JOURNEY

Annual Quality of Care Report

THE ROYAL WOMEN'S HOSPITAL

2003

THE ROYAL WOMEN'S HOSPITAL

SUMMARY OF CONTENTS

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WE LISTEN
WE CARE
WE CHANGE
AND WE GROW

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

This is our journey.

Introduction

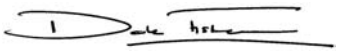
MESSAGE FROM THE ROYAL WOMEN'S HOSPITAL

The Executive and Board of Women's & Children's Health (WCH), which includes The Royal Women's Hospital and the Royal Children's Hospital, are committed to providing the best health care to the women and children of Victoria. It is the responsibility of the Board and management at all levels to be confident that systems and processes are in place to achieve the best outcomes for women and their babies and to ensure a continuing culture of improving patient care.

Clinical Governance, a legislative responsibility, describes how hospitals are accountable for continually improving the quality and safety of our services by creating an environment in which excellence in clinical care will flourish. We are doing this by adopting a formal clinical governance framework based on managing our clinical risks, involving and learning from consumers, ensuring equitable access, peer reviewing and benchmarking of our clinical performance, ensuring that clinical practice is based on good research evidence and that our staff are qualified and competent.

Quality and safety are the responsibility of all of our staff. Our priority in this area for the coming year is to promote a reflective 'no blame' culture, which supports staff to learn how to improve the knowledge, systems and processes to create a safe and supportive environment for staff and patients. This is the best way we can learn to continue to provide better patient care. We seek to attract and maintain high quality staff, and support them with the skills, information systems, tools and resources to improve services and outcomes.

We know that multidisciplinary care, team-work and collaboration, based around the needs of the women and their families, is how we will achieve even higher standards of care.



Dale Fisher
Executive Director
The Royal Women's Hospital

Associate Professor Christine Kilpatrick
Chair, Quality and Safety sub-committee
Women's & Children's Health Board

The Royal Women's Hospital (RWH) aspires to be a hospital that provides excellent services to women and their babies, which are patient centred, safe, effective, appropriate, accessible, and timely.

The RWH Quality of Care Report informs our consumers, key stakeholders and the Department of Human Services (DHS) about how effective and safe our health care is, and how we work to ensure this. We have spoken extensively with our consumers and our hospital staff who have guided us in providing information that is relevant, detailed and of interest. We have worked closely throughout the development of this report with members of our reference group, the Community Advisory Committee on Women's Health and the Quality and Safety Committee.

In this report, we describe the clinical governance framework which governs accountability for quality and safety, the population we serve and outline some of the consumer pathways through our service. We also show how the hospital works to ensure effective and safe practice and highlight key quality and safety strategies.

We will demonstrate how we ensure quality across a range of program areas, and describe the continuum of care in maternity, neonatal, gynaecology and cancer services.

In this third annual Quality of Care Report we will provide new information as well as follow-up details that were provided in previous years to show how our hospital continues to meet the needs of women and their babies.

We have integrated five founding principles that our consumers have informed us to be critical in the care provided at the RWH:

- Community Values
- Quality
- Access
- Service Options
- Patient Care

These community principles are integrated throughout the content of this report, and will be used to highlight how we address quality and safety in all aspects of the care we provide.

RWH CLINICAL GOVERNANCE

The RWH implements the clinical governance framework through the Quality and Safety Plan. The plan co-ordinates the quality and safety activities across the hospital to measure and review progress and communicate outcomes to our stakeholders.

The RWH Quality and Safety Committee discusses issues that arise about safety and quality, and process and system issues are identified and improved. The committee receives regular reports, all with the aim of ensuring good care and learning from instances where the care could have been improved.

A major initiative for 2002/2003 was the establishment of the Quality and Safety Unit. The unit incorporates clinical effectiveness and audit, clinical risk management, the Consumer Advocacy Service, consumer participation and accreditation.

For more information go to:
www.rwh.org.au/quality_rwh/

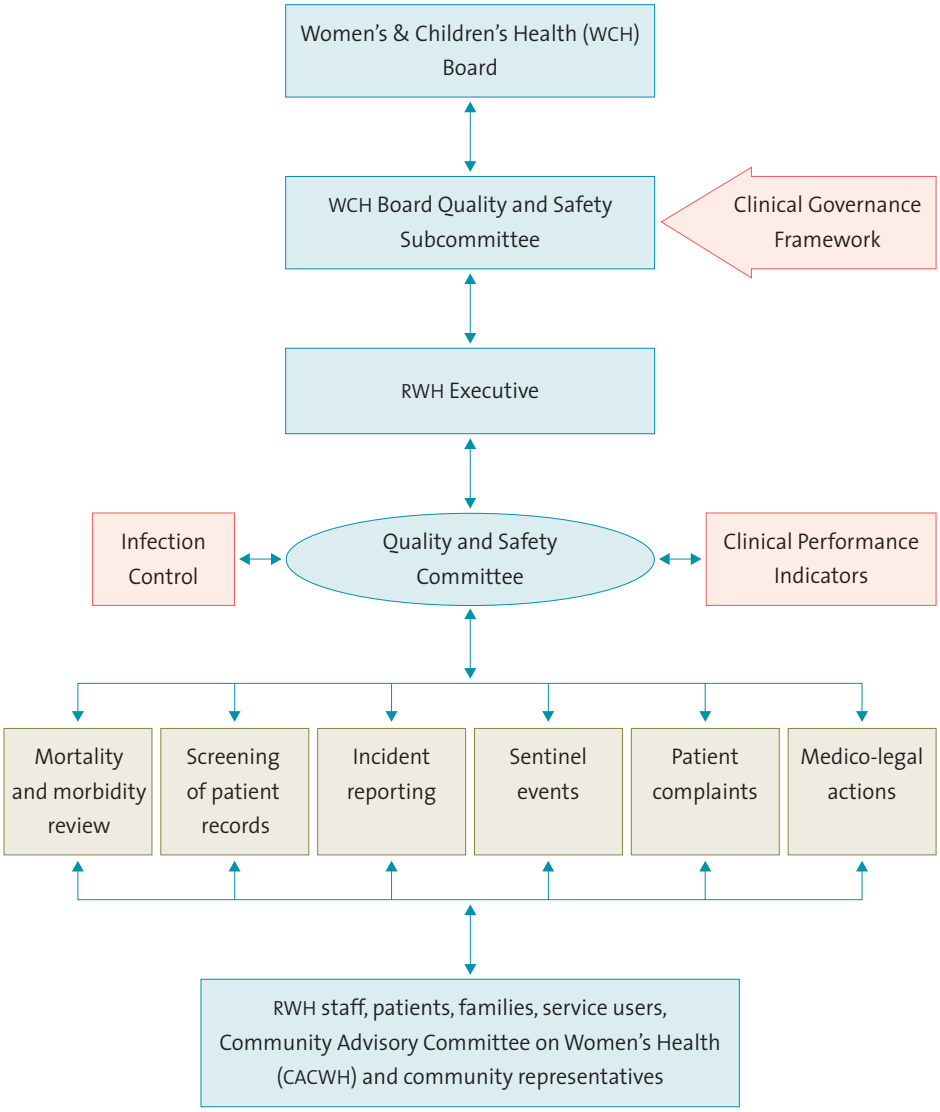
ACCREDITATION

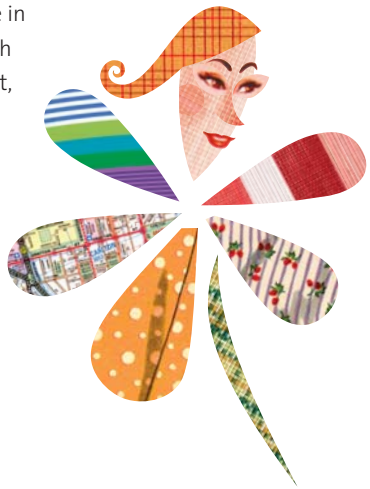
The Victorian Government requires all health services to achieve and maintain accreditation with an approved accrediting body. In Victoria acute hospitals are accredited through the Australian Council on Health Care Standards (ACHS) and the Evaluating Quality and Improvement Program (EQuIP).

The RWH underwent a re-accreditation late in 2002, and was fully accredited, with no high priority recommendations for improvement, and a number of commendations.

Accreditation information can be found at:
www.rwh.org.au/accreditation

CLINICAL GOVERNANCE ORGANISATIONAL FRAMEWORK





Our service challenges

The Royal Women's Hospital (RWH) was established in Melbourne in 1856, as a public maternity and gynaecology teaching hospital providing health care for women and newborn babies, with a traditionally strong connection to women who were socially and economically disadvantaged.

In 2003, the RWH continues to meet the complex and evolving needs of women throughout their lives. The health needs of women are changing. Women are having fewer children later in life or not at all. They are living longer and thus more likely to experience illnesses such as osteoporosis, cancer and gynaecological problems.

In partnership with their families, the care we provide to premature babies has improved with advancements in our knowledge and technological expertise.

Our model of care aims to be 'woman centred', understanding that women's health needs relate to physical, as well as social, economic, cultural and emotional needs. Comprehensive care is provided by a range of services in maternity, gynaecology, women's cancer, women who experience sexual assault, neonatal services and reproductive and fertility management, including termination of pregnancy.

This care of women and their babies is supported by a range of services within clinical operations, research, education and development and environmental services.

RESEARCH

The RWH is committed to research and learning. Our community consultation identified that the RWH research role is important to build a body of knowledge and evidence on women-specific illnesses and conditions and neonatal care, as well as the impact of gender on more generalised health issues.

See www.rwh.org.au/pebp/pubs.cfm for our monthly research publication 'Discovery'.

RWH CONSUMER PROFILE IN 2002/2003

Where do they come from?

- 32% of our inpatients and 60% of our out-patients were born overseas, whereas 25% of the Victorian population was born overseas.
- The women who use our services come from 165 different countries and follow 42 different religious faiths.
- The top four overseas countries our women were born in were Lebanon, Turkey, Vietnam and China.
- Just as many of our women were born in Italy (mainly older women) as were born in Somalia and Iraq (mainly young women having babies).
- The four top languages we provided interpreters for were Arabic, Chinese, Vietnamese and Turkish.

Where do they live?

- 95% of inpatients come from Victoria, 5% from interstate.
- 82% of our outpatients come from inner Melbourne suburbs, but we also have patients from Whittlesea through Melton to Frankston.
- Our top suburb for outpatient appointments is Broadmeadows.
- 18% of outpatients travel more than 30km to attend the RWH.

What is the age range?

- 85% of women are aged between 20 and 50.
- 10% of women are over 50.
- A small but significant group of younger women use our services.

What services do we provide?

- A total of 4679 babies were born at the RWH between July 2002 and June 2003, with 124 sets of twins and six other multiple births (triplets etc).
- 72% of deliveries were vaginal deliveries, including complex deliveries.
- 1319 babies were admitted to our Neonatal Unit between July 2002 and June 2003, with an overall survival rate of 98%.
- 7410 women had surgery at the RWH, with 6312 day surgery patients.
- The demand for our reproductive and fertility services grows at 6% a year.
- 527 women were treated for gynaecological and breast cancers.
- Overall there were 188,412 patient contacts.
- 28,327 women and babies were admitted to the RWH as inpatients.
- There were 133,599 outpatient appointments – 82% were with a doctor or nurse and 18% were with allied health.
- There were 26,486 contacts with the emergency department.
- The demand over three years for social work provided by Women's Social Support Services (WSSS) is estimated to have grown by 50%.
- Our provision of language (interpreting) services grew by one third over the year.

What does this mean about our service provision and planning?

- We have a different age mix from most hospitals.
- We have a wider range of cultural and linguistic diversity than many other hospitals.
- We have a broad social mix of women, some with significant emotional and social needs.
- Our clinical range is wide, from healthy women and babies to seriously ill women and babies, from primary health care services to complex tertiary services.
- The Women's is a teaching hospital – this means that we provide comprehensive support and training to our medical, midwives and nursing staff.
- The Women's undertakes a wide range of research.

ACCESS TO SERVICES

Our community consultation processes have highlighted the value our consumers place on access. For our consumers, this means access to world-class technology, research and expertise. The hospital must be accessible in location, cultural accessibility, waiting time and disability access. To assist with access, community clinics operate for maternity and cancer services.

A number of services support better access including the Family and Reproductive Rights Education Program (FARREP) supporting women experiencing female genital mutilation (FGM), the Child Care service, Family Accommodation, Language services and the Aboriginal Women's Health Business Unit (AWHBU). The AWHBU works together with other RWH and community services to facilitate access and provide social, emotional and cultural support to Aboriginal and Torres Strait Islander women. To facilitate the coordination of this service, a data base is currently being developed.

For more information about our support services, visit: www.rwh.org.au/comm-health

COMMUNITY PRINCIPLE – Access

An example – Women with Individual Needs (WIN) Project

The Women with Individual Needs (WIN) clinic was established in 2002 and tailors maternity care for women with intellectual disability and/or learning needs and provides both midwifery and social work antenatal and postnatal support. The complexity of women's social and clinical profile demands an intensive service response. For this reason WIN is now attached to the Maternal Fetal Medicine team (see page 10).

Women frequently present with significant social issues as well as clinical complexity, each compounding the other. Clinical appointments are therefore more flexible to provide the time and support needed. Continuity of care is also provided with postnatal follow-up six weeks after delivery to ensure adequate parenting support during this critical phase. This includes an outreach service, and linkages are also made with community agencies.

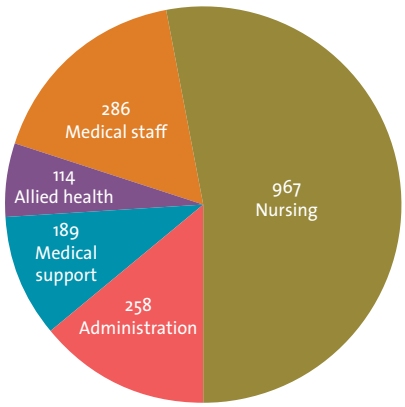
For more information about making a booking or referral to the RWH, including the WIN clinic, go to: www.rwh.org.au/discharge/

ATTRACTING THE RIGHT STAFF

Providing highest quality services is dependent on committed, skilled and professional staff across the whole of the organisation working together, supported by management, with resources and policies to enable them to perform at a high level.

- 87% of our workforce is female.
- 43% of our permanent workforce work part-time by choice, and 23% are casual.
- The average duration of employment is six years.
- The average age of staff is 42 years.

Currently the RWH employs 1814 staff covering a range of clinical and non-clinical professions:



Women's & Children's Health is committed to becoming an 'Employer of Choice' and to attract and retain the best staff. The Positive Nursing and Positive Midwifery strategy to recruit nurses and midwives to Women's & Children's Health was implemented during 2003.

The percentage of permanent midwifery staff has improved since October 2002 from less than 60% to in excess of 85%. The majority of our staff are nurses and midwives. In 2002/2003, there will be an emphasis on continuing to improve the morale and satisfaction of midwifery staff through listening and responding to their issues.

WHAT DOES THIS MEAN FOR OUR SERVICES?

Striking a balance between providing continuity of staff for our patients and rostering staff in a sensible way and allowing our mostly female staff to manage their family responsibilities is a big challenge. One of the ways we try to manage this is to provide a child care centre and by providing flexibility in rostering.

As a major training hospital, the RWH provides educational opportunities to medical, nursing and allied health staff and supports them to acquire skills to be the next generation of specialists. Each year a large number of doctors training as obstetricians and gynaecologists pass through the hospital. To ensure acceptable training standards, we have begun work on formal credentialling guidelines for junior doctors that will be used as evidence of proficiency. With changes to our maternity model of care outlined later in this report, there is also a challenge of ensuring our midwives and nurses have the right skills for their broader roles.

Like all hospitals, we ensure that our staff have the right qualifications. We also need to ensure the ongoing competence of staff, especially as health care changes and grows. We are working on the formal adoption of credentialling policies to achieve this.

SUPPORTING STAFF – THE CLINICAL ETHICS ADVISORY GROUP (CEAG)

In response to clinicians and management, the Hospital Executive Committee set up a group to act as a resource to advise on issues of clinical ethics. The aims of the group are to give advice, and foster informed discussion on ethical issues of a clinical nature. The CEAG is not proscriptive, as clinicians remain clinically and medico-legally responsible for their decisions. The process provides an opportunity to be more reflective, take more time, and to gain a wider opinion base when confronted with a clinical problem with a difficult ethical dimension.

How does the hospital engage with consumers?

There are a range of ways we involve consumers from formal representation of the Community Advisory Committee on Women's Health; using patient feedback, compliments and complaints to improve services; as well as using consumer focus groups to inform health promotion.

Information about consumer participation at RWH can be found at: www.rwh.org.au/quality_rwh/consumer.cfm

INVOLVING CONSUMERS – COMMUNITY ADVISORY COMMITTEE ON WOMEN'S HEALTH

The main focus of the Community Advisory Committee on Women's Health (CACWH) is to consider the best interests of current and potential service users of RWH, as well as their partners, carers and families. The CACWH supports and advises the Board of Women's & Children's Health, management and staff on strategies to place consumers at the centre of service design in all aspects of women's health service planning and delivery. It is made up of community-based women who are representative of a wide range of women's experiences and knowledge.

The redevelopment of the RWH is the main priority for the CACWH. Consumer input has been integral in the planning of the redevelopment and has involved a number of stages including:

- **First stage** – drafting a statement of principles which incorporated the recommendations of a community consultation of 1000+ women to identify guiding principles for the redevelopment to ensure the balance of patient need, clinical effectiveness and efficiency in service delivery.
- **Second stage** – the development of a community consultation strategy which involved past and present consumers of the hospital to address redevelopment concepts of layout and placement of services identified in the 'functional brief' and also considered improved service models.
- **Third stage** – ongoing community involvement in the design and implementation.

LEARNING FROM OUR CONSUMERS – PATIENT SATISFACTION SURVEY

Consumer feedback is a vital part of how we assess risk, monitor service provision and make necessary changes. An important tool the RWH uses is the Patient Satisfaction Monitor. The Monitor reports on patient satisfaction and the index of care. The index of care is a robust measure of satisfaction and requires consistently high ratings by patients.

Areas we performed well in:
Generally, the results are similar to the results obtained by the RWH last year. Results in non-maternity compare favourably with other like hospitals across Victoria, and showed an improvement in ratings in cleanliness. Results in maternity scored well on preadmission information, clarity of written information, and awareness of complaint mechanisms.

Areas for improvement:
The RWH did not compare as well with a small number of maternity hospitals in Melbourne. Areas that were identified for improvement were staff attitudes, communication, responsiveness and respect, particularly in nursing staff (bearing in mind that scores were still over 90%).

In maternity, the physical environment, privacy, restfulness, cleanliness and temperature of food were identified as issues concerning some patients.

What we have done as a result:
Many of the issues in the maternity survey have been directly addressed since this survey was undertaken. These responses include the implementation of a new model of care – TeamCare (see page 9), increases in the number of permanent nursing staff, renovations of wards and birthing suites,

including reducing room sharing to three women, and an external review of food services. The audit showed that RWH is meeting the required standards in food production and service.

What we need to address in 2003/2004:
We plan to listen to staff and our consumers to ensure that communication issues are addressed and that women experience all staff as responsive and courteous. When our new kitchen is rebuilt, it will include a halal kitchen to cater for a specific group of consumers. We will review the outcomes of these changes in the next Quality of Care Report.

LEARNING FROM PATIENT CONCERNS AND COMPLAINTS – THE CONSUMER ADVOCATE SERVICE

The RWH encourages feedback and complaints as a way of resolving concerns and improving the quality of services provided, and is managed by the Consumer Advocacy Service. This vital information is monitored and used to inform our quality improvement programs.

RESOLUTION OF COMPLAINTS

The Consumer Advocate Service received 375 complaints in this past year compared to 363 last year. Whilst this is very small by comparison with over 180,000 hospital contacts (representing 0.2%), we take each and every complaint seriously and respond accordingly to ensure a speedy and satisfactory outcome for our consumers.

Hospital staff work with the consumer advocates to resolve problems, concerns and unmet needs of patients and their families. The majority of complaints are resolved quickly with significant consumer satisfaction. One third of complaints received are resolved within twenty-four hours, over half are settled within seven days, and 85% are resolved within thirty days.

The majority (86%) of patients were fully satisfied with the outcome of the complaint process, and 13% were satisfied. In those cases where the patient remained dissatisfied the Consumer Advocate Service encouraged these consumers to make contact with the Health Services Commission.

The issues of greatest concern for our consumers are poor communication, difficulty in accessing services and problems in relation to treatment. The good news is since the implementation of TeamCare in maternity services, the number of complaints in relation to waiting times for appointments has declined significantly and there have been fewer concerns raised in relation to care provided in the birth suites.

PROCESS IMPROVEMENTS IN 2002/03

To ensure that complaints data is used to drive quality improvements, the Consumer Advocate Service is now part of the hospital's Quality and Safety Unit. Other activities include attendance at a number of key Quality and Safety forums, involvement in service reviews, and providing input on complaints data for analysis of trends and 'trouble spots' relevant to service provision. We have a new pamphlet about the service in 12 community languages.

PROVIDING WOMEN WITH GOOD HEALTH INFORMATION

Accessible health information for women is a priority for RWH. This is crucial if there is to be a partnership between women and their care providers, and for women to be able to make decisions. The Quality Improvement Consumer Health Working Group has been established with both staff and consumer representation to oversee the development of consumer information. We try to create an environment where consumers are constantly feeding back and working in partnership with the hospital. Our standards are that information should be evidence-based, relevant and informative and provided to women in their own language.

A website has also been developed to provide a range of information to staff and consumers. It includes a guide for writing consumer health information and engaging consumers, information about translations and cultural appropriateness and consumer information projects happening at the RWH.

The website at www.rwh.org.au/qichi/ also has the capacity for discussion and virtual consultation with consumers.

Our Maternity Services

A new model of health care known as 'TeamCare' was introduced this year. TeamCare provides holistic woman-centred care by a team of midwives and obstetricians across pregnancy, childbirth and postnatally in hospital and at home.

Partnerships between services within the RWH as well as external providers (shared care) ensure continuity of care and choice in care options.

Maternity Highlights for 2002/03:

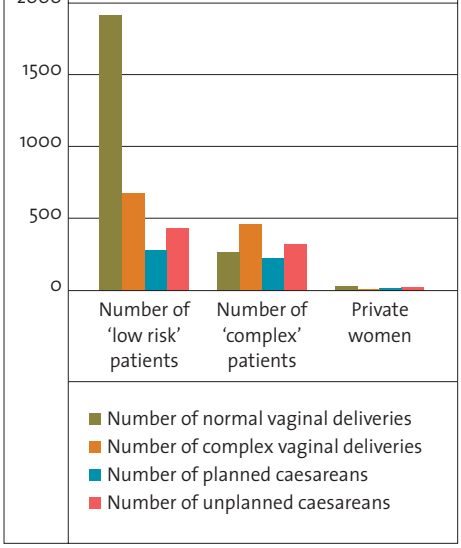
- TeamCare – the new model of care.
- Antenatal appointment waiting times improved by 50%.
- Implementation of the '3 Centres Guidelines' for improved antenatal care.
- A new hand held pregnancy record – used by women.
- A manual for clinicians covering low risk antenatal care protocols.
- The RWH Clinical Guideline website.
- Improvements to Shared Care.
- Renovations to our postnatal wards, reducing beds from four to three.

SERVICE STATISTICS

A total of 4679 babies were born at the RWH between July 2002 and June 2003. The vast majority were 'low risk' (71%) births, 27% births from 'complex' pregnancies and 2% to women who chose a private obstetrician.

72% of deliveries were normal vaginal deliveries (n = 3372). The caesarean section rate is at predicted levels and is a reflection of the trend in Victoria of increasing maternal age, improved survival rates and extremely premature babies.

Figure 1: TeamCare model



This chart demonstrates the three different TeamCare options at the RWH of 'low risk', 'complex' and 'private patients', and the subsequent type of delivery for women from each of these maternity streams.

IMPROVING MATERNITY CARE THOUGH COMMUNITY BASED PARTNERSHIPS

The Shared Maternity Care Model incorporates a team approach between the hospital and the community. Antenatal care is provided between general practitioners (GPs) and midwives in the community and the hospital. The birth and immediate postnatal care are provided at the hospital. RWH has recently worked with the Mercy Hospital for Women and Sunshine Hospital to improve communication with community based providers such as GPs.

Access to evidence based health care information is critical in ensuring the success of this partnership between hospital and community care providers. The RWH launched the 'General Practitioner Access' website in June 2003. It provides reliable and easily accessible information on hospital services, pathways, and protocols as well as professional resources.

Go to www.rwh.org.au/gpaccess/ for more information.

A review of the Shared Care Model was conducted in January 2001, and followed up in September 2002. This audit demonstrated that whilst this model of care is generally working well, some problems have been identified. One area of concern is the increased presentation to the RWH emergency department:

- More than a third of women doing shared care accessed the RWH Emergency Department.
- 33% (2001) and 69% (2002) did this in office hours.
- 15% (2001) and 10% (2002) were referred by their GP.
- Notification to GPs of the visit to emergency department occurred in only 5% of cases.

These results suggest that women as well as their GPs continue to rely on the RWH for clinical reassurance and review, and that communication with community care providers needs further improvement. These process issues in the shared care model will continue to be monitored and improved.

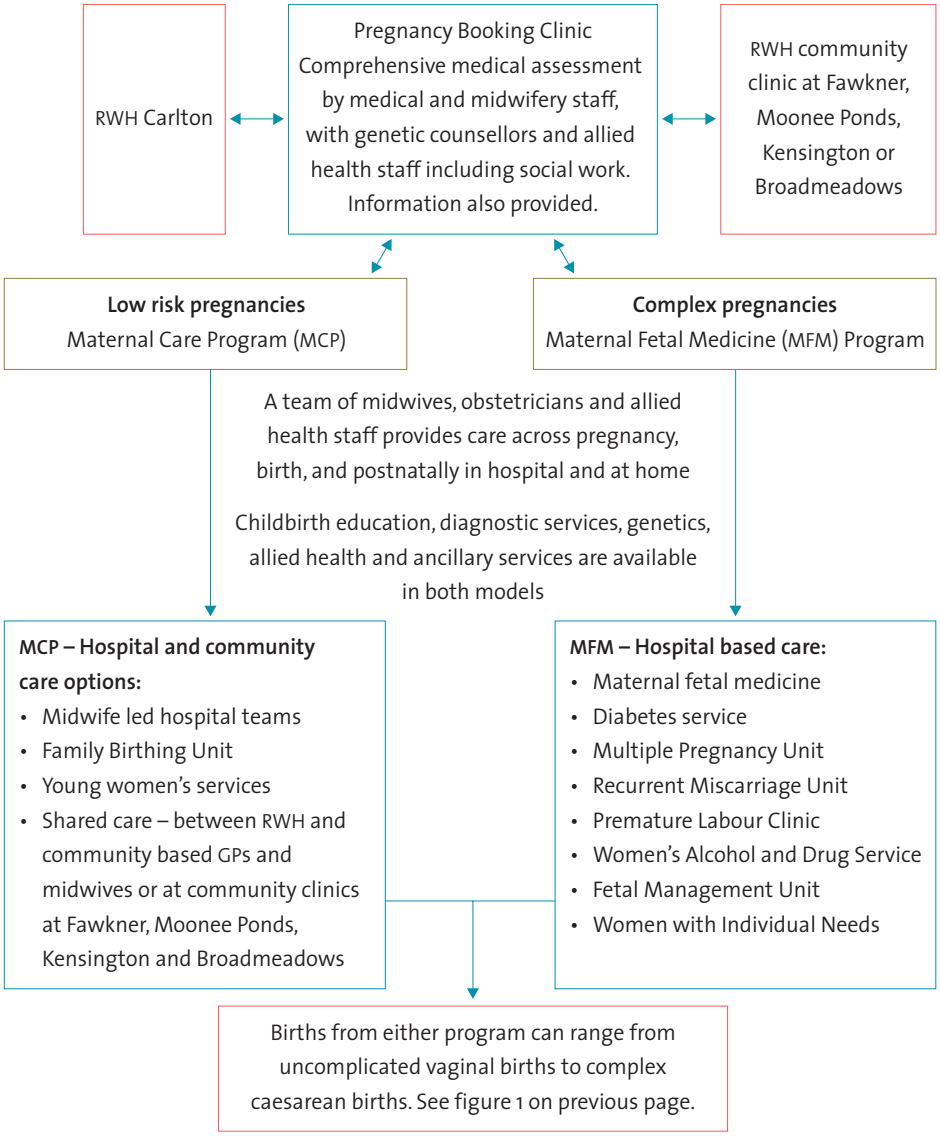
COMMUNITY PRINCIPLE – Patient Care

Hand Held Pregnancy Record

We have improved the way we document medical information about pregnancy with the development of the 'Hand Held Pregnancy Record'. The aim is to involve women and give them ownership in the care they can expect, and to be a communication tool between the multidisciplinary TeamCare members.

Choices in care are dependent on women's preferences and their medical needs. Women with pregnancies that are considered 'low risk' are allocated to the Maternal Care Program (MCP) and those with 'complex' pregnancies are allocated to the Maternal Fetal Medicine (MFM) Program. This is illustrated in Figure 2.

Figure 2: TeamCare maternity care model at the RWH
Basing care on personal preference and medical needs



IMPROVING MATERNITY CARE THROUGH HOSPITAL PARTNERSHIPS – '3 CENTRES GUIDELINES'

Another way that RWH Maternity services ensures quality of care to women is through developing and using standards that are based on the best available evidence. The RWH, in partnership with the Victorian Department of Human Services and two other tertiary maternity hospitals, Southern Health Service and Mercy Hospital for Women, developed 17 standards for antenatal care for women with low risk pregnancies. Evidence was systematically reviewed and classified according to the National Health and Medical Research Council (NHMRC) recommendations and peer reviewed by multidisciplinary reference groups from each centre and from independent experts in evidence-based pregnancy care.

These standards are known as the '3 Centres Consensus Guidelines on Antenatal Care' and were implemented by the RWH in 2002.

The guidelines can be found at: www.3centres.com.au.

MATERNITY SERVICES SHARING PRACTICE WISDOM

Clinical practice guidelines (CPG) have been developed through the evaluation of 'best practice' evidence. These guidelines are designed for use at the RWH, but will also be available to support health professionals in rural, regional and remote locations. A CPG website was set up in April 2003, and currently there are 30 guidelines available. To ensure they are current and reflect best practice, they will be reviewed and evaluated every two years or as required.

Go to www.rwh.org.au/rwhcpg for more information about CPGs.

HOW DO WE MAKE SURE THE HOSPITAL PROVIDES GOOD MATERNITY CARE?

The quality of care we provide across maternity services can be compared and measured against other hospitals throughout Victoria and Australia by using clinical indicators. These indicators define acceptable standards of care and identify trends across a range of areas important to the care of both mother and baby. Data collected from the RWH over the period 2001/2002 has been compared with data collated by the DHS for Victoria, and also with data benchmarked by the Women's Hospitals Australasia (WHA), an organisation that collects and measures data from hospitals throughout Australia and New Zealand. We will report these results each year.

PROVIDING GOOD MATERNITY CARE

What are the chances of a woman with no health or pregnancy complications (the standard primiparae) of:		
Having her first child induced?		
RWH	Benchmark	Comment
24%	Victorian average 23.6%	RWH is at the average rate for both Victorian and WHA hospitals.
Having her first child by caesarean section?		
RWH	Benchmark	Comment
18%	Victorian average 16.8%	The RWH rate is within the Victorian and WHA benchmarks.
Having a perineal tear (third and fourth degree) with her first child?		
RWH	Benchmark	Comment
2.2%	Victorian average 3%	This is a good result. This is an important issue for women's long-term well-being and further information is provided later in the report.

The administration of antenatal corticosteroids (medication given to develop babies' lungs) to women who are at risk of delivery or have delivered prior to 34 weeks gestation is optimal:		
RWH	Benchmark	Comment
88%	100%	This is a good result. The rate is less than 100% because women arrive who already in advanced premature labour and about to deliver do not receive medication.

What are the chances of a woman having a vaginal birth following a caesarean section for the previous birth?		
RWH	Benchmark	Comment
35% of women planned a vaginal delivery	Victorian average 34.4%	The same number of women as elsewhere in Victoria after a previous caesarean want to try a vaginal delivery.
35.9% of these women achieved a vaginal birth	Victorian average 50.7%	On these figures, RWH has lower results than the Victorian average and lower than WHA averages. An internal audit of 6 months to February 2003 suggests that our rate is higher than this and well within the averages. RWH will continue to audit and reconcile its data, its performance and the research evidence on safety.

How safely does RWH deliver babies?		
RWH	Benchmark	Comment
94.35 Standardised Perinatal Mortality Ratio. It measures actual deaths as a proportion of expected deaths.	100 Results less than 100 represent a better perinatal outcome.	There are unpreventable perinatal deaths, e.g. extreme prematurity. This measure shows that for the more high risk babies delivered here, our perinatal survival rate is good, indicating good care.

Proportion of women who wait no more than 30 minutes for hospital antenatal clinical visits:		
RWH	Benchmark	Comment
71.6%	This has not been established for other Victorian hospitals.	This is a major quality improvement. Twelve months ago, the figure was 38.3%. For some clinics, the result is 100%.

How frequently will women from a non-English speaking background without proficiency in English receive appropriate interpreter services?		
RWH	Benchmark	Comment
In February 2003, 61% of women requiring an interpreter when attending an antenatal appointment received the service.	No Victorian benchmark has been established.	This is an improvement of 5% since the previous data collection. RWH is very good at identifying women who need an interpreter. The resources available affect this provision. Nevertheless, there will be continuing efforts to improve this.
100% of women requiring an interpreter received one at their first appointment in the Pregnancy Booking Clinic.		This is a very good result.

Proportion of women referred to postnatal domiciliary care (follow up care to mother and baby at home):		
RWH	Benchmark	Comment
87.4%	This is now a normal aspect of maternity care. The average for metropolitan hospitals was 89.3%.	This figure has improved significantly at RWH and will continue to improve. Our rate is better than this and we are not capturing this data accurately. Work is being done to correct this.

What are the chances of a woman having a caesarean getting a urinary tract infection from having a catheter inserted?		
RWH	Benchmark	Comment
2001 1.9% 2002 1.8%	This rate is consistent with other published data.	Awareness of 2001 results and efforts with attention to all aspects of catheter care saw improvement rates of infection in the emergency caesarean patients. However, the results for elective patients increased slightly, which suggests that the rates can be further improved.

What are the chances of a woman having a caesarean getting a surgical site infection?		
RWH	Benchmark	Comment
5.55%	Benchmark not available.	This data will be submitted to VICNISS to establish benchmarks and we will explore measures to reduce them further. Most of these are superficial wound infections. This will be monitored and reported in the next Quality of Care Report.

HOW WELL IS PAIN MANAGED?

The Acute Pain Service (APS) is a specialised service, co-ordinated by a clinical nurse consultant with the support of an anaesthetic registrar and consultant. Every day, the APS reviews patients receiving analgesic therapy and shows patients and staff safe and effective management of acute and chronic pain.

During 2002/03 the APS had 2734 referrals. 65% were for post operative pain management of inpatients, and of these:

- 57% were post caesarean section
- 26% were post major gynaecology surgery such as abdominal hysterectomy
- 9% were post major oncology surgery such as a laparotomy.

The day after surgery, 83% of patients reported their pain as none or mild and 1% had severe pain. No patients with severe pain on day one had severe pain on day two, indicating the effectiveness of the pain service team in aiding a pain-free recovery. Almost all (97%) of patients reported their satisfaction with their care as good or excellent.

SOME SERVICES IN A COMPLEX PREGNANCY

For women with a complex pregnancy, there is a range of services that women may use. Some examples are outlined to illustrate how we are constantly improving services.

Fertility

Reproductive Services provides assessment and treatment of female and male infertility, offering medical, nursing, scientific and counselling services. The unit is at the forefront of research and clinical implementation of assisted reproductive technology. Not all its services are high technology. The Big Girl's Group is a six-month weight loss and lifestyle program designed for women who are overweight and having trouble getting pregnant.

Pregnancy Day Care

The Pregnancy Day Care Centre has reduced hospital stays. If women experience complications in their pregnancy, such as swelling in hands and feet indicating raised blood pressure, they are able to access the RWH Pregnancy Day Care Centre or receive care at home.

Management of diabetes in pregnancy through education

When the 'Diabetes in Pregnancy Unit' started in 1966 more than one in four babies would die because they were born to mothers who had diabetes. In 2000, 98.5% of babies born to diabetic mothers survive. This improvement has been the result of advancements in neonatal care and diabetic management in pregnancy, which includes insulin therapy and diet and exercise changes. In addition to women with pre-existing diabetes, the number who develop diabetes during pregnancy (gestational diabetes) is on the rise. The Diabetes Service at the RWH works with around 40 women a week who have developed gestational diabetes mellitus.

For full PowerPoint presentation of a Diabetes seminar hosted by RWH in November 2002 which attracted local, interstate and overseas clinicians, see website: www.rwh.org.au/diabetes_manual/

COMMUNITY PRINCIPLE – Patient Care

Engaging and informing consumers

The Gestational Diabetes booklet was developed in conjunction with consumers from five main language groups. The English text was developed and reworked to culturally suit each of the groups. An evaluation of these booklets has recently taken place in the Diabetes Service using interpreters in a one to one interview situation. Further input was also sought from the QICHI consumer mailing list and the RWH 'Absolutely Women's Health' mailing list (of over 300 women) to ensure this information was meaningful to women.

To order RWH health publications go to: www.rwh.org.au/wellwomens

Research in maternity services

The RWH has an established partnership with the University of Melbourne to integrate clinical practice and research. The clinical emphasis is on providing continuity of care from the diagnosis of a pregnancy complication through to the birth of the baby, and care of the mother and baby in the postnatal period. Research involves the consideration of this 'practice wisdom' to study the causes and treatments of common and important pregnancy disorders.

For information about research being undertaken, see: www.rwh.org.au/perinatal_medicine or www.rwh.org.au/research_ethics

COMMUNITY PRINCIPLE – Quality

Applying research evidence into practice

Anti-D project

RWH has recently implemented the NHMRC best practice guidelines for the use of Rh D Immunoglobulin in obstetrics to prevent Haemolytic Disease of newborn babies. This disease occurs when there is incompatibility between the mother's and infant's blood groups. The new guideline has changed the way we care for pregnant women whilst in addition to screening all women, we now provide a prophylactic dose of Anti D to Rh D negative women having their first pregnancy at 28 and 34 weeks gestation.

For more information go to: www.rwh.org.au/rwhcpg

COMMUNITY PRINCIPLE – Quality

Research

Support and Safety Needs of Women During Pregnancy

Women's Social Support Services is currently undertaking a large research project titled the 'Support and Safety Needs of Women During Pregnancy' which has involved interviewing 400 women. Whilst this research has been used to inform clinical practice at the RWH, the outcomes have been further widespread. The definition of violence used by the RWH is now used by the Victorian State Government.

For general information about many aspects of pregnancy go to: www.betterhealth.vic.gov.au/

COMMUNITY PRINCIPLE – Service options

Holistic care

Social Screening in Pregnancy Booking Clinic

The implementation of TeamCare provides an opportunity for midwives to work with Women's Social Support Services (WSSS) to consider the social aspects of health. Evidence indicates that the health and well being of women and their children is related directly to the social context in which they live. A Social Screening Tool was developed and piloted in mid-2002. This tool identifies a range of social issues where women would benefit from additional support, and midwives make referrals to WSSS as appropriate. This method of identifying holistic health needs has now become an integral part of service delivery with a social worker permanently part of the initial pregnancy assessment at the Pregnancy Booking Clinic.

COMMUNITY PRINCIPLE – Quality

Applying evidence based practice

Baby Friendly re-accreditation

In August 2002, The Royal Women's Hospital was re-accredited for the second time as a Baby Friendly Hospital. Assessment criteria is determined by the World Health Organisation (WHO) and UNICEF with the primary goals to create an environment that protects, promotes and supports breastfeeding throughout the hospital and guides the way we provide care to mothers and their babies. For our consumers this means that the care they receive and the advice that they are given has a basis in clinical research and offers consistency between clinicians.

The Breastfeeding Education and Support Services (BESS) provides a range of clinical care and support services to women, with 63% of women fully breastfeeding their babies on discharge from hospital. A further 20% feed using a combination of breast milk and formula.

Creating a learning environment to ensure safe care

As a teaching hospital, we have the important challenge of teaching new skills to doctors and nurses while maintaining safe standards.

While most births are straight forward, birthing can suddenly become more complicated and we have to prepare for that risk.

Some of our neonates are fragile and good care is paramount. Older women can be very ill or have complications and these need to be managed.

We support our staff by trying to make it easier to provide safe effective care. Our philosophy is that to create a safe environment for patients and staff, we support a 'no blame' culture. This means that when things do go wrong, we focus on improving the systems and processes rather than blaming individuals who usually find themselves at the end of process and system deficiencies. These are some of the ways we do this.

Mortality and morbidity review – These are weekly multidisciplinary reviews by the Perinatal (around the time of birth) Mortality and Morbidity Review Committee of all deaths, including all pregnancy loss after 20 weeks gestation and/or weighing more than 400 grams, stillborn babies, deaths of babies in the first 28 days, and maternal deaths, which are rare.

There were no maternal deaths in the last year.

In 2003/2004, we plan to institute a similar committee to review maternal morbidity.

We reviewed 117 cases of pregnancy loss after 20 weeks, including terminations for fetal abnormality, fetal deaths in utero, stillbirths and neonatal deaths at full term. Most of these were between 20 and 30 weeks gestation. We identified ways we could improve care by:

- ensuring results are acted upon
- managing maternal infections in pregnancy, including referral to specialists
- managing premature rupture of membranes
- ensuring access to interpreters to assist decision making
- making sure there is a care plan for women who present to the Emergency Department during pregnancy
- contacting women's GPs when there is a fetal death.

Screening of patient records – Patient records are screened for particular events such as bowel perforations, blood transfusion, transfer to a high dependency unit or another adult hospital, and return to theatre. These patient records are then reviewed to ensure that good care has been provided and to identify ways to improve care.

We now review all women transferred out to adult intensive care units as this represents a group with complex needs requiring high risk management. In 2003/2004, we will strengthen this with multidisciplinary review. Issues we identified and have developed clinical practice guidelines for and skill development were:

- predicting and managing shoulder dystocia (when the shoulder of the baby jams against the mother's pelvic bones during birth)
- managing potential bleeding when the mother refuses blood transfusion for religious reasons
- Managing premature rupture of membranes.

See: www.rwh.org.au/rwhcpg

Incident reporting – We encourage incident reporting as an important learning and quality improvement measure. Reports are collated across the hospital identifying 'incidents'. These include incidents involving harm or potential harm to patients, which sometimes can be described as 'near misses'. These are particularly important in identifying ways to improve processes and systems. Most do not result in serious harm to patients.

The Quality and Safety Committee received 226 incident reports for closer examination. These included:

- medication errors
- identification incidents
- feeding errors
- wrong filing and documentation
- faints and falls
- equipment failure
- aggression and security issues
- technique issues.

Improvements include:

- babies having their own drug charts
- additional staff in anaesthetics
- pre-admission review for gynaecology, surgery and caesarean section
- improved processes for tracking cytology results
- improved pathology processes for biopsy samples.

Sentinel events – These are defined as significant incidents that were preventable and had a very harmful outcome. These are required to be reported to DHS and include preventable maternal deaths, surgery on the wrong patient or wrong side, instruments left in the patient after surgery, or a medication error that resulted in death.

There were no sentinel events reported in 2002/2003.

We are organising a series of workshops on root cause analysis so that we can use this approach to analyse any sentinel events or events we consider were 'near misses'. This will help us learn from the incident, reduce the risk of it happening again and improve our processes and systems.

Patient complaints – Complaints data is now reported to the Quality and Safety Committee to ensure that process and system improvements are made as a result of complaints.

Medico-legal – Actions taken against the hospital, as well as coroner's reports into deaths at RWH and other hospitals. These are analysed to identify preventable factors and find ways to improve systems and processes. One of the issues we have identified is improving accessible documentation in patients' records to improve communication.

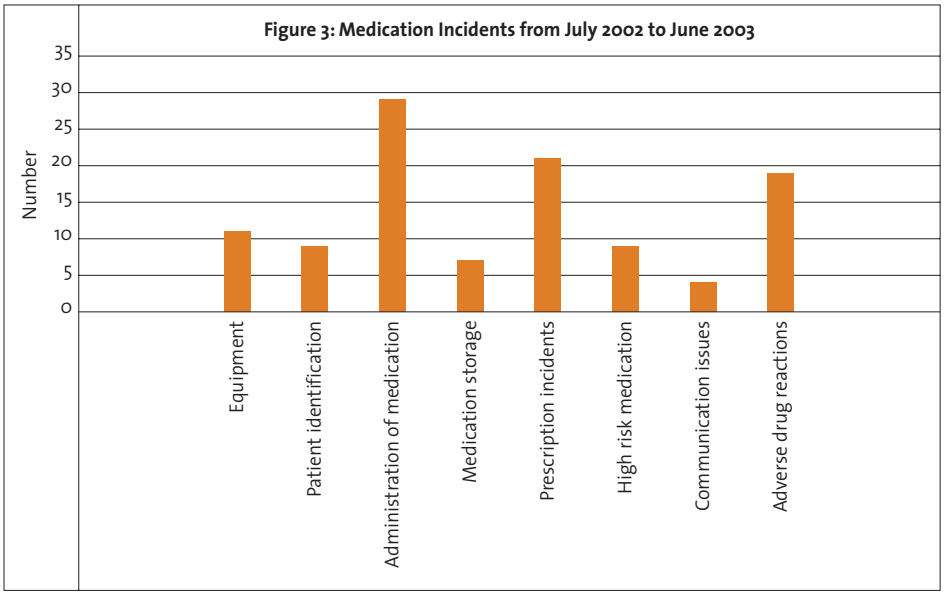
The Department of Human Services has asked all hospitals to report on a number of safety and quality issues, including medication incidents, pressure ulcers, falls and infection control.

MEDICATION INCIDENTS

The Medication Safety Committee was formed in April 2003 to review trends in medication incidents and examine serious incidents. Other aims include promoting a culture of identifying and reporting incidents so that the hospital puts safer processes in place and communicates these guidelines and improvements across the hospital. This multidisciplinary committee will ensure that medication administration is based on evidence of effective and safe practice. Most medication incidents at RWH don't result in major harm to patients, but it is important to have safeguards in place and learn from minor incidents how to prevent a major incident. For example, women who were well informed about their drug allergies prevented two incidents. Our pharmacy department has further safeguards in place.

Medication safety will be a key focus for 2003/2004 with a plan to identify the key medication risks for RWH and improve the processes around the prescribing and administration of drugs (see figure 3).

Figure 3: Medication Incidents from July 2002 to June 2003



PRESSURE ULCERS

Due to the type of hospital we are and the patients we care for, (generally younger and active) pressure ulcers are not typically a problem at the RWH.

There have been no pressure ulcers in adults in the past 12 months. Oncology patients receiving palliative care are most at risk, and a routine of positional changes is adhered to. Babies in the newborn intensive care unit are another group at risk. These babies are nursed on sheepskin and are turned frequently. Very premature babies with relaxed muscles are particularly at risk of developing pressure areas, which need to be actively managed. These pressure areas may occur as a result of the treatment used, such as tubing for breathing or catheters, and can develop quite rapidly. They are treated with a form of plastic film and positioning and a management plan is recorded in their medical history.

FALLS MONITORING AND PREVENTION

In 2002/2003, there were 26 reported incidents relating to falling patients, husbands, children, and visitors. Because of the age profile of patients of the RWH, the risk of serious injury from falls is less than in general hospitals. No serious injuries (such as fractured limbs) occurred from falls. One post surgical patient was transferred out to Royal Melbourne Hospital for observation. Patients are generally monitored closely and supported when first getting up and about after surgery. Any confused patients are nursed in rooms close to the nurses' desk.

Some additional ways of preventing falls include:

- ensuring women are discharged on time
- supporting women post-caesarean section with babies in the neonatal unit
- anticipating faints from support people during childbirth.

See: www.rwh.org.au/css/risk/
for a more complete report.

INFECTION CONTROL

Infection control has a major role in ensuring quality care for our patients. The RWH Infection Control department, known as the 'IMPACTeam', aims to minimise the risk of patients acquiring an infection. Many patients will undergo procedures or have underlying illnesses that make them susceptible to infections. Standards of care are determined by procedures based on 'evidence' or 'best practice' which guide staff to manage and prevent infections. These are based on national and international standards. Staff receive regular training to ensure their knowledge is current.

RESPONDING TO INFECTIONS

The IMPACTeam conducts audits to ensure that guidelines are complied with as well as surveillance to identify hospital acquired infections. RWH now contributes data to VICNISS, Victoria's hospital acquired infection surveillance program. This allows us to compare our rates with other Victorian hospitals and with the US Centres for Disease Control and prevention (CDC) and Nosocomial Infection Surveillance System (NISS) rates. Specific infection rates are discussed elsewhere in the report.

Infection control must also be able to respond to outbreaks, epidemics and the changing antibiotic resistance of some bacteria. The importance of timely and effective infection control procedures was highlighted by the recent worldwide alert to Severe Acute Respiratory Syndrome (SARS). The IMPACTeam manages possible infections with microbiology laboratories, trains staff and implements special infection control procedures, communicates with staff, patients and visitors, and manages any patient identified as at risk by placing them away from others until they are screened and treated.

For more information about RWH infection control visit:
www.rwh.org.au/infection_control/

COMMUNITY PRINCIPLE – Patient care

An education campaign for improving hand washing by both staff and families has been implemented in NICU in April 2003. This aim of campaign 'Wash-up' was to reduce infection rates in vulnerable babies. The success will be measured through reductions in infections.

ENSURING A SAFE HOSPITAL ENVIRONMENT

Accidents and risks are also managed by the ongoing monitoring of the hospital to ensure that a clean and safe environment is provided to all hospital users. We have recently undertaken hospital renovations that have not only improved the wards and offices to make them more attractive, clean and modern, but also upgraded the way information is signed around the hospital. Other ways we ensure a safe hospital environment include:

Cleaning audits

Regular cleaning audits are undertaken to ensure that the hospital environment meets the cleaning standards for Victorian hospitals. An external audit was undertaken and submitted to DHS to be benchmarked against other hospitals. These results indicate that RWH is meeting the cleaning standards required. With the benchmark at 80%, RWH scored:

- Group A – Very High Risk areas such as Operating theatres, ICU and NICU = 89%.
- Group B – High and Moderate Risk areas such as the Emergency Department, Pharmacy and Wards = 92%.
- Overall Hospital Score (all areas) = 90%.

Safety whilst renovating

The Infection Control Department implemented strategies to reduce the risk of infections from dust generation during renovations, with a risk assessment tool used throughout the various stages of the works to identify any possible problems. No infections related to the renovations were identified.

Maintenance of the environment

The Engineering Department conducts surveillance of cooling towers and warm water systems for legionella, routine air conditioning and air filtration system cleaning, and maintenance of sterilisation units to ensure that the environment is safe.

Our Neonatal Services

Neonatal Services comprises the Neonatal Intensive Care Unit (NICU) and Special Care Nursery (SCN), which provide neonatal care to premature and critically ill newborns within a family centred model. The majority of babies admitted to the service are born in the RWH. Referrals are also received from suburban Melbourne, regional Victoria, southern New South Wales and Tasmania.

Neonatal Services manages the statewide Newborn Emergency Transport Service (NETS) and works in partnership with other nurseries and NETS to develop and implement best practice neonatal care. It plays a key role in education and training for local, national and international health professionals and has in place an extensive research program. Neonatal Services has a long-term follow-up program, which is internationally renowned for its related research program and outcome data.

There has been an increase in the number of admissions to our nurseries since the last report, with 1319 babies admitted to the level two and three nurseries between July 2002 and June 2003, with an excellent overall survival rate of 98%.

LEVELS OF NEONATAL CARE

Care for the newborn is provided at three levels:
Level 1 – care for healthy babies at mothers' bedside, and/or stabilisation of unexpected complications.
Level 2 – 'special care' for babies who require nursery admission for monitoring, investigation and/or medical and nursing treatment not including life support.
Level 3 – 'neonatal intensive care' for babies who require a full range of monitoring, investigation and medical treatment including life support. This includes babies born at extreme degrees of prematurity and mature but very sick babies.

The RWH nurseries provide all three levels of care. It is therefore called a tertiary hospital.

SERVICE STATISTICS

Figure 4: NICU admissions between 1/7/02 and 30/6/03

Gestation	Number	Min Birth Weight	Max Birth Weight	Number Survived	% Survived
23	4	525	592	2	50%
24	14	580	752	9	64%
25	17	606	1125	15	88%
26	36	420	1065	34	94%
27	37	675	1259	36	97%
28	36	420	1425	34	94%
29	41	575	1835	39	95%
30	24	800	1865	24	100%
31	33	900	2600	30	91%
32	27	1060	2339	27	100%
33	20	1275	2440	17	85%
34	19	1440	3670	18	95%
35	16	1305	4005	16	100%
36	10	1915	3870	10	100%
37	15	2180	4918	14	93%
38	21	2636	4210	20	95%
39	16	2760	4300	16	100%
40	18	2475	4325	16	89%
41	14	2490	4761	13	93%
42	2	3310	4538	1	50%
Unknown	5	1370	1934	0	100%

The total number of admissions to the Neonatal Intensive Care Unit was 425, and the overall survival rate of these babies is 93%, with 29 babies dying.

The total number of babies admitted to the Special Care Nursery was 894 with a 100% survival rate.

COMMUNITY PRINCIPLE – Access

The NICU environment has recently been refurbished to reduce noise and control lighting in accordance with best practice recommendations and feedback from parents.

HOW DO WE MAKE SURE THE HOSPITAL PROVIDES GOOD NEONATAL CARE?

The centre of our quality strategy is our commitment to evidence based practice. This is achieved by implementing good research evidence, constant clinical audit and our commitment to conducting research and clinical trials to improve neonatal care. We cooperate with other neonatal services to do this.

The quality of our neonatal care is benchmarked against like neonatal services within Australia and New Zealand (the Australian and New Zealand Neonatal Network – ANZNN database) and internationally. The ANZNN is a voluntary collaboration of nurseries in both Australia and New Zealand which reviews and audits the standard of neonatal care provided. The audit looks at factors that can be measured that may affect the outcomes of babies while in hospital. The NICU at the RWH contributes data to this network, with the last reported figures being published in 2001.

In interpreting these results, it is worth understanding that the profile of the RWH neonatal unit, is that compared to the ANZNN group, RWH has more babies born under 30 weeks. This means we care for a higher risk population of babies.

For more information regarding ANZNN benchmark data go to: www.health.usyd.edu.au/

PROVIDING GOOD NEONATAL CARE

Chronic lung disease at 36 weeks:		
Incidence of babies receiving supplemental oxygen or any form of respiratory support at 36 weeks when born at <32 weeks gestation:		
RWH	Benchmark	Comment
21%	Less than 20%	This result is consistent with the benchmark.

Cranial ultrasound is undertaken:		
RWH	Benchmark	Comment
100%	More than 95%	RWH achieves the benchmark and has improved since the previous year.

Intraventricular haemorrhage (IVH):		
RWH	Benchmark	Comment
22%	Less than 45%	RWH is well within the benchmark.

Eye examinations are undertaken:		
RWH	Benchmark	Comment
94%	More than 90%	RWH achieves the benchmark and has improved since the previous year.

Incidence of stage 3 or 4 retinopathy of prematurity in babies:		
RWH	Benchmark	Comment
21%	Less than 8%	This result requires further review. This may reflect the profile of more smaller babies in RWH NICU, may be better detection, or may show a genuine need for improvement.

Neonatal infection rates:

RWH has no MRSA (golden staph – antibiotic resistant staphylococcus infection) in its NICU, but this is a group of high-risk infants, and a higher level of care is taken to prevent and reduce infection.

	<28 weeks	28-36 weeks	>36 weeks	Total
ANZNN 2000 benchmark rates	41.9%	8.6%	7.3%	13.6%
2002 RWH infection rates	41.2%	5.6%	1.4%	12.4%

This table demonstrates that:

- RWH infection rates compare well with Australian rates.
- Not unexpectedly, infection rates in premature and extremely low birth weight babies are higher than older babies, as they are more at risk.
- We plan to compare our rates internationally to ensure we meet best standards.

Group B Streptococcus

In 2002, only one baby was admitted to NICU with a Group B streptococcal infection – a blood stream infection. This is an infection that babies can get from their mothers, who may carry the bacteria without being sick from it. RWH policy is to routinely screen women for this infection at 36 weeks and to give antibiotics to all women who deliver before 36 weeks.

RWH	Benchmark	Comment
0.2/1000 births	0.6/1000 births	This is a very good result and shows that our screening and treatment of mothers for this infection is effective.

Adele

CARING FOR PREMATURE BABIES

A Newborn Intensive Care Unit (NICU) example:

Toula was referred to the RWH from country Victoria after experiencing threatened premature labour when her baby was at 23 weeks gestation. She was admitted to the antenatal ward and seen by specialist doctors, including the paediatrician who talked to her about what to expect and discussed the implications of her baby's extreme prematurity. She visited the Intensive and Special Care Nurseries with one of the Care Managers. Toula was given a course of corticosteroids, which are proven to improve premature baby outcomes.

Baby Adele was born at 26 weeks gestation (14 weeks early) with a birth weight of 930 grams. She was admitted to the NICU, where she received 24 hour care and support by the nursing and medical team. In the first few days, Adele had her own nurse dedicated to her care. Adele's parents, Toula and Jim were involved in her treatment plan and were regularly updated and given opportunities to ask questions. They were concerned about how small Adele was and how much intervention she needed, but were assured that this was necessary and Adele's chances of survival were greater than 90%.

During the first few weeks of her life Adele received a range of treatments (all evidence-based and proven to be effective) including optimised ventilation strategies (to assist in her breathing), control of blood gases, optimised nutrition and ultrasound scanning for ICH (intracranial haemorrhage). The family were invited to participate in a number of clinical trials being used to evaluate new treatments, and were provided with information about these research projects.

The next few weeks were very difficult for the family. A team of allied health professionals including the care managers, social workers and pastoral care workers provided additional emotional support. The social worker arranged accommodation for Toula and Jim in the RWH Family Accommodation Units situated next to the hospital, as well as other relevant community supports.

After two weeks in Intensive Care, Adele was weaned from full tube ventilation to CPAP (Continuous Positive Airway Pressure), which assisted her to breathe on her own, supported by pressure (air and oxygen flow) via a different breathing machine. As Adele's condition improved, she became stronger and shared a nurse with another premature baby. Over the next few weeks her ability to feed improved and the breathing support was discontinued after five weeks. Soon after this she was transferred to the SCN, with less intensive nursing care.

When Adele reached six weeks of age (equivalent to 32 weeks gestation), she was examined for Retinopathy of Prematurity (ROP) by an ophthalmologist and found to have a condition of the eye that required a corrective laser procedure. She also had a hearing test performed which showed her hearing was normal.

Toula and Jim were actively encouraged to care for Adele as they would at home. The nurses encouraged lots of parent contact, as this is known to help premature babies grow and develop. The care manager began to prepare Adele and her family for discharge.

After eight weeks in NICU, the NETS (Newborn Emergency Transport Service) transported Adele to a Level 2 nursery in a regional hospital closer to home. She finally went home at 38 weeks gestation (approximately when she was due to be born). When Adele was equivalent to full-term in age, she returned to the RWH for follow-up tests, which demonstrated that she was developing well. Ongoing follow-up was arranged for when she was one and two years of age at the Neonatal Low-Birth Weight Follow-up Clinic.

COMMUNITY PRINCIPLE – Quality

Research

CPAP or intubation at birth (COIN study)

Most very premature babies have breathing problems. This study is designed to find out which is the best way of helping babies between 25 to 28 weeks gestation breathe following birth. It is a randomised trial comparing the effect of supporting breathing with a short tube in the nose (nasal CPAP) with a longer type passed down the windpipe into the lungs.

CARING FOR THE CARERS

In 2002 a Neonatal Team Review was conducted which looked at the key issues affecting staff morale, well-being and workplace culture and how these affected service delivery. A multidisciplinary approach was taken and a 'Family Focus Group' was formed to undertake cultural mapping of the unit and the expectations of families. A series of interviews were conducted with families who provided crucial feedback about their experience of care and what was important. This information was then used to inform the team review process.

Some of the key findings highlighted were:

- The majority of parents were highly satisfied with the care their babies received.
- Continuity of carer was vital to parental satisfaction and one of the most challenging aspects for a large unit to achieve with the complexities of staff rostering.
- Counselling and preparation prior to the delivery were rated as particularly important, with those able to tour the unit prior to their baby's admission able to adjust to the intensive care environment more easily.
- Parents actively involved in the care of their baby was paramount.

"What is required to provide the very best care will be an even greater move to the notion of parents as partners in care and greater acknowledgement of the important role parents' love and bonding plays in the experience of the parents and baby, and the clinical outcome."

RWH Neonatal Review Project, 2003

BEREAVEMENT CARE

Unfortunately, not all babies born premature survive and the impact on the families as well as staff working in neonatal services is immense. The RWH bereavement care team is a multidisciplinary team of staff from genetics, pastoral care and Women's Social Support Services (WSSS) who respond to families whose babies have died and provide support and linkages with community agencies. This support is also available for all forms of pregnancy loss.

Some parents will consent to a post mortem taking place to learn more about why the death occurred. The RWH together with the Royal Children's Hospital joined forces with consumers to develop a new information booklet for families to clearly explain what was involved in a post mortem and what families should expect, titled 'Post Mortem Information for Families'. New hospital autopsy consent procedures were also developed, and both were implemented across the hospital in April 2003. An evaluation will follow.

Additional information can be obtained at: www.rwh.org.au/rwhcpg/site.cfm/

RESEARCH IN NEONATAL SERVICES

Neonatal research focuses on improving the health of sick infants and their families by undertaking research into the causes of babies' illnesses, the treatments used and the long-term outcomes. The researchers collaborate with other departments within WCH, other hospitals within and outside of Australia, and research institutes internationally.

The RWH is the base for three international studies in neonatal care, and has won international recognition for the quality of research produced. There are currently six international Fellows in the Fellowship program, undertaking neonatal research projects.

The Very Low Birth Weight Follow-up Program assesses the outcomes of the very low birth weight infants throughout childhood for growth and development, including their lungs, eyes and ear function, general health, how they are progressing at school, and how their families are adjusting to changing circumstances, as they grow older. The majority of these infants are assessed at the ages of two, five and fourteen years. The assessment demonstrates that most children who had a very low birth weight grow and develop normally throughout childhood, suffering the usual childhood complaints at the same rate as normal birth weight infants.

Planning for women and babies after hospital

The RWH has a number of programs to assist women when they return home. These include Post Acute Care (PAC), Hospital in the Home (HITH), postnatal domiciliary care, the Breastfeeding Education and Support Service (BESS) and the use of case managers in the NICU. Effective discharge planning is the key to making sure women receive the service they require and are referred to appropriate community agencies.

The basis for effective discharge is established early and in pregnancy continues throughout the antenatal period.

For more information about how RWH provides continuity of care between hospital and home see:
www. rwh.org.au/hacc/services
www.rwh.org.au/discharge
www.rwh.org.au/surg-services

CONTINUITY OF CARE – THE EFFECTIVE DISCHARGE PROCESS

With improvements in the ways we care for patients, hospital stays have become shorter. This has meant that we have had to look at ways to ensure that care is not just limited to the hospital stay, but both before and after. Discharge care planning considers all aspects of a patient's life to ensure they are supported adequately in the recovery period.

The overall aim of planning for discharge is to promote recovery, provide support for families and prevent re-admission to hospital. Discharge planning commences at pre-admission or on admission for non-elective procedures, so that women and babies with clinical or social needs are identified early. Routine planning for admission and discharge ensures a smooth transition home and makes links to community service providers prior to the woman/baby leaving hospital.

The RWH Effective Discharge process was implemented in a number of stages throughout the hospital. A recent audit was undertaken in June 2003 to monitor improvements to service provision.

Problem:
Different forms and formats for collecting clinical and social information were being used across the hospital.

Response:
RWH clinical staff and the Women's Social Support Service (WSSS) and GP representatives have developed a new tool, or 'suite of forms'. These aim to standardise discharge planning forms and how they are recorded in patients' medical histories.

Problem:
Documentation of the care pathway for women requiring short stays in the hospital was inadequate, with women accessing the RWH Day Surgery Unit being provided a copy of a manual discharge summary to provide to their GP.

Response:
Improved communication strategies have recently been implemented with Electronic Discharge summaries introduced to the Day Surgery Unit in June 2003, as well as patient CareMaps which promote effective communication and continuity of care between care providers.

RWH POST ACUTE CARE

The RWH Post Acute Care (PAC) Program is a partnership between the hospital, the government, and community health care providers. The aim of the program is to provide services as a short-term intervention to assist patients recuperate following a hospital admission. A multidisciplinary approach is taken to ensure effective planning for hospital discharge is made in advance, and making sure links between the hospital and other community health care providers are in place.

The services offered through PAC include home nursing, personal care, home care, assistance in caring for others such as children or older relatives and transport. Between February 2003 and April 2003, 121 referrals to PAC were made at the RWH by a range of staff including nurses, social workers and physiotherapists.

HOSPITAL IN THE HOME (HITH)

HITH is a specialised service offered to women having surgery, mothers and babies both in hospital and at home. HITH offers nursing care for women who choose to be at home and who are in a stable condition and not requiring 24 hour care.

The neonatal HITH program cares for approximately 165 babies per year, with each baby receiving an average of four visits by neonatal nurses. This number is relatively small as most babies are transferred back to either their referring hospital or to a level two nursery closer to home.

Nursing and midwifery staff provided HITH care to 1378 women during 2002/03.

Our Women's Health Program

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

For this report we have chosen to highlight Gynaecological Services. These services have been identified as a major growth area and the hospital is committed to ensuring services continue to develop in response to new clinical issues and increased demand for services.

SERVICE STATISTICS

The Gynaecology Outpatient service currently provides over 18 general and specialist clinics and has approximately 37,000 occasions of service annually. Between July 2002 and June 2003, a total of 7410 women had surgery at the RWH, with 6312 day surgery patients.

HOW DO WE MAKE SURE THE HOSPITAL PROVIDES GOOD GYNAECOLOGY SERVICES?

Comprehensive measures of the clinical quality of gynaecology care are not currently available, not only at RWH but also more broadly in other hospitals. A priority over the next two years is to develop such measures. RWH will work with Women's Hospitals Australasia (WHA) on this.

DO WOMEN NEED TO BE ADMITTED AFTER DAY SURGERY?

Of the patients admitted for a day stay procedure, just over 1% (n = 66) needed to be admitted unexpectedly into hospital for reasons such as vomiting, dizziness and pain. This is something we regularly monitor.

HOW DO WE MAKE SURE THAT WOMEN GET TIMELY SURGERY?

Making sure all operations are provided in a timely manner is essential. Through a standardised system, doctors assess surgery needs and how soon the operation needs to be done, and rate the level of urgency as urgent (category 1), semi-urgent (category 2) or less urgent (category 3). Women in Category 1 and 2 have their surgery performed within the times set by DHS. Category 3 women receive an operation date as soon as possible.

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

HOW WELL DOES RWH PERFORM ON WAITING TIMES?

RWH elective surgery performance 2001 – 2003	2001	2002	2003
Category 1 proportion of patients admitted within 30 days (%)	100	100	100
Category 2 proportion of patients admitted within 90 days (%)	100	100	100
Average waiting times (days) for category 2 patients on the waiting list as at June 30th	29.3	24.5	24.4
Average waiting time (days) for category 3 patients on the waiting list as at June 30th	136	114	75
Total Waiting List	680	396	452

Hospital Initiated Postponements (HIP)	2.85%	0.4%
Day of Surgery Admission Rate (DOSA)	State target = 85% RWH year to date = 94.6%	

The RWH continues to perform well in meeting women's needs for surgery, including women in category 3 where we have almost halved waiting times. We have improved our hospital-initiated postponements from almost 3% to less than 1%. The only area where we experienced an increase in waiting times was in the total waiting list, which is a measure of demand.

During May and June, we closed some theatres to upgrade the air-conditioning to meet minimum airflow standards for Operating Theatres.

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

WHAT DO PATIENTS THINK ABOUT THEIR DAY SURGERY?

Day surgery patients having minor surgery are given an opportunity to provide feedback about their experience at RWH. The most recent report covered September to December 2002, and patients made a number of recommendations. The unit has now implemented these. Examples include:

- Complaints about the waiting time from admission to the time of surgery.

  Patients are now asked to contact the RWH the night before their surgery to confirm their admission time, which are also now staggered to decrease waiting times.

- Inconsistencies were identified between medical certificates provided with advice given for recovery time for an anaesthetic.

  Medical certificates now cover the time period advised for recovery.

HOW SAFE IS GYNAECOLOGICAL SURGERY?

Complications are regularly reviewed by the hospital to identify preventable factors and ways to improve safety. In 2002/03 DHS sent data to hospitals, which indicated higher than expected rates of perforations (unexpected punctures of other organs or vessels) in laparoscopic (key hole) surgery. In the two year period from 1/7/00 to 30/6/02, the RWH had a rate of visceral perforations of between 1.3% and 1.5%.

We decided to review all 75 cases. The number of miscoded cases were nine, with no evidence of a relevant procedure or complication. The remaining 66 cases were reviewed, with the causal patterns difficult to establish. Findings were that:

- Most injuries were trivial, recognised at the time of surgery and immediately and simply repaired.
- There was no link with the level of experience of the surgeon.
- There was no link with whether it was elective or an emergency.
- Ten cases were found to be more serious and warranted closer review.

We are developing a more accurate and rigorous data system to assist our own internal audit and improvement. In three cases a different operative technique may have prevented the injury. The gynaecology staff are considering the evidence for a change in technique.

WHAT IS HAPPENING ABOUT IMPROVING OUTPATIENT ACCESS?

The 2001/02 Quality of Care Report indicated that we had issues about outpatient access. The Gynaecological Outpatients Service has established a project to address a number of issues including:

- managing an increasing service demand, improving patient flow and decreasing waiting times
- service delivery considerations including integration of nurse practitioners
- access and triage of patients
- the development of a clinical data base
- the development and implementation of clinical benchmarks.

This team plans to continue to meet and consider data and information collected by sources such as the Patient Satisfaction Monitor, a staff questionnaire and consumer advocates.

Imaane

A CARE PATHWAY IN THE PERINEAL CLINIC

An example of early intervention:

Imaane is a 29 year old woman who had a forceps delivery of her first baby. This resulted in significant tearing of her perineum involving the anal sphincter and required a surgical repair. While she was recovering, one of the postnatal midwives referred her to the Urogynaecology Pelvic Floor Service. A Continence Nurse visited Imaane, explained why the tear occurred during the delivery of her baby, and how she could look after herself to promote healing. A range of allied health services were also offered including the dietician to discuss the best ways of managing her diet to ensure uncomplicated bowel function, and the physiotherapist for ultra sound treatment and a pelvic floor muscle rehabilitation program.

On going home, Imaane was visited by the RWH domiciliary midwife who made sure the baby was well and also spoke with Imaane about her health and her pelvic floor function.

Three months after her baby was born, Imaane attended the Perineal Clinic. She was seen by a range of specialists including the urogynaecologist, continence nurse and the colorectal specialist. A range of tests were performed and indicated that her pelvic floor was healing well, and she received information about perineal management for future pregnancies.

An important area of women's gynaecological health is incontinence. The RWH provides continuity of care across a range of services, from prevention to clinical intervention for women throughout their lives.

PREVENTING AND MANAGING INCONTINENCE

In the section on maternity services, we reported on how we monitor third and fourth degree tears during labour. This is an important first measure.

Early intervention is seen as critical in preventing later gynaecological problems such as incontinence or prolapse. The 'Perineal Clinic' was established in 2003 and focuses on women who experience perineal problems as a result of childbearing. The RWH has partnered with GPs and maternal child health nurses to increase community awareness, and developed a clinical practice guideline, which is available on the internet to aid recognition, investigation and treatment of pelvic floor disorders.

Clinical audit is a valuable form of quality assurance, and a review of the care and outcomes of women sustaining anal sphincter tears will be conducted at the end of 2003. This process will consider data collected over the year and will review the use of the recently published RWH clinical practice guidelines.

See: www.rwh.org.au/rwhcpg/site.cfm/

THE UROGYNAECOLOGY PELVIC FLOOR SERVICE

The Urogynaecology Pelvic Floor Service commenced in January 2003 with a merger of previous services. This specialist service offers a multidisciplinary approach to female pelvic floor dysfunction. The team consists of urogynaecologists, gynaecologists, medical specialist trainees, a colorectal specialist, continence nurse/midwives, dieticians and specialist physiotherapists. The service currently has approximately 2500 outpatient clinic contacts per year and offers surgical and non-surgical forms of treatment. It is anticipated that this service will grow by 30-50% over the next five years.

Pelvic floor dysfunction affects women across their life span. Whilst early detection and treatment is important, studies have shown that many women do not voice their concerns regarding changes in pelvic floor function and do not seek assistance.

Statistics about pelvic floor dysfunction:

- 46% of Australian women have a form of pelvic floor disorder.
- One in three women over 65 years are affected by urinary incontinence.
- The current rate of surgery for pelvic organ prolapse in women over 50 years is 3.3 per 1000 women per year.
- The surgical success rate is 80 to 90%.

RESEARCH IN WOMEN'S HEALTH

Research projects have recently been commenced in the Urogynaecology Pelvic Floor Service (UPFS) that highlight the importance of non-surgical treatment options and the role of allied health services.

- The UPFS has recently commenced a research project in conjunction with Melbourne University Physiotherapy Department to investigate the effect of pelvic floor physiotherapy for stress incontinence in women over 70 years of age. This project will provide information about the value of pelvic floor muscle exercise training in older women. It will also give insights into group teaching as a means of improving program compliance in this age group, and the use of ultra sound technology in assessing muscle strength.
- Another method of treatment for bowel incontinence involves diet and dietary fibre, and research about to commence in the UPFS is considered particularly important as there is no current literature available to support this method.
- A research project is underway which investigates 'The Effect of Childbirth on Anal Muscles and Urinary Function in Women having their First Baby'. This project involves the recruitment of 400 participants and will take two to three years to complete. The aim of the research is to identify risk factors, particularly for incontinence as a result of nerve or muscle damage.

For links to other research being conducted at the RWH go to:
www.rwh.org.au/wellwomens/
www.rwh.org.au/pebp/pubs.cfm

Betty

UROGYNAECOLOGY PELVIC FLOOR SERVICE IS ABOUT WOMEN'S QUALITY OF LIFE

Betty is a 64 year old woman referred to the RWH Urogynaecology Pelvic Floor Service (UPFS) by her GP with symptoms of prolapse and bladder leakage. Betty had suffered with varying degrees of bladder incontinence since the birth of her first baby 40 years ago. Initial assessment by a consultant Gynaecologist revealed Betty's prolapse warranted surgery. She was referred to the physiotherapist for pelvic floor muscle training, the dietician to review eating habits and commence a weight reduction program. Surgery was successfully performed, and involved a three-day stay in hospital. Like other patients, Betty was invited to be involved in a clinical review at approximately 12-18 months.

The 2002 clinical audit of the Sacral Suture Hysteropexy operation showed that 80% of patients had a patient perception rating (VAS) of greater than 80 (an important outcome measure), and 90% of patients had no or minimal prolapse.

Our Women's Cancer Services

The RWH Women's Cancer Program ensures women diagnosed with breast and gynaecological malignancies receive the highest quality treatment services within a woman-centred model of care. The RWH is currently the largest single provider of inpatient gynaecology-oncology services in Victoria, and also plays an important role in screening and prevention.

CERVICAL SCREENING

Cervical cancer is one of the most preventable cancers and yet globally it is the second most common cancer of women. Cervical screening is considered an important tool in preventing cervical cancer through early diagnosis and treatment. Throughout the RWH women's services, all women are able to access 'pap smears' which are designed to detect precancerous changes of the cervix.

It is useful to make comparisons between the RWH cervical screening rates and other data collected by one of the largest pathology services, the Victorian Cytology Services (VCS) to determine the effectiveness of our testing. One measure is the 'endocervical component' which is one general measure of the effectiveness of the practitioner's skills and how good the pap smear is. Data from the WOMAN Clinic (now Women's Health Assessment Clinic) has been used for comparison.

COMMUNITY PRINCIPLE – Quality

Research

Cervical Cancer – where are we up to with a vaccine?

The RWH's Microbiology and Oncology Units recently held an international symposium on cervical cancer with a presentation on a vaccine for cervical cancer. This clinical trial is investigating a vaccine for the human papillomavirus (HPV) which has been shown to be strongly associated with the development of cervical cancer. This common viral infection is sexually transmitted, and as a result young women are particularly at risk. HPV vaccination has shown exciting results and has demonstrated no dysplasia developing in women who had been vaccinated. The trial is continuing.

COMMUNITY PRINCIPLE – Access

For many years, the RWH has been a major provider of health care to the women of Nauru. Recently, a nurse from the Oncology/Dysplasia Unit visited Nauru with the team of gynaecologists to teach local nurses skills in cervical screening, and to assist in a community awareness program.

Period from 1/7/02 to 31/12/02	RWH WOMAN Clinic	All VCS
All women aged <50 years number of smears with endocervical component	97.7%	83.8%
All women aged 50+ yrs number of smears with endocervical component	87.1%	74.4%

These results indicate that the RWH is performing above other VCS services in screening for the endocervical component in women accessing a nurse provided service.

CONTINUUM OF CARE IN SCREENING – IMPROVEMENTS IN PATIENT FOLLOW-UP

Recognising the importance of early intervention and treatment of cervical cancer, the RWH Dysplasia Clinic has recently conducted an audit to find out why women didn't attend their appointment.

Previously if a patient did not attend an appointment, the clinic would send a letter to notify them of their missed appointment and provide a new time. We know that many women who don't attend their RWH appointment follow-up with their GP or a private practitioner for assessment and treatment.

A new system has been implemented in the past six months that involves making phone contact with the patient, and if unsuccessful the patient's GP is notified of the appointment and a registered letter sent.

Jan – June 2002 – 1196 or 33% of total appointments did not attend.

Jan – June 2003 – 769 or 24% of total appointments did not attend.

These results indicate that the RWH concerted attempt to follow-up patients has significantly improved the rate of attendance.

SCREENING FOR BREAST CANCER

Another cancer screening service provided by the RWH is the Breastscreen Service. This service offers free mammography screening to asymptomatic women over 40 years of age with the aim to reduce the incidence of breast cancer. In 2002/2003 the target set was 4700 and 4755 women were screened.

HOW DO WE KNOW OUR SCREENING SERVICES ARE EFFECTIVE?

In 2003, Breastscreen demonstrated it was meeting defined service standards with the re-accreditation in the National Program for the Early Detection of Breast Cancer.

ONCOLOGY CARE

The RWH Oncology Unit is the largest specialist service for women with gynaecological cancers in Australia, and is a leader in clinical expertise, innovative medical approaches and clinical equipment as well as medical research that is recognised internationally.

Developments in service provision and care for patients has lead to multidisciplinary partnerships with other key health care providers of the RWH, Mercy Hospital for Women and Monash Medical Centre along with cancer service providers.

These services have worked together to address the health needs of women from rural and regional Victoria, and established 'Best Practice' clinics in outreach locations. The RWH is involved in community clinics in Geelong and Albury, and women travel to the hospital for surgery if needed.

SERVICE STATISTICS

A range of specialist surgical procedures are carried out in the Oncology Unit, and over the 12 month period of 2002/03 a total of 362 procedures were performed.

Every year in Australia around 1200 women are diagnosed with ovarian cancer and nearly 800 will die of the disease. About 75% of women diagnosed will be at an advanced stage, where the cancer has spread and is very difficult to treat successfully.

The reason for this is the symptoms for ovarian cancer are vague and non-specific including pelvic or abdominal pain or discomfort, abdominal bloating, weight gain/loss, tiredness and changes to urinary and bowel functions. These symptoms can easily be attributed to other causes, and therefore go untreated.

Of the women diagnosed in the advanced stages of ovarian cancer, 75% will die within five years of diagnosis. The main reason for the low survival figures is due to the late presentation of disease. When ovarian cancer is diagnosed at an early stage, which unfortunately only amounts to 25% of diagnoses, the outlook is very good with 90% of patients cured.

For more information go to:
www.ovcare.org
www.gcrc.cc

HOW DO WE MAKE SURE THE HOSPITAL PROVIDES GOOD ONCOLOGY CARE?

The Gynaecology Oncology Service approaches quality through evidence-based treatment, multidisciplinary teamwork, benchmarking of outcomes and internal morbidity audits. Like all RWH services, oncology services regularly audit and review their processes, and also compare their clinical results against international rates. Every two years the International Federation of Gynaecological and Obstetrics (FIGO) collate oncology data, including survival rates in cancer of the ovary and cervix.

The most recent data available was for RWH patients treated in the years 1993-1995. This data was published in the 24th Volume of the FIGO Annual Report. More recent data for patients diagnosed and treated in 1996-1998 will be available in time for the next Quality of Care Report.

IMPROVING ONCOLOGY SERVICES

The application of information technology advances to data management is crucial in a hospital environment to ensure optimal patient management and clinical audit. The RWH Oncology Unit has recently undertaken the lengthy process of replacing the former method of collecting information with an updated data system tailored specifically to meet the unique needs of oncology patients.

Benefits have included:

- Enhanced patient management in a multidisciplinary team, including follow-up of patients who fail to attend, correspondence with referring practitioners and accurate monitoring of waiting lists.
- Measurement of treatment success and outcomes with accurate statistical evidence available to justify interventions.
- Collation of trends and patterns of cancer survival by stage at diagnosis.
- Enablment of benchmarking of performance by comparing clinical research results.

RESEARCH IN CANCER SERVICES

The care of women with gynaecological cancers is a specialty area for the Women's. The growth in this specialised area of medicine highlights the need for a focused research effort. While we can now say that 75% of women diagnosed with breast cancer will survive, there has been less research and less success in the area of gynaecological cancers. The Gynaecological Research Centre has been established at the RWH in the last 18 months to develop a strong academic, scientific and clinical base for our cancer services. The centre is involved in a number of studies aimed at early detection of ovarian cancer, with this research influencing clinical practice and screening guidelines. Clinical markers for patients considered 'high risk' are also being developed.

The RWH is also involved in an international study carried out by the Gynaecologic Oncology Group (GOG), which is looking at different chemotherapy combinations to improve longer-term outcomes for patients with ovarian cancer. Approximately 60 RWH patients will contribute to the research, which will involve about 4000 participants from around the world.

The cancer services are currently undertaking 27 separate research projects.

For more information go to:
www.rwh.org.au/surg-services

Quality and safety priorities for 2003/2004

CLINICAL RISK MANAGEMENT PRIORITIES

- Creating a 'no-blame culture' so that staff are confident to report and analyse incidents openly.
- Development of a clinical risk profile.
- Implementing the recommendations of the Douglas Inquiry. This review of a major maternity hospital in Western Australia resulted from serious clinical performance concerns, and provides an opportunity for the RWH to compare its services against issues identified. One area to be considered by RWH is the supervision of and support for junior doctors.
- Encouraging a higher level of incident reporting, in particular to encourage doctors to use this form of reporting.
- Developing root cause analysis and open disclosure skills across the hospital.

STAFFING PRIORITIES

- Formal adoption by the Board of WCH, policy on credentialling of medical staff.

PRIORITIES FOR MATERNITY SERVICES

- Evaluate and refine the implementation of TeamCare.
- Continue to improve women's relationships with their care providers at RWH.
- Incorporate ongoing review of in performance indicators as part of regular operational plans.
- Continue to strengthen the safety of delivery suite care.
- Review Vaginal Birth After Caesarean (VBAC) data and rates.

PRIORITIES FOR NEONATAL SERVICE

- Replacement of monitoring system in NICU to bring to the bedside patient care protocols, drug dosages and modes of administration, pathology and imaging results to improve care and reduce risks by having information more accessible.
- Reduction of infection rates through better and easier hand washing practices.
- Development of a departmental Q & S Committee, including better reporting and resolution of incidents, adverse outcomes and sentinel events.
- Availability of the clinicians' handbook on the web so that it is readily accessible to all clinicians in the Health Service.

PRIORITIES FOR WOMEN'S SERVICES

- Implemention of the recommendations of the gynaecological services review.
- Development of a comprehensive assessment centre for pelvic floor and urogynaecological care.
- Improvement of waiting times for outpatient appointments
- Development of clinical indicators and clinical data-base.
- Consumer evaluation of services offered by the Centre Against Sexual Assault (CASA), Pastoral Care and Family Accommodation.

PRIORITIES FOR WOMEN'S CANCER SERVICES

- Finalisation of clinical data base for all cancers.
- Institution of ongoing morbidity audit of all cases, public and private.
- Utilisation of dysplasia data base to ensure optimal follow-up of women who have undergone treatment for pre-cancerous changes of the cervix and vagina.

Acknowledgements

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Quality of Care Report Reference Group

Consumer Advisory Committee on Women's Health

Executive Director, RWH

RWH Quality and Safety Committee

Quality and Safety sub-committee, Women's & Children's Health Board

WCH Educational Resource Centre

The RWH Quality and Safety Unit and Manager, Mary Draper

Project Coordinator Vivienne Raymant

We would also like to thank the patients and staff who agreed to be photographed for this report.

Feedback form

RWH Quality of Care Report

Please tick applicable category

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

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

How would you rate this report overall?

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

How could the report be more meaningful to you?

Once completed, please return this form to:

Quality and Safety Unit
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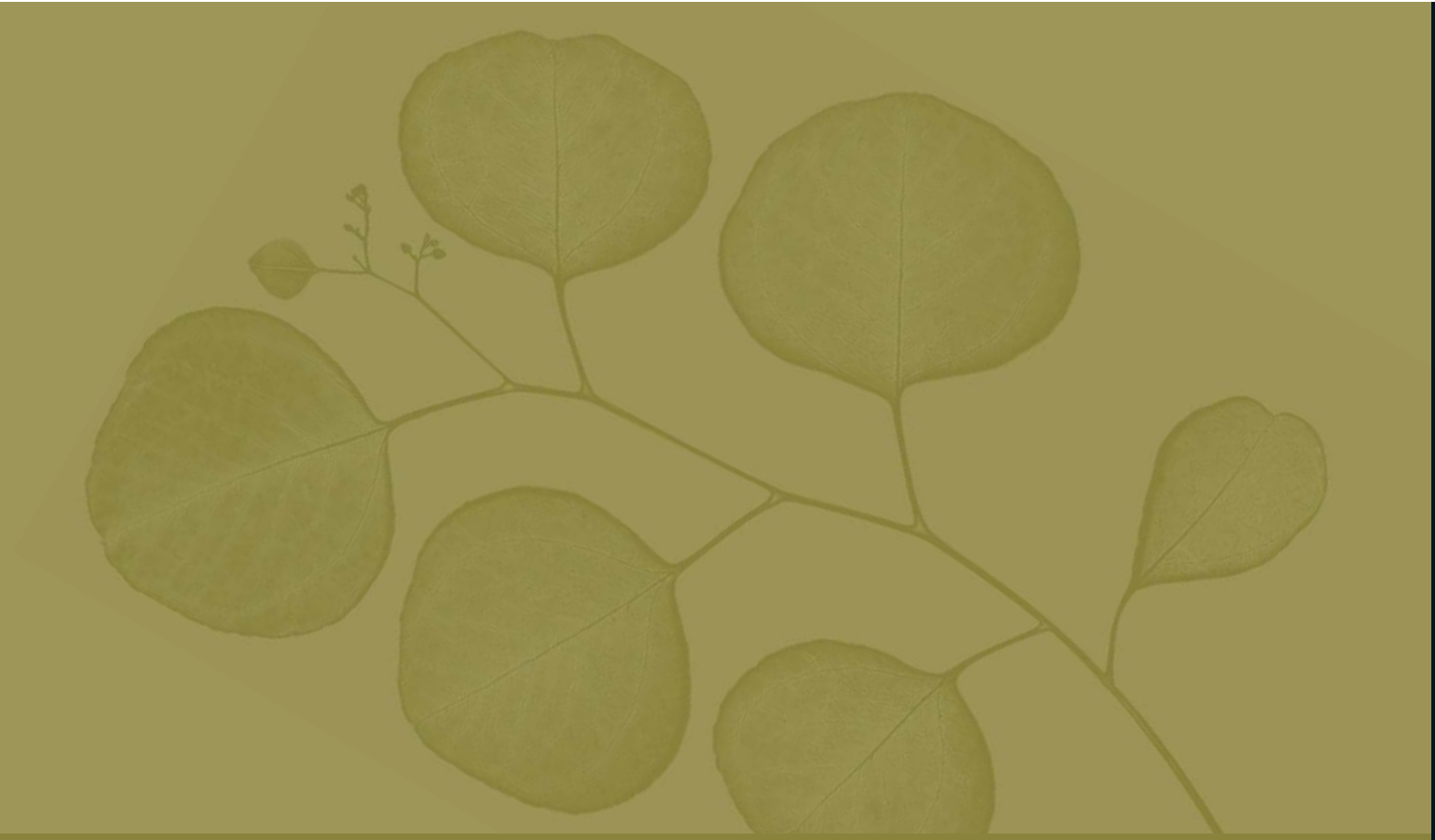
www.rwh.org.au/qualityreport_rwh



Design Educational Resource Centre, Women's & Children's Health 032018

THE ROYAL WOMEN'S HOSPITAL