignity.
- These **community principles** are integrated throughout the content of this report, and will be used to highlight how we address quality and safety in all aspects of the care we provide.

The Women's
provides services
for a culturally and
linguistically diverse
community



OUR DIVERSE COMMUNITY

The Women's is one of Australia's largest hospitals specialising in the health of women and babies. The hospital fosters a holistic approach to care and has an important role to play as an advocate for women, to ensure equity of access and quality health care.

The Women's has always had a more culturally and linguistically diverse community of women using the hospital than many other Victorian hospitals. A broad social mix of women uses our service with a broad clinical range of women's health issues. Women from all over Melbourne and Victoria attend the Women's for any of the full range of services we provide.

The last year was a very busy year at the Women's. We had 575 more births than last year and our neonatal unit operated at and above its capacity for much of the time. The demand for allied health was stable after increases the previous year. We have one of the largest outpatient services in Victoria. Forty four percent of women using our outpatients services were born overseas.

2003/2004	
Inpatient stays	30,476
Outpatient visits	146,338
Emergency visits	26,378
Births	5,252

OUR INDIGENOUS COMMUNITY

A significant number of women who were inpatients identify themselves as Australian born (21,753). Of these women, 157 women identified as Aboriginal or Torres Strait Islander. Whilst this number remained constant for the last two years, it represented an increase over the last four years. This is most likely explained by increased awareness of the Aboriginal Women's Health Business Unit (AWHBU) and improved service responses to indigenous women.

The AWHBU provides support and advocacy for indigenous women and their families accessing hospital services and links back to indigenous communities and services. Supported by hospital liaison officers and a Women's working group, the Unit is implementing recommendations from the 'Bringing Them Home Report'.

Some of the initiatives that have been implemented include:

- flying both the Aboriginal and Torres Strait Islander flags outside the hospital to acknowledge Aboriginal land and to symbolise welcome to indigenous Australian women and their families
- hosting annual ceremonies to mark the Journey of Healing. This event acknowledges the harm done to Aboriginal communities and is a contribution towards reconciliation
- adopting standard protocols acknowledging the traditional owners to be used at all Women's events
- examining how hospital records can be made more accessible to indigenous women and their families wanting to trace their relatives.

CULTURAL AND LINGUISTIC DIVERSITY

Women from many cultural backgrounds attend our hospital, with most overseas born non-English speaking women coming from Lebanon, Turkey, Vietnam and China. There has been a significant increase in the number of Arabic speaking women from Iraq and African women from Ethiopia and Somalia, during the last four years. These figures reflect broader changes in migration trends. We also see this as a reflection of the important service the Women's provides to refugees, some of whom have suffered torture and trauma and who may have significant and complex clinical and social support needs.

During the coming year, the Women's will be working on a Cultural Diversity Policy to make sure that cultural diversity principles affect all the ways we provide services. The Women's provides language services for women attending the hospital and provides on-site interpreters in a range of languages. In circumstances where there is no one on site who can speak a woman's language, we arrange a telephone interpreter.



Caroline Briggs, AWHBU

Given this diverse community, it is important that staff are skilled in using interpreters. A working party has been set up and a staff

survey conducted in February 2004 to gain insight into issues for staff and to improve language services provided.

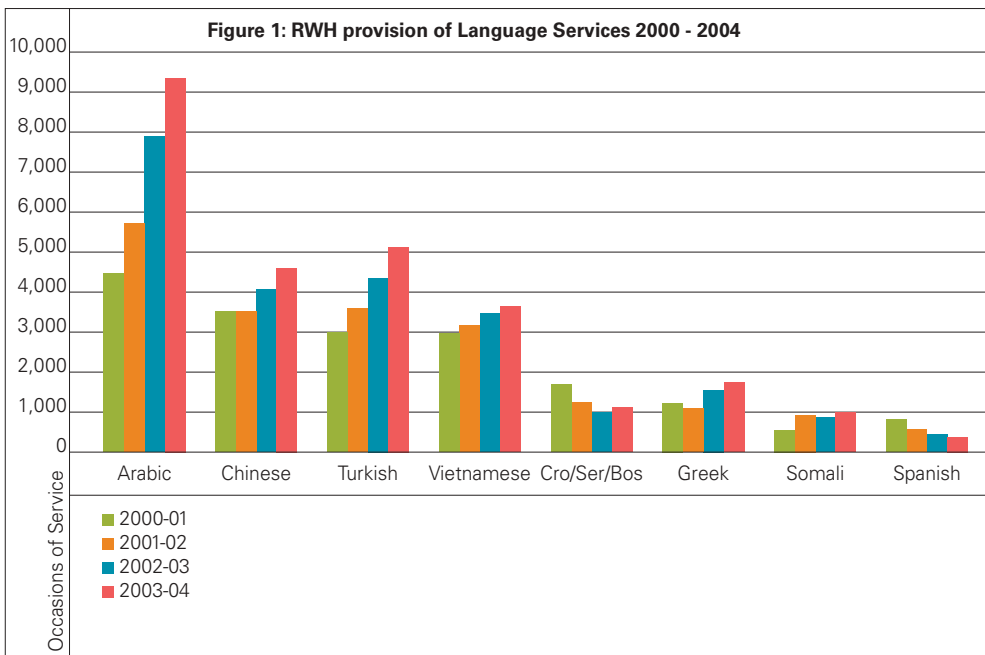
SACRED SPACE

One of the challenges in providing services to such a diverse population is providing for the spiritual needs of women and their families. In October 2002 an extensive consultation was undertaken which included management, staff, interested individuals and community groups to consider the redevelopment needs of the Sacred Space at the Women's and to provide a universal place of worship. About 50 people forming the Advisory Group attended the workshops, representing many faiths and beliefs. The workshops were facilitated by an architect who has consulted on many similar projects.

The outcomes of this consultation provided a number of design concepts aimed at providing a special place of sacred potential. This fosters mutual respect and is accessible to those of various faiths, beliefs and traditions providing a sanctuary for the hospital community—patients, staff and visitors.

A refurbishment of the Sacred Space at the Women's, incorporating the essential design concepts, will be implemented in 2004-2005 while awaiting development of a new Sacred Space when the Women's moves to the new Parkville site in 2008.

For more information about our pastoral care and spirituality services go to: www.rwh.org.au/pcss



This graph demonstrates that Arabic, Chinese, Turkish and Vietnamese continue to be the languages in most demand, with usage continuing to increase in 2003/04.

COMMUNITY PRINCIPLE – ACCESS

The Family and Reproductive Rights Education Program (FARREP)

The Women's provides support, information, cultural advocacy and referral for women from communities affected by Female Genital Mutilation (FGM). A team comprising three workers from Ethiopia, Somalia and Eritrea who work with a rights based, public health approach have over the last year:

- provided regular clinical training for all staff on clinical, social and cultural issues for women affected by FGM
- conducted childbirth education in conjunction with community health services on birthing issues with 32 sessions held in 2003
- supported a health services information and orientation program for young women from the Horn of Africa
- advocated for the provision of halal food for inpatients at the Women's.

For further information, check the website: www.rwh.org.au/fgm

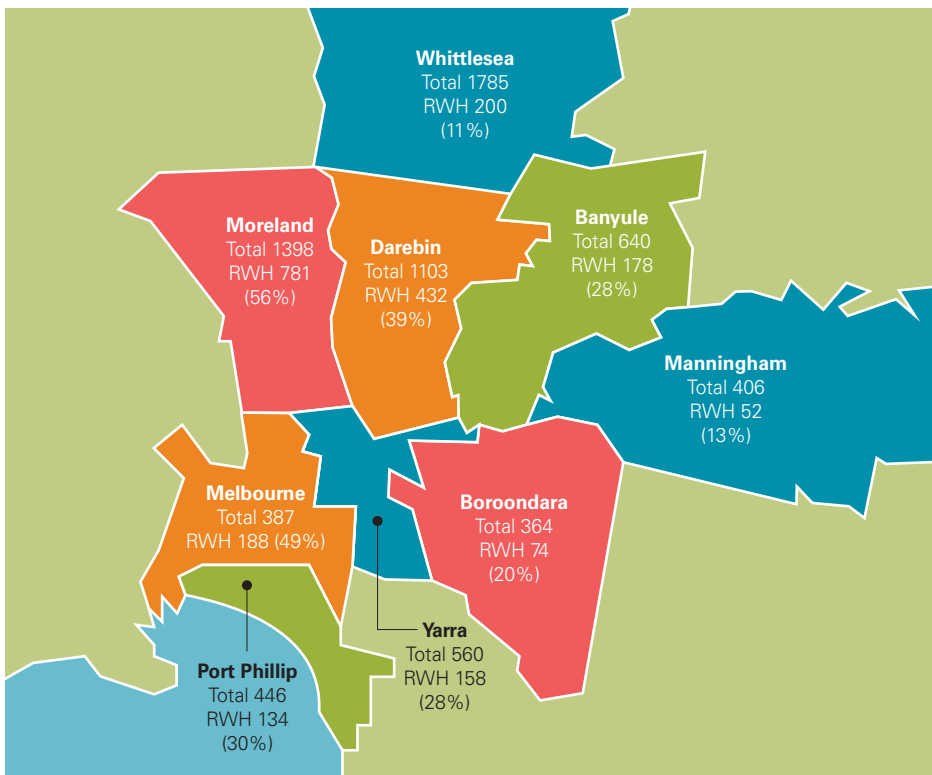


A diversity of ages

The age range of women coming to the Women's has remained the same as last year, with 85% of women aged between 20 and 50 years, 10% aged over 50 and a small number aged 20 years and younger. Of these women:

- 91% receiving maternity care were aged between 20 and 39 years
- the largest number of maternity inpatients were between 30 and 39 years
- 24% receiving care for cancer or dysplasia were aged between 20 and 29 years
- 58% of women over 70 who were inpatients received care for cancer
- 37% receiving gynaecological care were aged between 30 and 39 years.

Diagram 1: Births at the Women's as a percentage of total public hospital births



From all over Victoria and Australia

The Women's cares for women coming from all over the state and some from interstate. The highest number of women came from Broadmeadows, Preston, Whittlesea, Keilor and Coburg.

The Women's also plays an important role in service consultation to the broader community. During 2004, we responded to a request by rural health workers in Bendigo and Swan Hill in considering the health needs of rural women, including indigenous women. Information about how the Women's resources could be accessed was discussed, including the Women's Health Information Centre (WHIC) 1800 country phone service, the on-line health nurse facility and the Well Women's Website, as well as specialist services including the Pregnancy Advisory Service.

SKILLING AND SUPPORTING OUR STAFF

Because the Women's is a teaching hospital, there is considerable variation in the experience of our doctors and midwives and it is important that we support our staff and work to create a safe, reliable hospital.

Some of the diversity in our community is found also in our staff. In particular we train many overseas doctors in obstetrics, gynaecology and neonatology. What do we do to make sure that our staff are adequately skilled and trained?

CREDENTIALLING OF JUNIOR MEDICAL STAFF

The Women's has a commitment to training the next generation of obstetricians to the highest level. The Women's developed a credentialling document during 2003 that allows closely supervised training and evaluation of practical obstetric skills. Trainee doctors are provided with the credentialling document that outlines the requirements necessary when they commence at the Women's. Rather than measuring how often a trainee obstetrician has assisted women during childbirth, this credentialling system will record only those procedures supervised by a consultant. This makes sure trainee obstetricians have the necessary skills. In future, the credentialling process will include gynaecological surgical skills and communication skills.

CREDENTIALLING OF SENIOR MEDICAL STAFF

In 2004, the Women's is testing a method to credential senior medical staff in four areas: obstetrics, gynaecology, anaesthetics and neonatal medicine. The pilot units will involve the head of the unit confidentially discussing five domains of practice with staff individually. Following a review of the methods, this approach will be applied across all senior medical staff at the Women's. The five domains are:

- components of good medical practice
- professional development
- the specialist's goals, tasks and results
- review of appropriate areas of responsibility
- career planning and development.

THE MIDWIFERY SKILLS SELF ASSESSMENT TOOL

The Midwifery Skills Self Assessment Tool (MidSSAT) is currently being developed based on standards and guidelines established by the Nurses Board Victoria and the Australian College of Midwives. The MidSSAT is a self assessment tool that will be undertaken by individual midwives to analyse and develop their clinical skills. Information regarding professional development needs will also inform the Women's clinical staff development priorities. The MidSSAT will then be evaluated after six months.

THE ROLE OF THE NURSE PRACTITIONER

Many nurses at the Women's are working in advanced practice and are experts and leaders in their field. Some of these nurses are actively working towards being accredited as 'Nurse Practitioners'. This is a lengthy process whereby specific criteria must be met. This involves a rigorous assessment.

The Women's Health Assessment Clinic has participated in the DHS Nurse Practitioner Project as a demonstration model for Women's Health. There are five Women's Health Nurses working in the clinic, and their extended practice includes prescription of certain medications, initiation of diagnostics such as ultrasound, mammograms and pathology, referral to specialist services and writing sick leave certificates. Nurse Practitioners are qualified to undertake these tasks independently.

ATTRACTING AND RETAINING GOOD STAFF

All of these measures are important in attracting good staff. For example, in last year's Quality of Care Report, we reported on work that was done to improve teamwork and the morale of nurses in the neonatal unit. This process has had a significant impact on staff morale and recruitment and retention of nurses, as shown by:

- a reduction in neonatal nursing vacancies from 17 to none
- reduced turnover and attrition, especially in skilled and senior positions
- an increase in the number of applications for neonatal nursing positions.

OTHER INITIATIVES TO IMPROVE WORKING LIFE

Other initiatives in 2003/04 to support staff include:

- a new bullying policy
- a workplace aggression and violence policy
- working with clerical staff to improve their role as part of the team.

TRAINING
FOR THE
NEXT
GENERATION



JEAN WONG

We thought that you might like to know more about how we train young doctors and provide quality care as we do this. We have illustrated this by an interview with one of our senior registrars, Jean Wong who is in her sixth and final year of Obstetric and Gynaecology (O&G) training. Since we interviewed Jean, she gave birth at the Women's to a daughter, Sophie.

Q: What is your role as senior registrar?

Jean: "There are two of us this year – Wei Qing Huang and myself – and we also work in the Quality and Safety Unit as Clinical Effectiveness Fellows. This allows us to learn about clinical risk management, as we have previously had very little exposure to non-clinical work. Apart from this, we also supervise the registrars and residents in areas such as gynaecology operating, elective Caesarean sections and labour ward, as well as attending clinics".

Q: What have been the most important things that you have learned at the Women's to help you to become a good obstetrician?

"One of the most important things I have learned at the Women's about being a good obstetrician is communication and teamwork. This is at least in part because the Quality and Safety Unit has a high profile in this organisation, and they have made an effort to teach all involved with clinical medicine about these skills. I feel that this has made us more aware about the factors that can influence our work environment. Part of the major advantage of being trained at The

Royal Women's Hospital is the sheer breadth of work we are exposed to in obstetrics and gynaecology.

I think working with women is probably the best part of the job. I am constantly surprised at how open patients are willing to be, and how much access they give you into their personal lives. It is a privilege to be trusted like this."

Q: What does the Women's do to make sure that new junior doctors gain skills while we provide safe care to women?

"The Quality and Safety Unit has invested a lot of energy in educating junior doctors about the elements of safety in our workplace. This is usually via formal teaching as well as informal discussions and feedback, but I think one of the factors of most assistance is the reporting culture that has been instilled in our work environment. This encourages all of us to think about the systems and other factors that contribute to any adverse event and to learn from them.

Teaching clinical skills is done by simulated teaching, such as the laparoscopic skills and surgical skills workshops, as well as supervised learning. Junior staff have the opportunity to learn at almost every juncture in their working days from discussion with registrars and consultants, to labour ward and theatre, where skills are taught first via assisting and then being supervised as the resident or registrar gains more experience."

COMMUNITY PRINCIPLE – QUALITY

Providing sensitive clinical practice for women

Many surveys on women's health have identified that women are concerned about how sensitively vaginal examinations and Pap tests are done.

We have developed a specialised teaching program working intensively with small groups to teach examination skills using pelvic models and women as teaching associates. In 2004, the team of doctors who designed the learning model were

joint recipients of the new Norman Curry Award from the University of Melbourne, recognising Innovation and Excellence in Support of and Service to Teaching and Learning.



At the Women's,
we learn how
to improve our
services from
consumer feedback
and participation

HOW DOES THE HOSPITAL ENGAGE WITH CONSUMERS?

The Women's values consumer participation and consumer feedback and recognises that the consumer movement has become an increasingly important part of the hospital's service.

THE COMMUNITY ADVISORY COMMITTEE ON WOMEN'S HEALTH

The role of the Community Advisory Committee on Women's Health (CACWH) is to consider the best interests of current and potential service users of the Women's as well as their partners, carers and families. The CACWH advises the Board, management and staff on strategies to place consumers at the centre of service design in all aspects of women's health planning and delivery. It is comprised of ten women who each participate in a range of ways in the community and have links back to particular communities who come to the Women's at different points of their lives.

The membership of the CACWH has been reviewed over the past year and specific strategies put in place to draw on the diversity of the Women's community, particularly Arabic speaking women. A broad recruitment strategy over the next year will aim to improve membership from the aboriginal community, young women and consumers from rural regions of Victoria.

The CACWH provided advice to guide the Board on a community participation and consumer engagement framework. This framework assists the Chief Executive Officer to report to the Board on progress on consumer participation.

The Community Participation Plan has also been developed by the CACWH to assist patients who wish to be involved in improving services within the hospital. This plan will apply to each area of the hospital. We have already found it invaluable in the promotion of community participation in the redevelopment of the Women's.

The Community Advisory Committee has been closely involved in all the redevelopment planning to date and will ensure that the voice of the community continues to be heard. For more information go to: www.rwh.org.au/cacwh

LEARNING FROM OUR CONSUMERS – PATIENT SATISFACTION SURVEY

The Department of Human Services undertakes a state wide patient satisfaction monitor. In 2002/2003 the Women's improved our maternity result across all measures. We increased our satisfaction level by five points to the Victorian average (92%). This is on track with our predictions that with the introduction of TeamCare, a more permanent midwifery workforce and improved physical facilities, women's satisfaction would improve.

The overall satisfaction rate for gynaecology services was 94%. The index of care improved from 70 to 72 to be significantly better than average. The responsiveness of nurses improved from 91% to 96% and was maintained at that level.

Women think that the Women's staff:

- manage admission and pre-admission information well
- are helpful, available and courteous and treat women with respect – this improved over the last three years
- provide opportunities to ask questions and have got better at being prepared to listen to problems.

Women thought that areas for improvement are:

- more relevant information about looking after their condition at home
- the restfulness of the hospital
- the quality of food.

Women have a very high level of confidence in the doctors at the Women's. At the same time, they would like them to be more uniformly courteous. Women think that doctors could be better at explaining their treatment and what is happening and also explain more about medicines and their side effects.

We are pleased that women think that we have improved the way staff relate with women. Work done to improve admission and pre-admission is also reflected in survey results. The sense of privacy in the hospital has improved over the past three years, reflecting work done to improve patient accommodation and reduce the number of women in each room.

RESOLVING THE CONCERNS AND COMPLAINTS OF CONSUMERS - CONSUMER ADVOCATES

The Consumer Advocate Service provides support and advocacy for women to be 'active' health consumers and to express their concerns or dissatisfaction about their care. We understand that it is not always easy to make a complaint, but if there is a problem we encourage women to let us know, firstly so we can resolve their concerns as quickly as possible and secondly because the information we obtain from this feedback can be used to identify service improvements.

The location of our Consumer Advocate Service within the Quality and Safety Program ensures that this 'feedback loop' is complete. Every complaint has the potential to inform service improvement and patient care initiatives.

There were 327 complaints managed through the Consumer Advocate Service this year, less than last year when 375 complaints were received. The consumer advocates have been working hard to support staff to respond and resolve patients' concerns at the point of service. Whilst the numbers of complaints are lower, the complaints are more complex than previously. For example, a woman had planned to have her baby in our Family Birth Centre but ended up having an emergency Caesarean. Whilst pleased about the safe delivery of her baby, she felt traumatized by the delivery. Several weeks following the birth of the baby she contacted the Consumer Advocates. They organised a meeting between the family and senior clinical staff to discuss her concerns, which included the quality of the communication during the emergency and issues related to her postnatal care.

In another example, there has been an increase in the number of women seeking support to access female doctors.

Our consumer advocates are one of the groups of designated staff who are available to support women as part of our Gender Provider Policy. The majority of women who have accessed this support have done so for religious and cultural reasons.

As with previous years, the three main areas of complaint are communication, treatment and access. Thirty six percent of complaints received related to poor communication such as abruptness, lack of interest and inadequate information about treatment and outcomes. The hospital has been keen to respond to this trend and we established a multidisciplinary team to work out some strategies including:

- teaching of effective communication skills as part of the 'credentialling' process of all junior medical staff
- researching effective communication models for a variety of situations to establish best practice.

PROVIDING WOMEN WITH GOOD HEALTH INFORMATION

We have continued to develop written information for women to increase their understanding of their health situation and assist them to make decisions. Over the last year, we have developed the following information, which is also available online at: www.rwh.org.au/wellwomens.

Some of this information is also available in other community languages:

- Having Your Baby at the Women's
- Pregnancy Advisory Services (PAS)
- Endometriosis – Information for Women
- Treating Endometriosis with Laparoscopy
- Simply Breastfeeding
- Preparing for Pregnancy.

The Women's Health Information Centre has a specialised women's health library where women can browse and borrow books and videos. Brochures and newsletters from a wide range of sources are available, and information is available in languages other than English.

We also provide a free, confidential statewide service for women, offering advice, support and referral (country callers 1800 442 007). A women's health nurse/midwife is available to discuss all aspects of women's health, including pregnancy and childbirth. Women can call the telephone hotline, drop in, visit the website or have advice emailed.

COMMUNITY PRINCIPLE – ACCESS

Providing information: Preparing families for post mortem

We reported last year that we had implemented new procedures in relation to discussion and consent to post mortem. These included new consent procedures, a family information booklet, new consent forms, and a training package and program for doctors, developed with the help of community members and staff.

Because the Arabic speaking community comprises one of our largest non-english speaking communities, we sought the assistance of a group of Arabic speaking women to translate this information into Arabic. We did not know what the cultural meaning of a post-mortem was for these women, particularly as many Islamic people bury their dead within 24 hours. Through sensitive consultation, we found out that detail about post mortem was of interest

to the women, and provided them with important information about why their baby has died. The women consulted said that knowing why a baby had died was more important than burying the baby within 24 hours, and this should be explained to their husbands or partners. Because of this understanding, we will continue to develop this information in a range of community languages with the assistance of community members.

OUR COMMUNITY LINKS

Partnerships between hospitals and the community are more important than ever, and the Women's continues to develop these relationships to ensure that care planning for all of women's health care needs spans the service from before hospital, at hospital and again at home.

SHARED MATERNITY CARE

Our Shared Maternity Care Program is where women are cared for by their local doctor and/or community midwife (who have been accredited as shared care providers) as well as by the hospital. Additional services provided by the Women's include:

- a Shared Care Coordinator who is available for non-urgent contact for both shared care providers and women
- 24 hour access to obstetricians to discuss urgent or complex clinical issues
- a GP who works in the hospital to improve links with GPs
- direct referral to the Pregnancy Day Service. The referring community provider is notified within 48 hours of the outcome of the visit
- access to the hospital inpatient clinical management system (called CLARA) for the women they care for, via secure internet access from their rooms.

The Women's has now developed a joint accreditation and re-accreditation criteria and process for shared maternity care along with Mercy Hospital for Women and Sunshine Hospital. This was developed in consultation with the Royal Australian College of General Practitioners and General Practice Divisions of Victoria. This means there will be a single process to be re-accredited as a shared care

provider at all three hospitals from 2005. The GP access website (www.rwh.org.au/gpaccess) has been further improved and incorporates Clinical Practice Guidelines, information for women undertaking shared care in Arabic, Turkish, Somali and Vietnamese and extensive continuing professional activities available to GPs and community midwives.

The 'Find a GP' strategy continues for women without a GP. Posters encourage women to ask the help of doctors and nurses in finding a GP and staff have been educated in order to assist (computer desktops have been linked to the appropriate 'Better Health Channel' site and linked to printers).

Audits have been undertaken in:

- GP assessment and timeliness of Electronic Discharge Summaries. The timeliness has improved and they were rated as informative, relevant and assisting with women's care. Suggestions for improvement have been implemented.
- A profile of women using shared maternity care found that over 85% of women register for shared care with their regular doctor or practice. In addition, about half of the women undertaking shared care have their initial antenatal tests ordered by their doctor before their first hospital appointment.

COMMUNITY PRINCIPLE – ACCESS

'The Women's @ Home' telephone service

This year the Women's @ Home was established. This service was established because we wanted to improve our communication with community practitioners to assist in the planning and provision of coordinated services for women. As part of the first stage, a dedicated telephone/fax line for Maternal and Child Health Nurses was introduced in April 2004. Maternal and Child Health Nurses can contact us through this dedicated line to discuss the care of women and infants recently discharged. An evaluation is planned for 2004.

For more information about 'The Women's @ Home' service, or discharge planning go to: www.rwh.org.au/discharge or phone 03 9344 2324

NORTHERN COMMUNITY LINKS

We have participated with community organisations in the northern suburbs of Melbourne and Department of Human Services (DHS) to establish the Primary Care Partnership Strategy to improve communication and referral between hospitals and Maternal Child Health Nurses (MCHN).

Our achievements have been:

- Establishment of a network with health professionals as well as consumers.
- Development of tools to improve communication, including the new 'Women's @ Home' telephone/fax service for MCHN.
- Establishment of a working group internet "Chat Room" to discuss issues, maintain communication and organise joint forums. The Women's hosted the first forum in March.

We also established a committee to make sure that the strategies identified by the Primary Care Partnership were properly implemented at the Women's. This has ensured that hospital wide policies and guidelines are promoted to improve discharge planning and ensure continuity of care for women between hospital and home. For example, this group has identified the need for occupational therapy services.

HAVING A COMMUNITY PRESENCE

Absolutely women's health is a health promotion program that is one of the community faces of the Women's (www.rwh.org.au/wellwomens/awh.cfm). We work with other community organisations to organise events at the hospital, through which we aim to celebrate, inform, debate and discuss contemporary and controversial health issues that affect women's health. Over the past year, 3,496 people, including 577 young women, have attended our events.

We successfully engage other organisations and women with the hospital by:

- attracting women to different services at the RWH
- asking for yearly feedback and health issues they would like us to address
- providing consumers and staff with opportunities to update their knowledge on health issues
- raising the profile of topical women's health issues within the hospital and the community
- providing RWH staff with an opportunity to hear consumer health needs first hand that can inform and change practice
- providing consumers with access to interact with clinicians and influence RWH health care.

COMMUNITY PRINCIPLE – COMMUNITY VALUES

Centre Against Sexual Assault

The Centre Against Sexual Assault (CASA House) provides 24 hour crisis care and business hours telephone and face to face counselling, advocacy and support for around 1,500 victim/survivors of sexual assault each year. The Statewide Sexual Assault Crisis Line arranges access to crisis care for approximately 500 women and men across the state and receives around 7,000 calls for telephone counselling, advocacy and support. Both services provide consultation to a range of practitioners, community and professional education and work toward the prevention of sexual assault.

In the last year, CASA House has been working with the State-wide Steering Committee to Reduce Sexual Assault and the AFL in response to recent publicity about sexual assault. The aim is to develop strategies for player education, and develop community awareness campaigns to develop a climate of respect for women. In collaboration with the Western Bulldogs, CASA House is also developing a program for secondary schools in the region to foster respect in relationships.

Both services are working with the Victorian CASA Forum to organize Home Truths, the first international conference to be held in Victoria, which will bring together practitioners, victim/survivors, researchers and policy makers to consider best practice and initiatives for domestic violence and sexual assault.

See: www.rwh.org.au/casa

A SAFE HOSPITAL IS ONE THAT ALWAYS LEARNS

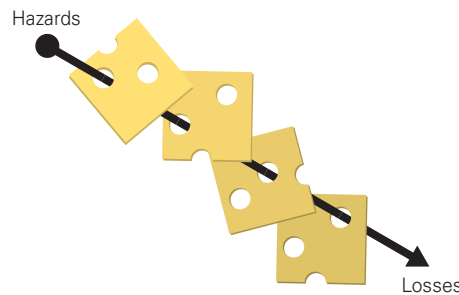
In our Quality of Care Report last year, we said that we wanted to create a hospital where we learned not only from what we do well, but also when we don't do well enough. We want to know when there are errors from human mistakes or from processes and systems. We describe this as a learning, reflective culture.

Our philosophy is to support a 'no blame' culture. This means that we encourage our staff to report things that go wrong and we use this information to improve our systems and processes rather than blaming individuals. In this chapter, we describe a number of ways we do this.

ROOT CAUSE ANALYSIS

Since last year, we have made progress in establishing a 'no blame' culture. One way we have done this is through conducting a number of root cause analyses (RCA). Root cause analysis is a multidisciplinary team approach that is used when something serious goes wrong to identify what happened, why it happened and what can be done to prevent it happening again. We use an image of Swiss cheese, to show that serious mistakes happen when more than one thing goes wrong. Because staff are human, errors will occasionally occur, but our job is to put protective processes and systems around patients so that these errors do not have bad outcomes.

Diagram 2: Process and system failures turn human error into adverse patient outcomes



Staff who have been involved when something goes wrong have either been part of our RCA teams or have been interviewed in the investigation. At times patients have been interviewed as well. This has often led to good solutions. This has been an important way of demonstrating that we are not blaming staff but looking to improve processes and systems. At the same time, we expect that our staff behave as responsible and conscientious professional people and that part of that is being open when things go wrong and learning from it. We think that we are making progress on a 'no blame' reflective culture because people are increasingly willing to report things that go wrong and keen to undertake Root Cause Analysis when it is serious.

INCIDENT REPORTING

This year we worked on improving our incident reporting policy and procedures. Over the past 12 months, staff have reported a total of 346 incidents. This is an increase from 226 incidents reported last year. This means that staff members, including doctors, are more willing to report incidents. The largest proportion of incidents reported (38%) still relate to medication errors.

Other incidents reported by staff include:

- care co-ordination, within the hospital and with other community health care services.
- communication breakdown
- equipment issues
- inadequate documentation
- managing issues related to aggression and security.

Improvements from incident reporting include:

- following analysis of a gynaecology surgical burn, changes in how surgeons use the equipment as well as checking and replacing equipment
- improving the process of obtaining consent for autopsy and the information provided to parents
- a hospital wide work practice audit on accurate labelling of blood specimens
- improving the way women are allocated to the various models of maternity antenatal care so that they get the right care for their pregnancy
- the introduction of an Alert sheet in the medical record to standardise the documentation of allergies and sensitivities as well as other factors that clinicians need to take into account.

SENTINEL EVENTS

Sentinel events are unusual incidents that cause significant harm to patients and result from process and system problems. These are reported to the Department of Human Services and include maternal deaths, surgery on the wrong patient or the wrong side of the patient, and medication error that resulted in death.

In 2003/04, the Women's reported two sentinel events, both involving a retained pack following Caesarean section. A surgical pack is used to absorb blood during surgery. In the first, the problem was identified immediately and surgery undertaken to remove the pack. The second was more serious as the key safety process, the pack count, failed to identify that this had happened resulting in a prolonged stay in hospital after the pack was removed. On these occasions, we have explained to the women what has happened, apologised and informed them about our root cause analysis process and the progress of our investigations.

Examples of recommendations from these RCAs include:

- plans to change the surgical drapes used in theatre for Caesarean section
- doing an extra pack count if an obstetrician is called away and the other obstetrician has to complete the operation
- developing and disseminating a team protocol when the pack count is unreconciled at point of final closure, which includes an X-ray while the patient is still in theatre
- policy that elective (planned) Caesarean sections are not to be performed by the 'emergency' team who are providing coverage of the birthing suites unless there are exceptional reasons.

SCREENING OF PATIENT RECORDS

Experienced clinicians review patient records where particular events occurred to make sure the care was appropriate. Their reports are discussed monthly at the Quality and Safety Committee and improvements discussed. This is the last line of detection of a preventable clinical incident. We are now almost always aware of preventable incidents before the screener's report. This means that our policy of encouraging incident reporting is working.

This provides us with an additional opportunity to review particular clinical events. An experienced obstetrician, for example, reviewed 46 cases of shoulder dystocia. Shoulder dystocia occurs during birth when the leading shoulder of the baby becomes wedged behind the mother's pubic bone. While this can lead to complications, it is well accepted that the skill of the clinician can ensure safe birthing. Clinical guidelines are now readily available on the website (www.rwh.org.au/rwhcpg/maternity.cfm). Regular 'hands on' rehearsals with midwives and doctors are held using models. Of the shoulder dystocia cases reviewed, all but one were regarded as well managed.

PATIENT FALLS

Over the past 12 months, 13 falls involving patients or relatives were reported. Falls are not a particularly critical issue at the Women's, although there is a risk in older women. Six of the 13 falls were associated with fainting. Of these, three were men fainting during a procedure performed on their partner.

In response to these incidents and a directive to all hospitals from the State Coroner, a Falls Prevention and Management Procedure has been developed which details a process for screening and communicating the identified risk in the medical record and 'Alert Sheet'.

PRESSURE ULCERS

As reported in 2002/2003, we again had no pressure ulcers in 2003/2004. This is a small risk at the Women's compared with other hospitals. There are two groups for whom we take special precautions – premature babies and women with cancer. Cancer patients who are receiving palliative care are nursed with positional changes.

As we reported last year, our biggest group at risk of pressure injuries are premature babies, particularly when they have very relaxed muscles. The neonatal nurses lay premature babies on sheepskin and turn them frequently. The main pressure injury risk is from the tubes for breathing and catheters. The Neonatal Unit have noticed that more early signs occur when there is an intake of new nurses and then reduce once there has been intensive training.

As part of a Victorian Quality Council project, we are obtaining pressure reduction foam mattresses for high risk areas to further reduce risks.

THE STORY OF A CLINICAL RISK

Some of our doctors and midwives noticed that there appeared to be an increased incidence of post partum haemorrhages (bleeding after child birth). Post partum haemorrhage matters because, if uncontrolled, there is risk of maternal death. We undertook audits, which found a higher rate than expected. We found that most serious post partum haemorrhages were properly managed, but some could have been managed better.

Speaking with other Australian tertiary hospitals, we found they were also concerned. Using comparative data from other Australasian hospitals, we were able to compare our rates and found that although higher than previously reported rates, they were similar to comparable units.

Our response

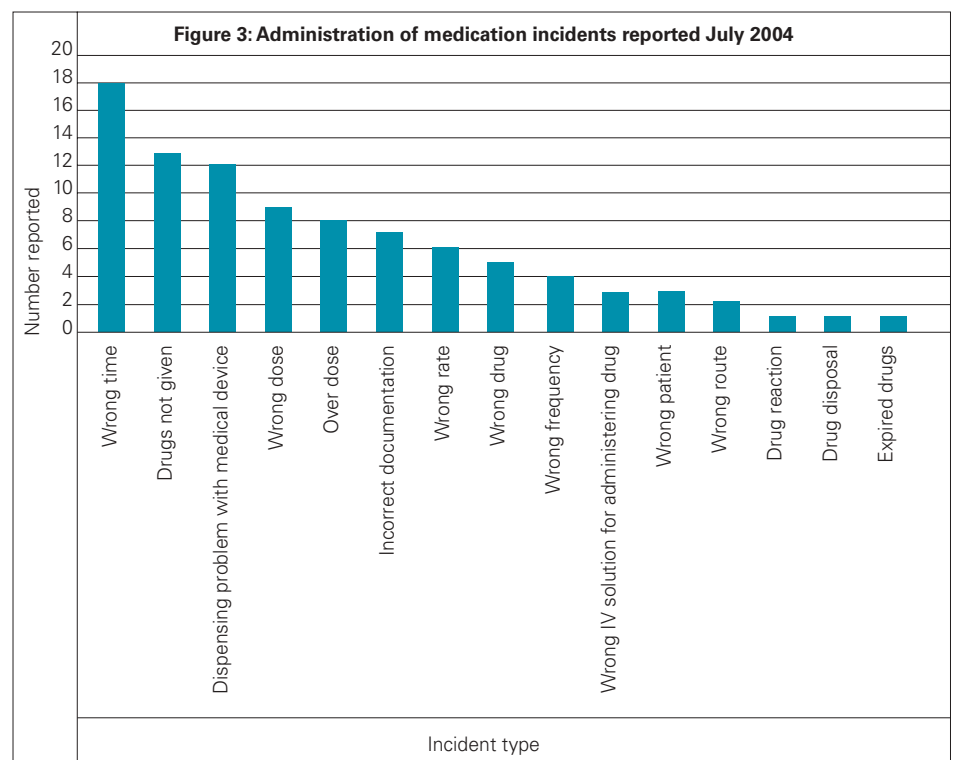
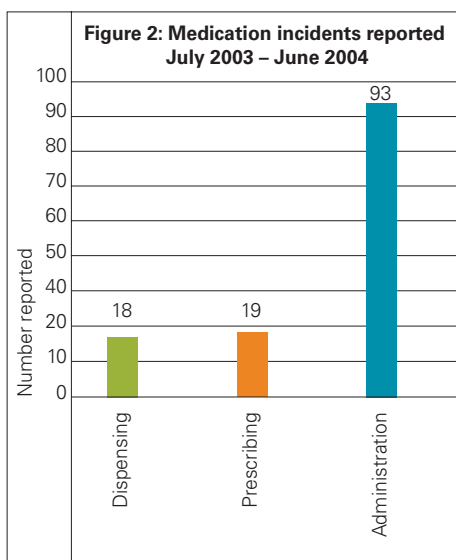
- We developed and trained our staff in a new Clinical Practice Guideline based on evidence on managing the third stage of labour (when the placenta is delivered).
- We highlighted post partum haemorrhage, for example, at clinical handovers.
- We are establishing a clinical forum with other Australian and New Zealand hospitals, who are part of Women’s Hospitals Australasia, to collaborate on a project to measure and improve post-partum haemorrhage rates.
- This will be a major focus over the next 12 months. We are convinced we can reduce our rate and will report this in next year’s Quality of Care Report.

MEDICATION INCIDENTS

The Women’s Medication Safety Committee is now well established after 14 months with excellent attendance and participation. Members contribute issues directly to the meeting from their clinical staff, therefore underpinning the importance of the clinical breadth of the membership. Issues also come directly through the Quality and Safety Unit, either as an incident or as a general issue brought to their attention. Reports from the Consumer Advocate’s office have also been useful. Most incidents reported were administration errors and most did not result in harm. The graphs below depict the numbers of errors occurring during the process of prescribing, dispensing and administering medications. By tracking where errors occur, as in these charts, we can work on specific ways to improve what we do.

Some of these are:

- A medication policy outlining the prescribing, dispensing and administration responsibilities has been developed and monitored.
- Pharmacy is conducting education about medication policy for medical staff including the Emergency Department.
- The manufacturer being notified about problems with one of the drugs in epidural packaging.
- Incidents involving Gentamycin, one of our most common drugs, were reviewed. Pharmacy compiled administration guidelines, available with the Clinical Practice Guidelines on the intranet.
- Inconsistency with new urine pregnancy testing kits has been addressed through improved staff education.
- Potassium chloride, a drug which is dangerous in the wrong concentration, has been removed from ward stock and premixed potassium chloride solutions introduced.



The Women's is well known in the community for its birthing service



HAVING A BABY AT THE WOMEN'S

Our hospital is probably best known in the community for its birthing services. Over the last year, 5,252 babies were born with 131 sets of twins and three sets of triplets. This number is 575 more babies than were born at the hospital last year.

We have now reached our second year of 'TeamCare'. Women are cared for by teams of midwives and obstetricians throughout pregnancy, childbirth and postnatally in hospital and at home. The major aim is to offer better continuity in those caring for all women. Midwifery-led care is provided to women with uncomplicated pregnancies. Obstetricians, working with teams of midwives, provide care for women with more complicated pregnancies. Twenty-eight percent of women are cared for by these higher risk teams.

TeamCare is a major initiative and is in line with the approach described in Victoria's Future Directions for Maternity Services (2004). Since we introduced TeamCare to the Women's in 2002, we have focussed on creating teams, training staff and implementing the hand-held pregnancy record, which provides women with information about their pregnancy.

MATERNITY HIGHLIGHTS FOR 2003/04

- TeamCare – maintained the number of permanent midwifery staff in excess of 85%, which assists us in providing continuity of care to women.
- We doubled the number of clinical practice guidelines (CPG) we developed and made public for community health care professionals. Guidelines available on the internet increased from 30 to 64. We have on average 300 plus site visits per day.
- Some CPGs now include health information for consumers about their health condition, which are available from the website or provided to them by their carer. For information go to: www.rwh.org.au/rwhcpg
- Introduced 'Women's @ Home' telephone/fax service for Maternal and Child Health Nurses wanting information about mothers and babies cared for at the hospital. For information go to: www.rwh.org.au/discharge
- Evaluated the hand-held pregnancy record and made significant improvements in format and content. There will be a full evaluation in 2005.

For more information about pregnancy hand-held records go to: www.rwh.org.au/sharedcare

Improving Breastfeeding Education and Support Services

In 2003/04, we reviewed the Breastfeeding Education and Support Services (BESS) to support women choosing to breastfeed and be more responsive to women's needs. To date, BESS has introduced many of the recommendations of the review including:

- providing phone access to a lactation consultant, thus promoting access to services
- implementing a weekly breastfeeding outpatient clinic

- increasing the availability of lactation services to women in the maternity wards and special care nursery
- monitoring success through the development of electronic record keeping and data collection.

In May 2004, BESS launched the 'Breastfeeding: Best Practice Guidelines' which were developed in consultation with a multidisciplinary team of health professionals and consumers. The guidelines present a framework for providers to assist mothers and babies establish breastfeeding. (see: www.rwh.org.au/rwhcpg)

BESS actively promotes the Baby Friendly Hospital Assessment guidelines and in the coming year will lead the hospital toward once again achieving Baby Friendly Hospital reaccreditation.

Promotion of early contact and breastfeeding following a Caesarean birth

We have introduced new practices to reduce the separation of women from their babies and partners after an elective Caesarean birth. A Practice Statement was developed after consumers and maternity staff identified that more could be done to improve contact and breastfeeding between mother and baby following a Caesarean birth. A trial was successfully conducted between March and August 2003 and the practice is now to promote early skin to skin contact and breastfeeding in the recovery area and reduce separation of the woman from her partner/support person.



KELLIE HADDRICK
ASSOCIATE UNIT
MANAGER FAMILY
BIRTH CENTRE
(FBC)

Kellie: "FBC is part of the Maternity Care Program for women with low risk pregnancies. We promote a homelike relaxed environment. Women stay on in the same room postnatally, often with their partners. We visit women in their homes postnatally. Some women are now coming back for second and third babies and it's great when you know them."

Q: What do you enjoy most about your job? Why is this so important?

"I love being with women and supporting them through pregnancy, labour and birth. It is a huge privilege to be able to do it. It is even more special when you can get to know the women and their families. I love the fact we are doing everything and that it changes on a daily basis. Improved continuity of care and the follow through of women is something we aim to improve all the time. This is a team effort."

Q: How does training and support for other staff impact on your job?

"We have students and new graduates rotate through the FBC to learn about birth care. As part of my role I support and teach them. Whilst this can take up quite a lot of time, the feedback from students is positive because their time at the birth centre always follows what they are learning at University."

SUPPORTING WOMEN WITH DIFFICULT PREGNANCIES

Providing comprehensive services to all women, particularly those with pregnancies that are more complex is a priority. Teamwork is crucial to how we support women. Medical services work closely with social workers, dieticians, counsellors and physiotherapists to provide care. Here are a few examples.

Women with multiple pregnancies:

In 2003/04 of the 5,252 babies born at the Women's, 2.4% were multiple births. All women attending the Multiple Pregnancy Clinic are screened by a dietician to ensure information is provided about diet and nutrition. This provides an opportunity to discuss with women some of the eating problems that can arise with multiple pregnancies. The nutrition department has contributed to knowledge about multiple births in a paper published in the Australian journal 'Twin Research' and a presentation at the 'Multiple Pregnancy Conference' held in Melbourne late 2003.

Managing 'morning sickness'

Approximately 60-90% of women experience some form of nausea and vomiting in the early stages of normal pregnancies (between 6-16 weeks gestation). Severe and prolonged nausea and vomiting in pregnancy is known as 'hyperemesis' and approximately 1% experience this condition. We have improved management of hyperemesis with a new approach aimed at preventing dehydration (a common consequence of severe vomiting),

and improving diet to help control symptoms and reduce nutritional complications. With the support of medical staff, dieticians, the Pregnancy Day Care staff and intravenous (IV) nurses, women are encouraged to attend the Pregnancy Day Care Centre for IV hydration at least two to three times a week while severe symptoms persist. This approach also requires appropriate use of anti-vomiting medication ('antiemetics'). For more information on hyperemesis go to:

www.rwh.org.au/rwhcpg

Antenatal support group for women needing a hospital stay whilst pregnant

The Women's Social Support Service (WSSS) established a new antenatal support group for women admitted to hospital due to pregnancy complications. This group was established because we observed that a hospital stay whilst pregnant can be a stressful and lonely experience. Women are often separated for long periods of time from their family and friends. Given that the length of stay varies for each woman, this group is open throughout the year to provide a supportive environment where women can discuss their reactions and concerns. After an initial eight-week trial period, the evaluation from women was positive, and as a result the group will continue to run on an ongoing basis.

For more information about WSSS go to: www.rwh.org.au/discharge

COMMUNITY PRINCIPLE – SERVICE OPTIONS

Genetic counselling

There has been a recent growing awareness of screening and prenatal testing options in pregnancy. In response, the Women's Genetics Service has begun surveying

women at their first antenatal visit in the Pregnancy Booking Clinic, to assess how they would like to receive information regarding options of screening tests and diagnostic tests in pregnancy. Women of all

ages have been consulted and these results are currently being evaluated, so that Genetics Services can improve services to women and their partners.

Priorities for Maternity Services for 2004/05:

- Audits of the number of carers a woman sees throughout her entire maternity episode have commenced and preliminary findings are encouraging. As women are seeing fewer new carers, they are more likely to know their carers.
- Improve consumer involvement in planning and evaluation of services.
- Midwifery clinical skill assessment tool to be integrated into performance management system.
- Credentialling for midwives and medical staff on CTG interpretation (monitoring of the baby during pregnancy and labour).
- Improving the pre-admission process for women having elective Caesareans.
- Training in communication especially in breaking bad news.
- Implementation of the next phase of TeamCare which involves creating smaller teams in midwifery-led care, implementation of the clinical practice guidelines, organisational cultural change around normal birth and midwifery care and audit and evaluation of the model.

HOW DO WE KNOW WE PROVIDE GOOD QUALITY MATERNITY CARE?

We submit maternity data to the Victorian Perinatal Data Coordination Unit, DHS and Women's Hospitals Australasia (WHA). This allows us to compare our trends with Victorian and Australian and New Zealand data. In interpreting our data, the main things that need to be taken into account are that we have the largest neonatal unit in Victoria and this will result in a higher number of women with complex and premature labour compared to other Victorian hospitals.

COMMUNITY PRINCIPLE – QUALITY

Pregnant women who are heroin or opiate dependent:

We have ensured that our clinical care remains consistent with new methods of assisting women who are heroin or opiate dependent to manage, reduce or cease their addiction in order to parent their children. Over the last 18 months, an increased number of pregnant women at the Women's use Buprenorphine (or Subutex®) as an alternative to methadone to manage their dependency. Unfortunately, not a lot is known about the impact of this medication in pregnancy and breastfeeding. The Women's Alcohol and Drug Service (WADS) in collaboration with Turning Point Alcohol and Drug Centre have developed new clinical guidelines for the use of Buprenorphine in pregnancy. The guidelines are based on consultation with experts in the field of addiction medicine and neonatology. Most research about the use of Buprenorphine in pregnancy comes from Europe, and we hope to be involved in the first clinical trials to be conducted in Australia.

For more information about the clinical guidelines, go to: www.rwh.org.au/wads

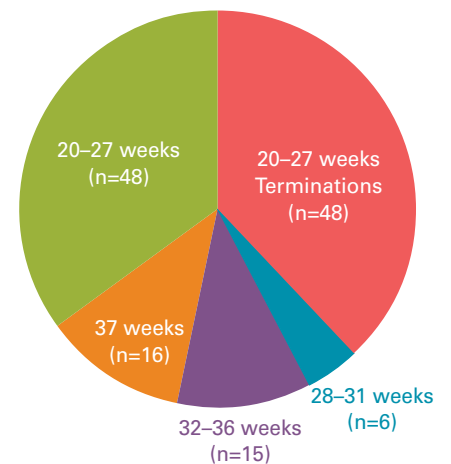
Reviewing pregnancy loss and management of pregnancy

The Women's Perinatal Mortality and Morbidity Review Committee consider all pregnancy loss that occurs from 20 weeks gestation. We report maternal, perinatal (around the time of birth) and neonatal (in the first 28 days after birth) deaths to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity who independently review maternal deaths and late pregnancy fetal deaths.

This diagram represents a breakdown of perinatal deaths by gestational age, indicating that approximately 73% of perinatal deaths occur in gestations less than 28 weeks, and that of these, half are terminations of pregnancy for congenital malformations. The other 50% of these very early births which make such a substantial contribution to the overall perinatal mortality rate are as a result of spontaneous preterm birth, a condition for which we have limited knowledge about detection and prevention. This remains one of the biggest challenges ahead for perinatal medicine.

There were no maternal deaths at the Women's in 2003/2004.

Figure 4: Pregnancy loss from 20 weeks onwards, July 2003 – June 2004



How safely do we deliver babies?

We measure this through the birth weight adjusted Standardised Perinatal Mortality Ratio. This measures actual deaths of babies as a proportion of deaths that are unpreventable, for example, because of extreme prematurity and lethal malformations. Our ratio of 104.01 for 2002/2003 is not significantly higher than expected, which means that we do this well.

Appropriateness

What are the chances of a woman with no complications of health or pregnancy (the standard primiparae) of:

Having her first child induced?

RWH 2002	RWH 2003	Comparison	Comment
24 %	19.1%	Victorian average 21.5%	This is a good result that reflects changes in induction of labour policy

Having her first child by Caesarean section?

RWH 2002	RWH 2003	Comparison	Comment
18%	20.5%	Victorian average 17.4%	The Women's rate compared with Victorian and WHA hospitals. Our rate is in the middle of the two other Victorian tertiary hospitals and reflects rising rates for this group. See further comment below.

Having a perineal tear (3rd and 4th degree)?

RWH 2002	RWH 2003	Comparison	Comment
2.2%	4.6%	Victorian average 3.7%	The Women's rate is within Victorian and WHA benchmarks. The rate is higher than last year. There is raised awareness and treatment of tears. Analysis of data will be undertaken to see if there are areas for improvement.

Caesarean section rates

When we compare our Caesarean rate overall across Australia, we are very similar to hospitals of our size. The increased rates may relate to the later age when women give birth, changes in practice, which are supported by research, for breech presentations and improved survival of premature babies. However, there is increasing concern about the longer-term impact of rising rates of Caesarean section on women in later pregnancies, so that efforts should be made to reduce unnecessary Caesareans.

These figures are based on figures from July 2003 to June 2004

Teamcare model	No of women	Caesarean section rate
Low risk teams	2,533	24.6%
Higher risk teams	1,435	40.5%
Shared care	996	23.8%
Private obstetrician	125	41.6%
Total	5,089	29.0%

Comment

It is likely that some women attributed to the low risk teams should have been looked after by the higher risk teams. Nevertheless, these figures are high and suggest that in order to reduce unnecessary Caesarean rates, we should concentrate on this group, particularly women having their first baby. To do this is a multidisciplinary team effort and we are working on:

- developing a Clinical Practice Guideline on management of normal birth, based on evidence
- introduction of guidelines developed by the Australian College of Midwives as to when midwives should refer to doctors
- regular audit of Caesarean section rates for this group.



SHANE HIGGINS
CONSULTANT OBSTETRICIAN
AND DIRECTOR OF
BIRTH SUITES

Q: What does your role as Director of Birth Suites entail?

"I provide obstetric care and cover as a consultant for the labour ward and take responsibility for the quality of care that is provided in the birthing suites. Part of this involves developing policies and clinical practice guidelines based on the most up-to-date evidence available. I spend a lot of my time on training and teaching both undergraduate medical students and junior medical staff in all practical aspects of obstetrics and CTG interpretation."

Q: What are the quality and safety challenges for the birth suites for the next 12 months?

"Getting and keeping the postpartum haemorrhage rate down is our biggest challenge, keeping inductions at a controllable level, ensuring women have appropriate choices when it comes to things like vaginal birth after caesarean."

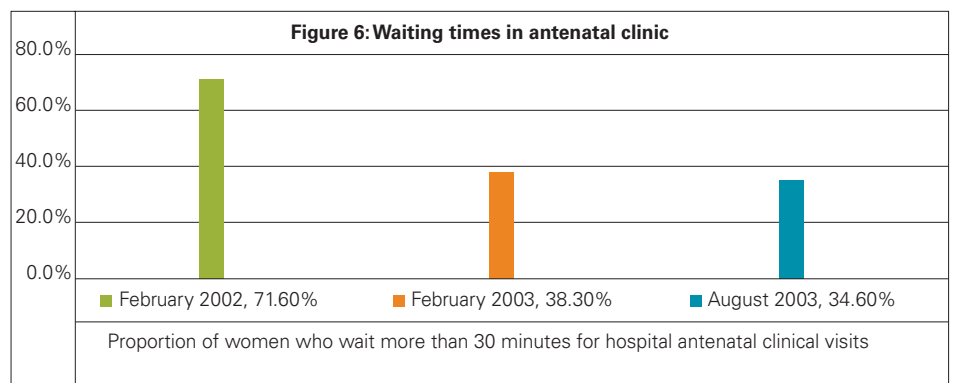
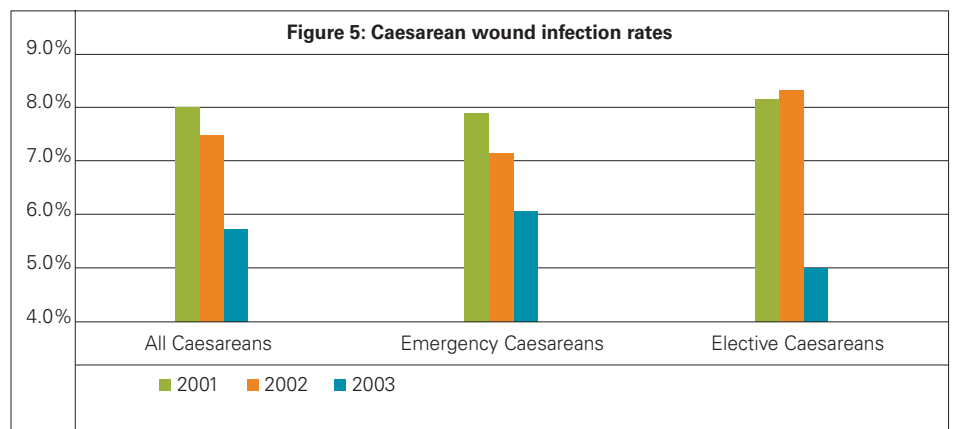
Vaginal birth after caesarean section

Based on 2003 data submitted to WHA, about 34% of women with one previous caesarean section attempted vaginal birth after caesarean section (VBAC). This is lower than the WHA average of 58%. Of those women who laboured spontaneously or were induced, our own internal audit shows that between 60% and 65% of women deliver vaginally – the WHA average was 53%. We reported no cases of uterine rupture amongst these women – the major risk with VBAC. We identified and fixed data collection problems, so that future submitted data will be more reliable.

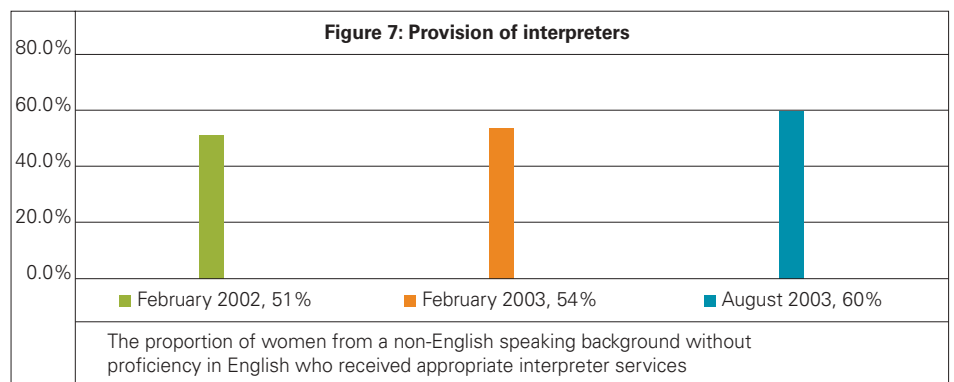
These figures tell us we are successful in supporting women to give birth vaginally, but that fewer women attempt vaginal birth. It may mean we are good at identifying women likely to succeed. If we wanted to increase our VBAC rate, we would concentrate on the earlier decision whether to have a caesarean or a trial of labour.

If I am having a caesarean section, what are the chances I will get an infection?

We have reduced our wound infection rates for caesarean section from 8.0% in 2001 to 5.7% in 2003. Our rates are now within the US NNIS (the international best practice) rates of between 2.9% to 6.6%. To improve this further, the infection control team surveyed clinicians about the use of antibiotics to prevent infection and fed back results with recommendations about appropriate antibiotic use. The urinary tract infection rate reduced from 1.8% to 1.1% and compares well with the best international results.



This table shows a continuing reduction in how long women wait for their antenatal appointments.



We have continued to improve our use of interpreters, although we have further to go in meeting well identified need.

The Women's provides a statewide neonatal service for babies in need of specialist care



OUR SPECIAL CARE FOR BABIES

Our facilities have been developed to look after very sick newborn babies and many babies are transported to us from other hospitals after they are born. Increasingly women are transferred before giving birth ensuring that the baby can go to intensive care immediately. The Women's Neonatal Unit is the largest in Victoria, with the highest throughput.

During 2003, 1,206 babies were admitted to the Special Care Nursery (SCN) and the Neonatal Intensive Care Unit (NICU). A total of 470 babies required intensive care and a further 736 were admitted to the Special Care Nurseries.

The Women's has special expertise in the care of the very smallest babies. In providing care for our babies, our concern is not just with their physical survival, but also their quality of life, so we need to look after the parents and their bonding with their baby. From the moment of birth, we are particularly concerned about establishing breathing and nutrition. We also are concerned to look after the baby's brain. We base our care on evidence about best care, and research is a key component to providing the right treatment for these babies. We have provided information about the survival rates of our babies.

SERVICE STATISTICS

Figure 8: Survival rates of NICU admissions between 1/7/03 and 30/6/04

Gestation	Number	Minimum birthweight	Maximum birthweight	Number survived	% Survived
23	5	480	695	3	60%
24	15	585	796	11	73%
25	24	605	990	20	83%
26	22	495	1,440	18	82%
27	37	526	1,365	35	95%
28	27	730	1,380	26	96%
29	37	800	1,745	35	95%
30	46	560	1,810	46	100%
31	47	870	2,180	47	100%
32	27	950	2,758	24	89%
33	21	1,460	3,040	21	100%
34	20	1,000	2,950	18	90%
35	16	795	3,300	14	88%
36	23	1,360	4,040	21	91%
37	18	2,075	3,730	18	100%
38	18	1,805	3,700	18	100%
39	17	2,515	4,436	16	94%
40	21	2,590	4,220	20	95%
41	10	3,150	4,595	9	90%
42	1	3,230	3,230	1	100%

Family friendly

Although we aspire to a family-friendly philosophy of care, in practice, we know we can always engage families better. A Family Focus Team has been convened to involve consumers to help us create a more family friendly environment. The team has developed a Baby Diary and a Family Care Plan for parents to use. The Family Care Plan is being piloted over the coming months before being implemented fully. The team is also reviewing with parents how we could manage visiting better.

Supporting babies' development

We know that developmental supportive care using a multidisciplinary approach to the management of babies is important because babies need more than just the technology that may be keeping them alive. Developmentally supportive care can have a positive effect on the outcome for high-risk babies by reducing the stresses on the baby and supporting the baby's growth and development. We have worked consistently on this for the last 12 months. We are recruiting allied health professionals to assist. The nurses have undertaken an active role in positioning the babies and in controlling the babies' exposure to light and sound.

Our staff

Neonatal Services was very busy last year, often experiencing periods of between 97-105% occupancy of beds. There has been a successful nursing recruitment campaign, which has allowed us to recruit nurses to manage this. Twenty-five nurses, with varying levels of expertise and experience in neonatal nursing, have joined the staff this year. This successful recruitment campaign has resulted in Neonatal Services being able to decrease casual, bank and agency staffing which means babies get care from nurses who know them, as well as us being able to meet the capacity of 50 beds.

Partners at work

We need staff who are happy in their work if we are to provide good care to families and their babies. We were recently granted \$50,000 from the Industrial Relations Commission to continue to implement changes and improvements to the workplace culture. The project will continue to develop models of multidisciplinary partnership to increase staff participation and involvement, to address issues of staff recruitment and retention and improve service delivery and care for babies and their families. The project commenced in June 2004.

Neonatal Hospital in The Home (HITH)

Neonatal HITH provides ongoing seven days a week care and support for babies and their families at home, assisting the move from hospital to home. The team consists of two registered nurses with neonatal and midwifery qualifications and a team of hospital-based doctors. We provide daily home visits usually for about five days.

Over the past 12 months the neonatal HITH program has cared for a total of 202 babies in the home (compared with 227 during 2002-2003 and 157 in 2001-2002). From the 1st July 2004, the name was changed to Neonatal Extended Support Team (NEST), which fits better with our philosophy of family friendly services.

Infant Home Based Withdrawal Program

This program allows babies who are withdrawing from narcotics with neonatal abstinence syndrome to continue to withdraw at home, with the support of the NEST team and paediatric follow-up. To prepare for this, there has been in-service education throughout the Women's, Neonatal Nurseries and in the community, working with Maternal and Child Health Nurses and the Australian Nursing Federation. It is expected that the number of babies admitted to the Infant Home Based Withdrawal program will vary, but is initially anticipated to be approximately 40 per year. This means that infants, who once remained in hospital for up to four weeks, will now be discharged after seven days, reducing the separation of infants from their families with support at home. The program will be evaluated after six and twelve months.

Safe equipment

The Neonatal Unit together with Biomedical Engineering undertook a complete audit of the equipment in the Neonatal Nurseries. Equipment that no longer meets the current Australian Standards and is more costly to repair than replace is being condemned. Over the past eight months in conjunction with specific grants from Department of Human Services and generous donations from the community via the Women's Foundation, we have been successful in purchasing urgently needed equipment.

Planning for a computerised cot-side information system

The current way we manage patient information in NICU has a number of problems that waste staff time and has a high risk for treatment and care errors. We are planning to implement a coordinated patient information system within the Neonatal Intensive Care Unit, which will allow the health care team to access test results, X-ray and ultrasound images, as well as intranet information such as clinical practice guidelines and drug information.

This system will improve:

- patient care due to reliable Care Plans
- accurate medication and fluid administration
- time for nursing care
- access to results of investigations that guide clinical care
- access to information for staff education and development.

WHAT DO WE KNOW ABOUT OUR QUALITY OF CARE?

Neonatal Research and ANZNN Data

Neonatal Services continue to contribute our NICU data to the national database of the Australian and New Zealand Neonatal Network (ANZNN) for benchmarking and comparison. Results indicate a higher than average number of very small babies who survive, and that we perform well by all the performance indicator criteria. Of concern is a higher than expected incidence of retinopathy of prematurity (ROP). A process is in place to determine if this is due to over-reporting or a true high incidence of ROP. We will report on this in the next Quality of Care Report.

Neonatal Quality and Safety Committee

We have always had a strong ethos about managing clinical risks, but now we have set up a formal committee to monitor the clinical quality of care and safety of babies we care

for and to recommend action to improve systems and outcomes.

The committee will:

- audit performance indicators of outcomes for babies in the Neonatal Unit, as well as infants cared for elsewhere in the Women's
- audit practices to promote best clinical practice, using available research evidence
- audit adverse events, sentinel events and patterns of incident reports
- recommend action to improve what we do.

We also have a monthly neonatal mortality and morbidity meeting which reviews all deaths and the care we provided.

We have a quality research project which has recorded more than 70 resuscitations at birth using clinical and lung function measures and video recordings to make sure that we have a high level of skills in establishing breathing, which is critical at birth.

Infection control in neonatal care

Newborn babies admitted to the Neonatal Intensive Care Unit or Special Care Nursery are at greater risk of infection. These babies may be premature or sick and have an underdeveloped immune response to infection. The most premature babies are most likely to develop infections as well as other problems.

We collect data to determine rates of bloodstream infections and compare with other neonatal units. We also collect data on antibiotic use and the presence of multi-antibiotic resistant organisms. The aim is to reduce unnecessary antibiotic prescribing and shorten the duration of antibiotic courses to reduce emerging antibiotic resistance.



AMANDA'S STORY

Amanda contacted our Reproductive Biology Unit (RBU) when she was 29 years old. She really wanted a baby but had irregular ovulations. She saw a counsellor and a doctor. Amanda went through seven cycles of treatment. She became pregnant on the fifth cycle, but at seven weeks lost the pregnancy, which was devastating. After radiation treatment, she then had to wait for three months before recommencing treatment.

Amanda became pregnant on the seventh cycle and at seven weeks was transferred to Maternity Services. This was made easy by the availability of appointments after work. She saw the same doctor from the beginning and at six months had a two hour session with the midwife, which she appreciated. After that, she attended fortnightly and in the last month, weekly. At eight and a half months, she had a fall and had to attend emergency for a few hours but fortunately, everything was fine.

Amanda's baby was a week overdue when she went into labour. Everything seemed to be going

smoothly until one point when "they couldn't find a heartbeat". A second midwife quickly checked and monitored the situation, as with each contraction the baby's heartbeat was either not found, or was racing unnaturally. The results were sent to a consultant and within a short period of time, the doctors explained that she needed an urgent Caesarean section. A Code Green was called. With her mother nearby for support, Amanda's new daughter Jaimee was born immediately and while distressed, she seemed fine.

Six hours later, Amanda's mother noticed that Jaimee was having fits. A midwife explained that it sounded as if she was having a seizure and a paediatrician confirmed this.

Jaimee was transferred to the Neonatal ward, and Amanda found herself "freaking out" with worry. Within an hour however, she herself was able to go up to the ward and see Jaimee. Over the next few days, Jaimee was kept under observation and the midwives took Amanda upstairs whenever and for however long she wished, which

really helped her to cope, even when Jaimee at one point stopped breathing and had to be revived. She could also call anytime of the day or night just to check on Jaimee.

Amanda felt really supported through all this, seeing a counsellor and the nurses and doctors frequently. She found that if she at least knew exactly what was happening that she was able to cope. Being kept so well informed by the staff made a big difference to her. Amanda went home after five days and after ten days in the Neonatal Unit, Jaimee was able to leave. During this time, Amanda visited her frequently.

As Jaimee had no more problems, she came home on Amanda's 31st birthday. She is now six months old and thriving.

Research

Jaimee was monitored with a new bedside EEG monitor, which one of our staff developed, which showed that the treatment not only stopped her fitting movements, but also brought her brain's electrical activity back to normal. The monitor also helped us to know when we could safely take her off her medication, and suggested that she had no serious long term damage. This was confirmed by MRI scan before she went home. This approach is available in relatively few hospitals in Australia, and we pioneered the EEG monitoring work.

Figure 9: Comparison of infection rates

	<28 weeks	28-36 weeks	>36 weeks
ANZNN 2000 Benchmark rates	41.9%	8.6%	7.3%
ANZNN 2001 Benchmark rates	41.8%	–	–
2000 RWVH	53.4%	9.9%	4.8%
2002 RWVH	41.2%	5.6%	1.4%
2003 RWVH	38.8%	2.4%	0.4%

This table demonstrates reductions in infection rates for all birth weights.

Controlling infections

Because of our stringent infection control procedures, we can confidently report on low rates of infection in new babies, infection contracted as a result of inserting a medical device or the contraction of multi-resistant organisms. No MRSA (Golden Staph) multi-resistant bacteria was identified.

The neonatal unit contributes demographic and clinical data to the Australian and New Zealand Neonatal Network (ANZNN). Comparisons are shown in Figure 9.

Infection control – the impact of the serratia outbreak

One of the things we are proud of this year is how we managed the Serratia outbreak. This is one of the infectious organisms that can be a concern in intensive care. Serratia outbreaks had been reported in two other neonatal units in Melbourne. Four babies were found to be colonised, but not infected with the organism in our unit, two of whom had been transferred in from elsewhere. We undertook separate nursing of these babies, as well as routine and weekly testing for the organism on all babies. Our hand hygiene program was in place. A united effort from all neonatal nurseries in Victoria, DHS, Infection Control experts, NETS and staff allowed The Royal Women's Hospital to remain open, functioning at above capacity to assist other units for the duration of the outbreak.

Following initial isolation of the colonised babies, there were no further cases of Serratia within the Neonatal Unit and all four babies were discharged home over the subsequent weeks.

Microbiological typing or 'genetic finger printing' of the bacteria is beginning to show that several different strains of the bacteria have been present in the neonatal units in Melbourne. This has shown us that not all infections or colonisations have resulted from 'cross infection' and that the infection control efforts of the staff have prevented further spread in this very high risk group of patients.

Neonatal research

Important areas of research include:

- development of the premature brain
- best practice mechanical ventilation
- long term follow-up studies, looking at the health and development of the babies from our unit
- cooling for brain injury at birth
- dietary effects on brain development
- evidence-based medicine reviews of neonatal practice.

The Neonatal Research Team continues to expand, with an additional Research Fellow and nurses. We currently have 12 NHMRC research grants. In the next year we are looking to increase our research area with our expanded team.



The Women's
provides health
services for women
of all ages

OUR WOMEN'S HEALTH PROGRAM

The Women's Health Program provides services across the life cycle for the full range of health issues including Gynaecology, Well Women's Services, Centre against Sexual Assault, Sexual Health Services, Cancer Services, Fertility Services and Breast Services.

Gynaecology services have been identified as a major growth area and the hospital is committed to ensuring services continue to develop in response to new clinical issues and increased demand for services. Many migrant groups who had their children at the Women's are now seeking gynaecology care.

OUR OUTPATIENT GYNAECOLOGY SERVICES

In late 2002, the Women's conducted a review of gynaecology services and identified a number of issues. Issues include the development of clinical quality measures, waiting time management and communication issues. Many women wait too long to get an appointment and too long when they come for their clinic appointment.

In 2004, we worked on:

- appointment of a gynaecology service coordinator to improve access and patient flow
- integration of the Nurse Practitioner role into gynaecology outpatient clinics
- new ways to follow-up on women who do not attend appointments, by our medical staff reviewing a woman's medical history and writing to her and her referring GP inviting her to rebook the appointment. We have monitored this and found that the number of 'fail to attend' appointments has reduced.

The Patient Flow Collaborative Project

The Patient Flow Collaborative project is an initiative of DHS and focuses on why delays occur from a systemic or 'whole' perspective. Often women have contact with many people around the hospital, so a multidisciplinary approach was taken, including medical, nursing, midwifery, allied health and administrative staff to look at delays and waiting times in Gynaecology Outpatient clinics. As part of this, we will look at how women can best get the service they want and how we might work more closely with GPs and other gynaecologists. We will report on progress next year in the Quality of Care Report.

The Urogynaecology Pelvic Floor Service

The Urogynaecology Pelvic Floor Service at The Royal Women's Hospital is the largest service of its type in Australia. The unit has developed both a national and international reputation for excellence in the assessment and treatment of female pelvic floor disorders.

In 2003 we reported on our commencement of the Urogynaecology Pelvic Floor Service to assist women to manage their incontinence. Since then we have:

- received an NHMRC grant for research with University of Melbourne Physiotherapy Department to evaluate conservative management of women aged over 65 years with stress urinary incontinence
- expanded our clinic for assessing and managing perineal trauma and anal symptoms following childbirth
- implemented new surgical methods to treat urinary stress incontinence which are minimally invasive and usually performed as day surgery
- introduced new prosthetic material designed specifically for the surgical treatment of pelvic organ prolapse, which has been shown to improve success rates and outcomes for patients.

Research

Our on-going commitment to the care of women with urogynaecological problems has meant that we undertake research to increase our effectiveness. Over the last year, we have initiated:

- a study to evaluate a new synthetic prosthetic material for pelvic organ prolapse surgery
- a multicentre study with the Royal Melbourne Hospital to evaluate the effectiveness of methods of treatment of difficult pelvic floor disorders
- a study of the effectiveness of dietary intervention in controlling anal incontinence.

Our contribution to global women's health

Over the last year, the Women's has been involved in an international project initiated by the United Nations Population Fund (UNFPA) in the establishment of a unit to treat genital tract fistula at the Dhaka Medical College Hospital in Bangladesh. The formation of a genital fistula is a problem in developing countries where there is poor access to antenatal and birth care and is the result of a prolonged and obstructed labour. This condition can lead to significant physical and emotional trauma for the woman (including incontinence of urine and faeces) and very often death of the baby during labour. A team of surgeons and nurse specialists from the Women's provided specialised and complex training and support to medical staff, and plan to make continued trips to Dhaka in 2005.

PREVENTING AND MANAGING ENDOMETRIOSIS AND PELVIC PAIN

A significant number of women in the community have endometriosis and pelvic pain. The Women's has created a team of staff who specialize in responding to the needs of women suffering from either or both of these conditions. Many of these women report that they have found life limited by pelvic pain, period pain, pain with sexual intercourse, or painful bowels.

There are many different possible reasons for having pelvic pain, including conditions like endometriosis (where the lining of the womb grows outside the womb), adhesions, ovarian cysts and adenomyosis (where the lining of the womb grows into the muscle layers of the womb). Many women have pain where the actual cause is never found.

The Endometriosis and Pelvic Pain Clinic has a team of nine consultant gynaecologists and a number of doctors training in gynaecology. The team has a uniform approach involving careful assessment, then providing information to allow women to decide what sort of management plan they wish to pursue.

The Endometriosis and Pelvic Pain Clinic has strong links with the Gastroenterology Clinic at the Royal Melbourne Hospital and the Barbara Walker Chronic Pain Management Clinic at St Vincent's Hospital. This allows women who need these services to be referred on.

Research

We are currently recruiting for a trial comparing two types of surgical treatment of endometriosis (burning it out versus cutting it out) to see which provides better long-term pain relief. This study is unusual as it involves a five year follow-up with women.

Two of the consultants in the clinic are in the process of completing research projects that look at the questions:

- What unique proteins are found in women with endometriosis?
- Is endometriosis an inflammatory condition and how does it cause pain?

Statistics:

- 15% of women of reproductive age have chronic pelvic pain
- 5-15% of women of reproductive age have endometriosis
- 40% of women with infertility have endometriosis
- 60% of women with pelvic pain have endometriosis
- The time between onset of symptoms and diagnosis of endometriosis is getting less with increasing awareness, but is still around 3-5 years
- 70-80% of women who have surgery completely treating endometriosis will have no further occurrence five years later.

COMMUNITY PRINCIPLE – SERVICE OPTIONS

The Women's Waterworks Workshop

Due to high demand for services in the Women's Urogynaecology pelvic floor service, women needing continence advice currently have to wait for some time for both a medical and/or an appointment with the Continence Nurse Advisor or physiotherapy. We are now undertaking a pilot workshop to inform women about areas of common concerns

and assist them manage their own condition. After an initial assessment of pelvic floor functioning, women will attend the group workshop where four sessions will be run over eight weeks on physiotherapy, psychology and lifestyle change and dietary advice. This workshop will be evaluated and we will report on it in next year's Quality of Care Report.

REPRODUCTIVE SERVICES

Reproductive Services is the main hospital based referral clinic for women with fertility issues in Victoria and is the largest clinic of its type in Australia. It is made up of separate but complimentary parts of infertility assessment and treatment:

- The Endocrine and Metabolic Service runs the Big Girls' Group, a program based on changing lifestyle to improve fertility and overall health in overweight women with polycystic ovary syndrome.
- Assisted reproductive therapy includes evaluation, diagnosis and treatment of male and female fertility problems, including fertility advice to help spontaneous fertility, ovulation induction, assisted insemination, in vitro fertilization and associated technologies.
- Reproductive surgery provides reconstructive microsurgical treatments to reverse sterilization.

Infertility counselling and support is available to help women and men making difficult choices and those where the outcome of treatment has been disappointing. Special interest groups, such as women with cancer, are held to evaluate the needs of these women and men and assist in the development of treatment policies. In the four years from 2000-2003, the number of new patient appointments has grown from 6,875 to 9,388, an increase of almost 40% over that time.

Reproductive Services is the main training unit in Australia and New Zealand for sub-specialists in reproductive endocrinology and infertility.

How do we know it is an effective service?

The Victorian Infertility Treatment Authority and the Reproductive Technology Accreditation Committee of the Fertility Society of Australia accredits Reproductive Services on a three yearly basis.

All outcomes from IVF and associated technology treatment are reported to the national Perinatal Statistics Unit and the

Infertility Treatment Authority. In the four years from 2000 to 2003, the chance of successful pregnancy has improved by 50% in women using the in vitro fertilization program at Reproductive Services, with the chance per embryo transferred leading to a successful outcome rising from 13.7% to 20% over that time in women under 36 and rising from 9.2% to 12.3% in women aged 36 or older. At the other end of the spectrum of fertility treatment, lifestyle modification through information giving, dietary help and exercise instruction and supervision led to successful pregnancy in 72 of 143 women (about half) who enrolled in the Big Girls' program.

The challenges facing Reproductive Services are mainly to find the balance between successful outcome and unwanted complications of treatment. Our triplets and quadruplets are a thing of the distant past, but the twin pregnancy rate remains between 20% and 25% of pregnancies in women younger than 36 years. A policy of increasing the frequency with which single embryos transfer is performed is in place to reduce this, given the risks twin pregnancies face, while respecting the wishes of many couples to have two embryos transferred.

The other challenge lies in reducing the frequency of ovarian hyperstimulation syndrome, which is a troubling consequence in between 0.5 and 1% of patients who undergo ovarian stimulation with medication known as 'gonadotrophins' to develop multiple eggs for IVF purposes. We review these, as do the gynaecology screeners for the RWH Quality and Safety Committee in order to improve our care.

CANCER SERVICES

The Women's treats women with breast and gynaecology cancers and has the largest inpatient gynaecology cancer service in Victoria.

We also run screening programs for cervical and breast cancer as part of our well women and preventative services.

Last year, we described how our cervical cancer screening techniques were very accurate and reliable. We had hoped to provide information about survival rates for ovarian and other cancers, but this information is not available yet. We have a very good oncology database and one of our priorities for next year is to use this to monitor our quality of care.

LIVING WITH CANCER EDUCATION PROGRAM

The Living with Cancer Education Program is offered to people living with cancer and is specifically gynaecology focussed. The program is run by specialist oncology nurses as well as a pastoral care worker, as an eight week course for women and men, in English as well as other languages.

The aims are to:

- increase knowledge of cancer and its treatments
- encourage discussion within a safe setting
- learn from each other
- increase coping skills
- discuss common concerns.

Topics covered in the program include:

- understanding cancer
- treating cancer
- communication
- personal reactions
- self-esteem and intimacy
- self-care.

Breastcare

The Women's is one of 16 Victorian hospitals in the Breastcare Performance Indicators Project implementation trial. This 12 month project aims to develop a comprehensive performance monitoring and reporting system in breast cancer and to improve quality in line with best practice. This will involve collecting and reporting on data on a set of indicators based on the NHMRC Clinical Practice Guidelines.

HOW DO WE KNOW WE PROVIDE GOOD WOMEN'S HEALTH SERVICES?

Timely surgery

Making sure that women get surgery in a timely way is essential. Through a standardised system, doctors assess surgery needs and how soon the operation needs to be done, and rate it as urgent (category one), semi-urgent (category two) or less urgent (category three). Women in category one and two have their surgery performed within the times set by DHS. Category three women receive an operation date as soon as possible.

To keep women informed, they receive confirmation that they are on the waiting list, information about the type of operation, the category, and an approximate waiting time, the Women's contact details and a follow-up phone call to make sure they still wish to have the surgery.

The Women's continues to perform well in meeting women's needs for surgery. Over three years, we have improved our hospital-initiated postponements from almost 3% to less than 1%.

During this time, the overall waiting times increased, but we were still able to meet all urgent requirements for surgery. All patients are assessed to see if they can be admitted on the day of their surgery. The Women's 'day of surgery admission rate' (DOSA) demonstrates that the vast majority of patients (94.6%) are admitted in this way.

Are our gynaecology services safe and effective?

We have a range of measures to ensure the quality and safety of gynaecology services at the Women's and that we are 'doing the right thing at the right time by the right clinician'. Examples are continuing professional education of our clinicians, an active weekly gynaecology education program, fortnightly review of the gynaecology scientific literature and a regular tutorial program for gynaecology trainees. All patients undergoing gynaecological surgery have a pre-operative safety and appropriateness check at the pre-admission clinic – in person if they are having major surgery or a review of their files if they are having minor surgery. During surgery, senior gynaecologists supervise specialist gynaecology trainees, whilst the senior surgeons undertake the more complex surgery.

Audit of deaths and complications occurs monthly. The meeting discusses all deaths, prolonged lengths of inpatient stays, severe gynaecological infections and other complications. Changes to practice are recommended, or if it is perceived to be a

hospital-wide problem, referred to the Women's Quality and Safety Committee. A recent example involved a patient with a postoperative complication who rang the hospital on several occasions and was given inappropriate clinical advice. The Quality and Safety Committee are reviewing and improving the process of clinical advice given over the telephone.

Collection of infection rates for hysterectomy has commenced and will be reported next year.

Priorities for 2004/05:

- Continuing implementation of the recommendations of the gynaecology services review.
- Reduce waiting times for outpatient appointments.
- Development of clinical indicators and clinical data-base.
- Implementation of the Patient Flow Collaborative project.
- Investigate collaborative models of care that provide for integration of nurse practitioners.

Figure 10: How does the Women's perform on waiting times?

RWH elective surgery performance 2001 – 2004	2001	2002	2003	2004
Category 1 proportion of patients admitted within 30 days (%)	100	100	100	100
Category 2 proportion of patients admitted within 90 days (%)	100	100	100	100
Average waiting times (days) for category 2 patients on the waiting list as at June 30th	24.4	28.5	29.3	24.5
Average waiting time (days) for category 3 patients on the waiting list as at June 30th	136	114	75	116.3
Total waiting list	680	396	452	655
Hospital Initiated Postponements (HIP)		2.85%	0.4%	0.87%
Day of Surgery Admission Rate (DOSA) 2004	State target = 85% RWH year to date = 94%			

LYN'S STORY

This story tells of one woman's experience of cancer and shows how important it is for women to take part in decisions about their treatment.

At 49 years of age, Lyn was referred to the Women's by her local GP after receiving the results of an abnormal pap smear. She had already dealt with a range of health problems and felt she would be able to deal with this. She did realise and was told that something was wrong but the word 'cancer' never really came into her mind at this stage.

Lyn was given an appointment at the Oncology and Dysplasia Clinic for a few weeks time. She noticed that the appointment was in her mind a lot and when she met with a female doctor (accompanied by her daughter), she was examined on the spot and was told that she may need a hysterectomy. It was at this point that she got very upset and felt strongly that she really couldn't cope with the operation. She felt really anxious that such an operation would be all too much for her. Lyn felt shattered and refused to have it done.

Lyn and her daughter then asked for a second opinion and that same afternoon, they met with another doctor, a Professor. He explained that they were indeed worried that it was cancer – the first time the word was used – and spent a lot of time talking to her about it. Lyn really appreciated this. She was also offered a biopsy to investigate further before a final decision was made. Lyn felt able to agree to this and an appointment was made for a month's time. Lyn felt like her concerns were acknowledged and really listened to and that the doctor understood her concerns.

Due to her broader health issues, Lyn was admitted two days before her biopsy and the procedure itself was explained clearly to her and she felt that she understood exactly what was going to happen. The anaesthetist spoke to her beforehand as did the original female doctor that she had seen and there were also social workers on hand which all helped her to feel less alone with the whole ordeal.

It took three days to recover from the surgery and she was given an

appointment for a fortnight later to discuss the results. While this was a nerve racking time, waiting, it at least gave her a chance to face what the future might bring.

In the end, Lyn didn't need a hysterectomy, which was an enormous relief and she felt grateful that her concerns had been listened to. The Professor explained that they had removed all that they could and that with regular checkups it was likely to be fine. That was five years ago.

Since then, Lyn comes back to the Women's every six months for regular pap smears. She feels more relaxed that her history is known there and notices that everyone, including the reception staff, have made her feel "almost like they know you personally". She really appreciates that at the Women's she is listened to and is able to discuss her concerns. In the meantime, Lyn has concentrated on living her life fully knowing just how important that is.

At the Women's,
we review our
practices to
improve care
for women



GEOFF STEELE

SAFETY IS OUR PRIORITY

In this chapter, we look at key clinical services, our Anaesthetics Department, our Infection Control Team, and the Women's Emergency Service, which provide critical care across the hospital.

HOW SAFE IS MY ANAESTHETIC?

The Anaesthetics Department provides anaesthetic and acute resuscitation 24 hours a day, including a 24-hour epidural service. The Department participates in pre-admission clinics where anaesthetists discuss anaesthetic and pain relief options with women. It runs a High Dependency Unit, and was one of the first Melbourne hospitals to run a specialist Acute Pain Service. The Acute Pain Service not only reviews all patients receiving pain relief daily but also teaches patients and nursing staff safe and effective management of acute pain.

GEOFF STEELE

ANAESTHETIST AND DIRECTOR OF THE HIGH DEPENDENCY UNIT (HDU).

Geoff:

"Australian anaesthetists have appreciated for a long time the benefits to patients and staff of confidential reporting of anaesthetic morbidity and mortality. We have held anaesthetic morbidity and mortality meetings at the Women's since 1974 – that's 30 years. During 2003, we held 11 meetings and presented over 30 different incidents. The meetings allow a review of management focussing on causes and any factors that lessened or contributed to the outcome. This helps to identify any risks or problems and is also an excellent teaching tool for anaesthetic registrars and consultants."

Q: What sort of incidents do you look at?

"The cases have ranged from problems with equipment, medications and pre-operative consultations to discussions about management of difficult cases both in theatre and in the HDU.

As a result of these meetings, some incidents are referred to the Quality Committee here at the Women's, some to the Victorian Consultative Council on Anaesthetic Morbidity and Mortality. If changes to practice are recommended, the Anaesthetics Department assists in ensuring these changes are implemented.

Recent examples of how this process improves patient care include changes to the administration of magnesium sulphate to upgrading the IVF recovery room; improving processes for transferring patients to other hospitals; measures to improve communication with other health professionals and identifying faulty equipment."

Q: Why should this be important to patients?

"Patients at the Women's and indeed patients throughout Victoria and Australia have benefited from the reporting of anaesthetic morbidity and mortality. Australia has become one of the safest places in the world to have an anaesthetic for many reasons including the high levels of training, high standards of practice and a long history and culture of identifying areas of risk and addressing them.

When we have a problem and examine why it happened and look at ways of preventing a recurrence, it means that we are continuously making changes and improving the care of patients at a time when they are often most vulnerable"

CARING FOR VERY ILL WOMEN

A woman who becomes very ill will be cared for in the High Dependency Unit (HDU). These are usually women being treated for cancer, surgery or complications of childbirth. The HDU is a four-bed unit located within Ward 51. It provides perioperative and medical care. The unit is run on a daily basis by staff from the Department of Anaesthesia and nurses from Ward 51, most of whom have postgraduate HDU training.

Highlights of 2003:

- We had a record number of admissions -167, maintaining an 8% increase a year since 2001.
- Most stays were short - 94% of patients were discharged within three days.
- There was increased clinical complexity.
- There were only 12 transfers from HDU at the Women's to HDU/ICU at other centres.

How do we know we provide good HDU care?

The HDU assesses trends and identifies problems, recording all data in the HDU database, which also allows us to follow up any issues. Cases of morbidity and all transfers are reviewed at the monthly Department of Anaesthesia Morbidity and Mortality meeting. The HDU steering committee meets four times a year, providing a forum to discuss issues with the administration of high dependency care at the Women's.

The database allows comparisons of patients and their treatments from month to month and year to year and is an invaluable reference point. For example, during 2004, the database showed an increased number of admissions of patients with Ovarian Hyper Stimulation Syndrome and this was reported back to the Reproductive Services Unit who have addressed this problem and altered their medication regimes.

From the database, we are doing an audit of severe pre-eclampsia (a complication of pregnancy). This is currently being done by an anaesthetics fellow and provides information for research on critical care management of obstetric patients.

WILL I GET AN INFECTION IN HOSPITAL?

The Infection Control Department, the 'IMPACTeam', looks after infection management, prevention and consultancy. We are constantly improving our responses to infection control and our rates compare very well. These rates were reported in the chapters on maternity and neonatal services.

The key areas for the infection control team are:

- identifying infection control issues across the hospital
- making sure that policies and procedures are based on research and standards
- reviewing hospital infection rates and trends by conducting surveillance
- recommending strategies to reduce hospital acquired infections and control outbreaks
- reviewing building and construction activities as they affect infection control
- conducting education programs for all staff to ensure their knowledge is up to date.

See: www.rwh.org.au/infection_control for a detailed report on infection control including infection rates.

The IMPACTeam reports to the Quality and Safety Committee. We work with Victorian Nosocomial Infection Surveillance System (VICNISS) and DHS to develop strategies to reduce hospital acquired infections.

Victorian Nosocomial Infection Surveillance System – VICNISS

VICNISS is responsible for collecting and analysing infection rate data from metropolitan public hospitals. We submit data on neonatal blood stream infections, Caesarean section and hysterectomy wound infections. This allows us to compare with other hospitals and with national and international rates. This helps us to monitor the effectiveness of infection control measures and improve care for women.

Risk assessment audits

Audits are undertaken in clinical areas to measure compliance with infection control procedures. The results are reported to clinical managers. If improvements are required, recommendations are made and re-audited. From these audits, we implemented new procedures such as the vaginal ultrasound processing procedure.

Protecting our staff

All staff are encouraged to review their immunization on employment and regularly throughout their career. Immunization campaigns are held to ensure that staff are fully protected from vaccine preventable diseases, both for their own health and for the women they care for.

Worksafe Victoria encourages hospitals to achieve best practice in key areas of staff health, including the prevention of needlestick injuries. Health care workers are most at risk of acquiring blood borne infections from needlestick injuries involving intravenous cannulae for inserting drips. The use of safety cannulae and needleless intravenous systems can significantly reduce injuries. We have trialled four devices at the Women's. We are currently assessing the preferred device and its appropriateness in our clinical settings.

Figure 11: Cleaning standards

	2003/4	2004/5
Very high risk areas		
ICU, NICU, theatres	89%	90%
High risk areas		
Emergency, wards	92%	88%
Overall score	90%	89%
DHS cleaning standard	80%	80%

Having a clean hospital

Last year, we reported on our work to ensure that the hospital meets the cleaning standards for Victorian hospitals. Regular cleaning audits are undertaken to measure this and then compared with other hospitals. We need to continue to focus closely on this area.

THE WOMEN'S EMERGENCY SERVICE

The Women's Emergency Service provides a 24-hour service for the management of acute or urgent obstetric and gynaecological problems and is an important link between the community and hospital care. Our staff are trained in a full range of skills specific to emergency care.

We provide:

- immediate assessment and intervention for a variety of conditions, including early pregnancy, pelvic pain, abnormal bleeding and breast problems
- a Short Stay Ward for monitoring early pregnancies that may be ectopic (outside the uterus), assessing women in early labour, antenatal assessment and short term treatment
- emergency contraception.

From this survey, we made a number of improvements including:

- sending the referring GPs a fax discharge letter and/or summary to promote communication and continuity
- arranging for junior medical staff to meet regularly with senior staff to review medical histories, discuss tests ordered, interpretation of results and treatment
- a system to monitor any waiting times which exceeds DHS standards of waiting time for Emergency Departments.

COMMUNITY PRINCIPLE – ACCESS

Asking our consumers:

In 2002, we saw an increased number of women attending our Emergency Service. In 2003/04, we decided to ask women why they were coming. Over the month of December, we surveyed 1,036 women and found the following reasons:

- 26% because it was a specialist Emergency (Women's Health) service
- 15% were referred by their GP
- 13% because female doctors were available
- 9% for the hours of operation
- 8% due to Bulk Billing arrangements (Medicare)
- 2% because after hours medication was free
- 7% because they couldn't access their GP
- 3% for interpreter availability
- 7% because family or friends recommended
- 10% for other reasons.

Figure 12: Patient waiting times - 1 July 2003 to 30 June 2004

Triage category	Treatment time target	Performance threshold	Performance recorded		
			Total no. of patients	No. seen within target	% seen within target
Category 1	Immediate	100%	13	13	100%
Category 2	Within 10 min	80%	195	167	86%
Category 3	Within 30 min	75%	5,959	5,662	88%
		Total	6,167		
Category 4	Within 1 hour	N/A	13,848	11,302	82%
Category 5	Within 2 hours	N/A	6,120	6,013	98%
Category 6	N/A	N/A	2		
Unknown	N/A	N/A	229		
		Total	20,199		

For the year ending June 2004, the Women's Emergency Department met all waiting time performance standards set by DHS.

GLOSSARY OF TERMS – WHAT TECHNICAL WORDS MEAN

Access:	includes access by patients as well as access to technology, expertise, research
Allied health:	health professionals such as physiotherapists, social workers, occupational therapists etc.
Analgesic therapy:	pain relief
Audits:	an examination of records to check accuracy
Benchmarking:	is the comparing of performance with similar organisations
Clinical governance:	is the framework through which health organisations are accountable for improving the quality of their services and safeguarding high standards of care
Clinical indicators:	measures which can show whether clinical standards have been met
Clinical practice guidelines:	provide a guide for how to best manage a medical condition or procedure based on best available research evidence
Continuum of care:	is the entire patient journey from pre admission to admission and discharge to community care
Cranial ultrasound:	is a scan of the brain
DHS:	Department of Human Services
Evidence based practice:	clinical care through the application of best research evidence
Fellow:	is a doctor who has completed or nearly completed of their specialist training
Genital fistula:	an abnormal passage from the vagina
High Dependency Unit (HDU):	provides medical care to the most unwell adult patients at the Women's
Hyperemesis:	is excessive vomiting during pregnancy
Incident reporting:	of any incident that affects health, wellbeing or security of a patient/consumer or staff member
Incontinence:	involuntary loss of urine or faeces
Intraventricular haemorrhage:	is a bleed in the brain ventricles
IVF:	in vitro fertilisation and assisted reproduction.
Neonatal death:	is a death occurring within 28 days of birth of a liveborn baby whose gestation is at least 20 weeks or weighing at least 400 grams
NHMRC:	National Health and Medical Research Council
Oncology:	the field of medicine devoted to cancer
Open disclosure:	refers to the open discussion of incidents, which resulted in unintended harm to a patient. It involves the hospital acknowledging and apologising when things go wrong and reassuring patients about what will be done to prevent such incidents happening again
Ovarian hyperstimulation syndrome:	is the over stimulation of the ovary to make follicles as part of fertility treatment
Pathology:	the science of the origin, nature and course of disease
Perinatal:	around the time of birth
Perineal tear:	when the area between the vagina and the anus tears, sometimes during childbirth
Perioperative:	around the time of surgery
Pregnancy booking clinic:	is the first antenatal assessment appointment at the Women's
Retinopathy:	a potentially blinding disease that affects the eyes of premature low birth weight babies
Root Cause Analysis:	is a tool that is used when something serious goes wrong to identify what happened, why it happened and what can be done to prevent it happening again. It is a multidisciplinary team approach
Sentinel event:	is a relatively infrequent event (as specified by DHS) that occurs independently of a patient's condition and typically reflects hospital systems and process deficiencies which results in unnecessary outcomes for patients
Urogynaecology:	care of women with pelvic floor problems such as incontinence or prolapse (dropped uterus or vagina)

FEEDBACK FORM

RWH Quality of Care Report

Please tick applicable category

- Consumer
- Department of Human Services, Victoria
- Women's & Children's Health Clinician
- Clinician from other organisation
- Other

Your opinion is important to us. Please tell us what you think of this year's report so we can make improvements in the future.

How would you rate this report overall?

Poor			Good				Excellent		
1	2	3	4	5	6	7	8	9	10

How could the report be more meaningful to you?

Once completed, please return this form to:

Quality and Safety Unit
The Royal Women's Hospital
132 Grattan Street
Carlton 3053

Telephone 9344 2000
Facsimile 9344 2325

www.rwh.org.au/qualityreport_rwh



Design Educational Resource Centre, Women's & Children's Health 041683

