QUALITY OF CARE REPORT **2006**

the women's
the royal women's hospital

"Finding that I was pregnant was one of the biggest shocks of my life.... Becoming a mother, and now a midwife myself, gives me a different perspective and greater understanding of what women are going through."

Midwife Zeinab with Judy and Harry.
To read Zeinab's story, turn to page 21.

Dale Fisher, Chief Executive

We are pleased to present the Women's Annual Quality of Care Report. This report is our accountability back to the community.

It is our responsibility to make sure that we have the right people and systems in place to monitor and improve the quality of care for women, babies and families. Led by the hospital Board and the Executive, we ensure that all hospital staff are aware of their responsibility for the quality and safety of our care.

In this exciting and challenging year, our number of births has continued to grow and we looked after more premature babies. Some women on waiting lists for gynaecology surgery at other hospitals took up the option to have their surgery earlier at the Women's. Our staff worked safely and effectively throughout.

We value our role as advocates for women's health, recognising how the circumstances of women's lives affect their health.

There will always be areas that we have to improve. This report helps us to identify these.

Rhonda Galbally, AO
Chair, the Royal Women's Hospital

Dale Fisher
Chief Executive, the Royal Women's Hospital

Contents

What do we mean by quality and why does it matter?

This report provides an account of quality of care at the Royal Women's Hospital (the Women's). It describes what the hospital has done in the last 12 months to improve women's health.

What do we mean by quality of care?

Good quality care is:

- **Safe** *Quality care avoids harm to patients when delivering their care.*
- **Effective** *Quality care occurs when our services are based on evidence from research and good science and are the right types of service for the patient.*
- **Patient centred** *Quality care is when hospital staff respect and respond to individual patients, to their needs and values, and involve them in decisions about their care.*
- **Timely** *Quality care reduces waits and harmful delays.*
- **Efficient** *Quality care avoids waste, including equipment, supplies, ideas, people and energy.*
- **Equitable** *Quality care does not vary because of a person's gender, ethnicity, where they live, or their financial circumstances.*

Quality of care

Quality of care is about having structures in place to make sure the hospital:

- is clean, hospitable and safe
- provides the right services to our community
- has skilled and competent staff.

Quality of care is about the processes in the hospital:

- how well your outpatient appointment went
- how long you had to wait, how easy your admission to hospital was
- knowing about what is going to happen to you next
- staff working well together
- how staff respond in an emergency.

Quality of care is about outcomes:

- healthy mother and baby
- surgery makes you better
- minimising complications from treatment
- being able to deal better with a chronic condition, or
- feeling supported through grief.

Both consumers and clinicians agree on some things that are important for quality of care and some things that are different. While clinicians focus particularly on the results of clinical care, consumers are also interested in access, timeliness, responsiveness and communication.

What do women think?

During the year, the Health Issues Centre, a consumer organisation, interviewed women about what they expected from care during pregnancy and childbirth at the Women's.

Women wanted and expected:

- to receive appropriate and timely use of health interventions, and essential care based on their own and their baby's needs
- to have their diagnosis, treatment and procedures explained to them
- to be treated with respect and empathy
- to be given opportunities to offer their opinions
- to receive personalised care
- to have confidence and belief in the care providers
- staff to be polite and available
- to be given information and education
- involvement of family and friends during labour, birth and post birth
- to be given reassurance and support.

In this report, we focus on our quality of care, how we work to improve our partnerships with women and their families, and how we improve the outcomes of our services. We see the report as a dialogue between the hospital and the community. It includes what both clinicians and consumers think is important. The structure and format of the report is based on feedback from consumers.

Research shows that measuring and reporting publicly on quality of care improves the quality of care. We see this as a journey in which we are constantly looking to find out what is not working well and how we can improve.

This report is produced by the Clinical Governance Unit. It is a collaborative effort between the Community Advisory Committee on Women's Health and the Women's Quality and Safety Committee, as well as many clinicians and staff across the hospital.

What can women do to improve quality and safety of care?

The best way to contribute to the quality and safety of your care is to be an active partner in your care.

Be informed Find out what you can about your pregnancy and giving birth, about your condition, what your treatment options are, what your test results are and what your treatment involves. Know what medications you are taking and what they do.

Speak up Ask questions. Write your questions down before you come to hospital. Tell us about all your symptoms and history. Bring a friend if that helps. Ask if you don't understand. Ask for an interpreter even if you speak some English, but don't understand what the doctor, midwife or nurse is saying. If you have concerns, speak to the midwife or nurse in charge. If you still have concerns, speak to the Consumer Advocate.

Be involved in decisions about your care with your doctor, midwife, nurse or other health professional.

Use this report to be informed
We expect that women using hospitals will want to be active participants and decision-makers in their own health care. This report provides women and the public with information so they are informed about our services, our clinical performance and the processes that we have in place to improve our quality and safety of care.

What does the community want from the hospital?

A consultation with over 1000 women identified these principles,

- community values. Women want a women's health service and cultural and religious respect from staff
- quality of staff, technology, teaching, training and research
- timely access to services as well as technology, expertise and research
- a balance in service options between critical care and community care, general and specialist services, and obstetrics and gynaecology
- family-friendly patient care which responds to the needs of the whole patient and protects privacy and dignity.

These community principles are integrated throughout this report.

Accreditation

The Women's is fully accredited with the Australian Council for Healthcare Standards (ACHS). In late 2005, the Women's underwent a periodic accreditation review against 19 mandatory standards. We passed this, with commendations for infection control, our clinical care planning, and policies and procedures.

Our community – characterised by diversity

In this chapter you can read about:

- Why understanding our community is important to providing good quality care
- Services we provided last year
- The age range of women, where they live and where they were born
- The use of interpreter services
- Information about our staff, flexible working arrangements, and staff retention
- Being an overseas trained doctor
- The oral history project with the stolen generation
- Providing interpreters for pregnant women
- Winnie Lee, a Mandarin and Cantonese interpreter
- Pregnancy and birthing services for women with intellectual disabilities
- The new Centre for Women's Mental Health

Our community

A diverse range of women use our hospital. Demographic information about where women live, the language they speak and their country of birth helps to influence the way we deliver our services, so that they meet women's needs.

Service information

The following pie chart gives a snapshot of the health care we provided in the last year. The break down of inpatient and outpatient services reflects the changes over the last 30 years in how hospitals organise health care. For example, as a result of advances in technology, especially in anaesthetics and endoscopy, most gynaecological procedures can now be done as day surgery. Service options like pregnancy day care and family accommodation means we can see pregnant women two or three times a week without needing to admit them as patients.

Figure 1. Episodes of care in 2005-06

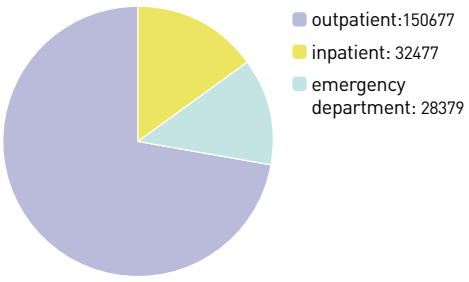
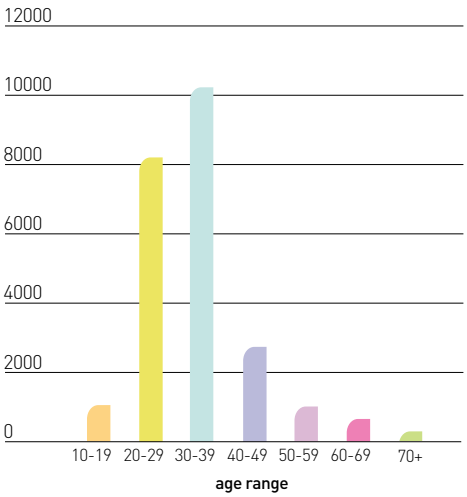
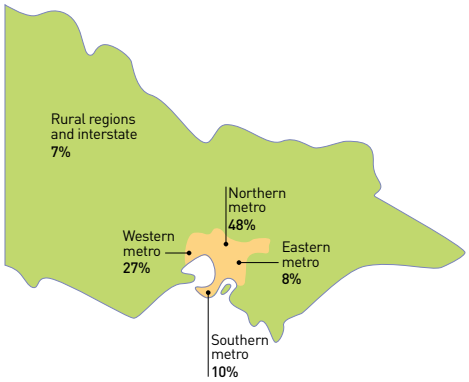


Figure 2. Age range of inpatients



The age range of women

Figure 2 gives a picture of the age range of women. In addition to having a baby, women were admitted for conditions and complications related to pregnancy and postnatal care, for reproductive services, gynaecological related procedures, cancer surgery and other cancer related treatments, general surgery and urological related procedures.



Where women live

The hospital provides health care for women and babies from northwest Melbourne, as well state-wide specialist services. This map shows the percentage of women using inpatient services in the last year according to the region that they come from. It clearly shows that our largest community lives in northern and western Melbourne.

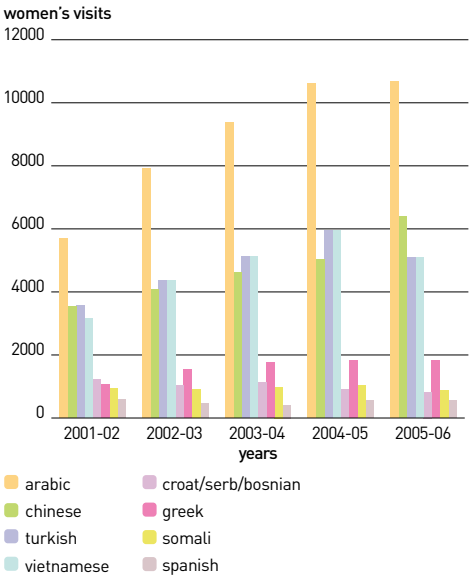
Where women were born

Most of the women using the hospital were born in Australia, but a significant number were born in Asia or the Middle East. The main non-English speaking countries where women were born are: Vietnam, Lebanon, China, Turkey, India, Iraq and Somalia.

The languages women speak

Being able to communicate with staff is essential to access to services and women making decisions about their health care. Figure 3 shows services provided by staff interpreters in the eight main languages spoken by women in our community. For less commonly requested languages, we book external interpreters or use telephone interpreter services. In 2005–06, we provided interpreter services in 60 different languages, including Auslan interpreters for women with a hearing impairment.

Figure 3. Language services provided by staff interpreters



Our community

Our staff

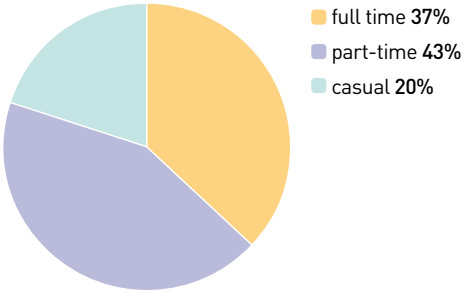
We currently have a workforce of about 1990 people. This includes nearly 700 full time or part time nurses and midwives, and about 350 doctors. Most doctors work on a 'sessional' or part-time basis, bringing specialist skills into clinics, delivery suite, theatres and on the wards. In the coming year, we are setting up a Medical Workforce Unit to provide support to this diverse medical workforce and strengthen our processes for making sure that all doctors are appropriately qualified and skilled.

The table below gives a snapshot of our staff profile as of 30 June 2006.

Flexible working conditions

Figure 4 gives a snapshot of the percentage of people who work full time, part-time or casual. The high percentage of part time staff creates particular challenges for our capacity to provide continuity of care for women. On the other hand, offering staff flexible working hours is an important part of our retention policy.

Figure 4. Percentage of full time, part-time and casual staff



Recruitment and retention

The aging workforce is a global trend, and we are working hard to be a preferred employer amongst new graduates. We recently introduced clinical nurse and midwifery facilitators on the wards, who provide advice and support to graduates and casual nursing staff who may be unfamiliar with hospital practices. They also provide skill development for nurses and midwives. In 2005 we retained 90% of our nursing and midwifery graduates.

Reconciliation with the Aboriginal community

In 2005-06, we cared for around 180 women who identified as Aboriginal and Torres Strait Islander.

The Women's has a mixed history for Indigenous women. It is a site of hope through birth, and support and care for women. However, like many other institutions, it participated in the removal of Indigenous babies from their families and communities. In recent years we have been working with local Aboriginal communities to acknowledge this history.

The Women's made a significant step towards Reconciliation in 1997 by establishing the Aboriginal Women's Health Business Unit.

The Unit provides cultural advocacy and support to Aboriginal and Torres Strait Islander women and their families, as well as education and training for staff.

The Oral History Project will document Indigenous women's stories and experiences of the Stolen Generation and the Royal Women's Hospital. A consultant worked with us on 'Getting the Recipe Right' to develop a process that will ensure that Indigenous women's stories and experiences are told in a respectful, dignified and supportive way.

Interpreters for pregnant women

One of the state-wide performance indicators for maternity services is the proportion of women assessed as needing interpreter services who then received them. Figure 5 shows a steady improvement and room to improve further. In the next year, we will introduce this performance indicator for gynaecology and cancer services.

fellow: a doctor who has completed or nearly completed specialist training

Table 1. Staff profile

	full time	part time	casual	total
midwives	38	106	~100	144*
health professionals	72	86	40	198
doctors	128	219	15	362
support services	250	150	75	475
nurses	252	289	~100	541*
	740	850	~400	1990

*excludes casual staff

Jayshree's story

I am in my last year of training to be a specialist obstetrician and gynaecologist. I received my medical degree and postgraduate degree in Obstetrics and Gynaecology from the University of Mumbai, in India. I then worked for three years as a lecturer at the University of Mumbai, teaching undergraduate and postgraduate medical students. Here at the Women's, I work as senior registrar in obstetrics and gynaecology and I am also a Fellow in the Quality and Safety Unit.

My training in Mumbai was very intensive; the hospital that I trained at delivers approximately 10,000 babies a year. This gave me exposure to a broad range of complicated medical conditions in pregnant women, like heart disease, HIV, tuberculosis. The large numbers of women we treated and poor access to diagnostic tests demanded clinically astute medical judgements from me and my colleagues.

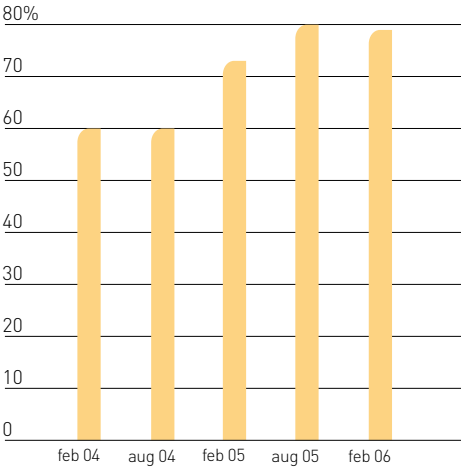
I have spent the last eight years working in Australian and New Zealand maternity hospitals. While what women want, and the way medicine cares for women, is the same just about everywhere, the difference in a hospital like the Women's is more resources and time. This means that I don't just treat the pathology; my practice takes a more holistic approach. I can talk to women about their family and social circumstances as well as their medical condition and then offer them more comprehensive care.

It always amazes me to see the cultural diversity at the Women's both in the staff who work here and the women we look after. That's why I love to work here.

Dr Jayshree Ramkrishna

Our community

Figure 5. Proportion of pregnant women who needed and received interpreter services



Supporting mothers with disabilities

The Women's Individual Needs (WIN) Team cares predominantly for pregnant women with an intellectual disability or learning difficulty, and occasionally for women with a profound physical disability requiring parenting support.

Women with disabilities are at higher risk of complications and low birth weight babies, reflecting the complex social and medical issues for women with disabilities. This includes women's vulnerability to sexual assault, difficulties understanding and negotiating the health system, their comprehension of the processes of pregnancy, labour and birth and their ability to get support with parenting.

The WIN clinic provides:

- early assessment of women's needs
- longer appointment times for antenatal care
- support with housing, income, and social connections
- childbirth and parenting education and resources
- support at home after the birth.

Centre for Women's Mental Health

Social factors such as poverty, social isolation and experiences of war are linked with mental health problems and affect many women who use our services. We have been funded by the Pratt Foundation and the Victorian government to develop a Centre for Women's Mental Health. The Centre will:

- Provide a range of mental health services.
- Undertake research into the effectiveness of treatment and how gender affects mental health.
- Raise awareness about women's mental health needs.

Winnie's story

Winnie Lee has been interpreting at the Women's for Cantonese speaking women from Guangdong Province in Southern China and Vietnam, and Mandarin speakers from China, Taiwan, Malaysia and East Timor for nearly ten years. Winnie is one of 11 professional, accredited staff interpreters who 'only interpret what is said, no additions, no deletions'. Every day the interpreters work with migrants and refugee women using the hospital, supporting them to make informed choices, to understand their medical condition and how to get the most out of the hospital's services.

Interpreters provide a familiar face to help patients navigate the hospital and lend a hand with making appointments. With specialist understanding of the needs of different groups in the community, interpreters can point women as well as new staff to support services like the hospital's childcare centre, social workers, the Women's Health Information Centre and health information fact sheets in different languages.

Winnie Lee
Mandarin and Cantonese interpreter

Women's voices

In this chapter you can read about:

- Performance indicators for community participation
- What our members say about the community advisory committee
- Complaints and feedback
- What happens when you make a complaint
- How we used complaints to improve ultrasound services
- How we used a complaint to improve communication
- Young women helping us to develop a new web site
- Women's input into the design of the new hospital

Women's voices

Community participation

In 2006, the Department of Human Services (DHS) launched its policy on community participation, which included new performance indicators for health services.

Table 2. Performance Indicators for Health Services

Indicator	Target or achievement
Meets ACHS EquIP standard 'the governing body is committed to consumer participation' to the level of Moderate Achievement.	We achieved this in September 2005 as part of accreditation
There are consumers, carers or community members on key committees.	Board Quality Committee, Medication Safety Committee, Clinical Ethics Committee
A Community Advisory Committee has been established in accordance with the Health Services Act 1988.	Achieved
The Quality of Care Report outlines quality and safety performance and systems that address the health care needs of the service's communities, consumer and carer populations.	Achieved
There is a Community Participation Plan, reported against annually to the DHS.	The new plan is being developed and will be completed in December 2006
Consumer participation in decision making about care and treatment as assessed on the VPSM Consumer Participation sub-index.	We expect this result in November
Information is available to enable consumers and carers to share in decision making about their care.	Information about treatment and care options meets the standards set in *Well Written Health Information: A Guide*

Community Advisory Committee

The Community Advisory Committee (CAC) advises the Board of the Women's on ways to involve consumers and get consumer feedback on all aspects of planning and service delivery. We asked CAC members to tell us about the CAC and what it does.

• Why did you join the Community Advisory Committee?

This is my way of giving back to the Women's as well as being a voice for my community.

• What's involved in being a member?

You can be as involved as little or as much as you want to be. Monthly meetings go for two hours, which involve some pre-reading, and provide the opportunity to have input to hospital policy and interact with key staff.

There is also the opportunity to read reports with a critical eye, or attend forums to ensure the community voice is heard.

• Why is it important to have a CAC?

The CAC is important if the hospital wants to stay in tune with community needs. As consumers, we bring a particular perspective, which informs the hospital, and ensure that the diverse needs of the community are met.

• What do you talk about at meetings?

We discuss issues that are currently affecting the Women's, like the new hospital being built. We discuss areas in the hospital like the maternity unit that is being redesigned to better accommodate the women who use it. As most of the CAC members are people from the general public e.g. stay at home mums, working women and women from different age groups; we can contribute to the discussion on many different levels. There is also feedback from the Chief Executive, or her representative – and an opportunity to respond.

• Why is it important?

I know one day my daughter and thousands of other women will use this hospital and I want to make sure they are cared for in the best possible way and one of the ways I can do that is by being a CAC member.

Women's voices

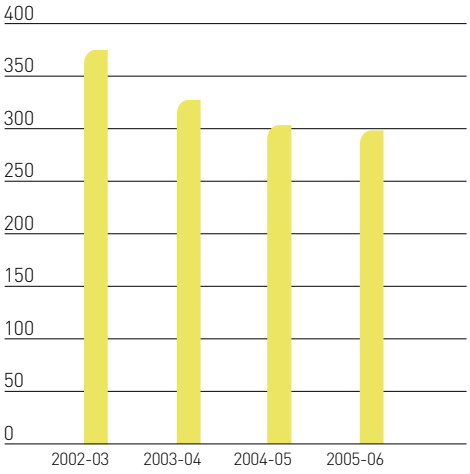
Using feedback to improve our services

We expect staff to respond to questions and problems that women might experience during their care. All complaints and feedback are welcomed as an opportunity to better understand women's experiences and improve our services. The Consumer Advocate steps in when problems are more complex. Staff can refer women to the Consumer Advocates, or women contact them directly, usually in person or by phone. We regularly analyse our complaints, in order to identify common themes and recurring issues.

Complaints data

There were 298 complaints from July 2005 to June 2006.

Figure 6. Complaints to the Consumer Advocate Office 2002 to 2006.



It is encouraging that complaints have declined, especially when more women are coming to the hospital. This may be because we have fixed some of the problems women have complained about and that staff are better at responding to complaints, which means that only more complex complaints come to the Consumer Advocate's office.

Some women feel the opportunity to tell their story – to be heard and have their experience validated – is a very positive, but somewhat unexpected part of the process.

It is our hope that at the end of the process, even though we cannot change the experience of the woman, she will at least have felt heard and acknowledged and confident that she has been taken seriously, and that, where necessary, steps have been taken to ensure that a similar incident is less likely to occur in the future.

If the woman making a complaint remains dissatisfied, she is encouraged to contact the Office of the Health Services Commissioner. This is an independent, impartial statutory authority designed to assist consumers in their dealings with all health service providers. Contact telephone: 8601 5200.

Using complaints to improve services

In November 2005, we reviewed our Ultrasound Services in order to improve them. There had been a number of complaints, with 11% of complaints for 2005 relating to Ultrasound Services.

As part of the review we interviewed women, who reported problems with:

- the referral process between departments in the hospital
- the provision of interpreter services and health information in women's first languages
- lack of flexibility with appointment days and times, and
- inconsistent processes for informing women about how to cancel and reschedule appointments.

This information was included in a comprehensive analysis of the service. The review recommended major changes: new booking processes, rearranging the location of machines, introducing more staff credentialing and buying new machines.

Using complaints to improve services

Recently, a woman whose baby was born with Down's Syndrome wrote a heartfelt six page letter about her experiences at the hospital. She was particularly critical about the way she and her family were told about her baby's diagnosis. She also criticised our limited interaction with Down's Syndrome Association, which provides support to families, and our lack of follow–up with her.

A mediation meeting was set up with the medical staff who acknowledged that communication with the couple had not been satisfactory. Most importantly, the meeting highlighted processes that needed to be introduced to ensure better communication with families in these circumstances. As a result, we drafted a management plan for babies born with Down's Syndrome and established a formal relationship with the Down Syndrome Association.

Victorian Patient Satisfaction Monitor

The Women's takes part in the Victorian Patient Satisfaction Monitor and uses the information as in Figure 7, on page 14, to identify how we need to improve services. Our satisfaction rating for 2005 was 94 percent, around the middle for our group of hospitals.

consumer advocate: staff offering support to patients who have a complaint

ultrasound: a type of imaging technique that uses high frequency sound waves

What happens when you make a complaint?

A woman walks rather hesitantly into the office.

"I'm not sure if I should be here...I don't know if you can help...It's not really such a big deal..."

Deciding to talk with someone when things aren't going quite as they should can be a difficult decision. However, feedback and complaints give us the opportunity to know when something is not working, and most importantly, to do something about it.

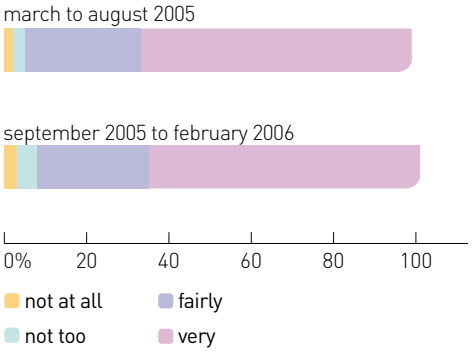
The manner in which a complaint is investigated is always discussed with the complainant. Usually, we start by looking at the woman's medical record (with their permission) in order to establish what happened, who was involved and to understand the whole picture. We then start talking with staff to clarify what happened, why it happened, and what steps need to be taken in order to reduce the likelihood of the incident reoccurring.

A satisfactory outcome might include:

- *The consumer advocate reporting back to the patient about these discussions and the actions resulting*
- *Letters of explanation and/or apology*
- *Further appointments to clarify and explain processes and procedures, or*
- *Meetings with the woman, her support people and the health professionals who have been involved.*

Women's voices

Figure 7. Thinking about all aspects of your hospital stay, how satisfied were you?



Talking to young women about the website

As part of updating our website, we gathered a group of young women to tell us about how they use, and what they want, from our website.

The focus group provided us with clear advice about:

- the information that these women want to find on our website
- the language they use about health issues and our services, and
- suggestions for making the website easier and more attractive to use.

The comments and feedback have been integrated into the format for the web design and content, as well as informing decisions about signage in the new hospital.

You can see from our new website front page how we used this feedback:

The key advice was to use plain English terms like pregnancy and childbirth instead of maternity and obstetrics.

There will be links to health information in languages other than English on the front page of the new website, to assist communication with our culturally and linguistically diverse communities. See www.thewomens.org.au

The Women's moves to a new site

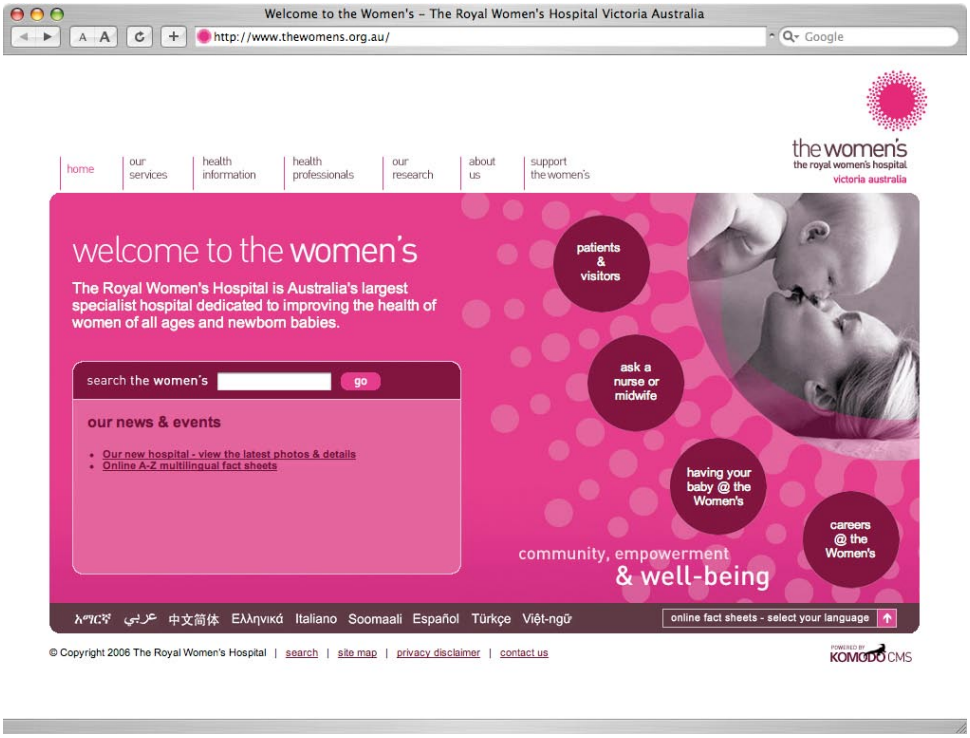
In 2008, the Women's will move to a new building next to the Royal Melbourne Hospital. The design of the new hospital is based on principles that came out of community consultations in 2001, including:

- a welcoming reassuring atmosphere
- family friendly patient and visitor facilities
- respect for privacy, religious and cultural needs.

In December, we tested the interior designer's interpretation of these principles with three groups of women, including a group of Arabic speaking women. Victorian Arabic Social Services recruited women, aged from 19 to 63, from Iraq, Egypt, Syria, Lebanon and Kuwait. The feedback from women was overwhelmingly positive: people agreed that the colours were warm, soothing, calming and welcoming, that the colour coding for directions was great, that the design was classic, modern and tasteful and that the overall effect was very family friendly in the neonatal unit, homelike in the patient's bedrooms (see artist's impression below) and like a hotel in the reception areas.

One person said, "No one likes to go to hospital and the design conveys the sense that you will be fine here, we will take care of you, you will be safe".

You can watch the hospital being built from the webcam: www.rwhp.com.au



Having a baby at the Women's

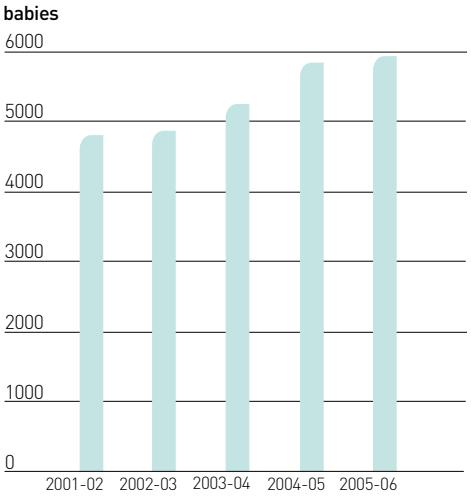
In this chapter you can read about:

- How many babies were born at the Women's this year
- What women want in pregnancy care
- Anna and Paul's story
- Effectiveness of care
  - Normal vaginal birth rates
  - Caesarean section rates
- Safety of care
  - Injury in childbirth
  - Post partum haemorrhage
- When and why a baby dies
- Waiting times in antenatal clinic
- Improvements in discharge planning
- Breast feeding re-accreditation
- Research relating to pregnancy
- Zeinab's story

Having a baby at the Women's

The number of babies born at the Women's continues to increase each year. In the financial year 2005/06, 5910 babies were born here. Our clinicians have worked safely and effectively through this extra challenge. This has, however, had an impact on waiting times for the pregnancy booking clinic and ultrasound appointments.

Figure 8. Number of babies born at the Women's



clinical practice guidelines (CPG): evidence based guide to help clinicians provide the best possible care

Partnership with women

Women centred care

In 2005, the Health Issues Centre interviewed women and midwives about 'women centred care' at the Women's. The research found that women's direct experiences of care were more important to them than how we organised care. Women's satisfaction with care did not appear to rely on an ongoing relationship with a single midwife, but had more to do with a consistent approach from the team of midwives and communication about their needs and preferences.

Our challenge is to sustain teams of health professionals who work well together to support women throughout pregnancy and birth, respecting their views about giving birth, and seeing the women through pregnancy and birth whether it is simple or complicated. We call this TeamCare. We have recently reviewed how well TeamCare is working and will make changes in the next year to improve 'women centred care'.

Being informed

After her first appointment Leila was handed a thick envelope stuffed with 16 brochures and three photocopied fact sheets, two booklets and a card that invited her to collect another bag of information from the kiosk. Research and feedback from women tell us this does not work well as a way of informing women.

We developed *Having your baby at the Royal Women's Hospital* to improve communication between women, doctors and midwives and improve consistency of advice. This was published in mid 2005 and recently evaluated. Overall, we found information playing a stronger role in the care of women.

Most women said:

- They received the booklet at their first visit and mostly from midwives.
- It was discussed at each of their visits.
- The layout and text was clear.
- They liked the images of 'real' women.

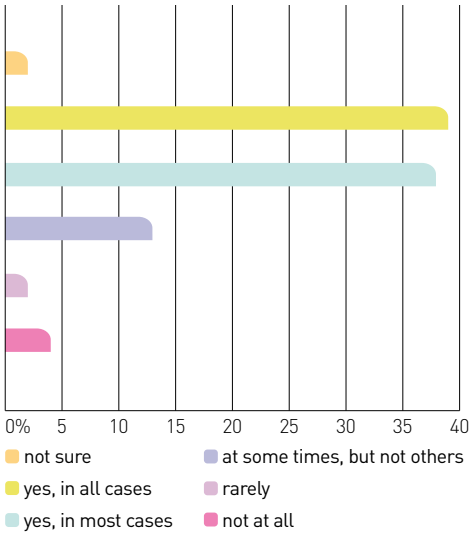
They made good suggestions to improve the next version. We learnt that information is only successful if it is developed with women and staff and they are encouraged to review the information together.

We aim to translate the information in a relevant and sustainable format. The text has been translated into Arabic. We held focus groups with 40 Arabic speaking women to ensure that it is meaningful to their community.

Partnership in decision making

The Victorian Patient Satisfaction Monitor now includes special questions for women giving birth. Figure 9 shows what women said about the Women's. We will monitor this measure as we make changes in our maternity services.

Figure 9. Active say in decisions



Anna and Paul's story

In the midst of our excitement at discovering I was pregnant, we quickly and easily made the decision to have our baby at the family birth centre. Its model of care was closely aligned with our values concerning childbirth and from our first visit we were impressed by the warm, professional and family-oriented environment. My antenatal care was so thorough that I felt well-prepared to give birth.

"I think I need some help," I said wearily after some 24 hours since my first contraction. My baby seemed to be stuck. Our midwife was very supportive and called in the doctor when the time was right.

We had not anticipated admission to a different ward but we had a birth centre midwife with us throughout, which enabled us to feel supported physically and philosophically. I can recall her reading our birth plan and that all our wishes were respected. My confidence in my body's ability to deliver our baby successfully was nurtured throughout my pregnancy and labour.

"It's a boy! He's beautiful." My husband, who had been so staunch and diligent throughout my labour, spoke these words with such tenderness. Our baby was on my chest and looking up into the besotted faces of his parents. It was the end of a happy pregnancy and the beginning of an overwhelmingly joyous and fulfilling relationship. We moved back to the birth centre shortly after delivery, with an immense feeling of achievement and an unimaginably perfect reward.

Having a baby at the Women's

How appropriate is our care?

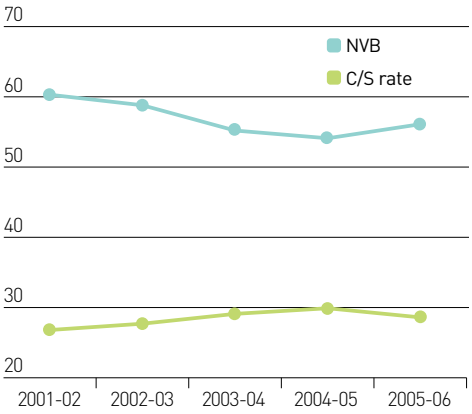
Normal vaginal birth and caesarean section

Our new Clinical Practice Guideline (CPG) for normal labour and birth, which provides guidance for doctors and midwives, was introduced in August 2005 to support clinicians in caring for women with low risk pregnancies during labour and birth. The aim is to reduce unnecessary intervention and improve the normal vaginal birth rate.

Figure 10 shows a modest improvement in the normal vaginal birth rate. The CPG has given clinical staff a clearer, shared view of their roles and responsibilities in caring for women in normal labour. Midwives' satisfaction has increased and documentation improved significantly.

The percentage of women having a baby by caesarean section has been increasing Australia-wide. There are risks associated with caesarean section – both for the mother and the baby, and over the longer term. We have worked hard over the last 12 months to determine when caesarean sections are appropriate. Figure 10 shows we have reduced our caesarean section rate.

Figure 10. Rates of normal vaginal and caesarean births



This data is from the Robin database (our maternity database)

Changing the rate

As a tertiary hospital, we often assume that our complex patient mix contributes to higher caesarean section rates. However, closer examination shows something different. The 'Robson Framework' allows us to divide the women who gave birth into ten groups. We then work out the caesarean section rate for each group and calculate which groups contribute most to our rate. For more detail, see www.thewomens.org.au

The key groups are women having their first baby with uncomplicated pregnancies, and women with subsequent caesarean sections. We were able to compare ourselves with the Maternity Hospital Dublin and our rates for uncomplicated first pregnancies were higher. This confirmed that we need to focus on our management of labour for women having their first baby. We are also adapting a decision aid to support women who have had a previous caesarean section to consider vaginal birth next time.

Women who have their labour induced have more chance of caesarean section, so we have reviewed our clinical practice guidelines for the timing of induction of labour for pregnancy beyond 40 weeks as well as our induction processes. This is a major project for this year.

Comparing ourselves (maternity services indicators)

We use uncomplicated first pregnancies (standard primiparae) as a way of comparing ourselves with other Victorian hospitals. Intervention rates for this group should be low.

Table 3 shows how our rates have changed and how they compare to the state average.

You can see how the Women's compares with other Victorian hospitals for this and other clinical indicators on www.health.vic.gov.au/maternitycare/

standard primipara: is a woman who is 20 to 34 years of age, giving birth for the first time, with no complications and carrying a single pregnancy at full term (37 to 41 complete weeks). Her baby is not abnormally small and the baby's head is down. The intervention and complication rates for this group of women should be low.

induction of labour: when labour is brought on artificially, using hormones and/or artificial rupture of the membranes

pelvic floor: A group of muscles between the anus and vagina

incontinence: when a woman leaks urine

Table 3. Intervention rates for the standard primipara

	RWH 2002	RWH 2003	RWH 2004	RWH 2005	Victorian rate 2005	Comment
What are the chances of the baby being induced?	24 %	19.1%	22%	8.8%	17.2%	This improved rate largely reflects more accurate data.
What are the chances of having a caesarean section?	18%	20.5%	24%	18.8%	18.5%	Our rate is similar to the Victorian rate. We work to reduce this.
What are the chances of a significant vaginal tear (third or fourth degree tear)?	2.2%	4.6%	3%	2.9%	4.3%	Our rate remains below the Victorian state-wide rate.

This data is from the Perinatal Data Collection Unit

How safe is our care?

Injury in childbirth

A very small number of women giving birth will have a major tear to the vagina - called 'third or fourth degree tears'. This can lead to later problems with incontinence, difficulties with sexual relationships or pelvic floor problems. Our new perineal clinic follows up women to prevent these complications.

The clinical nurse consultant visits women on the ward to discuss the tear, promote healing and arrange follow up appointments in the clinic. The clinic provides holistic care from a team that includes a urogynaecologist, colorectal specialist, physiotherapist, continence midwife, dietician and sexual counsellor. We also developed information for women. In a telephone survey, women who attended the clinic indicated a high level of satisfaction with their care.

We also review these tears to see if we can find ways to prevent them.

Reducing multiple pregnancies in fertility treatment

Multiple pregnancies carry a greater rate of complications, such as premature birth and high blood pressure. This is a very important issue for us and we set out to decrease multiple pregnancies from IVF, as shown in Table 4. To reduce the rate of twins or more, clinicians aim to reduce the number of embryos transferred, through:

- educating staff and couples about the risks of multiple pregnancy
- supporting more informed decision making between the couple and clinicians.

Table 4. Multiple pregnancies from IVF

	2004	2005	2006
Twins	172	159	90
Triplets	1	2	1

How safely do we care for women and baby?

One way we measure safety is through the Standardised Perinatal Mortality Ratio. This compares the number of deaths of babies born here with the rate for Victoria. It is a ratio of actual deaths to expected deaths. This is calculated over five years because of small numbers and takes account of prematurity (gestation). It excludes terminations for congenital abnormalities. The norm is 100. Our ratio of 83.6 for 2004-05 is a significantly better outcome than for the state as a whole.

Physiotherapists aim to see all women in the wards after birth to work with them on pelvic floor exercise, abdominal exercises and back care. There is research evidence that this improves women's health after birth and in the longer term.

Post partum haemorrhage

"Postpartum haemorrhage (PPH) is when a woman loses more than 500mls of blood after birth. We take it really seriously. PPH is the main reason for admission to intensive care for maternity patients, and can result in significant complications such as hysterectomy and even death. Even a small blood loss of 500mls may contribute to anaemia, decreased energy and difficulties with breastfeeding.

I don't think we'll ever be able to prevent all the PPHs, but we can manage them quickly before they become major blood loss. I think we now have good team processes to detect and manage PPH.

Our data shows that our PPH rate is still higher than we would like – around 13% for women having a normal vaginal birth. Our rate of blood transfusion after birth is steady around 0.2%, comparable with other Australian tertiary hospitals. Our rate of hysterectomy after birth is around 0.1%. We reviewed these hysterectomies for the last two years and found that they were all associated with problems with the placenta. This means that major complications from PPH are infrequent.

We are taking part in a national study looking at what having a large PPH means for women after they go home."

Karen Moffat
Birth Suite Clinical Midwife Consultant

Having a baby at the Women's

When a baby dies

A small proportion of babies die from complications of pregnancy or prematurity. This is a sad time for women and their family. The Bereavement Support Services Team provides specialist bereavement counselling, information and assistance and referrals to the community. Families are offered spiritual support according to their belief and faith traditions, such as blessings and prayer.

One couple wrote *"...The time you gave to us and the time we spent with our baby... will always stay close to us and add to our memories."*

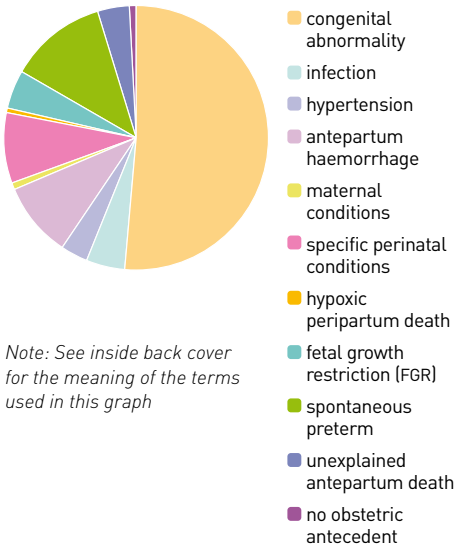
Our Sacred Space, with universal symbols of earth, fire, water and wind, is a quiet space for reflection or prayer, or for families to write in the memory book. Babies are remembered at a yearly memorial service, where families and staff come together to acknowledge the significance of their loss.

Why do babies die?

When a couple loses a baby, they often want to know 'why did this happen?' and 'will it will happen again?'

Every week, a multidisciplinary committee reviews pregnancy losses from 20 weeks gestation to review our care and help answer these questions. Maternal deaths, stillbirths and neonatal deaths are reported to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, which independently reviews them. Figure 11 shows the reasons for these 151 deaths, half of which were because of congenital abnormalities. Because we are a tertiary referral hospital, many of these women are referred here for specialist advice. The full report is available on www.thewomens.org.au

Figure 11. Perinatal deaths RWH July 2005-2006 by cause of death



Note: See inside back cover for the meaning of the terms used in this graph

"For women who experience perinatal death at the Women's, I am of the view that they are provided with very high standards of diagnostic and clinical care, and support." Assoc Prof James King, Chair of the Perinatal Mortality and Morbidity Review Committee.

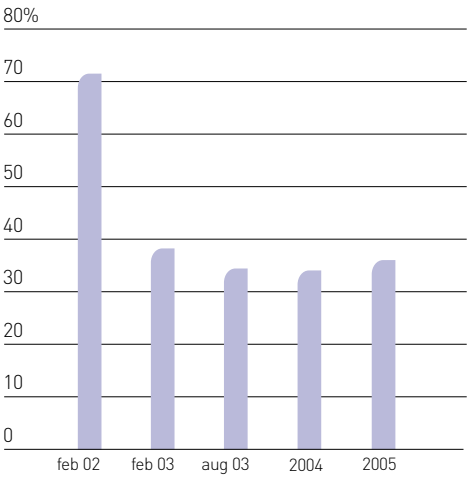
When an unborn baby dies unexpectedly, (unexplained stillbirth), investigations are begun to understand why. This can be very helpful for parents in coming to terms with the death and planning another pregnancy. Although this is a very difficult decision for parents to make at a time of great stress, an expert autopsy is sometimes the only way to provide answers. Many parents express relief in finding some explanation.

Access and timeliness

Figure 12 shows that about one third of women wait longer than 30 minutes for their antenatal appointment. Women tell us that they want to be advised when this is happening.

Most pregnant women (around 85%) attend our Pregnancy Booking Clinic to help decide the most appropriate clinic for them. At the moment the waiting time for an appointment is nine weeks, which is too long. We are working on ways to reduce this.

Figure 12. Proportion of women who wait more than 30 minutes for hospital antenatal clinical visits



Continuity of care – discharge

Too many women were waiting a long time to see a doctor before they could go home after giving birth. The maternity teams recently worked on a project to:

- improve the timing of medical discharges
- improve availability of beds for women being admitted
- reduce delays at discharge for women and their families.

The doctors now see women before the day of discharge. Initial assessments are that this has successfully reduced women's delays in going home.

Maternal and Child Health Nurses get additional information from us about women they are visiting through the Women's@Home phone/fax line. Their feedback also helps us identify discharge planning issues that we need to improve.

perinatal morbidity: babies who become ill within 28 days of birth

perinatal mortality: babies who die within 28 days of birth

Baby Friendly Hospital re-accreditation 2006

In 1995, the Women's was the first Australian public hospital to be accredited as a Baby Friendly Hospital under the UNICEF/WHO Baby Friendly Hospital Initiative (BFHI). The BFHI is world-wide and aims to improve breastfeeding rates. Hospitals are reviewed on their practices to support, encourage and assist mothers' efforts to breastfeed. We have now been re-accredited for the third time.

Pregnancy research

'It's nice to be recognised for something that you've really thrown your heart and soul into!'

Jo Said, Maternal Fetal Medicine Fellow, presented in Lisbon recently, the results of a study that she has done over the past five years. The study, the first of its kind to be presented, involved over 2000 women and examined how inherited thrombophilias (blood clotting disorders) affect outcomes such as pre-eclampsia, fetal growth restriction, placental abruption and stillbirth. She was recognised with the award for the most outstanding clinical work on the study of hypertension in pregnancy. The study will assist the care of pregnant women with these complications and help develop appropriate treatments and preventative strategies.

Other pregnancy research being undertaken at the Women's includes:

- identifying the mechanism responsible for the onset of labour
- improving tests to predict women at risk of going into preterm labour
- the effects of obesity in pregnancy.

Clinical trials underway at the Women's include:

- the best time to perform the procedure of external cephalic version (turning the baby) when the baby is presenting in breech position (bottom first) in late pregnancy
- the use of vaginal progesterone pessaries in women with a history of previous spontaneous preterm birth and whether it reduces the risk and severity of respiratory distress in the baby without increasing the mother's risks.

placental abruption: When the placenta comes away from the wall of the uterus

pre-eclampsia: A condition in pregnancy with high blood pressure, swelling and protein in the urine

Zeinab's story

Finding that I was pregnant was one of the biggest shocks of my life. I was in my second last year at university and couldn't imagine how I was going to manage. It wasn't a planned pregnancy, but my husband and I decided that if it happened, it was meant to be.

I chose to have my antenatal care at the Women's community clinic at Broadmeadows – just around the corner from where I lived. The midwives were great and it was good to see a familiar face each time.

At 39 weeks I was ready to have my baby. I was becoming very tired and restless. I couldn't sleep at night. I didn't have a birth plan, but decided to take things as they came. I kept active throughout my pregnancy as I knew this would help.

Two days before my due date I started to have contractions. I stayed at home as long as I could, as I knew this would help me cope. We arrived at the hospital at about 11pm. I knew it was going to be a long night and it was! The next morning the doctors and midwives told me that I wasn't progressing as well as I should be and needed some hormones to assist with the contractions.

By this stage I was exhausted and requested an epidural. It gave me the opportunity to have some sleep, rest and regain my energy to push the baby out. After a long night and a long day, Ahmad was born at 8:32 pm. Towards the end, I needed help to push him out as he was getting distressed, so he was born with vacuum extraction. I couldn't believe that I had done it and that it was over. I was overwhelmed and incredibly relieved when I saw him cry and held him for the first time.

In the postnatal ward, I needed a lot of assistance with breastfeeding as I discovered that it was a learnt art not one that you're born with.

Becoming a mother, and now being a midwife myself gives me a different perspective and greater understanding of what women are going through. Ahmad is now a happy and healthy 2½ year old boy.

Our special care for babies and their families

In this chapter you can read about:

- Caring for babies, families and staff in the neonatal unit
- Families as partners in care
- Story of Karl, Narelle and Emily
- Staff as partners in care
- Perspectives of team members
  - Graduate nurse
  - Social worker
  - Pastoral care
  - Occupational therapist
- Infection rates
- Data relating to survival rates of babies
- Research in Neonatal Services

For most people, the initial experience of the neonatal unit at the Women's is likened to walking into another world. The noise and technology can be overwhelming, but the fragility of the tiny and sick babies, the devotion of their families and the dedication of our staff are awe inspiring.

The neonatal unit, located on the 9th floor, is made up of the neonatal intensive care unit (NICU) and the special care nursery (SCN). This year over 290 staff assisted with the care of 1198 babies and their families.

Our philosophy is that staff are partners with families in the care of their baby. Our multidisciplinary team includes nurses, care managers, doctors, social work, pastoral care and developmental care specialists. With our Family Care Plan, we try to involve the family in all aspects of their baby's care and have them tell us what they think is important for their baby.

The neonatal unit also oversees care for all babies delivered at the Women's. We are present at the birth whenever we are needed, and our support in the postnatal wards means that more babies can stay with their mother and be more easily breast fed. Our Newborn Hospital in the Home program allows babies to go home sooner with family support.

Families as partners in care

The principle of family centred care was introduced in 2001. This approach recognised the baby's family as the most important people in the baby's life, critical to the baby's emotional, social and physical wellbeing and welcomed their role in the baby's care.

In 2004, we introduced the Family Care Plan. The multidisciplinary team works with the family on the care plan for the baby and writes this down. A 'Family and Baby Care' group has been working to improve our family centred approach, such as a 'how to be with your baby' pamphlet, a baby diary, and a staff education month.

A recent audit found that we needed to improve the use of the care plan. We obtained a training video for families and staff and rostered staff time to support Family Care Plans. We plan to evaluate the care plan process and provide more bedside education for families and staff.

Our special care for babies

Multidisciplinary partnerships: perspective of team members

The new graduate nurse (Phoebe)

"Working at the Women's neonatal intensive and special care nurseries is another world, unlike most hospital settings. It is unfamiliar and filled with busy people and big machines. Most people are not aware a service like this exists for such new and small babies.

Staff are often happy and obviously enjoy their work. Being new, you feel all 'thumbs'. Being a relatively new nurse in the neonatal intensive unit and special care nurseries is a tad overwhelming.

I learned that:

- *The babies are fragile and vulnerable – they are stable one moment and deteriorate the next.*
- *Some things just can't be explained. Why do some babies do well and others do not? That's difficult.*
- *Everything is smaller – smaller bodies, small drug doses, and small equipment.*
- *Assisting parents with the first cuddle is amazing.*
- *The sterile environment is softened with colourful quilts and bright cartoon stencils on the walls.*
- *Having a sick or premature newborn comes with lots of complications for families. Being the main bedside nurse, I try to help them with their concerns.*
- *When you're standing beside an incubator with the parents; that's when you see the baby's big eyes, large smiles and the special joy they bring to their families for just simply being here."*

Pastoral care and spirituality Joyce

"My role is to provide emotional and spiritual support for parents and families. We create spaces for parents to speak about their experience of the birth of their baby and their time in hospital. The sharing of a person's experience in difficult times can become a means of empowerment and hope.

For some families, having the baby blessed or baptised into their faith tradition is important. We sometimes arrange this, either at the baby's bedside or in the Sacred Space. We share this information with staff, so that they know about the spiritual dimension for the family.

Working here is sometimes challenging, but always rewarding, as we share the ups and downs of a family's journey with their baby. This process nurtures a relationship of trust enabling healing, reconciling, nurturing and guiding."

Occupational therapist Nisha

"The babies referred to neuro-developmental therapy (which includes occupational therapy, physiotherapy and speech therapy) are often those with the biggest challenges ahead. Some of these babies will stay a long time in the neonatal unit (up to 4-6 months or so). We provide parents with information about their babies' development and ways that they can help by understanding their babies' cues, providing physical support and positive experiences.

One cannot help being touched by these experiences and to be humbled by the strength shown by families and their babies."

Karl, Narelle & Emily's story

As a parent the NICU experience is one of awe and amazement as you watch a tiny, scrawny, translucent being develop into a gorgeous chubby baby. It is also very daunting, stressful and at times frustrating. It is a world of dedicated, skillful and compassionate doctors, nurses and support staff that enable miracles to happen. We have been very fortunate that our miracle, Emily, has survived and is on the very long road to home.

My pregnancy was filled with apprehension from the onset, having lost Thomas at 25 weeks, two years ago. Emily was delivered at 24 weeks weighing 432g.

Her early progress was up and down and associated with mixed emotions. You are scared to be so attached to a life which is so fragile, not knowing if she will live or die. With each inevitable setback you don't know if you will be able to pick yourself up again. You try to make the most of every moment as you may only be left with the memories.

The NICU becomes your home, the staff your family. Most go out of their way to make you feel comfortable and confident with what's happening. They show genuine concern for Emily's wellbeing which makes you feel caring for her is more than just a job.

The staff listen to your concerns and answer questions willingly. The open interaction between staff gives you the confidence that if anyone has any concerns they will be addressed.

The staff give you confidence and encouragement to touch and handle your tiny baby who looks so fragile and breakable. They allow you to do as much as possible in the care of your baby which is very important to make you feel like a parent, even though it may be only changing a nappy.

It is difficult to accept the reality that you cannot be there all the time for your baby and it is very unsettling leaving her behind when you go out for lunch or home at night.

We are grateful to the staff for their skill and support. The unit provides staff to assist with most problems you encounter or someone just to listen to your worries and moans. Our NICU experience has been very difficult but positive and a time which has changed us forever.

Our special care for babies

Staff as partners in care

In 2004-05, we were funded by Industrial Relations Victoria for a 'partners at work' project to improve multidisciplinary relationships. Working with very sick babies and their families is rewarding but stressful work for staff, so a group was formed to work on supporting staff. It was called Team Spirit and a value was established; "Together everyone achieves more supporting peers in roles and as individuals".

We surveyed staff and found that relationship issues were the most important cause of distress at work. A staff support month was held focusing on professional, social and personal people skills, with education sessions on management of high risk, high need families, grief and loss, and communicating with difficult aggressive people. There were fun sessions as well.

We sought the introduction of an Employee Assistance Program, now in place, to provide debriefing, individual counselling and support for staff. We worked on improving cross hospital communication around high risk, high need families. The neonatal unit orientation program now includes people and social skills training.

Has it made a difference?

- sick leave is down from 12% in 2001 to 6% in 2005
- exit interviews no longer list morale and work conditions as reasons to leave
- recruitment into leadership roles previously unable to be filled
- resignations down from 4-5 per month to 1-2 per month (out of around 190 staff)
- positive industrial relations/morale feedback.

Karen's story

Jess and Tom were not expecting their baby for another three months. When Jess was taken to the emergency department with abdominal pain, she did not expect to be rushed to the Women's to deliver her premature baby. When I first met with Jess and Tom at their baby's cot side, they were both very emotional and feeling overwhelmed. They had not had the chance to finish work, pack a bag or arrange for someone to care for their rural property or pets. Here was their first child, as small as their hand, attached to many leads and monitors, looking so fragile and vulnerable. They had so many questions and very few answers.

Jess, Tom and their baby Ruby spent 140 days in the neonatal unit. Because they were away from home, Jess and Tom had to find somewhere to stay close to their baby. I assisted them with the Family Accommodation Service where they stayed in a self contained flat across the road.

Because Tom could not get to his work, Jess and Tom needed financial assistance, so I helped them to get payments from Centrelink.

I met with Jess and Tom once a week to talk about the emotional impact of having a premature baby in hospital for a long period of time. Some days were harder than others as Ruby continued to fight for her life. Many issues were raised during our counselling sessions that highlighted the difficulties parents experience during times of illness. We also used this time to consider strategies for dealing with the stress and anxiety associated with a premature baby.

The day came when Ruby was transferred to a hospital closer to home. Jess and Tom were excited at the prospect of getting their much loved baby closer to home, however they were also terrified about how they would cope away from the neonatal unit which they were now so familiar with.

I received a card last week with a picture of a smiling Ruby, finally at home where she belongs, with her family. I feel privileged to have been a part of this family's very special journey.

Karen
Social support

Multidisciplinary case review

Partners at Work identified regular multidisciplinary case review as critical in improving team work and communication around care of each baby. We consulted our staff and developed guidelines, including how to conduct the reviews.

Multidisciplinary case review commenced in July 2006. Informal staff feedback has been very positive and all sessions very well attended. This has improved multidisciplinary communication around care planning, promoted consistency and continuity of information and supports a team approach of 'shared input' to care planning. It will be evaluated after six months.

How effective is our care?

The quality of our neonatal care is measured against other neonatal services within Australasia and internationally. The Australian and New Zealand Neonatal Network (ANZNN) database is a voluntary collaboration that reviews and audits the standard of neonatal care. The audit looks at factors that may affect the outcomes of babies in hospital. These factors are important for avoiding and predicting disability. We have more very low birth weight babies and this affects how we compare. See the inside back cover and the text below to find out what these terms mean.

We use the indicators in Table 5 to monitor our clinical care and guide our research. Retinopathy is damage to development of the retina in the eye, which can result in eyesight problems. Too much oxygen can affect the retina (the back of the eye). The Women's is a leading international research centre for researching the ideal oxygen levels for premature babies. We describe this later.

Chronic lung disease is a general term for premature babies who still need breathing help at 36 weeks. It results from lung injury to newborns who need assistance from a mechanical ventilator and extra oxygen for breathing. The high proportion of very premature babies in the unit affects our rate of chronic lung disease.

The neonatal unit is committed to reducing and preventing infection in our babies. Our figures in Table 6 compare favourably with Victorian and international rates and reflect work to reduce these, including our hand hygiene program.

In general, the chances of babies surviving improve at 26 weeks, as shown in Table 7 on page 28.

Neonatal research and quality care

Research is very important in finding ways to treat these tiny babies and avoid disabilities later in life. Our neonatal research into the short and long term outcomes of premature infants is recognised nationally and internationally and continues to expand.

Improving respiratory support and outcomes for very premature babies

A research team at the Women's and Monash University has been awarded a multi-million dollar NHMRC program grant to investigate and develop novel strategies for improving breathing support and outcomes for very premature babies. This research team is led by Professor Colin Morley and Associate Professor Peter Davis,

Table 5. For infants born at <30 weeks gestation or <1250 grams birth weight who survive to 36 weeks gestation

ANZNN clinical indicators	The figure we aim for	RWH 2001	RWH 2002	RWH 2003	RWH 2004	RWH 2005
Cranial ultrasound	More than 95%	97.6%	97%	96%	96%	96.3%
Intraventricular haemorrhage 1-4	Less than 45%	22%	26%	30%	36%	23.3%
Eye examination	More than 90%	94%	94%	90%	94%	87.1%*
Stage 3 and 4 Retinopathy of prematurity	Less than 8%	21%	12.6%	13%	9%	7.5%
Chronic lung disease – babies still needing assistance with breathing at 36 weeks	Less than 20%	21%	22%	26%	32%	28%

**This rate reflects incomplete data*

Table 6. Comparison of infection rates using ANZNN

	< 28 weeks	28-36 weeks	> 36 weeks	total
ANZNN 2004	36.5%	6.4%	5.4%	10.3%
RWH 2003	38.8%	2.4%	0.35%	–
RWH 2004	29.9%	5.9%	1.6%	6.8%
RWH 2005	21%	5%	0.1%	6.3%

Our special care for babies

working with respiratory physiologists and molecular biologists at Monash University. Together they are regarded as world leaders in their fields.

The major problem suffered by very premature babies is lung immaturity which affects brain development. Most very premature babies require resuscitation followed by breathing support, often for several weeks. This research aims to improve outcomes for very premature babies, with less lung injury, better respiratory health and shorter stays in hospital. The research covers:

- how being very premature alters the normal development of the baby's lungs after they are born and in later life
- the cellular and molecular processes involved in lung development to identify developmental processes that are disrupted by very premature birth
- better ways to resuscitate and ventilate these infants to avoid lung injury.

Such knowledge is necessary to provide a scientific basis (evidence) for managing and treating the lungs in premature babies

VIBeS (Victorian Infant Brain Study)

Another major concern for clinicians and families is the development of the brain in premature babies. With one of our former researchers now in the United States, there is improved international collaboration, particularly with St Louis and Boston centres.

This important research focuses on understanding the newborn brain and is fundamental to developing practical ways to improve the environment and the provision of care to babies and their families to support brain development. The research has been presented at many scientific meetings with many articles published in peer-reviewed journals.

Evidence based changes to neonatal resuscitation

Traditionally, babies who require assistance with breathing at birth have received pure oxygen. An article in the *Lancet* in late 2004, with two co-authors from the Women's, published evidence that babies have a significantly greater chance of surviving if air is used instead of oxygen.

As a result, the Women's changed to resuscitation with air rather than 100% oxygen. This involved a huge amount of planning, changing equipment (12 resuscitation cots) and educating and training over 300 staff. New equipment was funded by a trust grant so that the delivery of air could be safely monitored. There was extensive collaboration between neonatal and maternity staff.

The final change-over occurred on one day, 20th July 2006. The change-over has gone smoothly – a prime example of translation of evidence into practice.

Table 7. Survival rates of babies admitted to NICU and SCN 2005

weeks gestation	number	min of birth weight (gm)	max of birth weight (gm)	number who died	percentage who survived
22	1	560	560	1	0.0%
23	6	515	685	3	50.0%
24	19	583	920	9	52.6%
25	20	520	999	7	65.0%
26	28	500	1114	4	85.7%
27	25	560	1200	2	92.0%
28	31	460	1680	2	93.5%
29	38	645	1685	4	89.5%
30	42	885	2010	2	95.2%
31	58	840	3135	2	96.6%
32	64	1075	2598	4	93.8%
33	71	1470	2740	2	97.2%
34	86	1190	3290	3	96.5%
35	95	1255	4200	2	97.9%
36	93	1235	4170	2	97.8%
37	97	1504	4340	3	96.9%
38	136	2120	5578	2	98.5%
39	92	2055	5250	1	98.9%
40	111	2265	4965	3	97.3%
41	65	2015	4855	1	98.5%
42	20	2450	4588	0	100.00%
total	1198			59	95.08%

Cancer services at the Women's

In this chapter you can read about:

Our cancer services

Our cancer services treat around 1500 women each year. In 2005, 205 women with newly diagnosed gynaecological cancer were treated; including 63 women with uterine cancer, 43 with ovarian cancer, 36 with cervical cancer and 15 with vulval cancer. We also treated 89 women with newly diagnosed breast cancer, with a further 23 women having surgery as part of breast reconstruction.

Providing a good service is not only about medical and surgical treatment but also recognising women's social and emotional needs. A woman's sexual and reproductive health is closely bound up with her identity as a woman, mother and partner. Diseases that affect fertility and sexuality can have a devastating impact on women, their relationships and expectations of the future.

vulvar cancer: cancer on the outside of the vagina and surrounding area

Improving outcomes through early prevention and detection

Cervical cancer

If cell changes are detected through regular two yearly pap smears and treated early, cervical cancer is one of the more preventable cancers. Because pap smears are so important, we check that all women using our services have had pap smears.

Providing a patient perspective – making pap smears easier

- While regular pap smears are very important, women are often very anxious, finding them uncomfortable, embarrassing and causing feelings of vulnerability. This can be a barrier to regular screening. Women need doctors and nurse practitioners to be technically competent and sensitive.
- Clinical Teaching Associates are women from the community who are trained as teachers and are real-life models to train health professionals to do pap smears. They provide guidance and feedback on technique and communication. The women run the tutorial themselves, instead of being models in a tutorial run by a doctor or nurse. This encourages practitioners to work *with* their patients, rather than performing examinations *on* them. Feedback from these teaching associates has changed aspects of how we do pap smears.
- Our Well Women's Clinic is staffed by specially qualified nurses who are able to offer longer appointments to help women feel comfortable about discussing intimate concerns such as pap tests.

Table 8. Dysplasia Clinic indicators

Indicator	NHS Standard	RWH 2005	RWH 2006
Proportion of results and management plans communicated to the woman within 14 days of attending a clinic	At least 90%	75%	80%
Proportion of woman not attending follow up appointments	Less than 15%	21%	22%
Colposcopists accuracy of predicting high grade lesions or worse	65%	53%	58%
Proportion of women who have their histological diagnosis established prior to destructive surgery	100%	93%	95%
Proportion of treated women having a follow up smear within 6-8 months following treatment	At least 85%	81%	81%
Proportion of results and management plans communicated to the referring practitioner within 14 days of women attending a clinic	At least 90%	78%	73%

See inside back cover for what these terms mean

Dysplasia clinic

Women with an abnormal result from their pap smear are referred to our dysplasia clinic for further investigation and treatment if required. In last year's report, we discussed dysplasia services and compared them to the UK National Health Service (NHS) bench mark. We continue to do this. Some areas needed improving and we report on these in Table 8.

What are we doing to improve?

Because of the importance of early prevention, our biggest concern is reducing the number of women who don't attend follow up appointments. We are trying different ways of contacting women to confirm their appointment. We have introduced a nurse education clinic where women see the clinical nurse educator before they see the doctor. We will know next year whether this has improved follow-up.

A vaccine that prevents cervical cancer

Human Papilloma Virus (HPV) is the most common viral infection transmitted through having sex. While it is most commonly found in young people under 25 years old, about 80 percent of people who have sex will eventually be infected at some stage. Most infections clear up in less than 15 months, with no symptoms noted by either partner. In a very small proportion of women, the virus persists, for reasons that are not known, but smoking plays a role. A very small proportion of women with persistent infection with some types of HPV will develop cervical cancer, if abnormal cells detected by the pap smear are not treated. The pap screening program aims to identify most of these and treat them before they become malignant.

The Women's is involved in international trials to test different versions of HPV vaccines to prevent the two commonest strains of HPV causing cancer and determine the groups of women for whom they work. This will contribute to the development of an Australian program of vaccination for young people as well as older women. Combined with regular two yearly pap smears, this will further reduce the number of Australian women developing cervical cancer.

dysplasia: alteration in the size, shape and organisation of cells which may lead to cancer

Care which responds to the needs of the whole patient

"I was so pleased when Health and Wellbeing Workshops started – a class of exercise, stretching and relaxation. Other workshops consist of Tai Chi, meditation, laughter, art therapy, nutrition and yoga. Over the months that I have been attending the classes, I have been taught to relax in a way I did not know existed.

We not only enjoy the company of other people with an understanding of serious illness, we learn to communicate to each other some of our worries and learn to meditate and explore a part of us that we have perhaps kept hidden, not only from the world, but from ourselves. It is a journey of discovery, of a joy in getting to know oneself in a totally different way, of learning how to cope with the stress and sadness of serious illness but at the same time gaining so much insight into different emotions that life takes on another perspective.

The exercises have made me physically stronger, I have lost a lot of the tingling feeling in my toes and fingers, my balance has improved 50%, I am a lot more confident in myself, and, of greater importance, I look to the future in a new, enquiring and positive way. It is a class that is not only geared towards our physical and mental well being, but a class that enjoys a tremendous bonhomie."

Ruby's story

I was diagnosed with ovarian cancer in 2003. I had gone to the GP a couple of times (over a few months) with a puffy tummy, feeling tired and I'd been vomiting. I thought the tummy was just old age. The GP didn't even examine me. He said I was just putting on weight. I wish had asked him to do it. Then my right leg started to swell up and the GP referred me to an orthopaedic specialist. He examined me and straight away he found a lump in my side. He sent me to the Women's and I had surgery a few days later.

When I heard 'ovarian cancer' I was devastated. I thought that it might have been left for too long and it might have gone too far. I couldn't believe I had ovarian cancer. I had always looked after myself and had pap smears since I was 35. My husband and I cried together but the doctor told us that sometimes people have a good outcome from this.

I was started on my first chemotherapy program. This shrunk the tumor, but two years later it was back again.

More recently I was asked if I wanted to go on a trial for a new chemotherapy drug. I said yes straight away. If the trial doesn't help me it might be of benefit to others in the future. You have to move on when you have cancer and think about helping others.

I've been having chemotherapy for 13 weeks now with six weeks to go. I feel a bit tired for a few days after having it but there's been no nausea. My cancer count has dropped. I think the chemo actually agrees with me. I feel well!

I love coming in for my chemo each week. It sounds funny but I love seeing everyone here and I always go home with a really positive feeling. I like to talk to others about their treatment and how it is affecting them. You can ask the nurses and doctors anything and they explain things so that I understand.

My husband and son are both very supportive and helpful. There are always people who are worse off than you. We are all very lucky to have each other.

Our cancer services

Treating cancer

How successful is our treatment of cervical cancer?

The Women's oncology unit sends data about our treatment of women with gynaecology cancers to the International Federation of Obstetrics and Gynaecology (Figo). This contributes to world-wide data about gynaecological cancers and means that we can compare our survival rates internationally. For a more detailed report, see www.thewomens.org.au

Table 9 shows that diagnosing cervical cancer early makes a big difference to survival (stage 1 is a less serious cancer, stage 4 the most serious). This is why pap smears are so important.

Ovarian cancer

Every year in Australia over 1290 women are diagnosed with ovarian cancer and about 850 women will die. Nearly 7,000 potential years of life are lost. Being diagnosed with ovarian cancer is worrying news for women, but there are improvements in outcomes; more women are going into remission and women are living longer, and quality of life is given more importance. For women diagnosed in the most advanced stages of ovarian cancer, successful treatment is difficult.

The reason that diagnosis is often late is that 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. For more information about ovarian cancer, see www.ovariancancerprogram.org.au

How effective are our cancer services?

To provide effective care, we base our treatment on research evidence and contribute to research evidence through clinical trials. We contributed to the development of the first national Clinical Practice Guideline for the treatment of ovarian cancer, which guides our own clinical care. See www.ovariancancerprogram.org.au

Table 10 shows that diagnosing ovarian cancer early makes a difference to survival (stage 1 is a less serious cancer, stage 4 the most serious). Our results for stage 3 are very good. We hope to see these figures gradually improve with more attention and research on ovarian cancer.

Chemotherapy side effects

By linking our pharmacy and oncology databases (GEMMA), we have been able to review chemotherapy side effects and delays in treatment. Figure 13 for July 2005 to June 2006 (114 women) shows important side effects that we monitor. We identified an increase of reactions due to one particular drug. This is being followed up by pharmacy. We plan to do a survey with women who have had chemotherapy this year to find out about their experiences.

remission: when a person with cancer has no signs of cancer activity detected by the clinician or herself

oncology: the study of diseases that cause cancer

Table 9. Cervical cancer: percentage of 82 women treated at the Women's in 1999-2001 who have survived (still living after their diagnosis)

strata	number of women	mean age of women (years)	overall survival at				
			1 year	2 years	3 years	4 years	5 years
stage I	55	44.5	97.9%	93.0%	87.8%	81.7%	81.7%
stage II	11	59.8	88.9%	44.4%	44.4%	44.4%	44.4%
stage III	12	63.7	56.5%	36.0%	36.0%	36.0%	36.0%
stage IV	4	74.3	100%	25.0%	25.0%	-	-

Data submitted to Figo

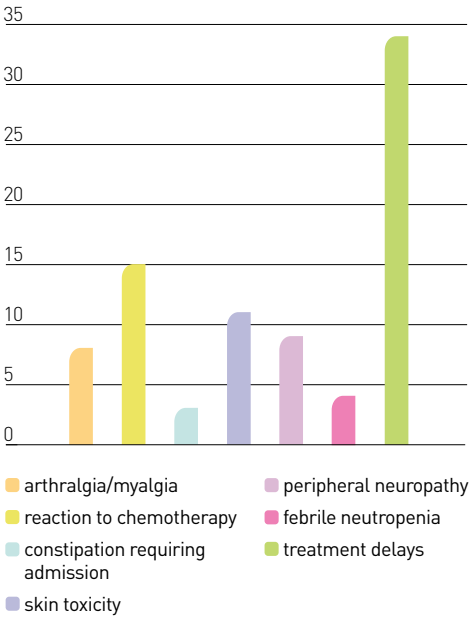
Table 10. Ovarian cancer: percentage of 184 women treated at the Women's in 1999-2001 who have survived (still living after their diagnosis)

strata	number of women	mean age of women (years)	overall survival at				
			1 year	2 years	3 years	4 years	5 years
stage I	66	49.9	93.2%	91.2%	85.0%	77.7%	77.7%
stage II	15	60.5	92.9%	92.9%	92.9%	92.9%	78.6%
stage III	91	59.0	83.6%	61.0%	51.5%	40.9%	36.2%
stage IV	12	57.8	72.7%	62.3%	62.3%	20.8%	10.4%

Data submitted to Figo

Our cancer services

Figure 13. Numbers of women with toxicity and treatment delays



Note: See inside back cover for the meaning of the terms used in this graph

When treatment doesn't help any more

While women experience a longer and better quality of life, many will die from ovarian cancer. For women at this stage, we usually refer them to community palliative care, but support them with readmission, often because of pain or other symptoms. About ten women a year will die in hospital. We have developed a care map to make sure we look after these women and their symptoms well.

Breast cancer

At present, the Women's provides surgery for breast cancer, but then women are referred elsewhere for radiotherapy and chemotherapy. The Women's and the Royal Melbourne Hospital (RMH) have agreed to combine breast services. The relocation of the Women's next to the RMH in 2008 provides a great opportunity to combine the things we each do well to create a single comprehensive multidisciplinary breast service. A Professor/Director of the Women's/RMH Integrated Breast Service, linked to the University of Melbourne, has been appointed and work has started on planning the new service with staff and consumer input.

Cancer research

- We contribute to knowledge about more effective treatments through clinical trials, sometimes of new drugs and sometimes new combinations of drugs.
- We have clinical research nurses who work closely with, and support women, who are part of clinical trials.
- Since 1975, the Women's has kept a register of all women in Australia with a very unusual cancer of the placenta (hydatidiform mole). With over 20 years of follow up data, we have been able to change how women are followed up and provide advice about when some women can safely get pregnant again.
- The Gynaecological Research Centre is involved in research aimed at early detection of ovarian cancer. There is currently no effective screening test.

palliative care: care given while a person is dying and the cancer is no longer treated

Advocating
for women's health

In this chapter you can read about:

- Violence against women clinical practice guideline
- Chlamydia
- Abortion services
- The Women's Centre against Sexual Assault

Our advocacy services

The Women's services are underpinned by the 'social model of health'. This means that women's circumstances contribute to their health and wellbeing and that we acknowledge those social aspects in our services. Part of this is a commitment to advocacy on women's health issues. This section describes some of what we do.

Responding to violence against women

In the last 12 months, we developed a clinical practice guideline – the first in any Australian hospital – on violence against women to guide staff on providing health care sensitive to the needs of women who have experienced physical or sexual violence. The guideline was informed by research, focus groups with women who were victim/survivors of physical or sexual violence and consultation with staff and external service providers.

Women told us that they did not necessarily want to talk to a health practitioner about their experience of violence, but they did want health care that was sensitive; they wanted information and choice; they wanted as much control as possible over procedures and they wanted to be treated with respect.

A central element of the experience of violence is a loss of control and feeling of powerlessness, therefore the governing principle is to give all women as much sense of control over their health care as possible.

Chlamydia

Chlamydia trachomatis is the most common bacterial infection transmitted through sex. In general, infections with Chlamydia occur in young, sexually active groups, particularly those under 25 years of age. At the time of infection, it has no symptoms, yet later on can result in significant pelvic inflammatory disease in women, resulting in chronic pelvic pain and infertility. In pregnant women, it is associated with an increase in pre-term labour and can be transmitted to the infant.

We are undertaking research to determine how often Chlamydia is present in a sample of women in our antenatal clinics and if antenatal screening for Chlamydia is effective and acceptable to women. This will inform ideas about screening for Chlamydia.

Pregnancy Advisory Service

Our Pregnancy Advisory Service (PAS) provides professional counselling and advocacy for women with unplanned and/or unwanted pregnancy, with around 7000 new calls from women each year. Women who contact the service are provided with skilled support and offered referral to a full range of information and choices, including abortion, antenatal care and parenting support or other care arrangements for a child, such as adoption.

PAS works with women dealing with issues such as domestic violence, assault, crisis, homelessness, mental illness and women who are culturally and linguistically diverse, or newly arrived refugees or migrants. We consider the knowledge gained from working with women about the issues facing them is fundamental to any service providing pregnancy counselling.

How do we know PAS is an effective service?

We measure ourselves against Australian and overseas standards and reported on this last year. In October 2005, PAS conducted a survey to find out the experiences of women who used PAS. Women indicated that there were many positive aspects of their experience, particularly the support provided by counsellors in making decisions. The majority of women reported feeling respected and supported; including when they need to have an abortion.

RU486 (Mifepristone) – advocacy and safe practice

International evidence supports non-surgical (medical) abortion as a safe alternative to surgical abortion and many women prefer this. Mifeprisone produces miscarriage like symptoms. Women need more follow up than if a surgical termination is performed. Medical abortion has a 95% success rate in women who are nine weeks pregnant or less.

We wrote a submission for the recent senate enquiry on the debate in Parliament. Mifepristone can now be considered by the Therapeutics Goods Administration in the same manner as all other drugs. The Women's is developing a service plan for the

introduction of this option for women who prefer this, with clinical practice guidelines and follow-up of complications.

Abortion research study

The Women's and the Key Centre for Women's Health in Society are undertaking Victoria's first large-scale study to examine unplanned pregnancy and abortion, funded by the Australian Research Council and VicHealth. The study will look at the factors associated with unplanned pregnancies including age, socio-cultural background, financial circumstances and mental health, among others.

This research will address concerns raised by the National Health and Medical Research Council a decade ago that abortion has received little attention in health policy development, in planning and coordination of delivery services, or the education of health professionals.

Secondary Schools Sexual Assault Prevention Program

The CASA (Centre against Sexual Assault) House Schools program began in 2004 and has evolved with input from young people to a five week program into three secondary schools in our region. CASA House has embarked this year on a partnership with secondary schools and young people that are committed to a whole of school community cultural change. We have begun a longitudinal evaluation into the impact of the program on young people's attitudes and behaviour.

Accessible services for our diverse communities

We have an established outpost of CASA House at Dianella Community Health in Craigieburn. In 2006, we will establish a second outpost at Anglicare in Broadmeadows. This has been guided by a commitment to engage culturally and linguistically diverse womenby being accessible to them in their communities.

Helen's story

On the 14th of December 2005, CASA (Centre against Sexual Assault) House moved from where it began 19 years ago in terrace houses in Cardigan Street Carlton to the 3rd floor of the Queen Victoria Women's Centre at 210 Lonsdale Street in the city.

It seemed the end of an era. The organisational change was enormous. We were moving further away from the Women's to a smaller space, to a building rather than a house and many of our practices had to be reviewed and changed. The organisation was a buzz with so many varied emotions, including anxiety, sadness, anticipation and excitement. Managing the change involved much preparation, discussion and planning.

The move happened smoothly. With input from service users, we have improved our space. Service users have commented on their improved access to the service due to better public transport and the calm environment.

Nine months down the track, CASA House is well and truly settled in its new premise and continues to work towards the elimination of sexual assault and providing crisis services and counselling and advocacy to over 2,000 victim/survivors a year and training and education to numerous service providers.

CASA Crisis Care Unit has remained at the Women's and will be part of the new hospital. The new Crisis Care unit will be an improved space for recent victim/survivors of sexual assault with easier access for both staff and service users.

Helen Makregiorgos
CASA House

Some selected indicators

In this section you can read about:

- Waiting times for surgery and outpatient appointments
- Waiting in the Emergency Department
- Infection rates

Some selected indicators

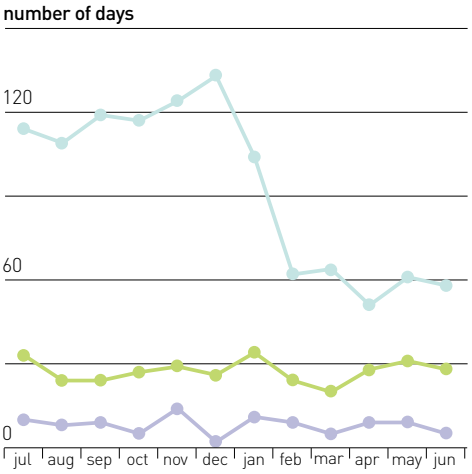
Waiting for surgery

The state government set waiting time targets for surgery. We meet all our government targets. Our waiting times for surgery are well below the state average. Figure 14 shows how many days on average women wait for urgent, semi-urgent and non-urgent surgery. Our postponement of surgery rate is well below the state average.

This year, the Women's became the state-wide referral centre for women waiting a long time for gynaecological surgery at other hospitals. Ninety-five women had their surgery sooner by coming to the Women's.

Our preadmission unit provides women with a central point of contact before their surgery. Ninety-eight percent of women surveyed in May 2006 stated that they received all the necessary information about their surgery and had adequate contact with the hospital before surgery.

Figure 14. Average waits for surgery



Category 1 = Women with urgent needs. These women must receive surgery within 30 days.

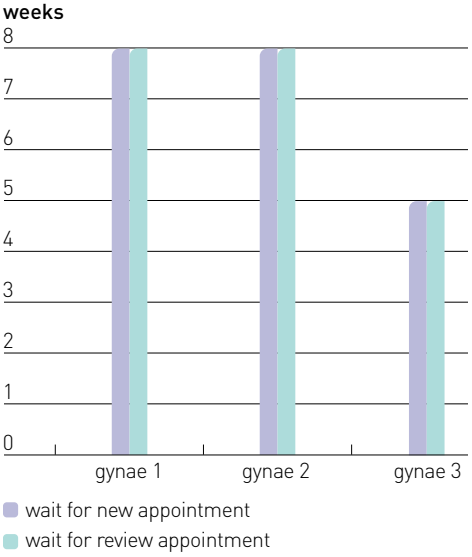
Category 2 = Women with semi-urgent needs. These women must receive surgery within 90 days.

Category 3 = Women with less urgent needs. Although there are no targets regarding waiting times, surgery should be provided to patients within 365 days.

Waiting for outpatient appointments

Last year, we reported on work we had done as part of the Patient Flow Collaborative to reduce the time it took to get a specialist gynaecology outpatient appointment. For some appointments, women had had to wait about 20 weeks and there had been complaints from women about this. We have been able to sustain reduced waiting times. Figure 15 shows our waiting times for new gynaecology appointments and for review appointments as at the end of June 2006.

Figure 15. Waiting times for gynaecology outpatient appointments



Gynaecology 1 clinic sees women with problems with bleeding

Gynaecology 2 clinic sees women with pain from conditions such as endometriosis

Gynaecology 3 clinic sees women with problems such as incontinence

We have developed a patient satisfaction survey for our outpatient clinics, based on a UK National Health Service outpatient survey. We will use this survey to find out from women's point of view how to improve our service. Two issues were identified in the trial of the survey. Women would like all staff to introduce themselves. They would also like to be informed if they have to wait before they are seen by the doctor.

Waiting in the Emergency Department

The Women's Emergency Service provides a 24-hour service for the management of acute or urgent obstetric and gynaecological problems and is an important link between the community and hospital care. Our staff are trained in a full range of skills specific to emergency care. There are national waiting times set for emergency departments. Table 11 shows that we met all targets for waiting in the Emergency Department. Ninety-six percent of women were seen within two hours.

Table 11. Emergency Department waiting times 2005/2006

triage category	treatment time target	standard	performance recorded		
			no. of patients	no. seen within target	% seen within target
category 1	immediate	100%	9	9	100%
category 2	within 10 minutes	80%	174	154	89%
category 3	within 30 minutes	75%	7053	6100	86%

Data source: Women are prioritised (triaged) into a category, depending on how urgently they need treatment.

Some selected indicators

Infection rates

We have improved all our caesarean section infection rates, through measures such as giving preventative antibiotics (antibiotic prophylaxis) just prior to surgery and improving urinary catheter care. Our results compare well internationally. For a full technical report, see www.thewomens.org.au

Figure 16. Urinary tract infections for caesarean section

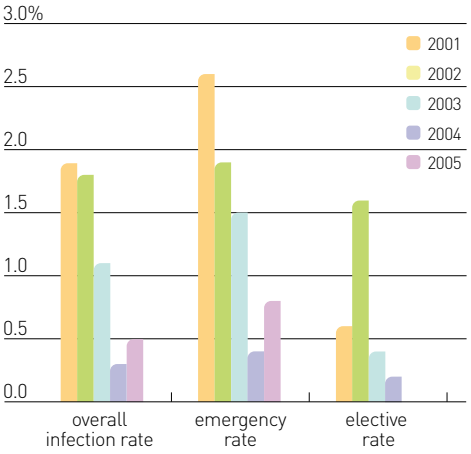
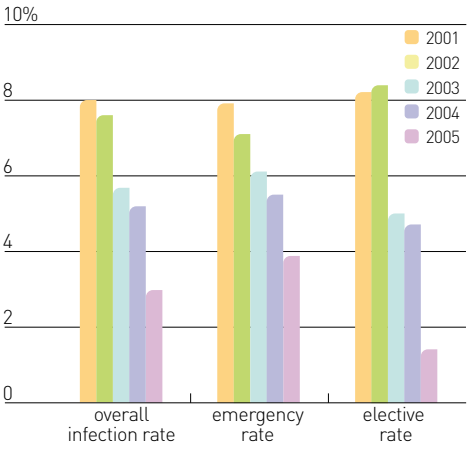


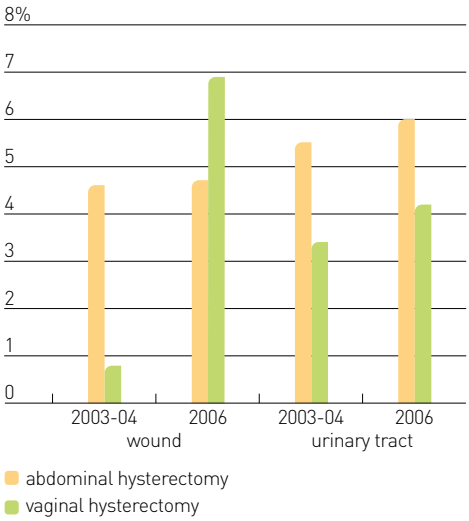
Figure 17. Surgical site infection rates for caesarean section



Infection rates for hysterectomy

Women such as those with cancer have a higher risk of infection. Our infection rates are consistent with other hospitals when adjusted for complexity and risk factors, but we are keen to improve these. Our measured rate in 2006 appears higher because we have collected more accurate data about superficial infections.

Figure 18. Infection rates for hysterectomy



Data source: RWH infection control surveillance

urinary catheter: a tube placed into the bladder to drain urine

urinary tract infection: an infection of the urinary tract, usually the bladder

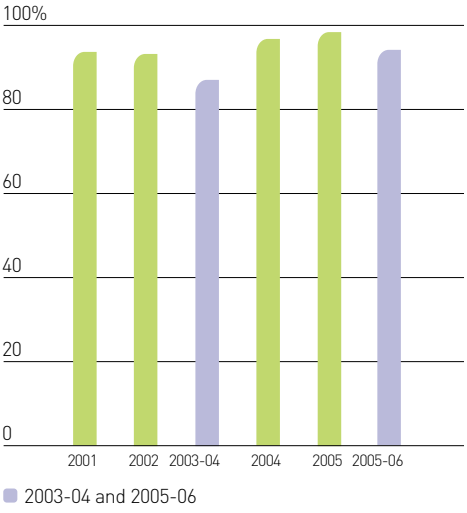
hysterectomy: surgical removal of the uterus

prophylactic: a preventative measure

Prophylactic antibiotics

Prophylactic antibiotics given at the time of surgery more than halves the risk of infection. Figure 19 shows our improvement for caesarean section. We plan to increase the rate for hysterectomy in a similar way by having the anaesthetists routinely give the antibiotic.

Figure 19. The percentage of women who receive prophylactic antibiotics before caesarean section and hysterectomy



Creating a safe hospital

In this chapter you can read about:

- How we improve patient safety
- The importance of incident reporting
- Medication safety
- Falls
- Pressure ulcers
- Infection control programs
- Women who need high level care
- Staff safety

Our safe hospital

Patient safety is about all the things that may result in patient harm and working out what could be prevented, ways to prevent errors happening and creating systems that are reliable.

Not all hospital care goes to plan. Sometimes this is because the patient has a very complicated condition, or because there are risks associated with pregnancy, treatment or medication. However, things sometimes go wrong because of errors: something that should have happened, didn't happen (a test result was not seen); the wrong thing was done (the wrong drug given), or because there was a 'mistake waiting to happen'.

We are open and frank with women and their families when things don't go as planned and especially when there has been an error that caused harm.

What do we do to make our hospital safe?

Safety culture

- We work to create a culture in which every-one is conscious of patient safety and works together to find workable solutions.
- We promote reporting, review and analysis of anything that goes wrong – incidents, sentinel events and patient complaints.
- We have strategies to reduce risks to patients, such as infections.
- We learn from things that go wrong in other hospitals.

Leadership

- We have commitment from the Board and the Chief Executive and expect senior clinical managers to be responsible for patient safety.
- We report on patient safety to our Quality and Safety Committee and the Board.

Review of clinical practice

- We review all major complications and deaths to see if anything could have been prevented and find ways to improve care (mortality and morbidity review).
- We measure our clinical performance and compare it to other hospitals.

Clinical practice based on evidence

- We based treatment on research evidence that it works. Our clinical practice guidelines (CPGs) are based on research and provide guidance for clinicians. Over 100 CPGs are available on our website. See www.thewomens.org.au
- We provide education, support and back up to junior medical staff and graduate nurses and midwives to support their clinical care.

Incident reporting

The key to patient safety is to have an open and fair culture which encourages staff to report and learn from all the things that go wrong or could have gone wrong and share this with other staff. If staff report smaller things that happen, or 'near misses', then we can identify any 'accidents waiting to happen' and fix them before there is an accident. This creates increased awareness of the need for vigilance on patient safety.

Figure 20 shows we have increased our incident reporting, which is what we wanted to do. Figure 21 shows that this increase has been in less serious incidents.

Figure 20. Clinical Incidents Reported

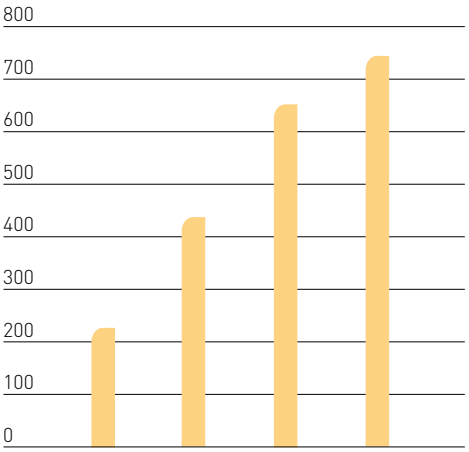
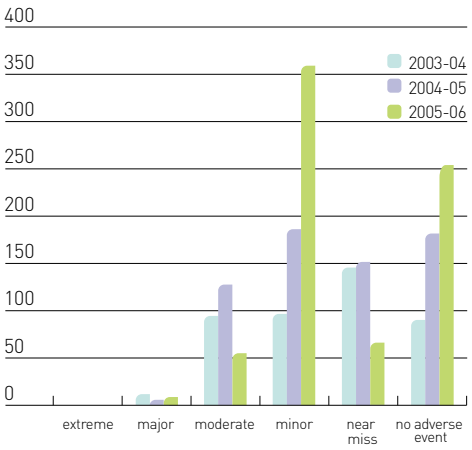


Figure 21. Clinical incidents by seriousness



Data source: Riskman

The top five reported groups of incidents in the last 12 months were medication errors, communication problems within the hospital, access (waiting, women not booked in the right clinic), delays in care, and problems with the medical record.

sentinel events: is a relatively infrequent event (as specified by DHS) that occurs independently of a patient's condition and typically reflects hospital systems and process deficiencies which results in unnecessary poor outcomes for patients

Examples of improvements from incident reporting include:

- Through incident reports and patient complaints, we identified a few women whose babies were born before they got back to the hospital, after having come to hospital early in labour and being advised to go home until labour was more established. In general, sending women home in early labour is appropriate, so long as all checks are fine. We needed to give women better information about when to come back, ring them at home to check how they were going, not give them pain killers to take home, and for the midwife in charge to make sure all the checks were done.
- Campaigns to make sure blood samples are correctly labelled at the woman's bedside.
- In-service education and development of a training DVD on education for doctors examining women who have been sexually assaulted.

How do we work out why something went wrong?

One way we do this is through root cause analysis, a method for reviewing very serious incidents to see what went wrong and look for ways to prevent it happening again. It is also used if an incident could have had serious results (a near miss). Root cause analysis is multidisciplinary, so we get different views and perspectives. This can include the patient, either by interviewing them or involving one of the hospital's consumer advocates.

There are some events where we will always do a root cause analysis, such as unexpected deaths, which are unusual in this hospital. There were no maternal deaths in 2005-06. We reviewed one death in gynaecology and one perinatal death, both with unexpected complications.

Sometimes, after a root cause analysis, we conclude that we could not have changed what happened, but it still helps us to reflect on our care and respond to questions from women and their relatives.

Over the past three years, most recommendations have related to improving communication, education, policy, improving safety barriers and documentation. Examples of improvements have been:

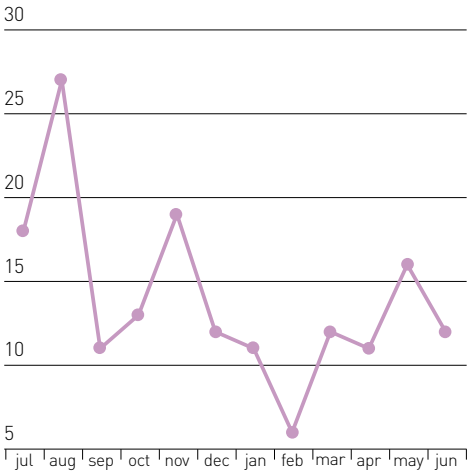
- Establishing a process for obstetric, midwifery and paediatric review of all babies born at term admitted to the neonatal intensive care unit or special care nursery.
- Improved communication between maternity and neonatal services.
- Changes to dressings for chemotherapy patients to prevent infection developing in hot weather.
- After a near miss, finding a way to make visually obvious the difference between drugs being given to contract the uterus after a baby is born and drugs given for pain relief.

We have identified from incidents and complaints that the way we communicate with women who have had traumatic births is important and needs improvement. One of our obstetricians has been awarded a Victorian Travelling Fellowship to develop a better service for these women.

Medication safety

Figure 22 shows medication incidents. There was no major harm to women from medication errors. Most errors were in administering, prescribing and documentation.

Figure 22. Number of medication incidents 2005-06



Data source: Riskman

The Medication Safety Committee, a multi-disciplinary group, meets monthly and reviews incidents. Pharmacists do daily ward rounds, check drug charts and advise on changes. They record these changes on palm pilots and report them to staff and the committee. This is one of our important safety mechanisms for medications. Pharmacists may then highlight particular high risk medications in our monthly Clinical Practice Review Newsletter.

An important improvement was neonatal services using the handover of information from one shift to the next to do a safety check of babies' drugs and ventilation.

National medication chart

The Women's is implementing the national medication chart. All Australian hospitals will use the same chart for prescribing and tracking a person's medication (drugs). This will improve patient safety as doctors and nurses don't have to do this differently in different hospitals. We are undertaking audits to make sure it works as intended. This provides an opportunity to further improve our management of medications.

Yvonne's story

I have been a midwife for over 20 years and more recently a lactation consultant as well. I love my work and have enjoyed caring for women throughout the birthing process and in the postnatal period. Five years ago, on night duty at the Women's, I was injured and suddenly unable to perform duties that had always been second nature to me.

The Women's gave me the opportunity to recover by allowing me to work in other positions. This gave me an opportunity to learn about other things and develop new skills. I did so many different things. But what was really important to me was that I was working.

Eventually I took a 'patient load', but with restrictions. It was becoming clear though that I would never fully recover and I realised I was no longer getting the same enjoyment and satisfaction from my work. It was time to rethink my future. The Women's offered a scholarship for diabetes education, so I applied and was offered a partial scholarship.

Being on 'Workcover' has been the single hardest thing to deal with in my career, something that I thought would never happen to me but to someone else. It is an emotional and physical roller coaster. My team leader was very supportive, as was the Workcover Officer who provided invaluable advocacy and support.

Now I am working three days a week as a Diabetes Nurse Educator; a role that is challenging, varied, interesting, and especially rewarding. On the other two days I am in the Outpatients Department working in the antenatal clinics. Now I am an important part of two teams. I still need to be careful but I have learnt to adapt.

Our safe hospital

Patient falls

There were 32 falls and faints reported in 2005 – the same as last year. One third of incidents were women fainting post delivery and anaesthetic. The highest risk area was the bathroom. This means we need to take care to escort women when they first go to the bathroom after giving birth. Apart from grazes and bruises, there was no serious harm to any women.

Although the majority of our patients are fit young women, we have a small but significant older population within cancer and gynaecological services at increased risk of injury from falls. In addition to our policy, we are developing a comprehensive strategy with staff education and training, which we believe we can further reduce the risk of falls in the hospital and give women the support they need to prevent falls at home.

Pressure ulcers

In the annual survey of Victorian hospitals, we had the sixth lowest rate of pressure ulcers. We have measures in place for patients at risk. We regard all our sick and premature babies as at risk and address this with pressure reducing mattresses, regular repositioning of babies, and careful monitoring of devices such as ventilation tubes in the nose. Our four pressure injuries were in premature babies and were superficial – redness of the skin or small abrasions and blisters.

Women undergoing complex treatment for cancer or gynaecological conditions may have other risk factors for skin injury. No pressure ulcers were found in the survey in this group. Use of an alternating pressure mattress for our most vulnerable patients is a key strategy to prevent pressure ulcers in women with limited mobility.

Hospital acquired infections

Our infection rates for neonatal, caesarean section and hysterectomy are reported on pages 27 and 40.

How the infection control team works

- The team identifies patients most at risk of infection – babies in the neonatal intensive care unit, cancer patients and women having surgery. The team collects data on infections in these groups and compares these to other hospitals nationally and internationally. This data is fed back to clinicians with recommendations about policies and procedures, skin antiseptics and antibiotics, equipment processing, etc.
- They look at research about ways to prevent infections and make sure that our practice reflects this.
- They review all aspects of the hospital where there are infection control issues, for example, sterilising equipment and managing infectious waste.
- They provide education for staff on infection control.
- They look after staff health, for example, vaccination of staff and preventing needle stick injuries.
- They support nurses and midwives who look after infection control issues in their departments, who meet and discuss infection control concerns and act as a resource for other staff.
- They conduct annual audits in clinical areas to measure compliance with infection control procedures. The results are fed back to the units showing the rate of compliance, comparison with the previous audit and areas for improvement.

Victorian Nosocomial (hospital acquired) Infection Surveillance System – VICNISS

VICNISS collects, analyses and compares infection data from metropolitan public hospitals. We submit data on neonatal blood stream infections, caesarean section, mastectomy and hysterectomy wounds. VICNISS reports back to us on how we compare with similar hospitals. There is research evidence that comparing infection rates this way is effective in reducing infections. See www.vicniss.org.au

Antibiotic resistant infections

Multi-antibiotic-resistant infections are uncommon at the Women's, but we now see strains of community acquired resistance. Over a nine-month period, there were six MRSA infections, only one of which may have occurred in hospital. Strict infection control precautions prevented transmission to other women. We control inappropriate antibiotic use, work to reduce all infections and keep urinary catheters in as short as possible. We do not have resistant infections in the cancer ward or the Neonatal Intensive Care Unit, where they are most dangerous.

Protecting our staff

Prevention and management of staff exposure to potential infections is an important part of infection control.

- We improved the collection of vaccination and infection history from new staff to make sure they receive appropriate vaccinations.
- We encourage staff to have an annual influenza vaccination so they are less likely to pass the flu on to patients and pregnant women. Compared to the state hospital average of 38%, 51% of Women's staff were vaccinated in 2006.

Our safe hospital

- Whooping cough (pertussis) is particularly dangerous to young babies especially those under six months. Babies may be infected from adults who have not been immunised or whose immunity has decreased over time, so we are vaccinating all staff in contact with pregnant women and babies.
- Staff who handle any sharp item used on a patient are at risk of acquiring viruses found in blood if these items pierce the skin or if they are splashed with blood or body fluid. As well as supporting staff, data is collected to determine how to reduce these risks and compared with other Victorian hospitals through the Victorian Blood Exposures Group (ViBES). New intravenous cannulae with automatic blunting devices have been introduced to protect staff from 'sharps' injury when inserting cannulae into patients. We have also surveyed medical staff about ways to reduce needle stick injuries in surgery.

Hand hygiene

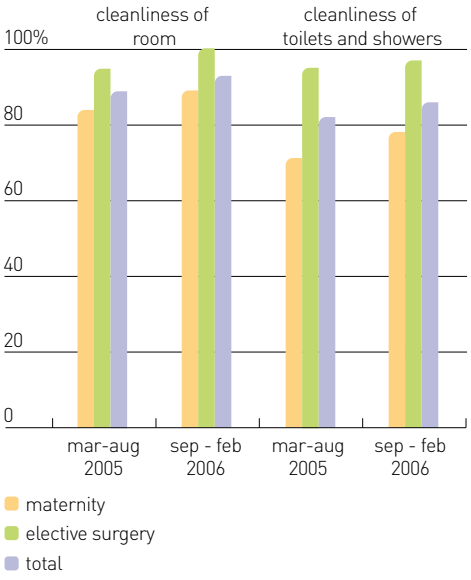
Making sure that staff have clean hands between patients is a key strategy to reduce the chance of infections being carried from one patient to another, particularly in high risk areas like the neonatal nurseries. We use every opportunity to highlight this issue and have been working on an audit tool to measure compliance that is easy to use to monitor this.

Having a clean hospital

We audit our cleaning standards against the cleaning standards for Victorian hospitals. Our combined score for our highest risk areas such as theatres was 92.8. The Victorian standard is 85.

The Victorian Patient Satisfaction Monitor asked women how satisfied they were with the cleanliness in the wards and bathrooms. Our results were not as good as last year. Figure 23 shows a big difference between maternity and gynaecology wards. The maternity wards were the busiest they had been in a decade. While we employed more midwives to cope with this at the time, we hadn't employed more cleaning staff.

Figure 23. Cleaning satisfaction comparison



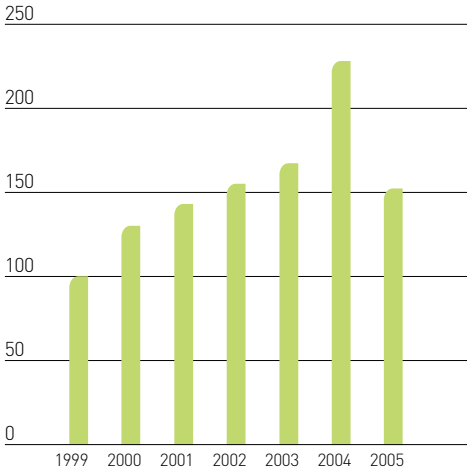
Looking after women who need high level care

The High Dependency Unit (HDU) provides care for women requiring complex nursing and medical skills, for example, cancer patients or women with severe bleeding. Admission to HDU may be planned or unplanned. Women come from within the hospital or transfer from other hospitals. Seven women were transferred to an Intensive Care Unit.

mastectomy: surgical removal of a breast

cannula: flexible tube inserted into a body cavity or blood vessel to deliver medication or drain fluid

Figure 24. Number of Admissions to the High Dependency Unit



This chart shows that admissions to HDU fell in 2005. They were high in 2004 partly because of Ovarian Hyper Stimulation Syndrome (OHSS) in women having fertility treatment. After action taken to address this by changing the protocol, as described in last year's report, there has only been one admission in the last year.

Safety for staff

We are committed to improving the health and safety of our staff. In 2005-06, we reduced our number of Workcover claims. Our insurance injury claims frequency rate, which is used to calculate our Workcover premium, has fallen over the last three years, thus reducing the insurance premiums we pay.

We are working with injured employee's doctors and physiotherapists about return to work plans. This means that modified duties can be discussed to get an injured employee back to work in their job quicker. Where necessary, we discuss a suitable new career. For the coming 12 months, we will extend this to employees with injuries or illnesses not sustained at work, but which affect their ability to work.

How we put this report together

In this section you can read about...

- How we used consumer feedback to improve the report
- The data we use
- How we are accountable for patient safety – clinical governance
- Distributing the report

How we put this report together

The Women's produces this Quality of Care Report to ensure our accountability for quality and safety, to provide consumers with information and to provide a framework to promote and improve quality and safety of care. This is our sixth report and the fourth in this format.

After our last report, we conducted focus groups with a mix of consumers and asked them what they thought about the report. They told us that the report was attractive but daunting to pick up and read, too crowded and the font too small. Once they started reading, women found that the report was written in a friendly, relaxed style and very interesting. *"I wanted to read more."... "I felt empowered".* Women were impressed with the honesty and transparency and the use of standards and indicators beyond what was mandatory. They were concerned however that the concepts and terms used could make it inaccessible to some women who use the hospital, *"women from my country wouldn't understand all those words".*

For us this meant that we should continue to value the type of information we published, that we had a good writing style, but that we needed to do more to invite women to read the report. We have made changes in the order of the report and have outlined why quality of care matters. Women said that they often read the stories first, so we have made more use of stories to convey information and photos to make the content more personalised. We explain the technical terms where they occur in the report. We have the report professionally designed to encourage women to pick up the report and enjoy reading it. This year we changed the design based on women's feedback.

Women from the focus groups and the Community Advisory Committee joined the report reference group and have helped with the ideas, themes, structure and text of the report.

Trusting the data

Where we can, we have published data that we submit to external organisations for comparison with other hospitals. We use data from a number of hospital data bases about our services. We use these to describe what the data shows over time.

Some reports we use are published, such as the Maternity Services Performance Indicators, www.health.vic.gov.au/maternitycare/; the Victorian Patient Satisfaction Monitor www.health.vic.gov.au/patsat

Being accountable

The type of clinical information we report here is what clinicians use to monitor and improve our clinical care, what we report to the hospital Board and to its Quality Committee.

At the Women's, there is a broad organisational and management responsibility for quality and safety of clinical care, with the Board, executive and clinical managers having responsibility for leadership on quality and safety of clinical care. We have a Quality and Safety Plan, which provides a framework for quality and safety activities across the hospital. Each clinical area includes this in the yearly operational plans. The clinical directors and managers are responsible for quality and safety in their areas of responsibility. The Clinical Governance Unit works closely with them.

For clinicians, it means accepting shared collective responsibility as well as individual responsibility for patient safety, being prepared to report incidents and contribute to learning and finding solutions, being alert for potential errors and clinical risks and communicating openly with consumers when things do go wrong.

We describe this as clinical governance.

Distribution of the report

We distribute the report to key community, consumer and women's health groups, to community health centres and GPs. We distribute the report in areas of the hospital where women are gathered or waiting. We also make the reports available to our staff.

We publish the report on our website www.thewomens.org.au

We do not translate the report, but prefer a distribution to key ethnic organisations in touch with ethnic communities and make sure we cover issues that matter to them.

Women who do not read English can contact the consumer advocates who will arrange an interpreter, if required, to discuss the report.

Additional copies can be obtained, telephone: 9344 2114.

Glossary of terms – what technical words mean

Figure 11 (page 20)

congenital abnormalities: babies who are born with abnormalities

antepartum haemorrhage: when a woman loses blood vaginally before the baby is born

hypoxic peripartum: when a baby does not get enough oxygen during labour

unexplained antepartum death: when a baby dies before birth and no reason can be found for the death

obstetric antecedent: where the cause of death is not related to the pregnancy

hypertension: high blood pressure

Table 5 (page 27)

cranial ultrasound: scan of the brain

intraventricular haemorrhage: is a bleed in the brain ventricles (cavities), babies less that 33 weeks are more prone to this because of immaturity – less severe bleeds may have no long term consequences

retinopathy: disease of the retina (back) of the eye

Table 8 (page 30)

dysplasia: alteration in the size, shape and organisation of cells which may lead to cancer

colposcopy: diagnostic assessment of the cervix to detect abnormal cells

histological: the study of cells under the microscope

Figure 13 (page 33)

chemotherapy: drugs given to a woman to treat cancer

toxicity: when drugs given to treat a condition cause a patient to become ill with side effects

arthralgia: aching in joints

myalgia: aching in muscles

peripheral neuropathy: numbness and tingling in the hands and feet

febrile neutropenia: temperature due to infection caused by a reduction in white blood cells which normally fight infection

Acknowledgements

The Women's Quality of Care Report 2005-06 was made possible by the invaluable contribution of over 70 staff members and consumers of the Women's, who contributed data, text, stories, photos and editing. Thanks to all contributors and to the RWH Quality and Safety Committee and the Community Advisory Committee on Women's Health.

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D06-111

此《醫護質量報告》(Quality of Care Report)是關於皇家婦女醫院改進婦女醫護的工作。如果您想了解此報告的信息，請致電消費者呼籲工作者(Consumer Advocate)，號碼9344 2351。如果您需要傳譯員的協助，請告訴我們，我們將在傳譯員的協助下給您回電。

Αυτή η έκθεση Ποιότητας Περίθαλψης (Quality of Care Report) σχετίζεται με τη δουλειά που κάνουμε στο Βασιλικό Νοσοκομείο Γυναικών (Royal Women's Hospital) για να βελτιώσουμε την περίθαλψη που παρέχουμε για γυναίκες. Αν θέλετε πληροφορίες γι' αυτή την έκθεση, παρακαλείστε να τηλεφωνήσετε στον/στη Συνήγορο Καταναλωτή (Consumer Advocate) στο 9344 2351. Πείτε μας αν χρειάζεστε διερμηνέα στη γλώσσα σας κι εμείς θα σας τηλεφωνήσουμε πίσω με διερμηνέα.

Questa relazione sulla qualità di assistenza (Quality Care Report) riguarda il lavoro compiuto all'ospedale Royal Women's per migliorare l'assistenza alle donne da noi offerta. Se desiderate ricevere informazioni su tale relazione, telefonate per cortesia al Tutelatore del consumatore (Consumer Advocate) al numero: 9344 2351. Diteci se avete bisogno di un interprete nella vostra lingua e vi richiameremo usando un interprete.

Bản Báo Cáo Chất Lượng Chăm Sóc này (Quality of Care Report) nói về công việc mà chúng tôi làm ở Bệnh Viện Phụ Nữ Hoàng Gia Melbourne (Royal Women's Hospital) nhằm cải tiến việc chăm sóc phụ nữ của bệnh viện. Nếu muốn biết thêm thông tin về báo cáo này, xin quí vị điện thoại cho Dịch Vụ Bênh Vực Người Tiêu Thụ (Consumer Advocate) qua số 9344 2351. Xin cho chúng tôi biết nếu quí vị cần thông ngôn nói ngôn ngữ quí vị và chúng tôi sẽ gọi lại cho quí vị qua thông ngôn viên.

Este informe sobre la Calidad de la Atención se refiere al trabajo que realizamos en el Hospital para Mujeres (Royal Women's Hospital) para mejorar la atención a las mujeres. Si usted quiere información sobre este informe, por favor llame al Defensor del Consumidor al teléfono 9344 2351. Díganos si necesita un intérprete en su idioma y le llamaremos de vuelta con uno.

Овај Извештај о квалитету неге се односи на наш рад у Royal Women's Hospital у циљу побољшања наше неге жена. Ако желите информације о овом извештају, молимо вас телефонирајте заступнику клијената (Consumer Advocate) на 9344 2351. Реците нам ако вам треба преводилац за ваш језик и ми ћемо вас назвати са њим.

Bu Bakım Kalitesi Raporu (Quality of Care Report) Kadın Hastanesinde (Royal Women's Hospital) kadınlara sunduğumuz bakımı daha da iyi hale getirmek için yaptığımız çalışmaları anlatmaktadır. Bu rapor hakkında bilgi isterseniz, lütfen 9344 2351 numaralı telefondan Tüketici Temsilcisini (Consumer Advocate) arayınız. Kendi dilinizde tercümana ihtiyaç duyuyorsanız, bize söyleyiniz. Tercümanla birlikte sizi geri arayacağız.

Warbixintan Tayada Daryeelka waxay ku saabsan tahay shaqada aan ka qabano Isbitaalka Royal Women's Hospital si aan kor ugu qaadno daryeelka haweenka. Haddii aad doonaysid macluumaad ku saabsan warbixintan, fadlan ka soo wac Qareenka Macaamiisha (Consumer Advocate) taleefoonka 9344 2351. Waxaad kaloo noo sheegtaa haddii aad u baahan tahay turjumaan luqaddaada ah anaga ayaa ku soo wacayna anagoo adeegsanayna turjumaan.

the women's
the royal women's hospital