



the women's
the royal women's hospital

women's *health matters*



2010

QUALITY OF
CARE REPORT

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We belong to you, the community

Our mission is to provide quality health services that meet the needs of women and newborn babies – especially those requiring specialist care.

This year's report will be distributed to our many consumers in the hospital, to our referring GPs around Victoria and to community health centres in our area. The report is also available on our website at www.thewomens.org.au

Last year you told us the Quality of Care report was too long and detailed – what do you think of this year's report?

We value your feedback so please email us on communications@thewomens.org.au or contact our Consumer Advocates on (03) 8345 2290.

welcome

We are pleased to present our 2009/10 Quality of Care Report with more staff and patient stories about how the Women's is improving your care.

As the largest women's hospital in Australia and having cared for women and babies for more than 150 years, the Royal Women's Hospital continues to play a very important role in Victoria's health system.

Women's health matters because medical treatments and care for women is based on evidence from studies of men. This affects prevention, diagnoses and treatments of diseases in women (including drug treatments) and also health promotion programs.

The Women's is leading the way in gender based research and care through several Australia-first initiatives. One of these is the Centre for Women's Mental Health, the only gender-specific mental health research centre in Australia, which was made possible through the generous support of Heloise Waislitz and the Pratt Foundation. Another initiative is the establishment of the Pauline Gandel Women's Imaging Centre, which is using Magnetic Resonance Imaging Guided Focused Ultrasound (MRgFUS) technology to non-invasively treat uterine fibroids. The MRgFUS technology, the only one of its kind in Australia, could not have been introduced without the support of Pauline Gandel, the Gandel Charitable Trust and a new technology grant from the Victorian Government.

From our broad community survey of 1000 Women to contacting every person who has made a complaint or compliment on our services in the last year, we are working with you on the issues that matter most to you. The number of patients, families and medical staff turning to our Consumer Advocates for help and advice has tripled and this is helping us make significant and relevant changes to the way we treat and care for you.

One example is that mothers of sick and premature babies wanted more support to be able to breastfeed, and so we re-arranged our services to specifically support our intensive and special care nurseries. Another is that men told us they wanted to know more about how they can help their partners through unplanned pregnancy, so this year we developed a series of four fact sheets with advice for men on caring for women with unplanned pregnancies (*Unplanned Pregnancies, Continuing an Unplanned Pregnancy, Abortion, and After an Abortion*). A near revolution has taken place in our busy day clinics after patients and GPs told us about the barriers and significant waits to get an appointment with a medical specialist. We are also conducting the world's largest research trial on one-to-one midwifery care, a model of care preferred by many women.

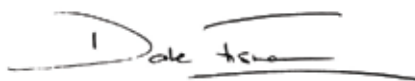
Which brings us to this year's Quality of Care Report. Following your feedback we have made this year's Report easier to read and, we trust, far more interesting for you. There are more stories about issues you told us you wanted to hear about, including menopause, breastfeeding and sex after cancer. There is also a special section with the key quality of care indicators for health specialists and women's health services.

The best people to tell you about our improvements are those most involved in your care – our dedicated staff. Thank you to our 70 plus hard-working contributors who shared their stories, data and photographs, and to our Quality and Safety Committee and our Community Advisory Committee for their specific advice and wise counsel.

We do hope you enjoy reading this year's report, and please don't forget to tell us what you think – because women's health really matters.



Dr Rhonda Galbally
Chair, Royal Women's Board



Dale Fisher
Chief Executive



The reality is women respond differently to treatments than men because every cell is sexed and every person is gendered.



TELL US WHAT YOU REALLY THINK

“Our job is not to take the hospital’s side, or to point the finger,” says Caroline Rose. “We look for problems in the system and how can we prevent them from happening again

When Caroline Rose began as the Consumer Advocate at the Women’s four years ago, her biggest concern was the possibility of doctors hiding under desks at the sight of her.

“Here she comes, what’s the problem,” was the response she feared. The reality has been altogether different, with medical

staff approaching her for advice on how to sensitively handle situations.

“The staff here are fabulous – there is a real culture of welcoming feedback and taking it on board,” Caroline said.

A former social worker with a counselling background, Caroline ran relationship education and conflict resolution groups before joining the Women’s. She has noticed a very positive cultural change since the Women’s moved to Parkville.

At the Carlton site, the Consumer Advocate’s office was underground, down a dark corridor, making it almost impossible to find. “Now look, we’re here for everyone to see. We’re right by the pharmacy, near the outpatient’s clinic – we’re making it easy for people to tell us about their experience here. “And people are turning to the Consumer Advocate in growing numbers, which is a tremendous change that is improving the quality of care at the Women’s.”

"The staff here are fabulous – there is a real culture of welcoming feedback and taking it on board," Caroline said.

"This office is much more visible and is used a lot more. The number of complaints has tripled – and I see that as a very positive thing. I believe it's because people trust that this is a good service, patients and medical staff know it's a good process, and they know it will improve services in the hospital."

This is backed up by the latest consumer survey that found six out of 10 people rated the service as good to excellent; nine out of 10 said the advocate was easy to contact; and two thirds believed their issues were seriously considered.

While the final results of the survey are still being collated, Caroline said the survey was part of the hospital's ongoing commitment to identify issues important to patients and to improve the way services are delivered.

The latest survey was sent to everyone who made a complaint between November 2009 and April 2010. It was designed in consultation with the Women's Quality and Safety Unit, the Consumer Advisory Committee and focus groups held with women who had previously made complaints to gather their shared knowledge and insights.

"We value the feedback because it helps us change wherever we can," says Caroline.

"For example, people used to have trouble making appointments with a specialist. They would send a fax and then ring to make sure it was received. And it was very difficult to confirm that. So now we've redesigned the whole Access Centre [see pages 6-7], so that all faxes

and phone calls come in at the same point."

Feedback from patients is now also being fed into a service review of the Women's Emergency Care to improve this crucial area of service.

In Caroline's experience, most complaints are about poor communication, where patients or families can't find out what they need to know or don't understand what is happening.

"Often it is just a misunderstanding. Our strategy is to sit down and talk as soon as possible, as most staff are very responsive and almost 50% of complaints are resolved in a day.

Most nursing and midwifery staff have been trained in good customer service skills. In the last financial year, 222 staff members have been trained in conflict management or attended forums on violence against women (see page 30).

"Dealing with grieving and traumatized people does take special skills and staff are keen to learn. For example in neonatal care, staff have been trained in how to deal with parents who are naturally terribly anxious and upset. Staff learn to balance the need to be getting their job done in a way that is extremely sensitive."

The Women's is also sharing its consumer advocacy skills and ideas with other hospitals. A recent workshop held at Goulburn Valley Health in Shepparton attracted more than 50 staff, from a range of health services in the area, wanting to improve their response to feedback.

So have we finished improving the quality of care at the Women's? The short answer is no, says Caroline. "It sounds twee, but there is always room for improvement. There's always other ways to do things and we are open to that."

YOUR SAY

We value your feedback – positive and negative – so we know what works well and what needs improving.

We aim to provide women and newborns with the best possible care at all times.

If this isn't your experience, talk to the staff first, and if you're not satisfied, contact the Consumer Advocate by:

Dropping in to Level 1, Consumer Advocate's office at RWH between 9am and 5pm Monday to Friday

Phoning (03) 8345 2290 or (03) 8345 2291

Faxing (03) 8345 2298

Emailing consumer.advocate@thewomens.org.au

a revolution in access



Every week, GPs refer 400+ women to the specialist clinics at the Women's and make 500 follow-up calls wanting to confirm appointments.

Having sometimes waited many weeks for acknowledgement of their initial request, frustrated GPs were sometimes resending their referral letters "just in case." This created more work for both the GPs and for the Women's.

After a number of complaints to the Consumer Advocate, the Women's completely reviewed the GP referral and appointment process for day patients – and the turnaround has been stunning.

We've discovered that some women forget their appointment, so now we're testing an SMS appointment reminder program, which looks great.

Consumers, GPs and our own clinicians were consulted by the Women's project team, who also looked at other hospitals' referral systems. Our referral system was found wanting.

A lack of a central coordinating system meant some women were referred to the wrong clinics, some were given multiple appointments and some were waiting too long to see a specialist.

GPs were often left in the dark and there was no communication at all with women. Nothing short of a revolution was needed.

The upshot has been the creation of a central Access Centre so all requests and enquiries come to the one place – making them easier to track. Outpatient referral and appointment processes have been completely revised from the use of staff right down to the guidelines and information provided to GPs.

One of the key operational changes was moving from a paper-based to an electronic system – a push across the Women's to incorporate new innovations, improve efficiency and reduce our environmental impact. The roles of the Access Centre staff have been reorganised so that highly-skilled nursing staff and

clerical staff have clearly defined roles and appropriate training. The Women's GP Liaison Officer updates GPs on any changes to our processes and referrals, so they know what health tests their patients need prior to seeing the specialist.

The consumer experience has now turned around, with speedy confirmations and shorter waiting times. Receipt of referral requests are now logged within 2.7 days compared to up to 53 days under the old paper system. Waiting times for specialist appointments has dropped from an average 15 to nine weeks.

Not surprisingly the number of consumer complaints has also fallen from an average 10 a month to one a month. But the Manager of the Access Centre, Joanne O'Connor, is not stopping there.

"Although we've made significant and meaningful improvements, we're going to keep monitoring our performance targets every week and improving our system as new technologies are introduced. For example, we've discovered that some women forget their appointment, so now we're testing an SMS appointment reminder program, which looks great."

Before and after: a revolution in patient referrals

BEFORE ACCESS CENTRE	AFTER ACCESS CENTRE
GPs had no way of knowing whether their referral had been received	GPs <i>and</i> patients receive an acknowledgement letter in 2 days
Phone enquiries and faxes came in on multiple telephone lines making individual paper files hard to track	All enquiries answered by central team with immediate access to all patient files on electronic system
Average wait to log a GP's referral request 8 days Longest wait 53 days	Average wait to log a GP's referral request 2 days Longest wait 2.7 days
Up to 43 days for a letter of appointment to arrive	Average of 4 days for letter of appointment to arrive
Average 15 week wait to see specialist	Average 9 week wait to see specialist
10 consumer complaints a month	1 consumer complaint a month



Community participation is the Women's way. We consult consumers, carers and community members, and involve them in decision-making. This is the best way of improving our services and meeting the health care needs of women of all ages and the families of newborn babies. The Women's also supports the State Government's *Doing it with us not for us* strategic direction (2010-13).

Some of our consumer feedback highlights and works in progress in 2009/10 are:

- Our *Hospital in the Home* steering group working with consumers to explore how we can better prepare people for discharge, especially with more information for parents
- The development of feedback forms, information folders and advice booklets for parents of newborns needing special care developed as a result of feedback from consumers, carers and health professionals
- The development of a new medicines guide for pregnant women and breastfeeding mothers for pharmacists and doctors in Australia and New Zealand
- Partnering with many government and non-government agencies and holding consumer workshops and focus groups to help develop the Victorian Comprehensive Cancer Centre
- Undertaking a major survey of patients who made a complaint to the hospital, as part of our ongoing commitment to involving consumers, carers and the community in health reform

1000 WOMEN'S VOICES



We want to know what women want to better meet their health care needs. That's why we've asked more than 1000 women about their expectations of the Women's future plans. Online and paper-based surveys, focus groups and one-on-one interviews were used to understand women's priorities and preferences. This information will be used to assist us in decisions we make in relation to clinical service and social development plans. Building on our 2002 survey of 1000 women, the 2009/10 survey results are giving us a more detailed picture of the changing health and wellbeing requirements of women.

Preliminary results from the survey tell us that we are a trusted health service, an invaluable source of health advice and that women want more health information from us. Young women and older women tell us they need more services to meet their needs. The full results, to be reported next year, will be factored into the Women's new Strategic Plan 2011-2015.

THE WOMEN'S COMMUNITY ADVISORY COMMITTEE

Our Community Advisory Committee advises the Women's Board on how to consult and involve more consumers, carers and community members in our future planning through our Community Participation Plan and other initiatives.

In the last year, the Community Advisory Committee has focused on three health plans that will set new directions for women's health under a new Diversity Framework:

- the Disability Action Plan 2010-12, designed to remove barriers to women with a disability enjoying high quality health care at the Women's, and opening up job opportunities to people with disabilities
- a newly-revised Reconciliation Action Plan 2010-12, to close the health gap between indigenous and non-indigenous women and improve the wellbeing of Aboriginal and Torres Strait Islander women by building trust in the quality and safety of health services (see pages 12-13)
- the Cultural and Linguistic Diversity Action Plan 2010-12, which aims to make the Women's a more welcoming environment, and to build a culturally and linguistically diverse workforce (see pages 10-11)

REMOVING BARRIERS

Women from all walks of life can come to the Women's knowing that they will be welcome, safe, cared for and understood.

The Disability Action Plan 2010-2012 aims to remove barriers both for women attending the hospital as patients and is also intended to identify further employment opportunities for people with disabilities.

In 2009, the Women's Human Resources Department surveyed staff to develop a profile of our workforce and found that 1.2% of our staff report having a disability.

Our Community Advisory Committee Members:

Elleni Bereded-Samuel
(Chair, Women's Board Member)

Aileen Berry
(Women's Board Member)

Serena Bridges

Kate Graham

Tricia Malowney

Afshan Mantoo

Toni Mason

Anna Moo

Irene Ryder

Renza Sciblia

you're speaking my language

The Women's is not new to the challenge of meeting the needs of patients who speak rare or emerging languages with almost a third of our catchment population born overseas.

Our Language Services department provides support in 81 languages, with 5.6 equivalent full time interpreters covering the most requested languages.

The top seven languages provided by interpreters in 2009/10

NAME	OCCASIONS OF SERVICE	RANKING
Arabic	6643	1st
Mandarin	6362	2nd
Vietnamese	4311	3rd
Turkish	3422	4th
Greek	1768	5th
Cantonese	1534	6th
Italian	1248	7th

As the fabric of Melbourne changes, so too does the requirement for languages at the Women's. There is a growing demand for language services, with the number of requests for help increasing by 13% in the last year. There is a strong increase in demand for Italian-speakers (up 40%), Mandarin (up 25%) and Arabic (up 15%).

Language group changes between 2008/09 and 2009/10

NAME	% INCREASE
Vietnamese	0.3%
Spanish	5%
Turkish	11%
Cantonese	11%
Arabic	15%
Russian	17%
Urdu	19%
Serbian	23%
Mandarin	25%
Punjabi	26%
Persian	28%
Dari	34%
Tigrinia	35%
Italian	40%
Oromo	58%
Tamil	64%
Karen	75%
Thai	79%
Hindi	85%
Pushtu	123%
Tagalog	380%
Telegu	394%
French	396%
Somali	-13%



BILINGUAL STAFF

A BONUS FOR WOMEN

A visit to hospital can be frightening enough without the added stress of not understanding the myriad of signs and directions. How do you find where you need to go if you are not fluent in English? How do you make a follow-up appointment if you do not speak the same language as the receptionist?

Approximately a quarter of staff at the Women's were born overseas, from an astonishing 76 different countries. To further boost language service support at the Women's, some of our bilingual staff have volunteered to be trained and accredited as language aides alongside their normal duties.

The *Language Aide Pilot Program*, launched in March this year, harnesses staff diversity by enabling bilingual staff to offer assistance to patients and visitors who speak English as their second language, to help them make appointments, find their way around the hospital or learn about available services.

This pilot project is helping put more women and their visitors at ease.

The project is being developed in partnership with government, higher education and non-government agencies in what could become a model for other health services.

In 2009-10, eight staff members were recruited and trained. Currently language aides speak Cantonese, Mandarin, Serbian and Polish.



BUILDING MORE TRUST WITH ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Ms Joanne Pappas and Ms Terori Hareko-Samios, from the Aboriginal Women's Health Business Unit, provide support and advice to Aboriginal and Torres Strait Islander consumers.

Building community trust in the quality and safety of health services at the Women's is at the heart of our Reconciliation Action Plan 2009-2011 (now revised for 2010-12) to improve the health and wellbeing of Aboriginal and Torres Strait Islander (A&TSI) women.

The Reconciliation Action Plan has been developed by the Reconciliation Working Group with advice from the dedicated workers in our Aboriginal Women's Health Business Unit (AWHBU) and consumer input and advice from our external Aboriginal Women's Advisory Group. The Plan aims to close the health gaps experienced by A&TSI women by creating a welcoming environment, providing cross cultural training for staff, providing culturally sensitive planning and establishing a referral base for Aboriginal workers.

A key new initiative this year has been developing a monitoring mechanism to report on how many A&TSI women are accessing inpatient and outpatients services at the Women's – and it is a growing number.

The first reports received this year show that our approach to providing cultural support and advocacy to A&TSI women and their families is working. The number of A&TSI women coming to the Women's for inpatient and outpatient services has increased substantially (see graphs opposite).

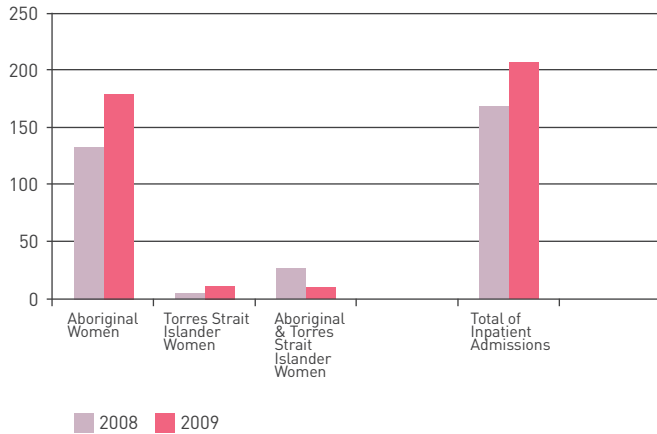
Positive trends in health outcomes include the percentage of premature babies falling from 36.4% to 29.4%.

While this is a good start to improving the health and wellbeing of A&TSI women, the first reports do point to the need for further development of gynaecology and oncology services to reach A&TSI women.

“Just having a yarn with an Aboriginal support worker and support and advice was helpful.”

Feedback from an Aboriginal woman attending the Women’s

Inpatient Admissions



Outpatient Visits



Sexual and reproductive health is also a significant issue that may require more outreach services targeted to communities to help women access prevention and treatment.

In 2009, the AWHBU and Reconciliation Plan Working Group supported the development of an outreach medical service to the Victorian Aboriginal Health Service (VAHS). A Senior Obstetrics and Gynaecology Registrar provides a fortnightly session to A&TSI women at the service, secondary consultation to VAHS staff and assists with their access to the Women’s if required.

CULTURAL TRAINING

The Aboriginal Women’s Health Business Unit runs monthly cross-cultural training sessions with more than 100 health professionals attending sessions over the past year. Our Aboriginal Health Associates – nearly 50 staff who have completed specialist training – continue to receive ongoing professional development with Aboriginal Controlled Services, such as the Victorian Aboriginal Health Service, presenting about their program and referral pathways.

“This session has helped me understand the ways I can expand my knowledge on culture and Aboriginal issues and its importance in the hospital community. Through the session I have also realized the significance of having Indigenous health workers, health professionals and social workers and how it can help the treatment of Indigenous people.”

Medical student after completion of an AWHBU-led training session.

“Culturally appropriate services and a comfortable place to wait for appointments was very helpful.”

Feedback from an Aboriginal woman attending the Women’s

WOMEN WANT MORE LATER IN LIFE

Our community is telling us (see page 8) that they want us to provide more high quality health-related information that will allow them to enjoy a good quality of life at all ages. The findings also show that our community wants more health services for midlife issues such as menopause.

Professor Martha Hickey, a leading health clinician and researcher who recently joined the Women's, is working to address these needs. Martha is leading the menopause service at the Women's, which offers a multidisciplinary approach to provide high quality information and improve care for women in midlife.

"The messages from the community are not surprising when it comes to menopause," says Martha. "We realise the quality of life and wellbeing for midlife women is extremely important."

According to Professor Martha Hickey, learning about women's health is a two-way street. "Those who come to the Women's are getting the most recent and relevant treatment and we are learning from the diverse experiences of women who come to us for treatment."

According to Martha, learning about women's health is a two-way street. "Those who come to the Women's are getting the most recent and relevant treatment and we are learning from the diverse experiences of women who come to us for treatment."

A clinical psychologist, obstetrician, and a leader in menopause care and research, Martha has a strong interest in midlife health issues, including the management of menopausal symptoms without hormones, sleep disorders, and anxiety and depression in midlife. She has also developed specialised services for women who have troublesome menopausal symptoms after cancer treatment.

Martha said she wanted to join the Women's not only because it is the top research hospital in Australia for women's health but because it brings together a range of health professionals – gynaecologists, mental health professionals, endocrinologists and clinical researchers – to coordinate care for women.

The Women's is leading new research studies on wellbeing and positive approaches to health, with several commencing this year. For example, the menopause team is collaborating with the Centre for Women's Mental Health to study anxiety and depression in women in midlife and to develop care based on that research.

Supporting women who go through early menopause because of cancer treatment is another area of study (see page 16). "Our research includes keeping records of the menopausal symptoms of cancer and non-cancer patients, so we will be able to compare how menopause affects the lives of these two groups of women and learn how best to help them," Martha said.



PUT A LITTLE SPRING IN YOUR STEP!



Nine out of 10 women will be menopausal by 55, so a large number of women want information and support through menopause.

That's why the Women's Health Information Centre began the *Put a Little Spring in your Step* program to support women going through menopause.

The free program gives women the chance to meet other women going through menopause, encouraging them to talk, share experiences and support each other in a relaxed and caring environment.

Women learn about continence, sexuality, mood and memory, hormone replacement and natural therapies, diet and body image. The program runs one evening a week for seven weeks, with a different guest speaker and topic each week, followed by gentle exercises led by a qualified physiotherapist.

Menopause has been recognised as a key time to introduce preventative health strategies and empower women by increasing their health literacy. With this in mind, the Women's Health Information Centre this year extended *Put a Little Spring in your Step* to reach a larger and more diverse group of women (see below). Also developed, a specialised program for women who have experienced early or surgical menopause as a result of cancer (see next page).

Finally, an e-course consisting of seven weekly emails was developed to further expand the reach of the program by supporting women unable to attend the hospital for face-to-face sessions. The weekly emails mirrored the content of the face-to-face sessions with key discussion points, health information, and links to other quality online health information.

Springing into Arabic and Chinese...



To enable women from culturally and linguistically diverse backgrounds to join the *Put a Little Spring in your Step* program, the Women's worked with the Muslim Women's

Council of Victoria and

the hospital's Language Services to develop a culturally sensitive program in Arabic and Chinese – the two languages most frequently interpreted at the Women's.

As many Muslim women find the topics covered uncomfortable to discuss, the help of the Muslim Women's Council of Victoria in developing material was invaluable. Cultural factors that might prevent Arabic-speaking women from accessing health services were also considered, and this led to the program being run over four weeks in the early evening, to fit with women's family commitments, and travel assistance being offered.

The women who participated were between 43 and 63 years of age and were mainly born in Lebanon. Listening to the women, the program was clearly useful because it led to positive behavioural changes in their own lives. As one woman summed up at the end of the program: "I am now ready for menopause!"

"Many of the topics covered at the menopause program are taboo areas for Muslim women," explained one participant.

"There are many wives tales that are based on myths and superstition around women's bodies and menopause. Mothers don't have the answers and often don't know themselves. It is better for me to be informed about menopause and the changes to the body so that I can be equipped to advise my daughter with the facts,"

said another participant at the Arabic-language *Put a Little Spring in your Step* program

...and beyond cancer



Gabby Sprague answers "Ask a Nurse/Midwife" calls in the Women's Health Information Centre and runs some of the *Put a Little Spring in your Step* programs.

A specialised program for women experiencing early or surgical menopause as a result of cancer began this year after women told us they wanted more advice on issues of sexuality and body image.

One million Australian women are breast cancer survivors and around 80% of these women will go through early menopause because of cancer treatment.

After listening to women at a *Living with Cancer Program* say they wanted more information and support, staff from the Women's Health Information Centre decided to tailor the *Put a Little Spring in your Step* program to women experiencing early menopause due to cancer.

"These women wanted to know more about menopause. A number of women felt the focus of health professionals was limited to survival, when their concerns reached to issues of sexuality and body image," said Gabby Sprague from the Women's Health Information Centre, who helped run two programs this year.

Some menopause treatments, such as hormone replacement therapy, are not recommended for breast cancer survivors. "Cancer treatment can be long and complex, and physically and psychologically damaging. These women need specific advice, treatment and support about menopause and that's where the Centre has helped," Gabby said.

"I am normal ... we all gain a bit of weight and this is just a normal part of the change during menopause ..."

Janet, a recent participant of the *Put a Little Spring in your Step* program for women experiencing early menopause due to cancer treatment

GETTING THE RIGHT ADVICE

In April and May this year the Women's ran two menopause programs for women who have experienced early or surgical menopause, and Linda and Janet found the advice they needed among women who shared their experience.

Linda was diagnosed with breast cancer at 40. During her medical journey, which included chemotherapy and radiotherapy, menopause kicked in. Menopause is considered to be 'early' if symptoms begin between the ages of 40 and 45, with 51 being the average age for menopause.

"It is not well known in the community that cancer treatment can bring on early menopause," said Linda. "Women need to know that cancer treatment brings on early menopause and the effect this has on women who are already dealing with many other health issues."

Linda said the seven-week program *Put a Little Spring in your Step* was highly relevant, with expert speakers who encouraged women to talk about their experience and a gentle introduction to weight bearing exercises as just one strategy to help manage menopause symptoms.

"There is a lot of information out there on the internet about women who have experienced early or surgical menopause as a result of cancer, but information received through the Women's is reputable and the program connects you to other relevant speakers."

The program has been so useful that Linda would like a follow-up session with the women in the program or a support group with an informed facilitator.

Janet, who finished chemotherapy two years ago and is experiencing menopause, said the program was powerful because it connected women going through the same thing.

"We all seemed to click as we could all relate to one another through our cancer and menopause experience," Janet said.

Medication for cancer treatment can make menopause symptoms – mood changes, hot flashes, tiredness, aches and the need to urinate frequently – worse.

Janet found the discussion on women's sexuality really useful and thought that the sexual counselling session could be expanded in future.

Since completing the program, Janet feels more relaxed about menopause – she now knows that her experiences are normal. "Now I understand how weight changes around menopause, which I didn't know before," she said.

WOMEN'S EXPERIENCES AT THE WELL WOMEN'S CLINIC

The Well Women's Clinic offers a free and comprehensive service that is designed to remove cultural and other barriers and provide women information on health and wellbeing.

At the clinic, you can get a free Pap test, learn about breast self-examination, and get advice on sexuality, safe sex practices and pregnancy. Testing for sexually transmitted infections is also available.

The clinic targets women who are marginalised, under-screened or who have never been screened, with confidential service and advice. With a range of interpreters available, the clinic can cater to women who speak many different languages.

When we ask women about their experiences at the Well Women's Clinic, they are overwhelmingly positive. Approximately 97% of women who used the service found the physical examination to be comfortable, and 100% were comfortable with the questions asked by the nurse.

While the positive feedback is great news, we also appreciate knowing what doesn't work and we now know there is one big area that needs improvement: making a booking. Approximately 21% of women said they had difficulty making an appointment to the clinic. Some women reported difficulties getting through on the booking line or having to wait for a long time to get an appointment.

A direct line to the Women's Health Information Centre has now been established for booking Well Women's Clinic appointments, and the Women's will monitor the number of complaints to see if this response has solved the problem.

(continued)

Women are overwhelmingly positive about the Well Women's clinic, saying:

- it was the best Pap test ever!
- much better than the GP
- the nurse really listened
- happy, comfortable and satisfied
- excellent service, I am a regular user

More than a Pap test

Having a Pap test is your best protection against cervical cancer, yet many women are uneasy about going to their GP for a regular test.

According to our a telephone survey on client satisfaction, many women are turning to our Well Women's Clinic for a Pap test because of the comfort that a female Nurse Pap Test Provider will perform the test.

To find out what women think of our service, the Women's followed up directly with half of the women who used the clinic for a Pap test in October 2008. The telephone survey found that women chose the clinic because:

- the Pap tests are done by a woman (84%)
- the Women's makes them feel safe (34%)
- the service is free (19%)
- they feel embarrassed to ask their local doctor (13%)
- an interpreter service is available (8%)

Around 93% of women were happy to receive a letter with the results of their Pap tests but some women have requested results are sent by email. Sometimes this is appropriate and sometimes it is not, particularly in the case when the results might need further explanation. When women request that they not receive a letter, Women's staff will negotiate with the woman to come to a contact plan of emailing or telephoning results so that they can be explained and discussed.

I had delayed having a Pap test because of a very bad previous experience - a friend suggested that I should come to the Well Women's Clinic and I was extremely happy this time.

Reaching out to all women

To understand who is accessing the Well Women's Clinic and assess whether we are serving the needs of our culturally and linguistically diverse consumers, we surveyed all women attending the Clinic between July 2009 and June 2010.

We found that 49% of the women came from 68 different countries. Nearly 9% of consumers used the interpreter service, and the availability of interpreters was one of the main reasons why they chose the clinic for their Pap test.

The largest groups of women were born in Greece, Italy, China and the United Kingdom. However, the results showed that we might not be reaching women born in the Horn of Africa, who represented just over 1% of appointments.

One of the aims of the clinic over the past year has been to reach women who are less likely to use health services, including Aboriginal and Torres Strait Islander women and women born in the Horn of Africa (Eritrea, Djibouti, Ethiopia and Somalia).

Although there has been an increase in the numbers of Aboriginal and Torres Strait Islander women accessing the Women's (see pages 12-13), there are still too few of these women using the Well Women's Clinic service. To understand why, the Women's is talking to other health providers—and the Women's own Aboriginal Women's Health Business Unit, Family and Reproductive Rights Education Program and Women's Social Support Services—to see whether the needs of these women are being met by other services, or what can be done to improve access.

Planning is underway to capture information on women with disabilities and mental health issues attending our clinics so that we can address whether these women's needs are being met by our services.

UNPLANNED PREGNANCIES DO HAPPEN

Women with unplanned or unwanted pregnancies have long received expert care and support from the Women's Pregnancy Advisory Service.

Men care too

This year the Pregnancy Advisory Service launched new support material to assist the carers—nearly always male partners—of women who have an unplanned pregnancy.

The material was developed because staff had noticed how many men were asking for information about how they could help their partners. Some women also told staff they felt their partners didn't know how to respond to their needs as they accessed the service.

The Pregnancy Advisory Service has produced four fact sheets covering decision-making about unplanned pregnancy, supporting women who are continuing or terminating a pregnancy and post-abortion support.

Available online (www.thewomens.org.au/unplanned_pregnancy), the fact sheets help men feel less alienated and more able to support their partners by having a better understanding of what women need.

Redesigning care for women with special needs

A more supportive and accessible service for women with cognitive impairment has also been developed by the Pregnancy Advisory Services this year.

The service staff found that women with cognitive impairment did not receive the specialised assessment and care, access to legal advice and counselling they needed when faced with unplanned or unwanted pregnancy.

The Pregnancy Advisory Service has developed and implemented a range of new methods and tools to improve the care and provide more services for women with cognitive impairment including:

- a new method of collecting information to help assess a woman's needs when she first attends the service
- new publications for health professionals, which are developed in consultation with health and legal professionals, that cover issues of decision-making and consent
- an internal process for the service to refer a patient to a social worker who will assist all women with cognitive impairment and ensure their access to specialised counselling, assessment and advocacy
- a service model for the sexual and reproductive health of women with cognitive impairment in existing programs, including abortion services, contraception services, and the Well Women's and menopause clinics

SHARED MATERNITY CARE GUIDELINES STRENGTHEN CARE

During and after pregnancy, a woman needs high-quality care and she needs good information so she can make choices about who provides it – her GP, obstetrician or midwife. Hospitals also provide maternity care, so throughout a pregnancy, a woman might receive care from many providers.

When these different care providers work together, it's called shared maternity care. The Royal Women's Hospital, and more than 700 GPs, obstetricians and midwives provide shared maternity care to approximately 1500 women every year.

Eighty-five per cent of shared maternity care is provided by a GP in a woman's community. One advantage is that the GP may be close to home or work. Also, it is common for a woman to know her GP, and for a GP to know a woman and her family, and to share her language and culture. GPs can also advise a woman about issues that are not related to her pregnancy.

For shared maternity care to work well, hospital clinicians, GPs, obstetricians and midwives need to communicate and share an understanding of the different types of care that are planned and when they need to happen.

To help everyone work together in shared maternity care, guidelines for providing a high quality community-based, holistic, safe

and culturally appropriate model of care were developed in 2002. Feedback from people who use the guidelines has been very positive as they are valued as a great resource. In early 2010, these guidelines were reviewed and updated to refresh useful information and replace out-of-date information (for example, changing addresses, and adding new services and clinical procedures).

The Shared Maternity Care Guidelines were developed in collaboration with those who are directly involved in shared maternity care. The Women's GP Liaison Unit consulted GPs, obstetricians, midwives, hospital clinicians, and women who have used or who are expecting to use shared maternity care. The Unit also held focus groups, where everyone was able to talk about their understanding of the guidelines, while bringing up and addressing potential problems.



"I am very proud of what we have achieved," says Madeleine Whinney, Project Officer, GP Liaison Unit at the Women's.

The guidelines clearly outline the roles, responsibilities and expectations of GPs, obstetricians, midwives, hospital clinicians and the women receiving the care. They provide clear pathways of referral, care and support.

They include schedules of visits that a woman may make during pregnancy and talk about what will happen during the visits; they recommend routine investigations and the reasons for them; and they help care providers align the care schedule with each other.

The guidelines will be available online from the Women's and the Victorian Government Department of Health. People from the GP Liaison Unit will give a workshop each year to teach people about the guidelines and how they are used in providing shared maternity care. Every three years, as part of their accreditation, each GP will commit to following, using and reviewing the guidelines.

world awaits COSMOS TRIAL

The Women's is dedicated to improving the care for women in the lead up to, during and post pregnancy – and a randomised trial involving 2314 pregnant women will provide us with invaluable advice on how to do it.



Tanya Farrell, Clinical Director of Maternity Services at the Women's

Della Forster from the Women's Maternity Services said it was only the third trial in the world to compare one-on-one midwifery care with traditional maternity services, and by far the largest. "There were two small trials conducted in England in the late '90s, but this is by far the biggest trial of this type in the world, and the world is awaiting the outcomes," she said.

The trial will evaluate pregnancy and birth outcomes, satisfaction with care and other longer-term outcomes such as breastfeeding, postnatal depression and women's general wellbeing.

Half the 2314 women on the COSMOS trial receive one-to-one, or caseload, care from midwives at the hospital, and the other half choose from traditional care models available at the Women's.

A woman allocated to caseload care has most of her pregnancy, birth, postnatal and follow-up visits at home provided by a primary midwife or a back-up midwife. If the woman develops any obstetric or medical problems the caseload midwife consults with and refers to the obstetric staff as per the current guidelines. The midwife continues to provide midwifery support for the woman regardless of the level of medical care she requires. There are four groups of caseload midwives, each with three or four midwives in the group.

The trial began at the Women's in late 2007 and is funded by the National Health and Medical Research Council (NH&MRC). Another 314 women were recruited to the trial in 2009/10 and the last woman in the study is due to give birth this December.

Della Forster from the Women's Maternity

"Many women favour the one-to-one midwifery and many midwives prefer to work this way, but there is little rigorous evaluation of this type of care, which is why we support this trial," said Tanya Farrell, Director of Maternity Services at the Women's. "We are also exploring the views and experiences of midwives and other pregnancy care providers, as well as looking at the costs of the different types of care and how these compare with the usual options for women," said Tanya.

One COSMOS recruit who needs no convincing of the value of one-to-one midwifery care is Zoe Ladyman who gave birth to her second child Griffin early on Australia Day.

"Coming from having a scary and wobbly first birth with Beatrix in 2007, it was great to have someone with me who knew me well, instead of the sea of faces where I didn't see anyone twice," said Zoe.

Juanita White, a Clinical Midwife Specialist at the Women's and one of 14 midwives involved in the COSMOS trial, was Zoe's midwife throughout pregnancy, birth and the postnatal period.

She said women felt more relaxed and empowered during the birth and in parenting because of the relationship established during pregnancy.

"Women tell us it makes a difference, having someone there who knows them, and who is very comforting and reassuring, while they are going through labour and establishing their breastfeeding and parenting skills," Juanita said.

Zoe said there was "a big contrast" between her two birthing experiences at the Women's, and Juanita had helped her work through the "emotional baggage" of her first, long labour.

"I felt quite alone the first time, but this time, the element of fear was taken away. Juanita helped me to make peace with what happened the first time and I was able to get rid of all of those issues and deal with them before the day came. She was so confident, and that inspired confidence in me."

The results of the COSMOS trial will be reported next year.



Zoe and Griffin Ladyman with Juanita White, a Clinical Midwife Specialist at the Women's

BETTER ACCESS TO BREASTFEEDING CARE AND ADVICE

Just because breastfeeding is natural, doesn't mean it comes easily. That's why the Women's sees thousands of women after they leave hospital to help with common issues around correct attachment, positioning and milk supply through to recurring mastitis and babies with a tongue tie.

"We know through studies that if women get early breastfeeding support and good quality information from the beginning, they're much more likely to have a successful breastfeeding experience and breastfeed for longer," explained Kaye Dyson, the Manager of Breastfeeding Education and Support Services, which is affectionately known as BESS around the hospital.

Now the Women's is helping hundreds more women in the weeks after they leave hospital under a new model of care in a new outpatient centre that is integrated with the Women's Maternity Services. A new funding and admission policy introduced by the Department of Human Services sparked the change.

Waiting times for appointments at BESS have this year been reduced from between 10 to 14 days to 3 to 7 days as a result of our new model of care.

"This means we are seeing 500 more women a year in the breastfeeding clinic and 400 more mothers whose infants were in Newborn Intensive and Special Care," said Kaye.

Kaye said there are many reasons why women find breastfeeding challenging. "One key reason is that we still, as a community, don't support women to breastfeed in public. Another reason is that many of us don't live with extended families so our experience of seeing our sisters, aunts and mothers breastfeeding are limited."



"Some women have never even sat next to a woman breastfeeding or held a newborn baby, so they don't know what it's like to breastfeed a baby," says Kaye Dyson, Manager of Breastfeeding Education and Support Services

At a one to two hour appointment, a lactation consultant assesses a full breastfeed and focuses on attachment and positioning issues, and low milk supply, and determines if there are any further issues such as breast or nipple thrush. "We also run a Lactation Disorders Clinic on Friday afternoons with Dr Lisa Amir, our medical consultant, to manage such complex issues as persistent nipple and breast thrush, recurrent mastitis and babies with a tongue tie."

This year midwives initiated a formal referral process for inpatients who require a lactation consultant, which has resulted in more timely access to specialist help. The Women's also has a team of midwives who conduct home visits and new mothers are able to phone BESS for on the spot breastfeeding advice.

"At our appointments for outpatients, we also introduced a review process so that mothers are confident before they leave. If they need more support, we make an appointment to see them again in a week's time or we refer them to the Friday clinic if they have more complex issues," Kaye said.

In developing the new model of care, the BESS team also identified that mothers of infants in Newborn Intensive and Special Care weren't being provided with enough breastfeeding support in the early days. This resulted in the development of materials specifically for breastfeeding sick and premature babies (see pages 24-25).

accreditation as a *'Baby Friendly Hospital'* ... again

The Royal Women's Hospital has been recredited as a *Baby Friendly Hospital* for the next three years. One of the key improvements, which contributed to our reaccréditation was a program for mothers to have skin-to-skin contact with their babies following a caesarean birth.



One of the World Health Organisation's 10 steps to support breastfeeding is to place all babies in skin-to-skin contact with their mothers immediately following the birth for at least one hour.

This was the only step that the Women's was not always able to meet – as a tertiary referral hospital with a high number of emergency caesarean births – but this has now changed.

"We now involve two staff so we are always able to have a midwife with a woman in the first hour after a caesarean, to get mothers and babies together as soon as possible after birth," explained Kaye Dyson from BESS.

In the past, almost a third of babies born at the hospital did not have this contact in the first hour because of the high caesarean section rate.

"So this is a big improvement in the quality of care because we know there are short and long-term benefits, including making babies more likely to be still breastfeeding four months later," Kaye said.

And the results for mothers and children are already being seen. In a recent trial, particular care was taken to provide mothers who have an elective caesarean section with skin-to-skin contact with their babies.

A promising success has been the reduction of the time to first breastfeed from around 147 minutes to 54 minutes.

The *Baby Friendly* quality accreditation process occurs once every three years, and was awarded to the Women's in February for the fourth time. The Women's was the first public hospital in Australia to be accredited (in 1995) as a *Baby Friendly Hospital*.

The Women's supports breastfeeding through an extensive breastfeeding education program for nurses, midwives, doctors and allied professionals. This year the education focus has been on the breastfeeding training of staff to promote a hospital-wide approach to supporting breastfeeding for sick and premature babies (see pages 24-25).



BREASTFEEDING *RIGHT FROM THE START*

Breastfeeding can be challenging for any mother, but even more so for those of sick or premature babies cared for in neonatal units. Mothers of vulnerable babies often face additional barriers to breastfeeding due to the health of their baby, their own health and the difficulty associated with making the transition from tube feeding to breastfeeding.

The *Enhancing Breastfeeding Support* project in Neonatal and Intensive Special Care (NISC) was developed to identify the barriers preventing mothers breastfeeding babies in neonatal care and to determine the day-to-day and specialist support needed to increase breastfeeding rates.

Feedback from mothers and staff, an analysis of the breastfeeding environment, support and information available, and a review of existing research, informed the development of the *Right from the Start* strategy.

The strategy aims to provide mothers with the right support, advice, information and education, at the right time.

NISC Care Manager, Lesleyann McGill, said the project revealed mothers understood and believed in the benefits of breastfeeding, but did not have the support to put it into practice.

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

“Mothers of vulnerable infants need proactive and consistent support and we aim to provide that at the Women’s through the *Right from the Start* strategy.”

The strategy recommended reviewing staff education, to ensure a consistent approach, and to provide the type and level of support most valued by mothers and their families.



Lesleyann McGill, from the Neonatal & Intensive Special Care Unit says most mothers of sick and preterm babies want to be able to breastfeed their babies.

FAMILY FOCUSSED CARE

Mothers of babies in NISC were among those who helped shape the project, attending focus groups to speak about their breastfeeding experiences. Many mothers spoke about the importance of consistent advice from all staff and ongoing support to help them breastfeed.

Other recommendations included:

- developing a referral process to ensure all mothers were seen by a lactation specialist between 24 and 48 hours of the birth, followed by routine, regular specialist support
- developing an online breastfeeding education program for staff at the hospital
- establishing written feeding plans for all NISC infants for pre and post-discharge
- refurbishing the NISC breastfeeding room to make it more comfortable and welcoming

Lactation consultants have already started attending NISC's weekly multidisciplinary team meetings to discuss feeding plans for all infants in the unit with the rest of the team.

In future, *Right from the Start* and its associated resources could be used more broadly across all units at the Women's and other similar organisations.



'Baby's first bedroom,' part of the family focussed model of care in NISC.

Following the introduction of a new model of care and the move to the new Women's hospital in Parkville two years ago, the Newborn Intensive and Special Care (NISC) unit has actively sought feedback from parents and staff to ensure we continue to engage families in the care of their sick or premature babies.

Our model of care continues to get good feedback as parents embrace the physical layout of the unit, which offers greater privacy, individual storage areas and the ability for families to personalise their baby's 'first bedroom.'

This year, in response to feedback from the Family and Baby Care Group, which is comprised of staff and consumers, we have implemented a number of new initiatives. Some of these include the development of a new parent's booklet and information folder, which contains more detailed medical and developmental care reports (see page 26).

These changes have occurred at a time when the capacity of the unit has been greatly expanded to meet a growing demand for neonatal intensive care cots. The unit accommodates about 1400 premature and sick babies each year, as well as their families and carers and more than 300 staff.

BETTER PARENT INFORMATION IN FOUR LANGUAGES

A new parents' booklet has been developed to support women and their families during and after the birth of their child.

The *Welcome to Newborn Intensive and Special Care* booklet was developed by a multidisciplinary neonatal team, which included parent representation of families that have had a baby in intensive and special care.

The booklet contains important information to orientate a family to the new and high tech environment of intensive and special care. It was also expanded to include medical and developmental care reports for the first time.

The booklet is in a format that can be personalised with more information added throughout a baby's stay. In this way the booklet can also become a memory book for the families to take home of their 'baby's first bedroom' and start of their life journey.

The new booklet was written using family friendly language and has also been translated into Arabic, Vietnamese and Mandarin, the three other languages most commonly used in the newborn and intensive care units.

The booklet is also designed to be interactive. Families and the bedside nurses go through the book together allowing the opportunity for questions to be asked.

In April this year, 1400 booklets were printed and staff are able to print further information handouts relevant to the baby's development and health level to individualise the booklets.

Feedback to date has been very positive with many parents feeling more empowered and well informed on a wide range of issues about the care of their baby.

IMPROVING ACCESS TO SURGERY



Reducing elective surgery waiting times and avoiding cancellations is the important goal of a new project called STEPS.

The Women's is participating in the Victorian Government's *Redesigning Hospital Care Program*, a statewide initiative to drive excellence in patient care.

The STEPS project is looking at how to improve perioperative services – the interventions hospital staff make prior to, during and immediately after surgery – for consumers having elective gynaecology procedures.

The four areas of focus are:

1. Scheduling – how we use the time we have available
2. Theatre flow – how a patient moves through theatre
3. Recovery flow – how a patient moves through recovery
4. Patient and staff experience – how satisfied are our patients and staff with their experience

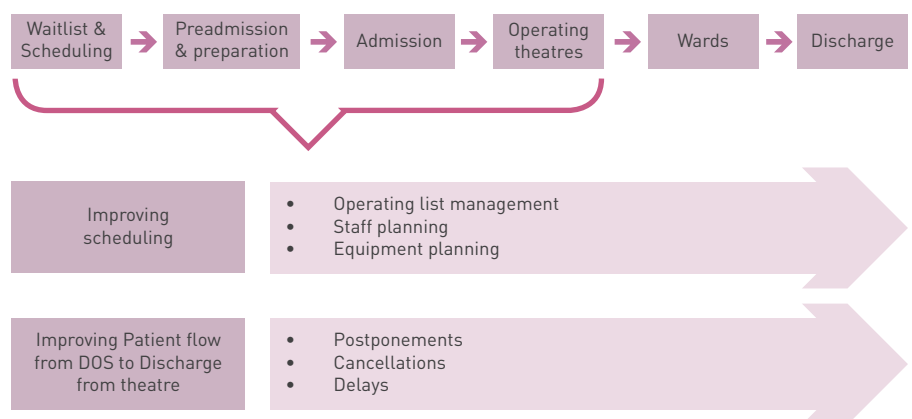
The leadership team for STEPS implementation (left to right) Ms Carolyn Bell, Clinical Director of Gynaecology, Cancer and Perioperative Services, Ms Charmayne Thompson, Operations Manager for Perioperative Services, and Ms Janet Joss, Project Manager, Strategy, Planning and Performance Unit

“The aim is to improve the efficiency of the use of the surgical theatres so that more people on the elective waiting list can be treated sooner,” says Carolyn Bell, Clinical Director of Gynaecology, Cancer and Perioperative Services.

The project, which began at the start of 2010 and is due for completion in October 2010, is identifying efficiencies at key stages in the patient's journey through surgery.

According to Carolyn, the project is producing results. “We're already seeing more patients and reducing the waiting time for elective surgeries. We're really happy with the improvements we're making through STEPS.”

Elective Gynaecology Surgical Patient Journey STEPS project scope





Dr Molika In, Quality Use of Medicine Pharmacist at the Women's

MAKING OUR MEDICINE USE SAFER

The Women's Pharmacy has introduced a number of initiatives this year to reduce the risk of drug errors, including bright new orange labelling and an orange syringe for high risk oral medicines.

"Orange is for oral" is the message behind the new bright stickers, explained Molika In, who is the Quality Use of Medicine (QUM) Pharmacist at the Women's.

High-risk medicines have bright stickers affixed on the shelves of Pharmacy to alert doctors to the special care needed when giving these medicines.

A chart has been developed on high-risk medicines known as *PINCH* (Potassium, Insulins, Narcotics, Chemotherapy and Heparins and other bleeding thinning agents), and a table of 'look alike/sound alike' medicines produced, to help doctors, nurses and pharmacists avoid confusion between generic names of medicines.

These initiatives were prompted by the Women's completing a measurement tool for quality use of medicines, the Medication Safety Self-Assessment for Antithrombotic Therapy in Australian hospitals in July 2009.

When compared with other Australian hospitals, the Women's scored above the national average for all eight key elements. However a number of areas for further improvement were identified, including improving communication of drug orders and other drug information, drug storage and standardisation. These are being addressed in a 12-month plan.



THE AUSTRALIAN REFERENCE BOOK – MEDICATION FOR PREGNANT AND BREASTFEEDING WOMEN

Dr Swee Wong, Director of the Women's Pharmacy surrounded by her team

The Women's produces the definitive guide used by doctors, pharmacists, nurses, midwives and other healthcare professionals across Australia and New Zealand to provide safe medications for pregnant women.

This year, the Women's launched a new edition of the 363-page medicines guide, *Pregnancy and Breastfeeding Medicines Guide*, which includes advice on medicines that are safe for breastfeeding mothers.

The guide has also been expanded to incorporate a number of new medicines, and complementary and alternative medicines. This helps health professionals select the most suitable treatment for women during pregnancy or when breastfeeding infants.

Leading obstetricians, doctors, paediatricians, pharmacists and hematologists—from the Women's and other hospitals—were among the many professionals who contributed to the guide.

As a specialist tertiary referral centre, our pharmacy staff are often asked to share their experiences with professional healthcare colleagues, for example GPs, nurses, midwives and pharmacists in non-specialist hospitals and clinics.

An audit of queries to the Women's dedicated drug information service showed that approximately 36% of queries relate to the use of medicines during breastfeeding and 42% of queries relate to the use of medicines during pregnancy. About 22% of the queries related to other specialty questions.

FASTING BEFORE SURGERY

To improve perioperative care, the Women's Pharmacy Department this year developed and published a consumer information sheet for patients with diabetes awaiting surgery.

Because of the need to fast before an operation, it's important that women with diabetes get information about managing their sugar levels to prevent fainting.

busting the motherhood bliss myth

The Centre for Women's Mental Health – the first gender-based mental health centre in Australia – is helping bust the myth that pregnancy and new motherhood protect women from anxiety and depression.



Dr Lia Laios says that part of the work of the Centre for Women's Mental Health is to train and support GPs as they play a crucial role in identifying signs of perinatal emotional stress.

“Between 10 and 15% of women experience some depression during pregnancy and up to 50% of those women go on to develop postnatal depression,” said Dr Lia Laios, a consultant psychiatrist at the hospital's Centre.

The Centre hosted a workshop in May this year to help psychologists from around Victoria and interstate expand their skills and understanding about perinatal mental illness, a relatively neglected area in women's mental health.

“Unfortunately perinatal depression and anxiety disorders are often

undiagnosed because women may be reluctant to talk to health professionals about it,” Lia says. “Or their symptoms are wrongly attributed to hormonal mood swings or physical changes that occur with pregnancy such as nausea, loss of appetite, insomnia, and lethargy or sleep deprivation in the postnatal stage.”

The Centre is also supporting GP training. “They (GPs) are at the front-line of seeing pregnant and postnatal women who are experiencing stress, anxiety and depression, so they can initiate treatment including a referral to a psychiatrist or a psychologist.” says Lia.

clinical risk management for mental illness

The Centre for Women's Mental Health provides what is known as a Consultation-Liaison Psychiatric Service for our consumers with mental illness.

Members of the service team work in each of the four maternity teams and with various other units such as the Foetal Management Unit, the Diabetes Clinic, the Women's Alcohol and Drug Service and Reproductive Services. The service helps assess and treat women while they are pregnant and, if needed, for a short period after they have given birth. Ongoing care for our consumers with mental illness is coordinated with private psychiatrists or psychologists or with the relevant public mental health service.

The Consultation-Liaison team is available 24 hours a day, seven days a week to ensure urgent assessment and treatment is available when required. After hours mental health services to the Women's Emergency Department are provided in partnership with the Crisis Assessment and Treatment (CAT) team based at the Royal Melbourne Hospital.

The Centre for Women's Mental Health, like other services at the Women's, is constantly assessing risks

to staff and to consumers and developing new initiatives to manage these risks. When it comes to working with people with mental illness, the risks include the threat of aggression and clinical emergencies due to disturbed behavior.

Over the past year, a Management of Behavioural Emergencies working party has reviewed existing policies and procedures relating to the management of these behavioural and clinical risks and developed new tools to deal with a range of potential risks from the management of delirium to a policy on responding to the presence of weapons.

The working party has also ensured that incident reporting and the recording of information relevant to the management of behavioural emergencies is coordinated across the hospital. Relationships with relevant external partners, such as Victoria Police, have also been established.

The needs of staff were assessed and specialised training was started. Some 222 staff undertook a series of 13 sessions covering conflict management and three sessions covering the subject of violence against women.



Professor Fiona Judd, Director of the Centre for Women's Mental Health, says that understanding how to manage disturbed behaviour is vital for staff and consumers.

MAINTAINING PROFESSIONAL STANDARDS

The Women’s believes that external and independent review and regulation provided by state and national bodies helps maintain the quality and safety of our services.

Hospital accreditation

“The accreditation process is a critical part of the quality improvement and risk management processes of the hospital,” says Therese Caine, Manager, Quality and Risk (pictured below). “And because it is an external and independent process, accreditation also provides an opportunity to showcase our achievements. Most importantly, it encourages us to always strive to do better.”

Accreditation is a formal process run by the Australian Council on Healthcare Standards (ACHS) to ensure hospitals provide safe, high quality care and services to patients and their families.

hospitals provide safe, high quality care and services to patients and their families.

In collaboration with healthcare professionals across Australia, the ACHS has developed clear standards for care and services that make up the Evaluation and Quality Improvement Program (EQuIP).

Full accreditation is obtained and kept through a four year cycle of ongoing review and assessment.

Every two years, we invite the ACHS to visit the Women’s and look at the extent to which we meet the EQuIP quality and safety standards.

In 2009, the Women’s underwent a periodic review, the half-way mark of the full accreditation cycle. ACHS surveyors visited the hospital for three days to review our quality and safety systems and processes and the Women’s was judged to be maintaining full accreditation status.

A key recommendation of the surveyor’s report was that the Women’s should continue to improve the provision of services for consumers from culturally and linguistically diverse backgrounds (see pages 10-11) and consumers with special needs (see page 19). Culturally responsive initiatives have been a big focus for the Women’s during the first half of 2010 and we will be able to demonstrate improvements when the surveyors visit again in March 2011.

Staff credentials



In July 2010, a number of registration boards for our staff, including the Psychologist Board of Australia and the Physiotherapists Registration Board of Victoria among others, will all be superseded by the National Health Professionals Registration Board. This central, national registration board is being introduced to provide greater safeguards for the public.

It’s a big job to ensure that all Women’s Allied Health staff, including dieticians, physiotherapists, psychologists, pharmacists, are able to transition seamlessly from their previous registration to the new national registration board and ensure professional (registered) care to patients. A Women’s working group has developed a series of formal processes to support the recruitment, appointment, reappointment and credentialing (verifying qualifications and experience) for the new scheme.

The team also had to “define the scope of clinical practice.” This means defining the type of clinical work that any allied health professional is allowed to undertake in a specific area of service. This is based on that individual staff member’s qualifications, skills, experience and the capacity of the Women’s to support these clinical activities.



maintaining *quality* *AND* *safety*

There is a surprising number of behind the scenes meetings, brainstorming sessions and group analyses of individual cases that doctors, nurses and other health professionals attend every day at the Women's.

Dr Hong Tran is the current Quality and Safety Fellow at the Women's and participates in many of the weekly, fortnightly and monthly clinical meetings. She says the meetings are a fundamental process in the continual pursuit for optimal patient care and that they are "all about being proactive rather than reactive."

Hong says that each meeting she attends focuses on a different aspect of quality and safety in the hospital. For example, daily hand-over meetings allow communication between day and night staff of current in-patients, while weekly unit meetings serve as checkpoints to review progress with patients who have complex needs or patients undergoing major surgery to ensure they receive appropriate management.

These meetings allow Hong and her colleagues to identify and address issues potentially affecting the quality and safety of care. For example, in cases where a

patient at the Women's had a suspected bowel injury, the team identified the need to know the roster of specialists at the neighbouring Royal Melbourne Hospital so that these specialists could be called in if necessary.

"Our staff now know who is on call, and we're not ringing around to find someone to give us a second opinion."

Another positive change from regular case review was the establishment of a working party in paediatrics to investigate how the displacement of tubes from the noses of babies in the neonatal unit could be avoided.

"It's good to take a look at cases from a different angle – not being involved directly can help. Everyone wants to improve things and people value the feedback," Hong says.

Mortality and morbidity meetings, on the other hand, review so-called adverse events where death (mortality) and injury (morbidity) have occurred while the patient was under the care of the Women's. "Part of my role at these meetings is to present cases as a teaching point, and to facilitate a discussion on how we could



Dr Hong Tran's meetings:

- Hand-over (daily)
- Gynaecology Unit (weekly)
- Gynaecology Mortality and Morbidity (monthly)
- Perinatal Mortality (weekly)
- Perinatal Mortality and Morbidity presentation (monthly)
- Neonatal Mortality and Morbidity presentation (monthly)
- Quality and Safety Unit (fortnightly)
- Adverse Drug Reaction Committee (monthly)
- Junior Medical Staff meeting (monthly)
- Transfusion Committee (three monthly)
- Quality and Safety Committee meeting (monthly)

Dr Hong Tran, the Women's Quality and Safety Fellow

have improved or avoided situations. The culture here is not to finger-point, rather it's about being open to learning from experience. We strive to optimise care through education and changing systems to minimise adverse outcomes."

If a major incident occurs, a root cause analysis is conducted. "We get all the relevant people together and retrace every single step to determine if anything could have been avoided. While certain complications are unavoidable, we can always learn from every event."

Hong also helps write an educational newsletter, the *Clinical Practice Review*, which updates hospital staff on safety protocols, and the hospital's quality and safety initiatives. One such initiative is the development of a monitoring system that ensures hospital units that have a high risk of adverse events are regularly audited. "That way we can report on any incidents in a unit over a month, and we can compare to other hospitals so we have a benchmark."

PUFFing at the women's



A baby on CPAP support in the Women's Neonatal and Intensive Special Care nurseries

PUFF stands for Pressure Ulcers, Falls and Faints, and the Women's takes these events very seriously. Although PUFF events occur very infrequently at the Women's, we still strive to reduce the clinical risks associated with pressure ulcers and falls.

Falls are a rare event at the Women's. Most often women fall because they faint after having their baby. Sometimes a sick, frail woman might fall. In the past year, 19 falls were recorded but none were serious.

PUFF events have been monitored for several years and in 2009/10, we introduced new assessment tools to measure the severity of the events. The Women's Nursing and Midwifery Council investigates every single occurrence and also studies and implements international best practice with the aims of both reducing the risk of PUFF events and continuously improving the care given to all consumers.

Pressure ulcers are rare at the Women's (there were 27 incidents in 2009/10) as most of our adult patients do not have predisposing risk factors such as fragile skin

caused by chronic illnesses or old age, and long-term bed-stays. However, some of our very premature babies are at risk of developing pressure ulcers in and around the nose when they are on continuous airway pressure support (CPAP). CPAP support helps the premature baby's lungs stay inflated, for easier breathing, by delivering air through prongs that are placed just inside the baby's nose.

Neonatal and Intensive Special Care (NISC) nurses use a nasal trauma score chart to check the baby's nose every shift and record whether there is any redness around the nose. The nurse then provides appropriate care to reduce the pressure on the nose if required. Our nursing staff have training on pressure care and prevention of pressure ulcers annually to ensure expert care for our babies.

Currently, the Women's is participating in a national clinical trial looking at delivering high flow oxygen. Pressure wounds in and around the nose is one of the elements being assessed as part of the trial.

PREVENTING INFECTION

Every admission to hospital carries with it the chance of an infection to the patient. The more procedures needed and the more ill the patient, the greater the risk of infection.

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

- monitoring infection rates from procedures that have a high risk of infection, such as common operations and insertion and management of intravenous (IV) lines
- comparing our infection rates with other hospitals in Victoria (and more broadly in Australia and internationally) to ensure we are providing the best possible care
- ensuring all staff clean their hands appropriately, which is a proven measure of reducing infections
- providing easy access to staff for appropriate vaccination (see page 38)

(continued)

HYSTERECTOMY WOUND INFECTIONS

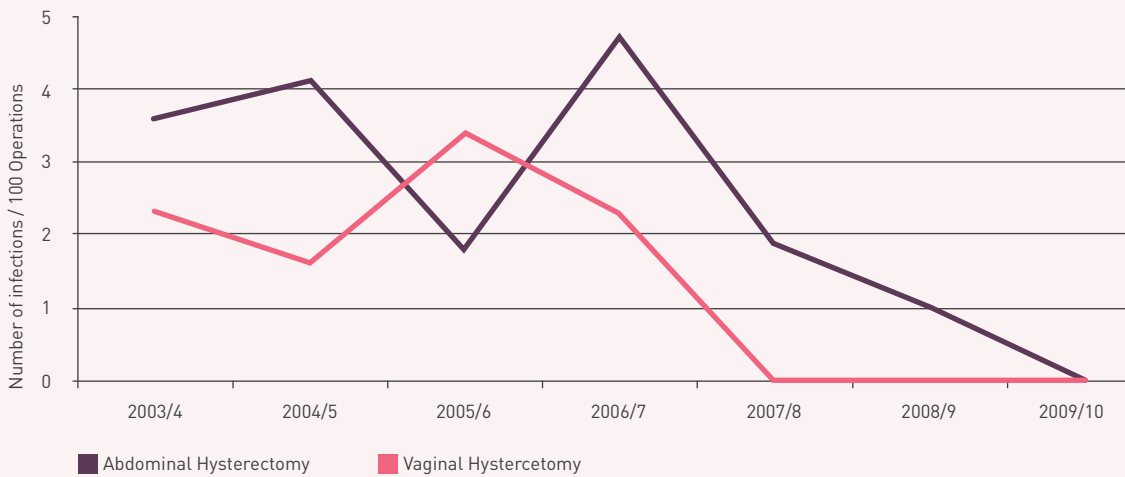
A hysterectomy is an operation that removes the uterus. Depending on the patient's needs, these operations are performed either through an incision in the stomach (an abdominal hysterectomy) or through the vagina (a vaginal hysterectomy).

The rate of infection, which is measured by counting the number of infections per 100 operations, has been monitored from January to June every year since the 2003/4 financial year. The infection rates at the

Women's are reported to the Hospital Acquired Infection Surveillance System (VICNISS) for comparison with other Victorian hospitals.

There have been no infections from vaginal hysterectomy in the January to June monitoring period since the 2007/8 financial year. This year, we are extremely pleased that our stringent quality and safety measures have resulted in no infections from abdominal hysterectomy wounds this year. Our goal is to maintain a hysterectomy wound infection rate of zero every year.

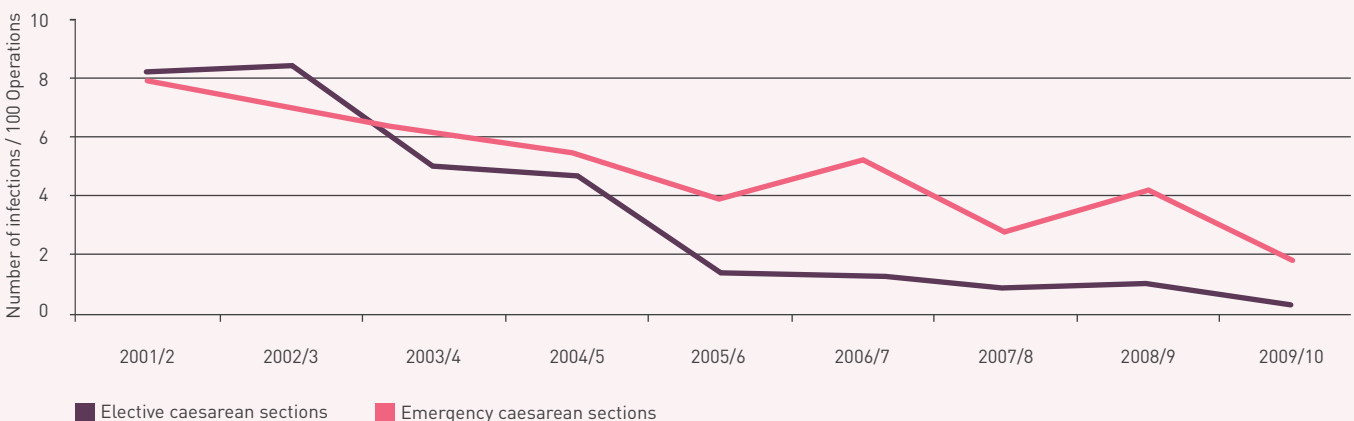
Hysterectomy Wound Infection Rates by Year



CAESAREAN SECTION WOUND INFECTIONS

Infections from caesarian section have been monitored from July to December every year since the 2001/2 financial year and these are also reported to VICNISS. The graph below shows that the rates of infection from elective and emergency caesarean section continue to decrease since monitoring began.

Caesarean Wound Infection Rates by Year



BLOOD STREAM INFECTIONS

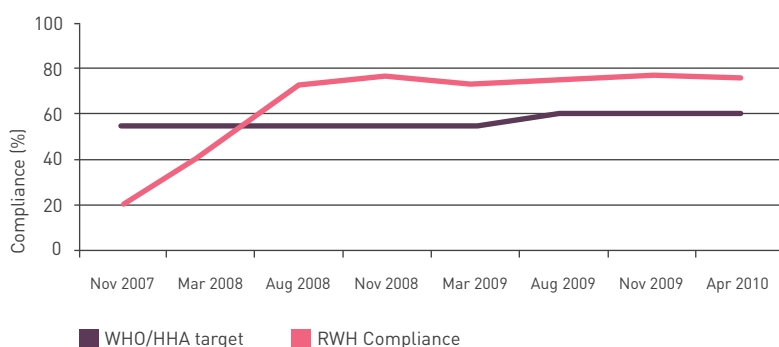
An intravenous line (IV) is used to administer fluid and medication directly into the blood stream. A central line, which is IV insertion into a major vein, may be used if the patient will need medication for a long time or is very unwell. All blood stream infections at the Women’s are monitored to assess if they have been caused by the use of an IV line. Blood stream infections in babies are reported to VICNISS.

BABY’S WEIGHT AT BIRTH	CENTRAL LINE INFECTIONS / 1000 CENTRAL LINE DAYS	PERIPHERAL IV LINE INFECTIONS / 1000 PERIPHERAL IV LINE DAYS
< 750 gms	5.5	0
751-1000 gms	6.4	0
1001 – 1500 gms	3.1	0
1501 – 2500 gms	0	1.1
> 2500 gms	0	0

HAND HYGIENE

At the Women’s, all staff are audited by observation to ensure they clean their hands in accordance with the Hand Hygiene Australia (HHA) and World Health Organisation (WHO) guidelines. These audits are conducted three times per year and are submitted to VICNISS. For the last six audits, the Women’s has surpassed the WHO / HHA target of 55%. The Department of Health target has now been increased to 65%, a figure the Women’s is also already surpassing.

Hand Hygiene Compliance



HOSPITAL CLEANLINESS

We know from past surveys that the cleanliness of a hospital is of great importance to our consumers.

Every month, the cleaning of the hospital is audited and reported to the hospital executive as part of a comprehensive report on the 'Patient Experience' at the Women’s.

In 2009/10, the cleanliness of our new hospital continued to be extremely high with the audits ranging from 92.3% (August 2009) to 98% (April 2010).

The other most important thing for consumers is the quality of the food.

In 2009/10, according to the Metropolitan Food Survey conducted by the Victorian Government, satisfaction with the food at the Women’s ranged from 83% (December 2009) to 92% (June 2010).

STAFF vaccination



Some of the Women's staff proudly wearing their orange immunisation stickers

Because many of our staff interact with pregnant women and newborns, the Women's takes staff vaccination very seriously. All new staff report on their vaccination status and the Women's Infection Control team follows up with them if vaccination is recommended.

Whooping cough for staff

Whooping cough (or pertussis) is an acute, highly contagious infection that is spread from person to person by airborne droplets. Although vaccination has made whooping cough a fairly rare disease, Australia does have outbreaks every few years.

The Women's funds an ongoing immunisation program to provide whooping cough vaccination for staff. This year, 165 staff were vaccinated bringing the total to more than 400 staff vaccinated against whooping cough.

Seasonal flu for staff

Annual vaccination against seasonal influenza, also known as "the flu," is recommended to prevent pregnancy complications. Each year, the Women's staff are encouraged to be vaccinated against the seasonal flu to protect vulnerable patients, including newborns. This year, nearly 1100 staff – more than half the Women's workforce – had a seasonal flu shot.

Swine flu shots for patients, carers and staff

Last year, pregnant women were quickly identified as being at increased risk of the swine flu, which is officially known as H1N1.

Recognising that H1N1 can increase the risk of complications for pregnant women, the Women's initiated and funded a vaccination campaign for inpatients and pregnant women, their partners and family members. The vaccination was given to 445 pregnant women and to 295 of their partners and family. Many were previously not aware that pregnant women are in a high risk group for H1N1 complications.

The Women's also conducted a staff education program and funded the campaign to provide H1N1 immunisation to staff as a means of protecting our patients. Despite already receiving a seasonal flu jab, 789 staff members chose to also receive the H1N1 vaccination.

A NEW MEASUREMENT SYSTEM FOR QUALITY AND SAFETY

In 2009/10, the Women's was chosen as one of just eight health organisations across Victoria to be a lead agency in implementing the Victorian Health Incident Management System (VHIMS), a web-based system to report incidents and consumer feedback.

Staff can now enter the details of any event directly into an electronic system so that senior managers are sent the information almost immediately. In the past, paper incident reports took many days to be received. Now that information is being received faster, senior management is able to put review processes in place much faster.

VHIMS also allows us to accurately and consistently assess the severity of the incident. Eventually the same scoring system will be used across all public hospitals in Victoria allowing us to benchmark ourselves against other hospitals.

Each month, we send details of the incidents that have occurred to the Department of Health to help identify statewide trends and risks.

The Women's Quality and Safety Committee (see pages 32-33) also receives this information so that they can review and recommend improvements to prevent incidents happening again.

