Menorrhagia or heavy menstrual bleeding is defined as a menstrual blood loss exceeding 80ml per cycle (average being 35ml). It is estimated as high as 20% of women suffer from menorrhagia. It can lead to iron deficiency anaemia, sometimes requiring blood transfusion and not discounting the disruption to daily living and social embarrassment. Many of these women fail to improve sufficiently with medical treatment and hysterectomy used to be the ultimate cure. However, there is another surgical procedure that has much less morbidity and mortality and is economically cheaper than hysterectomy – endometrial ablation.

There are many forms of endometrial ablation. The first generation technology, still used at the Women’s, is endometrial resection with loop wire and rollerball diathermy. This requires a high level of surgical skill and is usually performed under general anaesthesia. Currently there are second generation ablation procedures such as an impedance controlled endometrial ablation system that uses bipolar radiofrequency energy to desiccate the uterine lining and superficial myometrium (‘Novasure’). Other systems that are available use other forms of energy to ablate such as microwave, laser and thermal energy. These second generation ablation systems are in general faster, require less surgical skill, have lower morbidity and many can be done under local anaesthesia.

On 8 February 2007 at the Royal Women’s Hospital, a morning session was arranged to demonstrate the Novasure system. Dr Martin Healey started with a presentation of how the Novasure system works and the results of the clinical data to date. This was followed by four cases in operating theatres undertaken by some of the Women’s gynaecologists to demonstrate the system. There was audio-video linkage to the Yvonne Bowden Auditorium to broadcast the procedure being conducted in real time.

Endometrial ablation with the Novasure system does not require medical pre-treatment. The criteria for use of this system are – uterine cavity size of 6–10cm and excludes uterine cavity abnormality (polyps or submucous fibroids >2cm, bi-cornuate uterus, uterine septum), malignant and pre-malignant conditions, pregnancy and presence of infection. It uses a disposable 3D bipolar porous electrode which opens up to the shape of a fan. It is inserted into the uterus and once in position the cavity integrity assessment test is performed to ensure there is no occult uterine perforation before the treatment starts. Radio frequency is passed through the probe with continuous suction to remove any blood and vapourised tissue. The treatment stops automatically when tissue impedance reaches 50 ohms or at 2 minutes. Average treatment time is only 90 seconds.

A clinical trial comparing the Novasure system with wire loop resection and rollerball yields a success rate (pictorial blood loss-assessment chart score ≤ 75) of 88.3% in Novasure-treated and 81.7% in rollerball-treated patients. Amenorrhea rates at 1 year of 41% and 35% respectively.
Resource allocation issues are an ongoing, indeed a growing issue in public health. Cost effectiveness is not an exact science and even if it was, what is effectiveness? It’s a lot more than ‘it works’. QALYs (Quality Adjusted Life Years) are a more comprehensive measure. One of the more common objections to QALYs however is that they focus on maximising the benefit produced by health care without paying attention to other factors relevant to allocation such as the strength with which people wish to give priority to the severely ill over the less severely ill at the expense of the total amount of health produced. So what can we use as principles of fairness in healthcare rationing? There is no single set of principles that everyone accepts and this is the meat on many a clinical ethics discussion bone. Some would argue generically that we need at least three – need principles, maximising principles and egalitarian principles. I think that under our current system if a department, the hospital or the State make an allocation, they implicitly or explicitly use some conception of justice or another, but this is something for which they must take responsibility and for which they can accept criticism. It behoves us to apply pressure on them to explain why they think this a just decision and furthermore to lobby with logic, fairness and evidence on behalf of our patients. Let’s have second generation technologies for endometrial ablation. Leslie Reti

References

Mean procedure time was 4.2 minutes in Novasure group compared to 24.2 minutes in the rollerball group. Local anaesthetic +/- sedation was given in 73% of Novasure patients and 18% of rollerball patients. Adverse events (e.g uterine perforation, infection, haemorrhage etc) were also less in the Novasure group.

Novasure endometrial ablation system appears to be simple to use and fast and produces good result in carefully selected patients. Second generation endometrial ablation technologies are certainly worth considering as an alternative to the traditional endometrial ablation with resection and rollerball. The thermal balloon system will be trialled at the Women’s next month.

Claudia Cheng
Quality and Safety Fellow, Senior O&G Registrar

The move to the Parkville site in 2008 will require us to change the way we configure our services, and adapt the way that we work. This was the major catalyst for an Executive project called ‘TeamCare Towards 2008’, which commenced in 2006 with the aim to review and transition the TeamCare maternity model in preparation for the relocation.

So far, TeamCare Towards 2008 has involved a survey of consumers, interviews with over 50 key stakeholders from various disciplines, focus groups with staff, review of the evidence for maternity care provision, audit/mapping of current activities and consideration of the space/layout in the new hospital. A draft report including findings and proposals for change was developed and circulated earlier this year. The draft report outlines a broad vision for the TeamCare model for 2008. This includes the establishment of four TeamCare teams, each responsible for a specific geographical patch and each caring for a mix of high and low risk women. The revised model focuses on achieving continuity of care/carers across the continuum, providing more antenatal and postnatal care outside the hospital and developing a stronger multidisciplinary-team approach to the way we work.

The next step is to turn this vision into reality!

Key leadership positions including four Obstetric Team Leaders, four Midwifery Team Leaders and a Birth Suite Coordinator will be advertised soon. These individuals will play a key role in fine-tuning the proposed model and implementing the changes over the next 18 months. This transition stage will provide an exciting opportunity to work together to ensure that our maternity services are world class, responsive to women’s needs and provide a stimulating and satisfying work environment for staff.

Tanya Farrell
and Jeremy Oats

TeamCare Towards 2008

The revised model focuses on achieving
The New Centre for Women’s Mental Health

The Women’s Mental Health service within the hospital is changing! Professor Fiona Judd, the new Director of Women’s Mental Health, commenced work at the hospital on Monday 5th February, as did Ms Andrea Polonowita our new psychiatric consultation-liaison nurse, Dr Fiona Best, psychiatry registrar and Dr Lia Laios in her new role as a sessional consultant psychiatrist.

Fiona Judd’s appointment is a key step in the establishment of the new Centre for Women’s Mental Health funded by the Pratt Foundation and the Victorian Government through the Mental Health Branch. In addition to expanding the range of mental health services available to women attending the Royal Women’s Hospital, the Centre will provide secondary consultation to health professionals within and external to the hospital to assist in their care for women with mental health issues. The Centre will also undertake research and evaluation, provide education and training to a range of health professionals, and contribute to community education activities.

The appointment of the psychiatric consultation-liaison nurse will enable the mental health service to provide greater support to staff within the hospital to enhance care for women with mental health problems. Andrea will also take a key role in education and training and in the development of the secondary consultation service. Lia will work with WADS, YMC and the Aboriginal Women’s Business Unit, and also work with Drs Bruce Battagol, Rosemary Schwartz and Dennis Handrinos to further develop women’s mental health in other areas of the hospital.

Professor Fiona Judd
Director Centre for Women’s Mental Health

Keith Fitzmaurice Bursary comes to the Women’s

This bursary is endowed by the Victorian Managed Insurance Agency to the Victorian Regional Committee of RANZCOG, in memory of Mr Keith Fitzmaurice who died in February 2005. As Chairman of the Victorian Managed Insurance Authority (VMIA), Keith Fitzmaurice was admired for his insight and contribution to risk management in the area of women’s and babies health.

The bursary aims to acknowledge and perpetuate this contribution. It will support research into an area of obstetrics with the intention of improving maternal and neonatal outcomes.

This inaugural year, the bursary has been awarded to Dr Penny Sheehan for her project entitled ‘Incidence and Risk Factors for negative birth experience and adverse mental health outcomes at the Royal Women’s Hospital’. This project aims to investigate the incidence of negative birth experience and adverse mental health outcomes at the Women’s.

The main objectives are to:
- Investigate the incidence of post-traumatic stress disorder, anxiety and depressive disorders and negative birth experience at the Royal Women’s Hospital.
- Identify risk factors for negative birth experience.
- Use this information to develop a risk assessment tool.
- Cascade knowledge regarding postnatal debriefing through the Women’s maternity services.

Penny was awarded a Victorian Travelling Fellowship to develop a service model to trial at the Women’s to debrief and support women with distressing birth experiences, and this bursary will allow that work to be deepened and extended.
Every six months, the hospital gets a report on what women think about care at the Women’s, as part of the Victorian Patient Satisfaction Survey, which is done across all Victorian hospitals. Here are some of the free text comments, good and bad, which women made about their care at the Women’s.

‘The best things about my care were the level of care and attention provided by all the nursing staff. Very clear diagnosis of my illness, including all possible side effects, treatment and recovery. Again – wonderful staff! Positive atmosphere of the room I had treatment in.’

‘The best thing about my care was Dr A, a young guy and the most thorough doctor I have ever experienced.’

‘It was my first time and I was very afraid, but overcome it all by great staff.’

‘This is the best hospital experience I have had and I have been in eight hospitals.’

‘The worst thing about my care was when on the first night I had my son at 11pm after going back to the ward, around 4.00 – 5.00am; I called for help with my newborn. The midwife was terrible, grumpy, unhelpful and when she left I cried. I just wanted some help getting my newborn to breastfeed. I waited 20 minutes, and called for help again. This time another midwife came in and she was fantastic.’

‘The doctor who was called by the midwife when my bleeding didn’t stop was rude to her and originally didn’t agree that there was anything wrong. She was stressed and appeared overworked and tired. She kept having to leave to visit other parts of the hospital. After I lost a lot of blood, she finally agreed with the midwife and I was sent up for surgery.’

74% of comments refer to courtesy, caring and professionalism of hospital staff – midwives, nurses, doctors, catering staff, anaesthetists, night staff etc. Many mentioned ‘the team’.

Figure 1 shows the overall results of the survey.

Our best result is for complaints management where we did better than the average for category 2 hospitals and state wide. This measures the willingness of staff to listen to and respond to patient problems.

Our overall results were statistically better than category 2 hospitals for overall care, and for access and admission, general patient information, treatment and related information, complaints management – four of the six indices. For elective surgery patients, we did statistically better than our peer group on every index.

Over all, the VPSM results tell us that:

- The professionalism and caring of Women’s staff is generally very well regarded.
- There is a perception of a hospital team.
- There are some issues which can be improved:
  - Response times in postnatal wards
  - Improving the performance of individual staff who appear rude, rough and uncaring to women
  - Management of visiting hours
  - Cleaning in maternity areas
  - Food – the hospital is well below the state average

Mary Draper
Director, Clinical Governance

<table>
<thead>
<tr>
<th>Benchmark data comparing Royal Women’s Hospital with Category A2 Hospital and Statewide hospital benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge and follow-up</td>
</tr>
<tr>
<td>Physical environment</td>
</tr>
<tr>
<td>Complaints management</td>
</tr>
<tr>
<td>Treatment and related information</td>
</tr>
<tr>
<td>General patient information</td>
</tr>
<tr>
<td>Access and admission</td>
</tr>
<tr>
<td>Overall care</td>
</tr>
</tbody>
</table>

Figure 1
March 29 – 31st 2007
Crown Conference Centre, Melbourne

Program Highlights
Featuring the following International Speakers:

Prof Lynette Denny – Gynaecological Oncologist, University of Cape Town, South Africa
Kate Gilmore – Executive Deputy Secretary General, Amnesty International, London, United Kingdom
Dr Eric Moses – Faculty Scientist, Southwest Foundation for Biomedical Research, San Antonio, USA
Prof David Henderson-Smart – Director Centre for Perinatal Health Service Research and Pregnancy and Newborn Services Network, Sydney
Prof Allan Templeton – President, Royal College of Obstetricians and Gynaecologists, London, United Kingdom
Emeritus Professor André Van Steirteghem – Centre for Reproductive Medicine, University Hospital, Brussels Free University, Belgium
Dr Carole Warshaw – Executive Director, Domestic Violence & Mental Health Policy Initiative, Director, National Training and TA Centre on Domestic Violence, Trauma & Mental Health, Chicago, Illinois, USA

and the following National Speakers:

Dr Andrew Dobrotwir – Director Medical Imaging, Royal Women’s Hospital, Melbourne, Australia
Prof Fiona Judd – Professor Director of the new Royal Women’s Hospital, Centre for Women’s Mental Health
Ms Tish Lancaster – Clinical Nurse Consultant, Gynaecological Oncology, Westmead Hospital, New South Wales, Australia
Prof Bruce Mann – Professor Director of Breast Services, Royal Women’s and Royal Melbourne Hospitals, Melbourne, Australia

Mothers, daughters, girlfriends and wives are invited to reach for the bling and get ready to swing at The Glitter Ball 2007 to be held Saturday, March 31 at the Palladium at Crown.

Celebrating the 150th Anniversary of The Royal Women’s Hospital, The Glitter Ball 2007 will step back to Hollywood yesteryear with MC Damian Callinan and special guests and swing to two jumping big bands. It will sparkle with fabulous auction lots and prizes, including a Lexus IS 250 Prestige, a signed pair of Manolo Blahnik shoes, and a week at Pool resort in Port Douglas.

“The Glitter Ball is an opportunity to celebrate a job well done,” said Founding Chairperson Leanne Bradford. “So, if you or a loved one has been part of The Women’s past 150 years, invite your partner or a party and join us!”

Tickets are $170 per person (tables of 10) and are on sale at www.glitterball.org.
Complementary and Alternative Medicines (CAMs) are defined as ‘products or health treatments that are not presently considered to be part of conventional medicines’. National surveys of the general population have found that CAM use is widespread and has rapidly increased over the years, currently 50–60% of the adult population use CAMs on at least an annual basis. Australian data suggest that 39% of people taking CAMs will also consume conventional medicines.

A patient survey was done over a 3-week period in 2005 to investigate the use of CAM by patients of the Royal Women’s Hospital, the survey found:

- 53% of the patients surveyed used one or more CAMs.
- Vitamins and minerals were the most common groups of CAM used by patients, followed by dietary/nutritional supplements and herbal medicines.
- Multivitamin, aromatherapy, iron, calcium, folic acid, fish oil, nutritional supplement, soy product, evening primrose oil and Chinese herbal medicine were the most common CAMs used.
- Obstetric patients were among the highest group of patients who had used or would have used CAMs during their stay in hospital.
- Most of the CAMs used by patients were self-prescribed.
- Fifty-six percent of the patients who used CAMs did not inform hospital medical staff, the main reason being that they were not asked by hospital staff.
- Patients would often seek CAM information from medical doctors and pharmacists.

With the increasing use of CAMs in both the general population and our patients, a working group was formed to develop a Royal Women’s Hospital CAM policy for CAM use during inpatient stay. The policy is not an endorsement for or against use of CAMs, rather, it aims to encourage open disclosure and discussion about the use of CAMs by patients/guardians and their health care providers in order to promote patient safety and minimise adverse events.

The policy applies to CAM use during inpatient stay when:
- Initiated by patients or their guardians
- Endorsed by the medical team caring for the patients
- CAMs brought into the hospital to be administered during hospital stay

Procedure of the CAM policy (also see flow chart)
- All patients/guardians should be provided with the Royal Women’s Hospital CAM patient information brochure on admission.
- On admission, medical staff should enquire and discuss with patient/guardian about CAM usage as part of routine history taking and seek information about any CAM the patient/guardian wishes to use during the patient’s hospital stay.
- The decision to continue the use of CAMs during inpatient stay must be discussed with the treating doctor.
- The doctor should advise the patient/guardian of any increased risks or changes to the primary treatment which are necessary because of the patient’s use of CAMs, and document this in the medical record.
- When the doctor approves the use of CAMs, the CAM product(s) must be prescribed on the Medication Chart and can be self-administered or administered by the nursing staff/midwives.

- When CAMs are prescribed on the Medication Chart, a full description of the product including active ingredient(s), brand name, strength, dosage and Aust L/Aust R number (if applicable) must be recorded.

- All CAM products used against medical advice must be documented in patient medical record.

- When CAMs are used against medical advice, the patient/guardian is required to sign the CAM waiver form listing the products used without their doctor’s approval.

- The doctor should also sign the CAM waiver form to indicate that they have advised against the use of the listed CAM and the reason(s) for such recommendation during the inpatient stay at the Women’s.

- CAMs used without doctor’s approval must be self-administered and not administered by nursing staff/midwives.

- Patient/guardian/carer is responsible for their own supply of CAMs (unless they are available on the hospital formulary).

- Medical staff should record and report any CAM adverse reactions, interactions or incidents as per the Royal Women’s Hospital guidelines.

CAM policy flow chart

* Adapted from the Royal Women’s Hospital CAM policy
Responsibilities of medical staff

- Discuss and decide with patient/guardian the use of CAM during inpatient stay at the Women’s. Document discussion and decision in patient’s medical record.

- If the decision is to continue CAM use during inpatient stay then the doctor must prescribe the CAM on the Medication Chart. A full description of the product including active ingredient(s), brand, strength, dosage and Aust R or Aust L number (if applicable) must be recorded.

- If the medical decision is to advise against use of specific CAM, then explain why they are not recommended and document this in the patient’s medical record.

- If the patient/guardian wishes to use CAM against medical advice, treating doctor needs to:
  1. Document this decision in the patient’s medical record.
  2. Ask the patient/guardian to sign the CAM waiver form.
  3. Sign the CAM waiver form and document the reason(s) why the CAM product(s) is/are not recommended.

Responsibility of nursing staff/midwives

- Provide patients with the Women’s CAM patient information brochure on admission (see left).

- Only administer CAM when prescribed on the medication chart.

- The supply of CAMs is the patient/guardian responsibility unless they are available on the hospital formulary.

- Communicate with other health professionals involved in the care of the patient regarding the use of CAMs with the permission of patient/guardian.

- Report all suspected adverse drug reactions or interactions involving CAMs by completing the Women’s Adverse Drug Reaction (ADR) form as for ‘conventional medications’. See the Women’s ADR policy.

- Ensure that CAMs approved for use are labelled with patient’s name and stored appropriately in secure medication facility.

- Ensure CAMs not recommended for use are given back to patient/guardian/carer to take home.

- Disposal of CAMs must follow the procedure for disposal of any conventional medications.

The CAM policy can be found under “Policy and Procedure” on the Internet with links to CAM flow chart, waiver form and other useful resources/references.

Laura Leung
(on behalf of CAM policy working party)

References:
4. VicTAG CAM document 2005

Please let the associate editors have your views on the contents of this newsletter, or any other matters involving clinical practice which may be of interest to our readers.

Mary Draper, telephone (03) 9344 2722 or email mary.draper@rwh.org.au
Susan Braybrook, telephone (03) 9344 2606 or email susan.braybrook@rwh.org.au
The Clinical Governance Unit homepage www.rwh.org.au/quality_rwh
Claudia Cheng, claudia.cheng@rwh.org.au  Salwan Alsalihi, salwan.alsalihi@rwh.org.au